THE TIME IS NOW FOR THE FIVE WISHES DOCUMENT IN TEXAS

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I. INTRODUCTION

My journey on the path of addressing end of life issues began a few years ago with a friend who became a client after being diagnosed with end stage lung cancer in her early forties. Her greatest battle at the end of life was with a physician who would not speak with her about palliative care, hospice, or the progression of her disease. Because her physician would only speak about the latest treatment, when attempting to address the legal issues regarding end of life, and the documents that could be helpful, she could not hear me. It was a process physically painful for her and mentally painful for me. After she died, I knew there had to be a better way to communicate with people about these issues and I needed to find the right words to do it.

Attorneys are on the front lines of having the difficult but necessary conversations about the end of life and assisting clients by guiding them through the process of preparing legal documentation to reflect their wishes and speaking with them about how to communicate their needs to their

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physicians.[1] What has been called the silver tsunami is occurring.[2] The 2013 U.S. Census Bureau estimated there were 44.7 million people 65 years and above.[3] Currently, 1 in 7 Americans is over 65 years of age; by 2060, 1 in 4 residents of the US will be over 65.[4] That would be about 98.2 million Senior Citizens and almost 20 million of those Americans will be over 85.[5]

Because healthcare status can change in an instant, all adults over the age of 18 need advanced care planning education.[6] Decisions should be made in advance of any catastrophic events.[7] Sudden injury or illness can unexpectedly sideline even the healthiest.[8] As my practice has grown in this field, poorly planned end of life decisions have left families feeling lost.[9]

Whether the youth or elder population, attorneys attempt to provide their clients with peace of mind through proper preparation, information, and execution of powers of attorney, including healthcare documents and wills.[10] Having the legal language and the medical language providing insight for families will make us better advocates for those we hope to serve with intelligence and compassion.[11]

When addressing unique needs for families navigating palliative care, hospice care, and various medical options at the end of life, this field of medicine and the legal community need a comprehensive tool that can provide better communication for better outcomes.[12] Practitioners need to overcome the hurdle of how to have difficult conversations about various medical ailments by recognizing there are better outcomes for patients and

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1. *See* Mary Rose Shelley, *Talking About the Taboo Topic of Death: State and Federal Limitations to Reach Informed Consent at the End of Life Through Advance Care Planning*, 65 DRAKE L. REV. 583, 584 (2017).

2. *See* Lloyd B. Potter & Nazrul Hoque, Office of the State Demographer, *Texas Population Projections, 2010 to 2050* (Nov. 2014), http://osd.texas.gov/Resources/Publications/2014/2014-ILProfectionBrief.pdf.

3. *Id.*

4. *Id.*

5. *Facts for Features: Older Americans Month May 2015*, U.S. CENSUS BUREAU (May 8, 2015), https://www.census.gov/newsroom/facts-for-features/2015/cb15-ff09.html.

6. *See* Janet L. Dolgin, *Dying Discourse: Contextualizing Advance Care Planning*, 34 QUINNIPIAC L. REV. 235, 283 (2016).

7. *See* Perelman School of Medicine at the University of Pennsylvania, *Two Out of Three U.S. Adults Have Not Yet Completed an Advanced Directive*, NEWSWISE (July 5, 2017), http://www.newswise.com/articles/two-out-of-three-u-s-adults-have-not-completed-an-advance-directive.

8. *See Advance Directives Overview*, NORTHWESTERN MEDICINE (2017), https://www.nm.org/patients-and-visitors/patient-rights-website-policies/advance-directives.

9. *See generally id.* (emphasizing the importance of advanced directives for both the patient and family).

10. *See Living Wills and Advance Directives for Medical Decisions*, MAYO CLINIC (Nov. 4, 2014), https://www.mayoclinic.org/healthy-lifestyle/consumer-health/in-depth/living-wills/art-20046303.

11. *See generally id.* (emphasizing the importance of planning ahead by making a comprehensive advance directive).

12. *See id.*

families at the end of life.[13] No one gets out of this life alive, but better endings are possible.[14]

In 2009, a clinical study out of Melbourne, Australia measured whether Advanced Care Planning had any effect upon the patients or their families.[15] The Abstract explained the following:

> **Interventions:** Participants were randomised to receive usual care or usual care plus facilitated advance care planning. Advance care planning aimed to assist patients to reflect on their goals, values, and beliefs; to consider future medical treatment preferences; to appoint a surrogate; and to document their wishes.
> **Main outcome measures:** The primary outcome was whether a patient's end of life wishes were known and respected. Other outcomes included patient and family satisfaction with hospital stay and levels of stress, anxiety, and depression in relatives of patients who died.
> **Results:** 154 of the 309 patients were randomised to advance care planning, 125 (81%) received advance care planning, and 108 (84%) expressed wishes or appointed a surrogate, or both. Of the 56 patients who died by six months, end of life wishes were much more likely to be known and followed in the intervention group (25/29, 86%) compared with the control group (8/27, 30%; $P < 0.001$). In the intervention group, family members of patients who died had significantly less stress (intervention 5, control 15; $P = 0.001$), anxiety (intervention 0, control 3; $P = 0.02$), and depression (intervention 0, control 5; $P = 0.002$) than those of the control patients. Patient and family satisfaction was higher in the intervention group.
> **Conclusions:** Advance care planning improves end of life care and patient and family satisfaction and reduces stress, anxiety, and depression in surviving relatives.[16]

Less stress, anxiety, and depression from advanced care planning are results to strive for in establishing policies and protocols that would continue to produce these outcomes.[17] Is there a tool currently available that can be used to continuously achieve such positive results?[18] Yes, and it's known as the

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13. Barbara A. Noah, *In Denial: The Role of Law in Preparing for Death*, 21 ELDER L. J. 1, 19 (2013).

14. *See id.*

15. Karen M. Detering, Andrew D. Hancock, Michael C. Reade & William Sylvester, *The Impact of Advance Care Planning on End of Life Care in Elderly Patients: Randomised Controlled Trial*, BRITISH MEDICAL JOURNAL (2010), www.bmj.com/content/340/bmj.c1345

16. *Id.*

17. *Id.*

18. *Id.*

Five Wishes document.[19] Accepted in forty-two states and interpreted in twenty-seven languages, the Five Wishes document answers the simple, yet complex question: how to talk about the end of life to address the needs of the patient/client and assist families during the end of life?[20] The time is now for Texas to adopt the Five Wishes document.[21]

II. WHAT IS THE FIVE WISHES DOCUMENT AND HOW WAS IT CREATED?

Originally introduced in 1996, the Five Wishes document began in Florida.[22] It combines a health care power of attorney with a living will and addresses matters of comfort care and spirituality.[23] Eventually, Five Wishes expanded as a national document in 1998, due to help from the American Bar Association's Commission on Law and Aging.[24] Five Wishes was supported by a grant from the Robert Wood Johnson Foundation, making original distribution possible.[25] Five Wishes now meets the proper legal requirements in forty-two states and the District of Columbia.[26] The remaining eight states, which include Alabama, Indiana, Kansas, New Hampshire, Ohio, Oregon, Texas, and Utah, require the attachment of a statutory form in order to use the Five Wishes document as a guide within that state.[27]

A. Wish 1

1. The Person I Want to Make Care Decisions for Me When I Can't

In Texas, the Medical Power of Attorney document governs the appointment of the health care agent.[28] The Texas Health and Safety Code, Chapter 166, Sections 166.163 and 166.164 provide for the Form of Disclosure Statement and the form of Medical Power of Attorney.[29] Beginning January 1, 2018, the Texas Disclosure Statement and the Medical Power of Attorney Form are combined into a singular document.[30]

In comparing the two forms, the Texas Medical Power of Attorney (the version effective in 2018) and Wish 1, the analysis will focus on their differences and what has prevented Five Wishes from being accepted as the

19. *Five Wishes*, AGING WITH DIGNITY, 1, 4–5 (2011), https://agingwithdignity.org/docs/default-source/default-document-library/product-samples/fwsample.pdf?sfvrsn=2.
20. *See id.*
21. *See id.*
22. *See Five Wishes*, WIKIPEDIA, (Oct. 23, 2017), https://en.wikipedia.org/wiki/Five_Wishes.
23. *See id.*
24. *See id.*
25. *See id.*
26. *See id.*
27. *See id.*
28. TEX. HEALTH & SAFETY CODE ANN. §§ 166.163–.164 (West 2014).
29. *See id.*
30. *See id*.

Texas version of the Medical Power of Attorney.[31] The statutory form must be used—the Texas Real Estate, Probate, and Trust Law Section's attempt to make the form permissive rather than mandatory was rejected due to opposition from the medical industry.[32]

As of January 1, 2018, the Texas document for the Health Care Agent is as follows:

MEDICAL POWER OF ATTORNEY

DESIGNATION OF HEALTH CARE AGENT.

I, _____ (insert your name) appoint:

Name: _____

Address: _____

Phone: _____

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. 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.

LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

_____

DESIGNATION OF ALTERNATE AGENT.

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved, annulled, or declared void unless this document provides otherwise.).

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

A. First Alternate Agent

Name: _____

Address: _____

Phone: _____

B. Second Alternate Agent

Name: _____

Address: _____

Phone: _____

The original of this document is kept at

_____

The following individuals or institutions have signed copies:

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31. *See id*.

32. *See infra* notes 41–46.

Name: _____
Address: _____
Name: _____
Address: _____

DURATION.

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

(IF APPLICABLE) This power of attorney ends on the following date: _____

PRIOR DESIGNATIONS REVOKED.

I revoke any prior medical power of attorney.

DISCLOSURE STATEMENT.

THIS MEDICAL POWER OF ATTORNEY IS AN IMPORTANT LEGAL DOCUMENT. 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 unable to make the decisions for 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 is effective 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 if you were able to make health care decisions for yourself.

It is important that you discuss this document with your physician or other health care provider before you sign the document to ensure 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 facility, or residential care facility, 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 allow a person to serve as 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 that you intend to have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Once you have signed this document, you have the right to make health care decisions for yourself as long as you are able to make those decisions, 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. Unless you state otherwise in this document, your appointment of a spouse is revoked if your marriage is dissolved, annulled, or declared void.

This document may not be changed or modified. If you want to make changes in this document, you must execute a new medical power of attorney.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. If you designate an alternate agent, the alternate agent has the same authority as the agent 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 medical power of attorney is executed, has a claim against any part of your estate after your death.

By signing below, I acknowledge that I have read and understand the information contained in the above disclosure statement.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. YOU MAY SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC OR YOU MAY SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.)

SIGNATURE ACKNOWLEDGED BEFORE NOTARY

I sign my name to this medical power of attorney on ____ day of _____ (month, year) at _____ (City and State).

_____

(Signature)

_____

(Print Name)

State of Texas
County of _____
This instrument was acknowledged before me on _____(date) by _____ (name of person acknowledging).

_____

NOTARY PUBLIC, State of Texas
Notary's printed name: _____
My commission expires: _____

OR

SIGNATURE IN PRESENCE OF TWO COMPETENT ADULT WITNESSES

I sign my name to this medical power of attorney on ____ day of _____ (month, year) at _____ (City and State).

_____

(Signature)

_____

(Print Name)

STATEMENT OF FIRST WITNESS.

I am not the person appointed as agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending

physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Signature: _____

Print Name: _____ Date: _____

Address: _____

SIGNATURE OF SECOND WITNESS.

Signature: _____

Print Name: _____ Date: _____

Address: _____[33]

Wish 1 of the Five Wishes Document is the health care agent appointment provision of the document.[34] In addition to the appointment powers authorizing an agent to act on behalf of the principal for health care decisions, Wish 1 provides, in understandable language, information to the medical power of attorney about the type of decisions they may have to contemplate on the patient's behalf such as: authorize or refuse to authorize any medication or procedure needed to help with pain, make choices for the patient about my medical care or services, like tests, medicine or surgery, and even donate useable organs or tissues as allowed by law.[35] The document encourages conversation on a breadth of medical topics important to the patient that the Texas version simply fails to address.[36] This difference between the documents is the key to understanding the importance of increased comprehension between the principal (the patient) and the agent or the medical power of attorney.[37] Wish 1 addresses the various decisions that the agent may face on behalf of the principal.[38] The Texas document provides consent of the principal to the agent, but no further information on the contents of those decisions is discussed.[39] The Texas Medical Power of Attorney provides for the following:

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33. 12 *Texas Forms Legal & Business* § 24: 108, 109 (2017).

34. *Five Wishes*, AGING WITH DIGNITY, 1, 4–5 (2011), https://agingwithdignity.org/docs/default-source/default-document-library/product-samples/fwsample.pdf?sfvrsn=2.

35. *Id.*

36. *Compare id*, with 12 *Texas Forms Legal & Business* § 24: 108 (2017).

37. *Compare id*, with 12 *Texas Forms Legal & Business* § 24: 108 (2017) (showing apparent differences between the two forms).

38. *See Five Wishes*, AGING WITH DIGNITY, 1, 4–5 (2011), https://agingwithdignity.org/docs/default-source/default-document-library/product-samples/fwsample.pdf?sfvrsn=2.

39. *See* 12 *Texas Forms Legal & Business* § 24: 108 (2017).

> 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.[40]

The phrase "medical treatment" does not clarify the types of decisions the agent may face and there is no benefit to such vagueness when granting this decision-making authority to the patient's medical power of attorney.[41]

Contrary to the Texas limited consent to medical treatment language, in addition to the information provided to the agent stated above, Wish 1 also allows for the agent to "interpret any instructions I have given in this form or given in other discussions, according to my Health Care Agent's understanding of my wishes and values."[42] Furthermore, it lists the following: make the decision to request, take away, or not give medical treatments, including artificially provided food and water, and any other treatments to keep me alive; see and approve release of my medical records and personal files, if I need to sign my name to get any of these files and my Health Care Agent can sign it for me; and take any legal action needed to carry out my wishes.[43]

The expansive explanation of the authority provided to the agent under Five Wishes provides clarity and guidance to the agent.[44] The increased understanding provided regarding their important role ensures the patient will feel more confident that the agent will follow their wishes.[45]

B. Wish 2

1. My Wish for the Kind of Medical Treatment I Want or Don't Want

This portion of the Five Wishes document relates to multiple documents in Texas law.[46] The Texas Advance Directives allows a Texas patient to control what medical treatment they prefer at the end of life.[47] It becomes effective in limited circumstances: when the patient is in a hospital setting, a

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40. *Id.*
41. *See id.*
42. *Five Wishes*, AGING WITH DIGNITY, 4–5 (2011), https://agingwithdignity.org/docs/default-source/default-document-library/product-samples/fwsample.pdf?sfvrsn=2.
43. *Id.*
44. *See id.*
45. *See id.*
46. *See* TEX. HEALTH & SAFETY CODE ANN. § 166.001 (West 2017); TEX. HEALTH & SAFETY CODE ANN. § 166.205 (West 2018) (effective April 1, 2018).
47. *See* TEX. HEALTH & SAFETY CODE ANN. § 166.033 (West 2017).

physician has qualified the patient as being at the end of life, the patient is on machines maintaining their breathing, and the patient can no longer communicate in any effective manner.[48] After those determinations have been met, the medical staff will seek guidance from an Advance Directive if one has been provided by the patient.[49] At that point in time, the document controls what the next steps are in managing the patient care.[50] The Texas Advance Directives allows the patient to choose how they wish to be treated if they are dying from a terminal or an irreversible condition.[51] Because certain definitions are critical to understanding this area of law, clarification is needed.[52] Under the Texas Advance Directive, a terminal condition is defined as:

> . . . [A]n incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care. A patient who has been admitted to a program under which the person receives hospice services provided by a home and community support services agency licensed under Chapter 142 is presumed to have a terminal condition for purposes of this chapter.[53]

According to the Health and Safety Code:

> "Irreversible Condition" means a condition, injury, or illness: (A) that may be treated but is never cured or eliminated; (B) that leaves a person unable to care for or make decisions for the person's own self; and (C) that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.[54]

The Texas Advance Directives takes the following statutory form:

DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES

Instructions for completing this document:

This is an important legal document known as an Advance Directive. 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

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48. *Id.*
49. *Id.*
50. *Id.*
51. TEX. HEALTH & SAFETY CODE ANN. § 166.002(9) (West 2015); TEX. HEALTH & SAFETY CODE ANN. § 166.002 (13) (West 2015).
52. TEX. HEALTH & SAFETY CODE ANN. § 166.002(9); TEX. HEALTH & SAFETY CODE ANN. § 166.002 (13).
53. TEX. HEALTH & SAFETY CODE ANN. § 166.002(13).
54. TEX. HEALTH & SAFETY CODE ANN. § 166.002.

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 your advance directive. 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 your directive 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 advance directive, Texas law provides for two other types of directives that can be important during a serious illness. These are the Medical Power of Attorney and the Out-of-Hospital Do-Not-Resuscitate Order. You may wish to discuss these 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.

DIRECTIVE

I, _____, 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 or treatment 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:

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:

_____ 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

_____ I request that I be kept alive in this terminal condition using available life-sustaining treatment.

(THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

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:

_____ 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

_____ I request that I be kept alive in this terminal condition using available life-sustaining treatment.

(THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)
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 artificially administered nutrition and hydration, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.)

_____
_____
_____

After signing this directive, 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 I do not have a Medical Power of Attorney, and I am unable to make my wishes known, I designate the following person(s) to make health care or treatment decisions with my physician compatible with my personal values:
1. _____
2. _____

(If a Medical Power of Attorney has been executed, then an agent already has been named and you should not list additional names in this document.).

If the above persons are not available, or if I have not designated a spokesperson, I understand that a spokesperson will be chosen for me following standards specified in the laws of Texas. 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.
Signed _____ Date _____ City, County, State of Residence _____

Two competent adult witnesses must sign below, acknowledging the signature of the declarant. The witness designated as Witness 1 may not be a person designated to make a health care or treatment decision for the patient and may not be related to the patient by blood or marriage. This witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. This witness may not be the attending physician or an employee of the attending physician. If this witness is an employee of a health care facility in which the patient is being cared for, this witness may not be involved in providing direct patient care to the patient. This witness may not be an officer, director, partner, or business office employee of a health care facility in which the patient is being cared for or of any parent organization of the health care facility.
Witness 1 _____ Witness 2 _____

Definitions:
"Artificially administered 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 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 artificially administered nutrition and hydration. 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.[55]

55. TEX. HEALTH & SAFETY CODE ANN. § 166.033 (West 2015).

Wish 2 in the Five Wishes document is a more expansive discussion on end of life treatments.[56] More than just initializing choices on the Texas form, Wish 2 addresses the issue of providing dignity at the time of death and that also includes the patient's understanding of life support.[57] According to Wish 2,

> Life-support treatment means any medical procedure, device or medications to keep me alive. Life-support treatment includes: medical devices put in me to help me breathe; food and water supplied by medical device (tube feeding); cardiopulmonary resuscitation (CPR); major surgery; blood transfusions; dialysis; antibiotics; and anything else meant to keep me alive. If I wish to limit the meaning of life support treatment because of my religious or personal beliefs, I write this limitation in the space below. I do this to make very clear what I want and under what conditions.[58]

Additionally, Wish 2 recognizes varied physical conditions at the end of life: "Close to Death," "In a Coma and Not Expected to Wake Up or Recover," "Permanent and Severe Brain Damage and Not Expected to Recover," and "In Another Condition Under Which I Do Not Wish to Be Kept Alive."[59] This patient-centered approach addresses the needs of the patient and more purposefully guides the health care agent with increased instructions clarifying the patient's needs when they are facing a difficult and complicated exit from life.[60]

When pertaining to the specific issue of do not resuscitate (DNR) orders and cardiopulmonary resuscitation (CPR), Texas recently passed a new statute effective April 1, 2018.[61]

A BILL TO BE ENTITLED AN ACT relating to general procedures and requirements for do-not-resuscitate orders. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subchapter A, Chapter 166, Health and Safety Code, is amended by adding Section 166.012 to read as follows: Sec. 166.012. GENERAL PROCEDURES AND REQUIREMENTS FOR DO-NOT-RESUSCITATE ORDERS.

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56. *Five Wishes*, AGING WITH DIGNITY, 1, 6 (2011), https://agingwithdignity.org/docs/default-source/default-document-library/product-samples/fwsample.pdf?sfvrsn=2.

57. TEX. HEALTH & SAFETY CODE ANN. § 166.033 (West 2015).

58. *Five Wishes*, AGING WITH DIGNITY, 1, 4–5 (2011), https://agingwithdignity.org/docs/default-source/default-document-library/product-samples/fwsample.pdf?sfvrsn=2.

59. *Id.* at 7.

60. *See id.* at 2.

61. H.B. 2063, 85th Leg., Reg. Sess. (Tex. 2017).

(a) In this section, "DNR order" means an order instructing a health care professional not to attempt cardiopulmonary resuscitation or other life-sustaining treatment on a patient whose circulatory or respiratory function ceases.

(b) This section applies to a DNR order used in a health care facility, including a hospital or an assisted living facility, or in hospice settings, including hospice services provided by a home and community support services agency. This section does not apply to an out-of-hospital DNR order as defined by Section 166.081.

(c) A DNR order issued for a patient is valid only if the order:

(1) is issued in compliance with:

(A) the written directions of a patient who was competent at the time the patient wrote the directions;

(B) the oral directions of a competent patient delivered to or observed by two competent adult witnesses, at least one of whom must be a person not listed under Section 166.003(2);

(C) the directions in an advance directive enforceable under Section 166.005 or executed in accordance with Section 166.032, 166.034, or 166.035;

(D) the directions of a patient's legal guardian or agent under a medical power of attorney acting in accordance with Subchapter D; or

(E) a treatment decision made in accordance with Section 166.039; or

(2) is not contrary to the directions of a patient who was competent at the time the patient conveyed the directions and, in the reasonable medical judgment of the patient's attending physician:

(A) the patient's death is imminent, regardless of the provision of cardiopulmonary resuscitation; and

(B) the DNR order is medically appropriate.

(d) If an individual described by Section 166.039(b)(1), (2), or (3) arrives at the facility and notifies the facility of the individual's arrival after a DNR order is issued under Subsection (c)(2), the order must be disclosed to the individual in accordance with the priority established under Section 166.039(b).

(e) The facility may satisfy the notice requirement under Subsection (d) by notifying one person in accordance with the priority established under Section 166.039(b). The facility is not required to notify additional persons beyond the first person notified.

(f) A DNR order takes effect at the time the order is issued, provided the order is placed in the patient's medical record as soon as practicable.

(g) On admission to a health care facility or on initial provision of hospice services, as applicable, the facility or service provider shall provide to the patient or person authorized to make treatment decisions on behalf of

the patient notice of the policies of the facility or service provider regarding the rights of the patient and person authorized to make treatment decisions on behalf of the patient under this section.

SECTION 2. The executive commissioner of the Health and Human Services Commission shall adopt rules necessary to implement Section 166.012, Health and Safety Code, as added by this Act, as soon as practicable after the effective date of this Act.

SECTION 3. Section 166.012, Health and Safety Code, as added by this Act, applies only to a do-not-resuscitate order issued on or after the effective date of this Act.

SECTION 4. This Act takes effect April 1, 2018.[62]

Robert L. Fine, testifying on behalf of the Texas Hospital Association and Baylor Scott and White Health, made clear that this legislation needed further discussion and provided the following testimony:

> This bill will do more harm than good. I have been told the intent of this bill is to prohibit secret DNAR orders. I am personally unaware of any health care organization that allows such orders and BSWH prohibits 'secret' DNAR orders. If such orders have in fact happened, they should not, but I believe we can collectively discover less harmful ways to deal with that. SB11/HB2063 will be logistically difficult to comply with, and because of that, the easiest action for a physician is to leave every patient as a full code patient—the default status for all hospital patients unless ordered otherwise. This will inevitably lead to a significantly greater number of CPR attempts with concomitant worse overall patient outcomes including increased physical, emotional, spiritual, and financial suffering.[63]

Dr. Fine provided a review of how full codes have affected patient outcomes: the largest study to date involved a 10 year nationwide review involving a 20% random sample from 1100 hospitals across forty-four states totaling 813,493 attempted CPRs.[64] Over the 10 years of the study, as the percent of patients undergoing attempts at CPR increased by 31.8%, the percentage of patients discharged home decreased by 34.6%, while the number of brain injuries post CPR increased by 37.7%, and discharge to nursing facilities, long term care and hospices increased by 46%.[65] According to the data, although CPR was being attempted more frequently, the outcomes from a patient centered perspective were worse, unless one believes that patients

62. S.B. 80, 85th Leg., Reg. Sess. (Tex. 2017).

63. Robert L. Fine, Office of Clinical Ethics and Supportive Palliative Care, Baylor Scott and White Hospital, Testimony for Texas Legislature Special Session, Senate Health and Human Services Committee on Senate Bill 11 and 80. (July 21, 2017).

64. Hadiza S. Kazaure, Sanziana A Roman, & Julie A. Sosa, *Epidemiology and Outcomes of In-Hospital Cardiopulmonary Resuscitation in the United States, 2000–2009*, 84 RESUSCITATION 1255, 1255–60 (2016).

65. *Id.*

undergoing CPR desire brain injury and discharge to another medical setting.[66] In concluding his testimony, Dr. Fine clarified, "My colleagues and I across BSWH believe that SB11/HB2063 will lead to more frequent attempts at CPR and will sadly lead to worse outcomes such as those listed above."[67]

The Texas Hospital Association was not alone in its opposition to the legislation.[68] Ray Callas, M.D., testified on behalf of the Texas Medical Association in opposition to provisions of the legislation that might operate to limit the physician's judgment on when to use CPR.[69] Despite the legislative loss and efforts by the medical community, Dr. Callas's statement emphasized the need for more informed patients regarding the medical options and what happens at the end of life:

> When patients are dying due to the terminal stages of disease or the expected effects of advanced age, sometimes the best possible medical care is to take measures to relieve suffering but allow a natural death. Our goal should be to encourage and educate patients to use advance directives. The medical and legal professions should work together to develop new and better pathways for patients to communicate their own wishes.[70]

C. Wishes 3, 4, and 5

1. My Wish for How Comfortable I Want to Be, How I Want People to Treat Me and for What I Want My Loved Ones to Know

Texas statutes do not address the issue of comfort and dignity for the patient.[71] Rather, the Texas directives solely provide that a patient gives consent to treatment or the withholding of treatment without any understanding of what the patient's thoughts are about any of the potential medical interventions that may occur near the end of life.[72]

Wish 3 has the patient cross out and select their choices when it comes to the area of comfort care.[73] When considering the level of comfort desired at the end of life, some of the methods of care to select are the following:

> I wish to be kept fresh and clean at all times. . .I wish to have a cool moist cloth put on my head if I have a fever. . .I wish to have my favorite music

66. *Id.*

67. *See supra* note 72.

68. *See* Ray Callas, *Help Physicians Honor Patients' End-of-Life Wishes*, TEX. MED. ASS'N (Apr. 5, 2017), https://www.texmed.org/Template.aspx?id=44569.

69. *See id.*

70. *Id.*

71. *See* TEX. HEALTH AND SAFETY CODE ANN. §§ 166.032–.033 (West 2015).

72. *See* TEX. HEALTH AND SAFETY CODE ANN. §§ 166.032–.033 (West 2015).

73. *Five Wishes*, AGING WITH DIGNITY, 8 (2011), https://agingwithdignity.org/docs/default-source/default-document-library/product-samples/fwsample.pdf?sfvrsn=2.

> played when possible until my time of death. . .[and] I wish to know about options for hospice care to provide medical, emotional and spiritual care for me and my loved ones.[74]

Wish 4 allows the patient to express how they want to be treated at the end of life.[75] Some of the statements as a part of Wish 4 assist the agent in clearly understanding the needs of the patient in their final days. The patient has multiple choices in this section, but may select some of the following:

> I want to die in my home, if that can be done. . .I wish to have pictures of my loved ones in my room, near my bed. . .I wish to be cared for with kindness and cheerfulness. . .[and] not sadness, and I wish to have my hand held and to be talked to when possible, even if I don't seem to respond to the voice or touch of others.[76]

Wish 5 addresses what a patient wants their loved ones to know about their final wishes and some plans and thoughts about the funeral of the patient.[77] In addition to going more in depth about a patient's spiritual thoughts, this section provides a patient's loved ones' detailed information regarding the handling of the body or remains.[78] It also asks questions about how the patient may want to be remembered.[79]

Comfort care, how to treat and act around a patient at the end of life, and talking about the patient's wishes, has shown to extend the patient's life.[80] Studies have shown that palliative and hospice care resulted in increased life expectancy for oncology patients.[81] A 2010 study in the New England Journal of Medicine found patients with non-small-cell lung cancer lived an average of nearly two months longer if they received palliative care.[82] An earlier study found patients with the most common terminal diagnoses lived twenty to sixty-nine days longer when they received hospice care.[83]

According to Shirisha Reddy, M.D., a cardiologist and a medical director at Aetna:

> Reducing pain and symptoms allows you to continue the activities that are important to you longer, which helps people to remain purposeful in life-this

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74. *Id.*
75. *Id.*
76. *Id.*
77. *Id.* at 9.
78. *Id.*
79. *Id.*
80. *See infra* note 88.
81. *See id.*
82. Jennifer Temel, *Early Palliative Care for Patients with Metastic Non-Small Cell Lung Cancer*, 363 NEW ENG. J. MED. 733, 733 (2010).
83. J. Don Schumer, *Editorial*, 28 J. OF PAIN AND SYMPTOM MANAGEMENT 193, 193 (2004), http://www.jpsmjournal.com/article/S0885-3924(04)00277-5/pdf.

> is a huge psychological benefit. There's the emotional benefit of taking control of your destiny; choosing to plan for your death and choosing to die on your own terms and reaching out to get some finality and closure. These things make people live longer.[84]

III. THE DEVELOPMENT OF ADVANCED CARE PLANNING CONVERSATIONS

Effective January 1, 2016, the Centers for Medicare and Medicaid Services (CMS) pay for voluntary Advance Care Planning under the Medicare Physician Fee Schedule (MPFS) and the Hospital Outpatient Prospective Payment System (OPPS).[85] Having Advanced Care Planning as a reimbursable expense acknowledges the growing importance of this need in the medical community and for patients and their families.[86] Not only is the physician/patient visit reimbursable as an initial conversation, but billing now allows for an additional thirty minutes of Advanced Care Planning discussion to be covered by CMS.[87] The billing, Current Procedural Terminology (CPT), codes are as follows: 99497—Advanced Care Planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first thirty minutes, face-to-face with the patient, family member(s), and/or surrogate, and 99498—Advanced Care Planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional.[88] Because physicians are being reimbursed to discuss Advance Care Planning and the statutory forms governing them, attorneys and physicians need to be able to communicate using documents that allow for a common understanding of what the patient is facing.[89] The current consent forms in Texas are insufficient in ensuring a patient or client is on the same page with their attorney or their physician while implementing advance care planning.[90] The clarifying language of Five Wishes on a variety of health

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84. *Palliative Care Can Improve Quality of Life, Survival for Cancer Patients*, News and Analysis, AETNA (Feb. 9, 2017), https://news.aetna.com/2017/02/palliative-care-can-improve-quality-of-life-survival-for-cancer-patients.

85. 42 C.F.R. § 489.1 (2015).

86. *See id.*

87. *Id.*

88. *See* 42 C.F.R. §§ 405, 410, 411, 414, 425, 496 (2015).

89. *See supra* note 91.

90. *Compare* TEX. HEALTH & SAFETY CODE ANN. § 166.163, *and* TEX. HEALTH & SAFETY CODE ANN. § 166.164, *with Five Wishes*, AGING WITH DIGNITY (2011), https://agingwithdignity.org/docs/default-source/default-document-library/product-samples/fwsample.pdf?sfvrsn=2 (showing the difference between Texas forms and the Five Wishes form).

treatment options assists all conversations in understanding what treatments may be preferred at the end of life.[91]

Now that physicians and medical professionals can be reimbursed for speaking about Advanced Care Planning, how do they know what to say?[92] End of life conversations are difficult.[93] In recognizing the lack of education and training on end of life issues, the United States Congress seeks to pass legislation addressing this issue, known as the Palliative Care and Hospice Education and Training Act (PCHETA).[94] On March 22, 2017, Senator Tammy Baldwin and Representative Eliot Engel both introduced the bill, known as PCHETA, under S.693 in the Senate and H.R. 1676 in the House of Representatives.[95] Currently, 29 Senators and 253 Representatives have cosponsored the bill.[96] The official website for United States federal legislative information summarizes PCHETA as follows:

> This bill amends the Public Health Service Act to require the Department of Health and Human Services (HHS) to provide support for Palliative Care and Hospice Education Centers. These centers must improve the training of health professionals in palliative care and establish traineeships for individuals preparing for advanced education nursing degrees, social work degrees, or advanced degrees in physician assistant studies in palliative care. HHS may provide support to schools of medicine, schools of osteopathic medicine, teaching hospitals, and graduate medical education programs for training physicians who plan to teach palliative medicine.
>
> HHS must: (1) provide Palliative Medicine and Hospice Academic Career Awards to individuals to promote their career development; (2) support entities that operate a Palliative Care and Hospice Education Center; (3) support advanced practice nurses, social workers, physician assistants, pharmacists, chaplains, or students of psychology pursuing an advanced degree in palliative care or related fields; and (4) award grants to schools of nursing, health care facilities, or programs leading to certification as a nurse assistant to train individuals in providing palliative care.
>
> The Agency for Healthcare Research and Quality must provide for a national education and awareness campaign to inform patients, families, and health professionals about the benefits of palliative care.

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91. *See Five Wishes*, AGING WITH DIGNITY, (2011), https://agingwithdignity.org/docs/default-source/default-document-library/product-samples/fwsample.pdf?sfvrsn=2.

92. HOSPICE FOUND. OF AM., *Starting the Conversation*, https://hospicefoundation.org/Hospice-Care/Starting-the-Conversation (last visited Oct. 23, 2017).

93. *Id*.

94. Palliative and Hospice Education and Training Act, S.693, 115th Cong. (2017); Palliative and Hospice Education and Training Act, H.R. 1676, 115th Cong. (2017).

95. Palliative and Hospice Education and Training Act, S.693, 115th Cong. (2017), https://www.congress.gov/bill/115th-congress/senate-bill/693; Palliative and Hospice Education and Training Act, H.R. 1676, 115th Cong. (2017), https://www.congress.gov/bill/115th-congress/house-bill/1676.

96. Palliative and Hospice Education and Training Act, S.693, 115th Cong. (2017), https://www.congress.gov/bill/115th-congress/senate-bill/693/cosponsors; Palliative and Hospice Education and Training Act, H.R. 1676, 115th Cong. (2017), https://www.congress.gov/bill/115th-congress/house-bill/1676/cosponsors.

> The National Institutes of Health must expand national research programs in palliative care.[97]

Importantly, PCHETA distinguishes between palliative care and hospice care, which are commonly misunderstood.[98] In the proposed legislation, Congress makes the following findings:

> (1) Palliative care is interdisciplinary, patient- and family-centered health care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness, whatever the diagnosis. The goal of palliative care is to relieve suffering and improve quality of life for both patients and their families. Palliative care is provided by a team of doctors, nurses, social workers, physician assistants, chaplains, and other specialists who work with a patient's other health care providers to provide an extra layer of support, including assistance with difficult medical decisionmaking [sic] and coordination of care among specialists. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment. Palliative care is not dependent on a life-limiting prognosis and may actually help an individual recover from illness by relieving symptoms, such as pain, anxiety, or loss of appetite, while undergoing sometimes difficult medical treatments or procedures, such as surgery or chemotherapy.
>
> (2) Hospice is palliative care for patients in their last year of life. Considered the model for quality compassionate care for individuals facing a life-limiting illness, hospice provides expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. In most cases, care is provided in the patient's home but may also be provided in freestanding hospice centers, hospitals, nursing homes, and other long-term care facilities. In 2014, an estimated 1,600,000 to 1,700,000 patients received services from hospice, including non-Medicare beneficiaries. Nearly 48 percent of all Medicare decedents in 2014 received care from a hospice program. Hospice is a covered benefit under the Medicare program. There were 4,025 Medicare-certified hospices serving more than 1,300,000 Medicare beneficiaries in 2014.[99]

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97. Palliative and Hospice Education and Training Act, S.693, 115th Cong. (2017), https://www.congress.gov/bill/115th-congress/senate-bill/693; Palliative and Hospice Education and Training Act, H.R. 1676, 115th Cong. (2017), https://www.congress.gov/bill/115th-congress/house-bill/1676.

98. Palliative and Hospice Education and Training Act, S.693, 115th Cong. (2017), https://www.congress.gov/bill/115th-congress/senate-bill/693; Palliative and Hospice Education and Training Act, H.R. 1676, 115th Cong. (2017), https://www.congress.gov/bill/115th-congress/house-bill/1676.

99. Palliative and Hospice Education and Training Act, S.693, 115th Cong. (2017), https://www.congress.gov/bill/115th-congress/senate-bill/693; Palliative and Hospice Education and Training Act, H.R. 1676, 115th Cong. (2017), https://www.congress.gov/bill/115th-congress/house-bill/1676.

In other words, palliative care can be provided in any stage of illness while hospice care is considered palliative care at the end of life.[100] Knowing how to address patients and clients in all stages of their lives makes us better servants of our clients' needs.[101]

On a federal level, the U.S. government has provided for advanced care planning discussions between physicians and their patients as a billable expense under CMS and there is pending legislation increasing the education and training of physicians and ancillary health professionals regarding palliative and hospice care education and training.[102]

On a state level, the Texas Medical Power of Attorney and Directive to Physicians and Family or Surrogates documents, fail to speak in a level of language readily understandable to Texas patients and those who need to understand their information the most, their decisionmakers. [103]

Moving forward on both fronts with improved education and more detailed documents that clarify and define the wishes of patients are needed to provide families better outcomes at the end of life.[104]

This is about dignity and respect for the human condition at all stages of life.[105] Difficult conversations can be made easier by utilizing the Five Wishes document to guide us when needing to clarify with our loved ones what our wishes for medical treatment and comfort care might be before the need for it actually arises.[106]

Nothing can change the path that my friend went down towards the end of her life.[107] Her physician did not have the right words to address all of the personal and physical needs during her last stages of life and neither did I.[108] The end was incredibly difficult and not one to wish on anyone, but the legal field has a valuable tool in the Five Wishes document to not only markedly improve communications between a patient, their physicians, and their loved ones, but can prevent misunderstandings as well and may prevent such unfortunate endings.[109] Five Wishes provides the language needed to

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100. *See* Palliative and Hospice Education and Training Act, S.693, 115th Cong. (2017), https://www.congress.gov/bill/115th-congress/senate-bill/693; Palliative and Hospice Education and Training Act, H.R. 1676, 115th Cong. (2017), https://www.congress.gov/bill/115th-congress/house-bill/1676.

101. *See* Palliative and Hospice Education and Training Act, S.693, 115th Cong. (2017), https://www.congress.gov/bill/115th-congress/senate-bill/693; Palliative and Hospice Education and Training Act, H.R. 1676, 115th Cong. (2017), https://www.congress.gov/bill/115th-congress/house-bill/1676.

102. *See* Palliative and Hospice Education and Training Act, S.693, 115th Cong. (2017), https://www.congress.gov/bill/115th-congress/senate-bill/693; Palliative and Hospice Education and Training Act, H.R. 1676, 115th Cong. (2017), https://www.congress.gov/bill/115th-congress/house-bill/1676; *see supra* text accompanying notes 91–95.

103. *See supra* notes 40–43.

104. *See supra* Part II.

105. *See supra* Part II.

106. *See supra* Part II.

107. *See supra* Part I.

108. *See supra* Part I.

109. *See supra* Part I.

encourage meaningful conversations during challenging times.[110] Texas needs to encourage transparent and supportive conversations for improved medical outcomes based upon a clear understanding of the patient's needs at all stages of their medical treatments and conditions. Because often these initial conversations take place in the office of an attorney while preparing estate planning documents, adopting the Five Wishes document will provide a valuable tool that Texas needs to help not only attorneys and physicians better serve their clients and patients, but also provide their agents and loved ones comprehensive information about what the patient wishes at all stages of the patient's healthcare journey.[111]

110. *See supra* Part II.
111. *See, e.g.*, *supra* Section II.A.