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Hospice Care and Planning

Know the Pitfalls of Joint Ownership

One of the most common types of ownership is joint ownership with right of survivorship (JTWROS). JTWROS is commonly found on bank accounts, CDs, real estate, etc. When one joint co-owner dies, his or her interest passes automatically to the surviving joint owner(s), not to the decedent's heirs.

JTWROS does not avoid probate, it postpones it until the death of the surviving joint owner. For example, Fred and Wilma have a checking account at Bedrock Savings and Loan, held as JTWROS. If Fred dies first, the account belongs to Wilma. At Wilma's death the account will go through the probate process and be distributed according to Wilma's Will. So at Fred's death, there is no probate, but there is at Wilma's.

JTWROS can be an easy and beneficial way to pass assets at death. However, it can also wind up with disastrous unintended consequences. Adding a joint owner is relatively easy. However, changing your mind and removing a co-owner may be difficult. If mom adds daughter as a joint owner on mom's CD and later changes her mind, mom cannot remove daughter's name without daughter's permission. While daughter's name is on the account, daughter has total access to mom's money. Daughter's creditors may also gain access to mom's money, and can cause mom to lose all of her money. If daughter gets divorced, the funds in the joint account can be subject to the property settlement agreement.

If daughter withdraws money from the joint account, that can later cause mom to be ineligible for Medicaid. Another problem is that the surviving joint tenant(s), rather than the beneficiaries named in a will, inherit JTWROS property when one joint tenant dies. For example, if mom's will leaves everything equally to her five children, but only two are joint owners on mom's bank accounts, only those two will become the owners of the checking account at mom's death. The other three children do not get any of that money. This could cause some significant problems in some families.

Additionally, problems occur when people do not die in the order anticipated and no other estate planning is done. Let's say dad and son are joint owners on dad's savings account. If son dies first, then the savings account will have to go through probate at dad's death, which may not represent dad's wishes. Also, if a joint owner dies prematurely, that person's children may not inherit anything. For example, dad and two sons are joint owners (JTWROS) of dad's house. Oldest son has three children and dad would have wanted oldest son's share to go to oldest son's children. However, since the house is JTWROS after dad has died, at the older son's death, the younger son gets everything and oldest son's children get nothing.

People say they will change things if the situation changes, but often it never happens.

Most people are concerned about making sure their assets and property pass at their death to their children as simply and economically as possible. However, without proper planning, you could wind up with disastrous, unintended consequences. That is why it is important to consult with an attorney for all your estate planning needs, not the bank teller. Estate planning is done for your loved ones. The peace of mind knowing you have taken care of your legal and financial affairs is a wonderful by-product.

Ask the Expert . . .

The Philosophy of Hospice

Michael Neff, Trinity Hospice

The philosophy of hospice is that it recognizes dying as a part of the normal process of living and focuses on maintaining the quality of the remaining of life. Hospice affirms life and neither hastens nor postpones death. Hospice exists in the hope and belief that through appropriate care, and the promotion of a caring community sensitive to their needs, patients and their families may be free to attain a degree of mental and spiritual preparation for death that is satisfactory to them.

Hospice affirms life. It exists to provide support and care for persons in the last phases of incurable disease so they might live as fully and comfortably as possible.

Hospice care incorporates a multi-disciplinary team of trained professionals and volunteers that develop and create personalized plans of care and actually coordinate services. They specialize in meeting the individualized needs of terminally ill patients and their families. Under the direction of a patient's physician and the hospice medical director, the hospice team works together to provide the necessary physical, emotional and spiritual care to the patient and their family.

Would you like to be added to our mailing list for *Hospice Care and Planning* or be a guest columnist? If so, please contact our Director of Community Education and Outreach, Beth Frame, at (314) 567-9292 or (618) 659-9292, or email to beth@coulsonlawgroup.com to be included.

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Errors in symptom intensity self-assessment by patients receiving outpatient palliative care

Author(s): Garyali A, Palmer JL, Yennurajalingam S, Zhang T, Pace EA, Bruera E.

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The Edmonton Symptom Assessment Scale (ESAS) is a reliable and valid tool developed to assess the daily symptoms of palliative care patients. ESAS considers the **presence and severity** of ten common symptoms experienced by cancer patients: pain, fatigue, nausea, depression, anxiety, drowsiness, shortness of breath, appetite, sleep, and well-being. The ESAS score can range from 0 (absence of a symptom) to 10 (worst symptom imaginable).

The authors carried out a study to evaluate if patients misinterpret questions when responding to items on the ESAS. The charts of 60 consecutive outpatients were reviewed. After a patient completed the ESAS, the same physician immediately interviewed each patient in order to determine if they had scored the symptom properly. All patients were asked to revise their symptom score after the physician interview if the score was deemed to be erroneously reported.

A weighted ***K*** statistic was used to determine agreement between the assessments by the patients before and after talking with the physician. **Agreement** was defined as absent (0), mild (1-3), moderate (4-7) or severe (8-10). The screening performance of the ESAS for mild or moderate symptom assessment was determined by calculating the sensitivity, specificity, and accuracy of the patients' initial assessments. Forty-four percent of patients scored 263 symptoms in agreement, 131 symptoms were revised downward (24%) and 146 were revised upward (27%).

Complete agreement ranged from 58% for sleep to 82% for well-being. The weighted ***K*** for agreement ranged from 0.49 for drowsiness (the highest level of disagreement) to 0.78 for well-being. Dyspnea, nausea, anxiety and depression were symptoms that had more agreement, whereas there was less agreement for symptoms such as lack of sleep and lack of appetite.

The screening performance of the patient self-assessment ESAS for symptom intensity was less sensitive for nausea and drowsiness if the intensity was mild. It was less sensitive for pain, nausea, anxiety and drowsiness if the symptom intensity was moderate. The screening performance of the initial assessment for symptom intensity of moderate, or greater, showed a sensitivity of 100% for dyspnea, but was lower than 80% for pain, nausea, anxiety, and drowsiness. The specificity was also low for sleep, and low, but improved, for fatigue and appetite.

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