Estate Planning Ideas for Clients With Pulmonary Disease

Standard language used in many estate planning documents may be inappropriate for the disabling nature and treatment of chronic obstructive pulmonary disease.

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Why does an estate planner need to understand the impact of chronic obstructive pulmonary disease (COPD)? Because, according to various estimates, 12 million Americans are living with COPD[1] and more than another 12 million are estimated to be living with COPD and remain undiagnosed.[2] Other estimates place the number of Americans living with a chronic lung disease at closer to 35 million. That is nearly a tenth of the population. Furthermore, COPD is typically diagnosed after age 40, so the portion of estate planning clients living with COPD is substantially greater. COPD is one of the most common lung diseases and has a profound impact on the clients living with it, their families, loved ones, and caregivers. Estate, financial, and related planning for the substantial number of clients touched by COPD should take into account how COPD affects their lives, their health, and their finances.

Not only elderly male smokers

The Center for Disease Control (CDC) has recently determined that COPD is now the third leading cause of death in the U.S.[3] COPD is also, depending on the source, the second or third leading cause of disability in the U.S. Yet surprisingly few attorneys, financial planners, or CPAs have any familiarity with COPD, its disease course, or impact on a client.

COPD accounts for 58 million lost work days each year.[4] This makes planning for COPD flare-ups an essential consideration when advising clients living with the disease. COPD remains widely misunderstood. Most people assume it is a disease of elderly males. Presently, more woman than men are being diagnosed with COPD.[5] In recent years, the number of woman dying from COPD has in fact exceeded the number of men dying from the disease.[6] In addition, more than half of those living with COPD are between the ages of 45 and 64.[7] Thus, many with COPD may lose their employment, careers, or businesses at relatively young ages—long before their target retirement date. They are, however, typically at ages when they have already accumulated some wealth. Thus, planning for COPD cannot be limited to elder law or Medicaid planning considerations. It is more complex and different.

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Overview of how COPD affects planning

COPD is a chronic and progressive disease. The American mindset towards health issues is captured with the image of a Hallmark "get

well" card. If someone is "sick," Americans buy a get well card. COPD, like other chronic illnesses, does not heal. The absence of cards tailored to the 120 million Americans living with chronic illness is a symbol of the American cultural misunderstanding of chronic illness. COPD will continue, providing the continued absence of a cure, for the client's lifetime and may worsen over time. Presently, medical science cannot restore damaged lung tissue. An array of medical steps, however, can be taken to preserve and even extend the life of a client living with COPD. The client's efforts should be directed at capitalizing on those steps.

For practitioners this means that whatever health challenges the client has today will continue, and potentially worsen, but perhaps more slowly if the client is proactive in treatment. Understanding the client's current condition, his or her anticipated rate of decline, and the future prognosis, is key to planning. Just as the client's medical team will collaborate to stay a step ahead of the disease, similarly, the estate planning team must help the client stay several steps ahead of the anticipated future course of the financial and legal impact of the disease. Annual meetings to monitor changes and assure planning remains optimal are ideal.

What is COPD?

COPD may appear in various forms:

- Chronic bronchitis.
- Refractory asthma.
- Emphysema.
- Bronchiectasis.

Smoking is the primary cause of COPD. Even secondhand smoke can be a factor. Workers exposed to fumes and other pollutants are also at risk.

Alpha-1 antitrypsin deficiency (Alpha-1) is a condition that is passed from parents to their children through their genes. Alpha-1 occurs when there is a lack of a protein in the blood that protects lung tissue. This protein is called alpha-1 antitrypsin, or "AAT," which is primarily produced in the liver. Alpha-1 is currently the most significant known genetic risk factor for COPD, but current research suggests that additional genetic predispositions for contracting COPD will be identified.

COPD can result in the destruction of the lungs. The disease ultimately damages the alveoli, the tiny sac-like ends of the bronchial tubes where oxygen and carbon dioxide are exchanged from the lungs to the blood stream. COPD can destroy the cilia, the hair-like membrane that lines the bronchial tubes leading to the lungs. Since cilia keep debris from reaching the lungs, those with COPD are more likely to experience infection and may have to rely on mechanical means to filter the air they breathe (e.g., room air purifier).

Someone living with COPD experiences shortness of breath and difficulty breathing. This can lead to less oxygen reaching the lungs, blood stream, and body (called "hypoxia"), and for some individuals, an accumulation of carbon dioxide in the blood (called "hypercarbia"). COPD can trigger asthma-like attacks. Symptoms of COPD can include a cough with mucus, shortness of breath (called "dyspnea"), wheezing manifestations, and other conditions. This should not be confused with the cough one gets with a cold that later resolves. Rather, it is a chronic ongoing cough that is symptomatic of a much more significant underlying deterioration. The difficulties the COPD client has breathing typically worsens with mild activity. Other physical symptoms may include fatigue, frequent respiratory infections, and wheezing. COPD is a chronic illness; it is progressive.

COPD is often accompanied by co-existing ("comorbid") diseases[8] that commonly include lung infections, diabetes, sleep apnea, cancer, hypertension, cardiovascular disease, and depression. Complications of COPD are a significant issue for many clients. Oxygen deprivation resulting from COPD can lead to organ damage. Heart function and circulation can be impaired. Thus, merely knowing that the client is living with COPD is often inadequate to understand the full impact of their disease course and how it affects planning, and, in particular, the present status of the client. Practitioners must inquire generally whether

1 "What is COPD?" National Institutes of Health, National Heart Lung and Blood Institute website, http://www.nhlbi.nih.gov/health/dci/Diseases/Copd/Copd_WhatIs.html (posted on 6/1/2010).

2 Centers for Disease Control and Prevention (CDC), "Chronic Obstructive Pulmonary Disease Surveillance—United States, 1971-2000," 51(SS06) Morbidity and Mortality Weekly Rep't (MMWR) 1 (8/2/2002).

3 Kochanek, Xu, Murphy, Minino, and Kung, "Deaths: Preliminary Data for 2009," 59 Nat'l Vital Statistics Rept 1 (CDC, 3/16/2011). Available at http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_04.pdf.

4 Boehringer-Ingelheim, Discern, *White paper and technical specifications: Pay for performance for COPD*, Aug. 2009. Available at http://www.ihpm.org/pdf/COPD%20P4P%20White%20Paper%20Technical%20FINAL.PDF.

5 Akinbami and Liu,"Chronic Obstructive Pulmonary Disease Among Adults Aged 18 and Over in the United States, 1998-2009," CDC, National Center for Health Statistics Data Brief, No. 63 (June 2011). Available at http://www.cdc.gov/nchs/data/databriefs/db63.pdf.

6 CDC, "Deaths from Chronic Obstructive Pulmonary Disease—United States, 2001-2005," 57 MMWR 1229 (11/14/2008). Available at http://www.cdc.gov/mmwr/PDF/wk/mm5745.pdf

7 Novartis Pharma AG. Data on file:Mattsonjack COPD Est. 2000 US +EUS; Global COPD Chart Pull (Quant).

8 Barr, Celli, Mannino, Petty, Rennard, Sciurba, Stoller, Thomashow, and Turino, "Comorbidities, Patient Knowledge, and Disease Management in a National Sample of Patients With Chronic Obstructive Pulmonary Disease," 122 Am. J. Med. 348 (April 2009). Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2692705/.

a client has any health issues that might affect planning; if the response is affirmative, the follow-up question should be whether any secondary health issues are present that may be relevant.

Despite these symptoms, most people living with COPD live relatively normal life spans, into their 70s and 80s. Pulmonary rehabilitation efforts can extend both quality of life and life expectancy.

Impact on health care proxies and related planning

COPD, although progressive, is also commonly marked by flare-ups or exacerbations. An acute respiratory flare-up may require hospitalization. Many living with COPD are advised to have in place emergency plans to address a crisis (e.g., they cannot breathe and need to be rushed to the hospital). Estate and financial planners can serve an important role in facilitating that preparedness. For clients living with COPD, emergency planning is real, not hypothetical. While the steps are simple, if COPD clients are not prompted to focus on them, the steps may not be taken.

The client should have an accessible copy of his or her living will, health care proxy (medical power of attorney) and HIPAA release with the emergency documentation he or she keeps at the ready, typically in the client's home. Clients who travel should consider having an extra set of original documents to carry on trips so as not to worry about losing the home emergency documents. Similarly if the client has vacation property he or she frequents, an extra set of originals for that location may be useful as well.

These steps are simple, but for a client with COPD, the anxiety of having left critical emergency legal documents elsewhere could be more than an inconvenience. Oxygen requirements are increased when an individual experiences severe anxiety. For someone living with COPD, this could trigger further and more serious complications. So preparedness may, in itself, lessen the likelihood of an emergency occurring.

Experimental or costly medical procedures

A COPD client may desire to risk experimental medical procedures now or in the future. The client's living will and health care proxy should reflect these wishes. Costs may be associated with some approved medical treatments that insurance might not cover, as well as non-approved or experimental medical treatment. For example, there is an Alpha-1 replacement for those living with Alpha-1 Antitrypsin deficiency. Would the client wish to incur such a cost? The following is illustrative language that might be added to a revocable trust:

> Grantor is aware that this trust agreement authorizes the Trustee to pay for Grantor's medical and other health care expenses. Grantor further authorizes and directs the Trustee to pay for any medical procedure or drug, regardless of the cost, as well as for any experimental, unproven, alternative, or other medical procedures, drug therapies, or other medical therapies that [are authorized by Grantor's health care proxy] or [may assist Grantor in consultation with the medical specialists attending Grantor from time to time].

Intubation provisions in health care proxies

A typical form or boilerplate living will or health proxy provision might provide as follows:

> I direct all physicians and medical facilities in whose care I may be, and my family and all those concerned with my care, to refrain from and cease extraordinary or heroic life-sustaining treatments (i.e., that the following be considered heroic) including, without limitation, antibiotics, pulmonary resuscitation, ventilation, intubation, or other respiratory support.

Even if such language might be acceptable to a client with no respiratory issues (which is not suggested), it would be an unworkable course for a COPD client. For many with COPD, supplemental oxygen is essential. Many living with COPD use both stationary or base oxygen support systems and portable oxygen systems. A stationary system, for example, may include a liquid oxygen container, a concentrator with an electric motor, an electronic demand valve, tubing, and so forth. A face mask or even transtracheal catheter (a tube supplying oxygen into the windpipe) may be used to deliver the oxygen to the client. These oxygen delivery systems may be used regularly by the person with COPD, and he or she may maintain a rather ordinary and active life with the assistance of these devices. Yet, the boilerplate living will clause above provides that ventilation, intubation, and respiratory support are heroic measures to be avoided.

Ventilation is the act of breathing—oxygen going in and out. Intubation is inserting a breathing tube permitting someone to be connected to a respirator if he or she cannot breathe independently. The COPD client could be sitting at the document execution meeting in your office signing a document preventing the same device as is being used while at the meeting. Care must be taken by estate planners to review any boilerplate language concerning intubation, heroic measures, and the like and assure that it is appropriate for the COPD client. Some standard provisions will not be.

Similarly, the characterization of antibiotics as a heroic measure may also be inappropriate for a COPD client. As explained earlier, a common symptom of COPD,

especially for those with chronic bronchitis, is increased and thickened secretions that often become infected ("purulent"). Characterizing antibiotics, which may be a regular part of the medical regimen, as "heroic" may be inappropriate and, if acted on (i.e., classified as heroic), the death knell.

While clients with any known health issues certainly should be encouraged to discuss the end of life decisions with their physicians and social worker, counsel needs some understanding of the particular ailments in order to draft provisions memorializing the client's wishes. If the client has an emergency with breathing (e.g., due to pneumonia), medical providers will insert a breathing tube into the individual's trachea (i.e., windpipe) and put the patient on a ventilator. This is referred to as intubation.

The ventilator breathes for the patient while efforts are made to treat the underlying problem. For example, antibiotics and steroids may be introduced. Breathing tubes only stay in place for a short duration; a week, for instance, may be viewed as a long time. If there is no short-term hope to wean the client off the ventilator, the decision may be made to perform electively a "tracheotomy," which is to surgically provide an airway. This is also referred to as an "ostomy."

Tracheotomies are easier to care for, and are more comfortable for the patient, than being intubated. Intubation requires that an endotrachial tube be inserted in the patient's airway. A tracheotomy does not present the same risks of damage to the patient as an endotrachial tube. A tracheotomy is for purposes of longer-term airway management. The weaning process from the ventilator can be done more slowly.

Example. Thomas Smith, age 58, has chronic emphysema but at present no other diseases. He has been a relatively compliant patient, adhering to the regimen for his care. However, this past winter Thomas developed pneumonia. Without intervention, Thomas may not survive the bout of pneumonia because of his already weakened lung function. The use of a respiratory machine may provide Thomas the ability to rest and recuperate while antibiotics are introduced to combat the pneumonia. As Thomas recovers, presumably he can be weaned from the respiratory machine and return to a relatively normal life. The sample boilerplate heroic measures clause could prohibit the use of both antibiotics and the breathing machine.

As stated above, the decision making needs to be tailored to the client's situation. The preceding example is not intended to suggest that anyone living with COPD should use a clause mandating ventilation, intubation, etc. The example presents an acute event that requires life support for Thomas to live, and with those measures he would likely survive and have some quality of life. While this result is not assured in any acute medical situation, the key point is to contrast it with the more chronic end-stage scenario depicted below.

Example. Jane Craymour, age 78, has chronic emphysema, end-stage

ovarian cancer, and is in a generally weakened state of health as a result of a recent COPD flare-up. She now resides in an assisted living facility because it has become too difficult for her family to care for her. Jane's pulmonologist is concerned that a bout of pneumonia would likely be fatal in her weakened state. The social worker in the facility Jane is in encourages her to consult her attorney and put her affairs in order. In contrast to Thomas Smith, in the preceding example, Jane believes that intubation and the use of a ventilator and similar measures should be viewed as heroic if she is admitted to a hospital on an emergency basis.

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The sample boilerplate heroic measures clause prohibiting general respiratory support measures (e.g., antibiotics) may still be inappropriate. At the assisted living facility, Jane may receive respiratory treatments consisting of lung medications such as Proventyl or Atrovent. These are given as inhalant respirator therapies. She might also receive chest physical therapy. Jane will likely want this skilled nursing level of care continued. Jane may wish to provide in her living will, however, that she should not have invasive procedures. Jane might also wish to provide expressly that she does not want to be mechanically ventilated, which requires insertion of an endotrachael tube and being put on a ventilator.

Comparing and contrasting the two hypothetical situations above illustrates how at different stages of COPD, a patient might wish a different level of care specified in his or her medical directives. Perhaps in all cases, however, language in some standard forms is excessively and inappropriately restrictive.

COPD estate planning steps

The client living with COPD should have an immediate non-springing limited power of attorney. If the client faces an emergency, it might be helpful to have a power of attorney that differs from the format some estate planners typically use. Most powers of attorney prepared for estate planning purposes are broad or general in nature. Providing an agent with unfettered authority may be entirely unnecessary, however, if the COPD client is likely to be hospitalized or incapacitated for the modest duration of a flare up. Further, unlike many chronic illnesses, COPD clients generally have limited cognitive decline. Therefore, a power of attorney that is limited in the scope of power and authority it grants the agent may suffice. It may also be simple and hence easier to have accepted.

Finally, it may provide the COPD client a greater feeling of control over his or her own affairs. Bear in mind that a common psychological impact of COPD is a feeling of helplessness. That can be countered with an estate planning paradigm of empowerment.

Revocable trust. Revocable living trusts can be a powerful tool for protecting a client with COPD by creating a mechanism to facilitate management of assets and handling a variety of tax, legal, and other matters. If the COPD client is struggling with significant fatigue that is likely to worsen and hampered mobility, consolidating assets into a living trust with a co-trustee who can help with the administrative burden and serve if the COPD client is temporarily incapacitated or subject to a short-term hospitalization, can provide an important safety net for the client.

Drafting tips. When drafting a durable power of attorney, revocable trust, or even other documents containing disability provisions (e.g., shareholders agreement), the disability clauses and trigger mechanisms need to be considered. The circumstances for a COPD client are quite different than for the types of triggers that would serve clients with other chronic illnesses, disabilities, or health issues. Many disability provisions presume that a client who becomes disabled remains disabled. For many living with COPD, this is not the case. Instead, the COPD client may have a flare-up and perhaps be hospitalized, but then return to a relatively normal lifestyle thereafter.

A disability clause in a shareholders' agreement that provides for termination of a shareholder who cannot provide full-time services for 90 days may work a hardship on the shareholder living with COPD and even the corporation. It may be perfectly feasible for the COPD shareholder to return to work after recovery from a flare-up, but as the disease progresses, he or she may need to limit working hours. The feasibility of negotiating a reduced work schedule rather than strict termination should be considered.

If the event is acute rather than the result of end-stage disease or in an elderly COPD client, the disability might be temporary. Importantly, in contrast to many other chronic diseases, COPD generally does not affect the client's cognitive ability. However, end stage COPD with significant hypoxia (low oxygen levels in the blood) can affect the client's central nervous

system (CNS) and result in disorientation and other cognitive impairment. This is a critical difference in planning the degree of control and involvement in the client's affairs.

COPD clients commonly experience on/off periods of greater (e.g., a flare-up) and lesser disability. This factor must be incorporated into the drafting in order to assure the client of both protection and independence to the extent feasible. The following language serves as an example:

> Because Grantor is presently living with COPD, it is possible that periodically Grantor may suffer a short-term flare-up during which Grantor cannot effectively manage Grantor's financial and other affairs ("Event") due to hospitalization or physical inability. Following resolution of the acute Event, Grantor may resume such responsibilities. Grantor directs that, barring an emergency situation which cannot await Grantor's recuperation or recovery from such Event, that the disability provisions in this Trust shall not be applied so long as the period for which it is anticipated that Grantor will not be able to reasonably participate in the management of this Trust shall be less than Thirty (30) days. This condition shall be referred to as an "Ignored Disability." Grantor shall be deemed to have recovered from an Event when the other then-serving Trustee receives written certification from the Pulmonologist regularly attending to the Grantor's care, that the Grantor is no longer incapable of reasonably serving as co-trustee hereunder, and that Grantor is again able to manage his or her own financial affairs within the structure of this Trust and the participation of the Co-Trustee.

Another mechanism to address the risk of a flare-up is to draft, with respect to powers of attorney, two separate powers of attorney to protect the client yet preserve independence. The first power could be a typical general durable power of attorney with springing provisions for agents (assuming state law permits it). Should the degree of disability increase to the degree an agent will have to operate on an ongoing basis, this broad power of attorney, similar to that used for clients generally, will be available. The springing mechanism could be modified to address chronic illness:

> The Grantor shall be deemed disabled when Grantor is unable to manage Grantor's affairs and property effectively for a period anticipated being more than Thirty (30) days [This duration was included to avoid trigging the power of any successor agent to act, as a result of a flare-up.] Disability may be determined to exist for reasons such as mental illness, mental deficiency, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, or for any other reason allowable by law. In addition to any other method allowed by law to determine disability, it shall be deemed conclusive proof that the Grant to the Alternate Agent is effective upon a sworn statement being executed by Grantor's attending Pulmonologist or other attending physician.

Similar concepts may apply to other documents. Again, the objective is to modify the more traditional clauses the estate planner generally uses to address some of the unique nuances the COPD client faces.

COPD financial planning and related steps

From a financial planning perspective, strategies to assist a client with COPD in addressing the potential for financial emergencies is no different than for any other client, only more real and likely to be needed. If a client with COPD will likely experience unexpected urgent hospitalizations, assuring an immediately accessible cash fund and a mechanism to pay ongoing key bills (e.g., utilities) may be advisable. Again, while simple to many advisors, failing to address some of the basics, or guiding the client with COPD to do so will likely result in what is obvious to the professional advisor, not being done. Clients should consider the following steps discussed below.

Because the client living with COPD may experience sudden attacks and hospitalization, and since anxiety might worsen an attack or trigger one, preparedness is critical. Automate as many bill payments as feasible, especially key utility and other bills that could result in a disruption of service or legal problem if not timely addressed. For example, the client can be guided to have rent, gas, electric, phone, and health insurance billed automatically to the client's credit card and to have

the credit card automatically paid from the client's checking account.

On the income side of the equation, it might be possible to have certain dividends, pensions, or salary payments deposited automatically to the client's checking account to fund these core expenses. This will be especially important to assure vital or core expenses are covered. Even if the financial advisor is adverse to the use of annuities, a base of annuities or other investment instruments that generate a fixed cash flow sufficient to cover selected key expenses that are structured for automatic payment may provide the COPD client with considerable peace of mind and assure that the funding and payment of key costs are entirely automatic.

Guiding the COPD client to consolidate and simplify asset holdings may be a practical step with more importance than for other clients. The COPD client may not have the physical stamina to shuttle comfortably to various banks to renew certificates of deposit (CDs) or withdraw maturing CDs. Whatever financial advisors may know about the impropriety of clients investing in CDs in a myriad of different banks, the reality is that many clients, especially older ones, feel more secure in having some portion of their investment portfolio held in such a manner.

Emotional and psychological component

Someone living with COPD may feel helpless when experiencing severe difficulty breathing. This can lead to fear and a panic or anxiety attack.

The physical symptoms of COPD, deteriorating lung function, leading to reduction in physical abilities, increasing fatigue, and the difficulties they create can promote anxiety and depression. When this physical decline is coupled with the reality that COPD is both chronic and progressive, the client's level of anxiety and depression become common COPD side affects.

Because many of those living with COPD were smokers, an element of guilt is often associated with the disease that can heighten the depression associated with advancing symptoms. Since COPD for many is caused by smoking, the disease may have been avoidable. This fact can create tremendous guilt and anger that can make the stages the client traverses following diagnosis difficult.

Care must be taken by estate planners to review any living will boilerplate language concerning heroic measures and assure that it is appropriate for the COPD client.

The common history of smoking often translates into a stigmatization of those living with COPD. Many with COPD fear that family and even physicians will blame them for contracting the disease. These psycho-social considerations are rather unique to COPD as contrasted to those living with other chronic diseases. The reality is that only 20% of those who smoke ultimately develop significant COPD. This suggests that other factors, genetic and environmental, must contribute. Heart disease, diabetes, and obesity do not tend to have the stigmatization that COPD does. The result of all of this is that estate planning practitioners may have to be more direct to ascertain whether a client has a health issue that may affect planning. A client in denial is not apt to reveal critical information. Based on the statistics cited above, no planner can appropriately execute responsibilities for a client with COPD unless the planner knows that the client is living with this condition.

Being cognizant of the above factors is vital for estate planners and other advisors. Depression can prove a significant impediment to the client undertaking or completing important planning steps. It may be necessary, assuming permission is provided to avoid any issue with violating attorney-client privilege, to enlist family and other advisors to encourage progress. Clients living with other health issues may be well served by the practitioner communicating with family or others because of a worsening cognitive condition. However, for COPD, the communication may more likely be to address the above concerns. Practitioners might be able to accomplish this by incorporating an authorization, such as the following, into their engagement letter, or perhaps into the COPD client's estate planning documents, or both:

> I expressly authorize ATTORNEY NAME to communicate with the agent named under my durable power of attorney, health care proxy, as well as my wealth manager ADVISORY FIRM NAME, and my Certified Public Accountant CPA FIRM NAME. Collectively my agents and named professional advisors, and the successors to those advisory firms, are collectively referred to as "Recipients." I understand that ATTORNEY NAME will have to exercise judgment as to what communication is appropriate in the circumstances. Therefore, I authorize ATTORNEY NAME in their sole discretion to communicate, or not communicate, with any person named as a Recipient, or any successor or alternate to them. I understand and agree that this authorization constitutes an express waiver of the attorney-client privilege which I have with ATTORNEY NAME. I, on behalf of myself and

my estate, guardian, committee, or successors and assigns, hold ATTORNEY NAME harmless from the exercise or non-exercise of this power.

For most clients living with COPD, the time pressure for quick planning should not be as intense as may exist with other medical diagnosis (e.g., pancreatic cancer). Unless the client is quite elderly, or the COPD or other diseases are well advanced, there may be time to guide the client in acclimating to the planning process and easing into the tough personal decisions estate planning often requires.

Office visits

With a modicum of planning and effort, practitioners can make meetings with a client living with COPD easier, more pleasant, and hence more productive. As with any health issue, each client's disease and experience of the disease is unique, so openly discuss with the client what accommodations or simple considerations might be helpful. Consider the following:

- Ask the client in advance of the meeting if his or her condition would result in common office scents being respiratory irritants that could be uncomfortable, or even dangerous. Then if applicable, explain in the internal memorandum to staff who will be working with the client that excessive perfume, cologne, or hairspray could prove a dangerous irritant for the client and that the staff should endeavor to be mindful of how much they use the day of the meeting.
- Strong vapors may irritate the client's lungs and create increased difficulties. If the reception or conference room the client will use has infusers, which are common in many offices, remove them the prior day.
- If the office was recently painted, fumigated, or had carpets cleaned with a cleaning solution, discuss this with the client in advance to assure that it is not a problem. If it might be, consider rescheduling the meeting, or if feasible, moving it to a different floor or portion of the office.

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- Circulate an internal memorandum to staff in advance of a meeting explaining that a client coming for an appointment at a particular time has COPD and that colds and flu that might create a minor nuisance for others could trigger a significant health problem for the client and that if substitutions are possible, they should be considered (e.g., a notary that does not have a cold is used instead of the notary that typically notarizes will signings but who has flu-like symptoms). This is of particular concern because exposure to a staff member with a cold or flu could trigger a flare-up in the COPD client. That could have significant adverse consequences. Lung tissue lost as a result of a flare-up cannot be regenerated, so the loss would be permanent. Advance precaution is the compassionate and humane response.
- Many living with COPD are self-conscious about using supplemental oxygen with the exposed cannula (i.e., the tube from the oxygen canister to the client's nose). Alert staff in advance to this possibility to avoid staring or other overt actions that might make a client uncomfortable. Also inquire as to how long the particular oxygen will last. This might affect meeting time. If the client has traveled to and attended the meeting for more than three hours, the equipment may have to be plugged in.
- Place hand sanitizers around the office and encourage their use, especially before meeting with a client with COPD. These can be purchased for a nominal amount and be left inconspicuously on conference room tables, etc.
- Have water and glasses, as well as coffee and hot water for tea, and tissues all readily available in the conference room for the client. These may help the client deal with the coughing, mucus, etc.
- Plan meetings of moderate length in the event that the client becomes too fatigued to remain comfortable and focused.

Conclusion

Planning for a client living with COPD, the client's family, loved ones, and caretakers, entails the same techniques and processes as planning for all clients. However, many phases of the process, many of the documents, and some of the planning techniques may be susceptible to minor modifications to tailor them to the unique needs of the COPD client. This will afford the COPD client greater peace of mind and better achieve the client's goals. ■