

**ETHICS, LAW AND FAMILY DYNAMICS –  
LESSONS LEARNED FROM THE *BARNES* CASE**

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This presentation will provide you with the basic framework of the Albert Barnes case, while providing you with the legal definitions of relevant terms such as capacity and incapacity. This presentation will also explore the preventative measures a health care organization can take in a Barnes-related situation.

## **Health Care Directives**

### **What is a Health Care Directive? – Minn. Stat. § 145C.02**

Executed by a principal with capacity, listing one or more health care instructions for others to follow (I.E. DNR/DNI, invasive mental health decisions, access to medical records, etc.)

### **Authority of Health Care Agent – Minn. Stat. § 145C.07(1)**

The health care agent has authority to make any particular health care decision ***only if the principal lacks decision-making capacity***, in the determination of the attending physician, to make or communicate that health care decision

### **Inconsistencies Among Healthcare Documents – Minn. Stat. § 145C.07(4)**

In the event of inconsistency between the appointment of proxy, the most recent appointment takes precedence. In the event of inconsistency among the documents, the most recently executed document takes precedence only to the extent of the inconsistency.

### **Presumptions – Minn. Stat. § 145C.10**

Principal is presumed to have capacity to execute health care directive and a health care provider may presume that a health care directive is legally sufficient

### **Duties of Health Care Providers to Provide Life-Sustaining Health Care – Minn. Stat. § 145C.15**

If a proxy acting under a health care directive directs the provision of health care, nutrition, or hydration that, *in reasonable medical judgment, has a significant possibility of sustaining the life of the principal or declarant*, a health care provider shall take reasonable steps to ensure the provision of the directed health care, nutrition, or hydration if the provider has the legal and actual capability of providing the health care either itself or by transferring to a health care provider that does

## **POLST Orders – Provider Orders for Life Sustaining Treatment**

POLST is a medical order that provides immediate orders in cases of emergency or urgent health situations.

It should be consistent with other advanced planning documents, such as a health care directive.

If there are inconsistencies, then decisions made and medical orders written should be consistent with the individual's best interests (broad, objective standard).

## Defining Capacity

### Capacity to Execute a Health Care Directive

Statute requires "Decision-making capacity" – Minn. Stat. §145C.01, subdivision 1b

- Must have the ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision.

### Lack of Capacity/Incapacitated Person

"Incapacitated person" means an individual who, for reasons other than being a minor, is impaired to the extent of lacking sufficient understanding or capacity to make or communicate responsible personal decisions, and who has demonstrated deficits in behavior which evidence an inability to meet personal needs for medical care, nutrition, clothing, shelter, or safety, even with appropriate technological assistance. See Minn. Stat. § 524.5-102(6) (2009).

### Diminished Capacity/Undue Influence

Undue influence is influence of such a degree exerted upon the individual by another that it destroys or overcomes the individual's free agency and substitutes the will of the person exercising the influence for that of the individual (*In re Wilson*, 223 Minn. 409, 413 (1947))

Six Factors identified to determine whether undue influence has been exerted upon an individual:

1. Opportunity to Exercise Influence
2. Active Participation in the Preparation of the Document
3. Confidential Relationship
4. Disinheritance of Those who probably would have been remembered
5. Singularity of the Provisions (i.e. if the original document, for example a will, distributes all the assets to all children equally and then it is changed to removal all but one child)
6. Exercise of Influence or Persuasion to Induce the individual to Act

*In re Wilson*, 223 Minn. 409, 413, 27 N.W.2d 429, 432 (1947); *In re Estate of Opsahl*, 448 N.W.2d 96, 100 (Minn. Ct. App. 1989).

Must prove evidence of undue influence by clear and convincing evidence. Generally, direct evidence of undue influence is not available and circumstantial evidence can be sufficient. *In re Estate of Anderson*, 370 N.W.2d 197, 200 (Minn. Ct. App. 1985), pet for rev denied (Minn. Feb. 19, 1986)(citing *In re Estate of Olson*, 176 Minn. 360, 365, 223 N.W. 677, 679 (1929)).

Undue influence by its nature, is often shown only by circumstantial evidence. *In re Estate of Peterson*, 283 Minn. 446, 449, 168 N.W.2d 502, 504 (1969).

### Lucid Interval

Lucid interval refers to a period in which a person who may lack capacity or have diminished capacity regains the legal capacity to execute documents. An individual may lack capacity

before and/or after executing a document, but if it is made during a “lucid interval” the document remains valid.

### **Determining Capacity – What to Look For**

1. Medical documentation
  - a. Physician’s statements in support of/opposition of Guardianship/Conservatorship
  - b. Prior diagnosis of Dementia/Alzheimer’s
2. Social/Emotional/Behavioral Factors
  - a. Difficulty communicating
    - i. Loss of hearing
    - ii. Loss of speech
    - iii. Lack of focus or following topics
  - b. Comprehension issues
    - i. Lack of education, skills, training
    - ii. Drug/Alcohol Consumption
  - c. Stressful Event/Life Changing Event
    - i. Death of a loved one
    - ii. Moving into assisted living
  - d. Delusions
    - i. From being fearful to unrealistic thinking (i.e. the government is spying on you)
  - e. Uncleanliness
    - i. Not showering regularly
    - ii. Unkempt clothes, hair, teeth
  - f. Ability to perform ADLS
    - i. Dressing
    - ii. Bathing
    - iii. Toileting
    - iv. Eating
    - v. Walking
    - vi. Transferring between bed to chair
  - g. Cultural or religious influences
3. Comment 6 to Minnesota Rules of Professional Conduct Rule 1.14 (for Attorneys)
  - a. In determining the extent of the client’s diminished capacity, the lawyer should consider and balance such factors:
    - i. The client’s ability to articulate reasoning leading to a decision;
    - ii. Variability of state of mind and ability to appreciate consequences of a decision;
    - iii. The substantive fairness of a decision;
    - iv. The consistency of a decision with the known long-term commitments and values of the clients

### **Important Terms for Life Sustaining Medical Treatment**

***Life Sustaining Medical Treatment*** – The American Medical Association defines life-sustaining treatment as “any treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment may include, but is not limited to, mechanical ventilation, renal dialysis, antibiotics, and artificial nutrition and hydration.” Am.

Medical Assn., *Opinion 2.20 – Withholding or Withdrawing Life-Sustaining Medical Treatment* (2011)(available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion220.page>)

**Medical Futility** – Lawrence J. Schneiderman et al. in *Medical Futility: Its Meaning and Ethical Implications*, 112 ANNALS INTERNAL MED. 949, 951-52 (1990) offers two definitions of medical futility:

1. When physicians conclude . . . that in the last 100 cases a medical treatment has been useless, they should regard that treatment as futile.
2. If a treatment merely preserves permanent unconsciousness or cannot end dependence on intensive medical care, the treatment should be considered futile

### **Relevant Case Law Addressing End of Life Issues**

***In re Quinlan***, 355 A.2d 647 (N.J. 1976) – The New Jersey Superior Court found that a competent patient had a privacy interest in refusing unwanted medical therapies. *Id.* at 663-64. The Court further extended a patient’s privacy right by allowing a surrogate decision-maker to exercise this right on behalf of an incompetent patient, in this case Ms. Quinlan’s father, who ultimately authorized the removal of her ventilator. *Id.* at 671.

***Conservatorship of Torres***, 357 N.W.2d 332 (Minn. 1984) – The Supreme Court, on Petition for accelerated review, affirmed a Court Order authorizing the conservator to order the removal of the respirator of a patient who had been comatose and dependent on life support systems for almost eight months. The Court determined that one of the sources for the probate court’s authority to order removal of a conservatee’s life support was the Minnesota Patients’ Bill of Rights (Minn. Stat. § 144.651), which guarantees, among other things, the rights of patients “to participate in the planning of their health care” and the right “to refuse treatment.” The Court also held the probate court had the authority to empower the conservator to removal life support in Minn. Stat. 525.56, sub. 3(4)(a), the State Constitution (Article VI, §11), and the Declaratory Judgments Act, § 555.01. *Id.* at 337-38.

Of particular importance, although all justices joined in the decision, three (3) justices (Kelley, Yetka, and Peterson) concurred specifically but disagreed with the majority decision on the issue of whether a court order should be required, Justice Peterson stating “A requirement of judicial oversight is a basic recognition of the state’s undoubted interest in the safety of its citizens.” *Id.* at 341. All three (3) justices would require a court order under these circumstances.

Further, the Court, in addressing the issues of the “best interests” of the ward, gave a succinct, yet still objectively difficult analysis, which is best cited in full.

“Under Minnesota law, a probate court must act in the “best interests” of the ward or conservatee in a guardianship proceeding. *In re Schober*, 303 Minn. 226, 230, 226 N.W.2d 895, 898 (1975). Appellant argues, as a matter of law, that the “best interests” of a conservatee cannot be served by the removal of life supports when doing so may result in the conservatee’s death. This argument has an appealing simplicity; it has little support, however, among those who have considered the plight of individuals like Mr. Torres.

The President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research devotes a full chapter of its 1983 report, *Deciding to Forego Life-Sustaining Treatment*, to consideration of patients who have permanently lost consciousness. The Commission's conclusions regarding the interests of such patients are worth quoting in full:

'The primary basis for medical treatment of patients is the prospect that each individual's interests (specifically, the interest in well-being) will be promoted. Thus, treatment ordinarily aims to benefit a patient through preserving life, relieving pain and suffering, protecting against disability, and returning maximally effective functioning. If a prognosis of permanent unconsciousness is correct, however, continued treatment cannot confer such benefits. Pain and suffering are absent, as are joy, satisfaction, and pleasure. Disability is total and no return to an even minimal level of social or human functioning is possible.

Any value to the patient from continued care and maintenance under such circumstances would seem to reside in the very small probability that the prognosis of permanence is incorrect. Although therapy might appear to be in the patient's interest because it preserves the remote chance of recovery of consciousness, there are two substantial objections to providing vigorous therapy for permanently unconscious patients.

First, the few patients who have recovered consciousness after a prolonged period of unconsciousness were severely disabled. The degree of permanent damage varied but commonly included inability to speak or see, permanent distortion of the limbs, and paralysis. Being returned to such a state would be regarded as of very limited benefits by most patients; it may even be considered harmful if a particular patient would have refused treatments expected to produce this outcome. Thus, even the extremely small likelihood of "recovery" cannot be equated with returning to a normal or relatively well functioning state. Second, long-term treatment commonly imposes severe financial and emotional burdens on a patient's family, people whose welfare most patients before they lost consciousness, placed a high value on [sic]. For both these reasons, then, continued treatment beyond a minimal level will often not serve the interests of permanently unconscious patients optimally. (Commission's Report at 181-183).

***Cruzan v. Director, Missouri Dep't of Health***, 497 U.S. 261, 110 S. Ct. 2841, 111 L. Ed. 2d 224 (1990) – The Supreme Court recognized that although a person could refuse life-saving medical treatment, it held that clear and convincing evidence was required of an incompetent's wish to withdraw treatment. *Id.* at 280.

***In re Wanglie***, No. PX-91-283 (P. Ct., Hennepin County, Minn. 1991), health care providers sought to terminate life-sustaining treatment for an elderly woman whose family wanted the treatment continued. Ms. Wanglie had suffered a heart attack, depriving her

oxygen. Her body remained physically intact, but she was in a permanent vegetative state. Her physician determined that providing life sustaining treatment would be futile because she had a very little chance of recovery. The probate court appointed Ms. Wanglie's husband as her guardian, determining that he was the most qualified to determine and protect his wife's interests. Mr. Wanglie decided to keep Ms. Wanglie on life support and therefore, it become unnecessary for the court to address the contentions of medical futility.

**Terry Schiavo** – A series of cases involved life-sustaining medical treatment of Terry Schiavo. On February 25, 1990, Terry Schiavo, age 27, suffered a cardiac arrest as a result of a potassium imbalance. She never regained consciousness. *In re Guardianship of Schiavo*, 780 So. 2d 176, 177 (Fla. 2d DCA 2001). Eight (8) years after this tragedy, Michael, Terry's husband, petitioned the guardianship court to authorize termination of life support. The trial court found by clear and convincing evidence that Terry would elect to cease life-prolonging procedures if she were competent to make her own decisions. This decision was affirmed on district appeal. *Id.* Terry's parents appealed the final order and the Second District determined that the Schindlers, as "interested parties" had standing to file either a motion for relief from judgment under Florida Rules of Civil Procedure or an independent action in the guardianship court to the challenge the judgment." *In re Guardianship of Schiavo*, 792 So.2d 551, 560 (Fla. 2d DC 2001). The Schindlers' motion for relief from judgment was ultimately denied. *In re Guardianship of Schiavo*, 851 So.2d 182, 183 (Fla. 2d DCA 2003). The Florida Supreme Court denied review also, *see In re Guardianship of Schiavo*, 855 So.2d 621 (Fla. 2003) and Terry's nutrition and hydration tube were removed on October 15, 2003.

On October 21, 2003, the Florida Legislature enacted Chapter 2003-418, which Governor Bush signed into law; and ultimately issuing an Executive Order No. 03-201 to stay the continued withholding of nutrition and hydration from Terry. *Bush v. Schiavo*, 885 So.2d 321, 328 (Fla. 2004). The nutrition and hydration tube was reinserted pursuant to the Governor's executive order. *Id.* On the same day, Michael Schiavo brought an action for declaratory judgment in the circuit court, who ultimately determined that the Act was unconstitutional on its face and as applied to Terry Schiavo. *Id.* Ultimately the Florida Supreme Court separation of powers precludes other branches of the government from nullifying the judicial branch's final orders. *Id.* at 337. Therefore, the trial court's decision regarding Terry Schiavo was made pursuant to the procedural and statutory requirements in place. *Id.* The attempt by the Legislature to alter the final adjudication is unconstitutional as applied to Terry Schiavo. *Id.*

### **Alternatives if there is not a Health Care Directive or if Agents disagree**

1. Appointment of a Guardian
  - a. Clear and convincing evidence – Minn. Stat. § 524.5-310(a)(1)(2009)
    - i. The court may appoint a guardian if it finds by clear and convincing evidence that:
      1. The respondent is an incapacitated person; and
      2. The respondent's identified needs cannot be met by less restrictive means, including use of appropriate technological assistance.
2. Appointment of Conservator
  - a. Clear and convincing evidence – Minn. Stat. § 524.5-409(a)(1)(2009)
    - i. The court may appoint a conservator if it finds that by clear and convincing evidence, the individual is unable to manage property and

business affairs because of an impairment in the ability to receive and evaluate information or make decisions

- b. Preponderance of the evidence – Minn. Stat. § 524.5-409(a)(2)(2009)
  - i. The court may appoint a conservator if it finds that by a preponderance of the evidence, the individual has property that will be wasted or dissipated unless management is provided or money is needed for the support, care, education, health, and welfare of the individual or of individuals who are entitled to the individual's support and that protection is necessary or desirable to obtain or provide money

### **Ethical Dilemmas in Guardianship Cases**

- 1. **For all Parties:** Maintaining the “best interest of the ward”
  - a. Bill of Rights for Wards and Protected Persons – Minn. Stat. § 524.5-120 (2009)
    - i. The ward or protected person retains all rights not restricted by court order and these rights must be enforced by the court.
    - ii. These rights include, but are not limited to, the right to:
      - 1. Treatment with dignity and respect;
      - 2. Due consideration of current and previously stated personal desires, medical treatment preferences, religious beliefs, and other preference and opinions in decisions made by the guardian/conservator;
      - 3. Receive timely and appropriate health care and medical treatment that does not violate known conscientious, religious, or moral beliefs of the ward or protected person;
      - 4. Exercise control of all aspects of life not delegated specifically by court order the guardian or conservator;
      - 5. Be consulted concerning, and to decide to the extent possible, the reasonable care and disposition of the ward's protected person's clothing, furniture, vehicles, and other personal effect;
      - 6. Personal privacy;
      - 7. Vote.
  - b. Conflicts with treatment and Bill of Rights
- 2. **For Attorneys:** Zealous advocacy – Minnesota Rules of Professional Responsibility Rule 1.3
  - a. A lawyer shall act with reasonable diligence and promptness in representing a client.
    - i. Comment 1 – A lawyer should pursue a matter on behalf of a client despite opposition, obstruction, or personal inconvenience to the lawyer, and take whatever lawful and ethical measures are required to vindicate a client's cause or endeavor. A lawyer must also act with commitment and dedication to the interest of the client and with zeal in advocacy upon the client's behalf.
- 3. **For Attorneys:** Clients with Diminished Capacity – Minnesota Rules of Professional Responsibility Rule 1.14
  - a. When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental

- impairment, or some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.
- b. When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial, or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably protective action, including consulting individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator, or guardian.
  - c. Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(b)(3) to reveal information about the client, but only to the extent reasonable necessary to protect the client's interest.
4. For Attorneys: Third Party Paying Your Fees – Minnesota Rules of Professional Responsibility Rule 1.8
- a. A lawyer shall not accept compensation for representing a client from one other than the client unless:
    - i. The client gives informed consent or the acceptance of compensation from another is impliedly authorized by the nature of the representation;
    - ii. There is no interference with the lawyer's independence of professional judgment or with the client-lawyer relationship; and
    - iii. Information relating to representation of a client is protected as required by Rule 1.6

### **General Approaches**

1. Preventative Measures
  - a. Identify if a health care directive or POLST order exists.
  - b. If not, and patient has capacity, request them to complete a health care directive.
2. If there is a conflict:
  - a. Conflict involving a patient with a Health Care Directive
    - i. Determine if the patient lacks capacity to make medical decisions
      1. Do inconsistencies exist in the document?
      2. Are the agent's actions inconsistent with the health care directive?
      3. Look to the appointed health care agent and discuss the inconsistencies and potential conflicts
        - a. Are there other family members asking for different treatment?
        - b. Do other health care directives for the patient indicate different treatment?
      4. Address all of the medical issues through the treating physician
      5. Address all legal issues through risk management counsel or other counsel
    - ii. If conflict cannot be resolved through the health care agent, then consider petitioning the court to establish a guardianship
  - b. Conflict involving a patient without a Health Care Directive
    - i. Determine if family members agree to and know the patient's wishes.

- ii. Petition the Court to establish a guardianship, if conflict exists or no one is willing to make a decision.
- iii. If futility of care is an issues, petition for guardianship.

### **Case Study: The Albert Barnes Case**

The *Barnes* case presented several issues concerning the decision making authority of substitute decision makers related to life sustaining medical treatment. These issues included preferences in a health care directive, powers of guardian to terminate life support, medical futility, and the wishes of family members.

#### **Albert Barnes:**

Albert Barnes was in a non-communicative state since 2005. He suffered from various medical conditions including advanced dementia, renal failure, chronic respiratory failure, and chronic pleural effusion. In January 2011, Albert Barnes showed no response to outside stimuli, and was unable to communicate or respond in any manner. Albert Barnes was dependent on a ventilator for breathing and was fed through a feeding tube. Throughout the proceedings, Lana Barnes, Albert Barnes' wife, operated under the belief that Albert had been "mis-diagnosed", suffered from Lyme's disease, and that Albert should have all life sustaining medical treatment, including but not limited to, dialysis.

#### **Timeline of Events:**

June 10, 1993	<p>Albert Barnes executed a health care directive appointing Lana Barnes and specifying that he does not want to be kept alive by artificial means or receive certain life sustaining treatments.</p> <p>(As noted later, and unknown to the medical care providers, Lana Barnes 'modified' this health care directive by cutting out the portion of the health care directive which states that Albert Barnes did not want to be kept alive by artificial means or receive certain life sustaining medical treatment.)</p>
July 18, 1994	<p>Albert Barnes executed a subsequent health care directive, revoking the 1993 directive, and appointing Albert's son, James Barnes, as his health care agent, and again, specifying that he does not want to be kept alive by artificial means or receive certain life sustaining treatments. (The original document and all copies were contained in the drafting attorney's file until the first day of trial. No one was aware that this health care directive existed until the court-appointed guardian, Alternate Decision Makers, Inc., located the attorney late in the afternoon before the February 2, 2011 hearing. Also, the original June 10, 1993 Health Care Directive was found, "torn in half" in the attorney's file.)</p>
March 25, 2005	<p>District Court, Chisago County, ordered Lana Barnes to comply with all medical recommendations of Albert Barnes' medical treatment team regarding his continuing care treatment. This Order was never provided by anyone to the health care providers until after Methodist Hospital hired counsel and an investigation of</p>

Minnesota court actions under the names of Lana Barnes and Albert Barnes was completed.

- 2008 – March 2010      Albert Barnes was admitted to ten (10) hospitals in the Twin Cities Metro Area, including 78 emergency transfers (this means ambulance runs) of Mr. Barnes. The nature and extent of the emergency transfers was unknown by the medical care providers until after the 2011 Emergency Petition for Guardianship was filed and subpoenas for records was served after an appropriate investigation was conducted.
- December 25, 2010      Albert Barnes is discharged from Regions Hospital after a week stay. Albert Barnes is transported, by ambulance, to Methodist Hospital after a couple of hours at home with Lana Barnes.
- January 14, 2011      Methodist Hospital files Emergency Petition for Appointment of Guardian for Albert Barnes.
- January 14, 2011      Ex parte Order Appointing Alternate Decision Makers, Inc. as the Emergency Guardian of Albert Barnes is issued requiring that Albert Barnes' current level of care shall be maintained.
- January 19, 2011      Hearing held on the Petition for Appointment of Emergency Guardian.
- January 20, 2011      Court issues Order Modifying Emergency Guardianship in which the guardian was instructed to "take necessary and reasonable steps to preserve the life of the ward" which "include, but are not limited to, dialysis."
- February 2, 2011      Second Hearing is held on the Petition for Appointment of Emergency Guardian, specifically determining the treatment Albert Barnes shall receive.
- February 4, 2011      Order issued by the District Court specifically eliminating any requirement that Albert Barnes receive dialysis and requiring the guardian to follow the wishes of Albert Barnes' as expressed in his health care directive. The Court also determined, for a number of reasons that Lana Barnes should not act as guardian for Albert Barnes. These reasons included that Ms. Barnes misrepresented herself as the health care agent for Mr. Barnes, even though she likely knew that health care directive had been revoked. Also, the Court found that Lana Barnes had been deceptive to the Court and to others about the content of Mr. Barnes' health care directive.
- February 7, 2011      Alternate Decision Makers, Inc., as guardian of Albert Barnes, informs family that they intend to disconnect life support at 4:00 p.m.

February 7, 2011	Lana Barnes' filed a Motion to Stay Removal of Life Support for 48 Hours
February 9, 2011	Hearing on Lana Barnes' Motion to Stay was held and Court issued order staying removal of life support until further Court Order and gave Lana Barnes (and her counsel) until February 11, 2011 to find a medical expert to support her position
February 14, 2011	Albert Barnes died