

DEATH TAX

Written by **LUCAS HNATH**
Directed by **HEIDI STILLMAN**

DISCUSSION GUIDE

discussion guide by **MARTI LYONS**
design by **STEPHANIE SHUM**



lookingglass

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In Conversation with Heidi Stillman and Lucas Hnath

Interview by Literary Manager Marti Lyons

MARTI LYONS: Heidi, how did this collaboration come about?

HEIDI STILLMAN: I saw the production of *Death Tax* at the Humana Theatre Festival in Louisville in 2012. We loved the play so much I hunted Lucas down before we headed back to Chicago. I was very eager to meet him to express how much the play resonated with me. A few months later we scheduled a reading at Lookingglass. This past winter the Lookingglass Ensemble voted to include *Death Tax* as part of our 2014–2015 season.

ML: Lucas, what was the initial inspiration for *Death Tax*?

LUCAS HNATH: I never accurately recall the inspirations for plays. I think it's because they tend to come from a network of very different thoughts and ideas that had been running around my head for years. I can say that my mother, a Hospice chaplain, had once told me about some nurses that had been accused of "helping" patients die a little faster. The alleged motivations always had something to do with money. That's the obvious germ for the play. The less obvious germ probably has something to do with an old job of mine: I used to counsel folks who were fighting to keep their unemployment insurance benefits. I'd help claimants—and the law students who would represent the claimants at hearings—craft their stories into a compelling legal argument. I think that influenced the voice of the play; each scene works a bit like a set of legal arguments. Everyone is rationalizing; everyone is convinced that they're doing the only reasonable thing they can do.

ML: Heidi, can you tell us a bit about your collaborators?

HS: We are fortunate to have Ensemble Members J. Nicole Brooks and Raymond Fox as well as Artistic Associate Louise Lamson as part of the four-person cast of *Death Tax*. We are also honored that Deanna Dunagan is returning to the Lookingglass stage to play Maxine. Deanna gave an incredible performance in *The North China Lover* for me last season. I am thrilled to have her back for *Death Tax*. Additionally, Ensemble Member John Musial is designing the set along with Artistic Associate Christine A. Binder (lights) and my husband, Artistic Associate Rick Sims, designing sound. I'm really looking forward to this collaboration with my artist friends who have worked together for many years.

ML: Can you both speak a little bit about the title of the play? I know we can trace it back to Benjamin Franklin's quote "In this world nothing can be said to be certain, except death and taxes," but it also seems so relevant to our contemporary political conversations.

LH: Actually, the Franklin quote about Death and Taxes wasn't very close to my conscious mind. I was thinking more about the term for the estate tax that was popularized by Frank Luntz. It's a divisive, provocative term by design. Luntz took the language of "estate tax" which didn't arouse much feeling and renamed it in order to stir up strong emotions. This sort of reflects my interest in how our understanding of supposed facts and of our personal narratives can be so easily reframed and reinterpreted with the adjustment of a couple key words. Beyond that I just liked the title because it sounded vaguely like a B-movie thriller, and there's something kind of perverse about tacking such a blunt title onto a play.

HS: Like taxes, death is inevitable. Are we handling it well in America in 2014? We avoid death at all costs, quite literally. And we keep it at bay at much cost. We remove the dying from us. Few of us die at home. We put the old people elsewhere and we pay for expensive and invasive medical procedures well into old age. I think there are other cultures that live more intimately with death, who prepare for death in a psychological and emotional way, and handle the end of life in different ways than we do. 2



About Lucas Hnath

From *The New York Times* - February, 2013



Lucas Hnath didn't plan a career as a playwright. He arrived at New York University determined to pursue a pre-med degree in 1997. But then he saw "Benita Canova" by the avant-garde director Richard Foreman. "After that I decided I had to transfer into dramatic writing because I wanted to make things like that," he said.

Raised in Orlando, Fla., Mr. Hnath, (pronounced nayth), 33, grew up

enraptured by the theatricality of Disney World and the evangelical church he attended. But New York called to him. "I like a lot of stimulation, a lot of noise," he said. After earning a dramatic writing M.F.A. at 21, Mr. Hnath remained in New York, laboring as a writing instructor, a literary manager and working with law students on unemployment insurance cases, "which actually ended up being really, really great story training," he said.

All that time he kept writing, rehearsing shows with friends and "literally making props from stuff I found in the dollar store." A decade or so on, he seems poised to break out Off Broadway. Ensemble Studio Theater is presenting "Isaac's Eye" (through Feb. 24), his comedy about one of Isaac Newton's more outré explorations: jamming a needle into his own tear duct. And on April 30 Soho Rep's artistic director, Sarah Benson, will be at the helm of Mr. Hnath's experimental script, "A Public Reading of an Unproduced Screenplay About the Death of Walt Disney."

On a break from "Isaac's Eye" rehearsals Mr. Hnath, looking cheerful if slightly bleary-eyed and clutching an enormous container of coffee, spoke to Alexis Soloski about backyard theme parks and the surprising usefulness of long hair. These are excerpts from the conversation.

What tempted you to write a comedy about Isaac Newton? Was he a funny guy?

I didn't set out to write a funny play about him, it just inevitably happened. Newton was by many accounts very difficult to get along with, a curmudgeon. Towards the end of his life he was heading up the mint, and he really prided himself on how many counterfeiters he had executed. In some ways he was kind of a deeply unpleasant person, which I find funny.

Were you a theme park addict in Orlando?

Yeah. I had a pretty big backyard, and I was always trying to build theme park rides — a wagon on a rope, holes I'd dug up and filled with water, pieces of wood on pulleys. You often write about real figures.

How much research do you do?

I'm in many ways a sloppy researcher. I'll start reading things, but I won't finish anything. I want to start writing before I know too much about the truth. And then there comes this point late in the process where I'll think I'm making something up, but I'll go back and do my research and I'll realize, "Wait a minute, that really did happen." I hope the messier research process leads to work that doesn't feel researched, but more organic and less like a book report.

You have scripts about Anna Nicole Smith, Street Fighter II, Godard films, classic Japanese Noh plays. How do you navigate between high art and pop culture?

I guess the trick is I don't navigate. But there is a kind of blending of high and low culture. A lot of the Disney play story is cribbed from "King Lear."

The Humana Festival asked you to write a play about sleep science. Do you sleep well yourself?

During the process of writing that play ["Nightnight"] I actually became a better sleeper. I can sleep through pretty much anything. I slept through lightning hitting my house when I was a kid and the firefighters coming in and evacuating, and I don't remember any of it.

You have exceptionally good hair for a playwright. Is there any Samsonesque relationship between your hair and your creativity?

Hair can be very useful if you're in the audition room and need to hide your reaction. So I grew my hair out. Like Newton, unfortunately, I am starting to get gray hair. He started to gray in his 20s. So did I.

What is the Estate (Death) Tax?

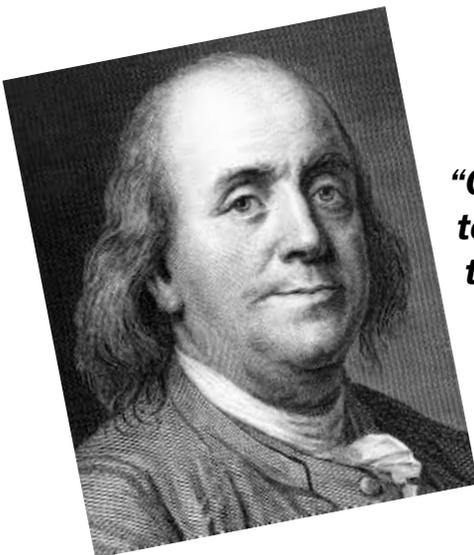
The Estate Tax is a tax on your right to transfer property at your death. It consists of an accounting of everything you own or have certain interests in at the date of death (Refer to Form 706 (PDF)). The fair market value of these items is used, not necessarily what you paid for them or what their values were when you acquired them. The total of all of these items is your "Gross Estate." The includible property may consist of cash and securities, real estate, insurance, trusts, annuities, business interests and other assets.

Once you have accounted for the Gross Estate, certain deductions (and in special circumstances, reductions to value) are allowed in arriving at your "Taxable Estate." These deductions may include mortgages and other debts, estate administration expenses, property that passes to surviving spouses and qualified charities. The value of some operating business interests or farms may be reduced for estates that qualify.

After the net amount is computed, the value of lifetime taxable gifts (beginning with gifts made in 1977) is added to this number and the tax is computed. The tax is then reduced by the available unified credit.

Most relatively simple estates (cash, publicly traded securities, small amounts of other easily valued assets, and no special deductions or elections, or jointly held property) do not require the filing of an estate tax return. A filing is required for estates with combined gross assets and prior taxable gifts exceeding \$1,500,000 in 2004 - 2005; \$2,000,000 in 2006 - 2008; \$3,500,000 for decedents dying in 2009; and \$5,000,000 or more for decedent's dying in 2010 and 2011 (note: there are special rules for decedents dying in 2010); \$5,120,000 in 2012, \$5,250,000 in 2013 and \$5,340,000 in 2014.

Beginning January 1, 2011, estates of decedents survived by a spouse may elect to pass any of the decedent's unused exemption to the surviving spouse. This election is made on a timely filed estate tax return for the decedent with a surviving spouse. Note that simplified valuation provisions apply for those estates without a filing requirement absent the portability election.



"Our new constitution is now established, everything seems to promise it will be durable; but, in this world, nothing is certain except death and taxes." –Benjamin Franklin (1789)



The History of Nursing Homes

In the twenty-first century, nursing homes have become a standard form of care for the most aged and incapacitated persons. Nearly 6 percent of older adults are sheltered in residential facilities that provide a wide range of care. Yet such institutions have not always existed; rather, their history and development reflect relatively recent demographic and political realities that shape the experience of growing old. Before the nineteenth century, no age-restricted institutions existed for long-term care. Rather, elderly individuals who needed shelter because of incapacity, impoverishment, or family isolation often ended their days in an almshouse. Placed alongside the insane, the inebriated, or the homeless, they were simply categorized as part of the community's most needy recipients.

In the beginning of the nineteenth century, women's and church groups began to establish special homes for the elderly persons. Often concerned that worthy individuals of their own ethnic or religious background might end their days alongside the most despised society, they established—as the founder of Boston's Home for Aged Women (1850), explained—a haven for those who were “bone of our bone, and flesh of our flesh”. Advocates for these asylums contrasted their benevolent care with the horrors of those who were relegated to the almshouse. “We were grateful,” wrote the organizers of Philadelphia's Indigent Widows' and Single Women's Society, one of the nation's earliest old age homes, in 1823, “that through the indulgence of Divine Providence, our efforts have, in some degree, been successful, and have preserved many who once lived respectfully from becoming residents of the Alms House”.

Although designed for those without substantial familial support, these early homes still generally required substantial entrance fees and certificates of good character. Through these policies, the founders strove to separate their own needy poor from, as the Boston founder explained, foreigners who “have taken possession of the public charities. . .as they have of the houses where our less privileged classes formerly resided”.

Not surprisingly, perhaps, throughout the nineteenth century the numbers of elderly people who found shelter in these institutions was rather limited. In 1910 the state of Massachusetts, reported that 2,598 persons resided in such asylums. The great majority of these individuals were widowed and single women who had lived their entire lives, or at least a great proportion, as citizens of the state. Although the institutions were hardly palatial, the amount spent on each resident was far greater than the allocation for each almshouse resident. Much as their founders had hoped, the nineteenth-century old-age home operated to differentiate the “worthy” old of a particular religion or ethnic group from the most needy and desperate of the aged population.

As a result, for the most impoverished individuals, the almshouse still served as the last refuge in their old age. Throughout the nineteenth century, in fact, this institution appeared to play an increasingly important part in the long-term care of the old. Some states, such as Pennsylvania, periodically revoked outdoor relief in the form of money, wood, or clothes, demanding that those in need either struggle on their own or enter an almshouse. Moreover, as charity advocates removed other, younger paupers to institutions organized to specific needs—such as orphanages, work homes, hospitals, or insane asylum—elderly persons became the dominant almshouse residents. Thus, although the proportion of the elderly population that was institutionalized remained stable at about 2 percent, the percentage of elderly within almshouses soared. In 1880, 33 percent of the national alms-house population was composed of elderly individuals, but by 1923 the proportion had increased to 67 percent. Many of the superintendents of state and local institutions responded to the changing nature of their residents by altering the names of their asylums. In New York City, in 1903, the Charity Board renamed its public almshouse the Home for the Aged and Infirm. The city of Charleston followed suit in 1913, transforming their almshouse into the Charleston

Home. In these institutions, their managers claimed, the old could find everything they needed in their last days.

Despite the name changes and the rosy descriptions that filled the institutions' annual reports, most people hardly looked upon the almshouse as a satisfactory solution to the demands for long-term care for the elderly. Throughout the early twentieth century, the institution remained a symbol of failure and despair. Poorhouse, according to early twentieth-century social analyst Harry C. Evans, was "a word of hate and loathing, for it includes the composite horrors of poverty, disgrace, loneliness, humiliation, abandonment, and degradation" (Epstein, p. 218). Often pointing to the rising percentage of aged individuals within these institutions as proof of increased dependency, pension advocates such as Abraham Epstein repeatedly argued that such institutions clearly revealed the inability of elderly persons to succeed in the industrial world. The almshouse, Epstein wrote in 1929, "stands as a threatening symbol of the deepest humiliation and degradation before all wage-earners after the prime of life" (p. 128).

By the 1930s, government officials accepted the argument that the rising proportion of elderly persons in almshouses was a sign that older people could no longer compete in the modern world. According to a government study in the 1930s, "the predominance of the aged in the almshouse is a sign of their increasing dependency" (United States Social Security Board). Despite the fact that the percentage of aged individuals who required such care appeared rather stable, both the tangible horrors of the almshouse and the rising percentage of aged individuals within such institutions convinced officials that radical measures needed to be taken. Moreover, many were sure that the almshouse had become a costly solution to the needs of the old. Assuming that all elderly individuals would eventually need support, they argued that small pensions were a less expensive solution.

In the movement to establish the Social Security program, therefore, concerns about the almshouse's central function in providing long-term care played an essential role. Hoping to eliminate the institution entirely, pension advocates barred any almshouse resident from receiving old-age support. "We were," wrote Pennsylvania's deputy secretary of public assistance, "rather enthusiastic to empty the poorhouses" (Thomas, p. 97). Although individuals who resided in a privately funded institution could be beneficiaries of pensions, almshouse residents were barred from such payments. This proviso was essential for establishing both the popularity and legitimacy of Social Security legislation. In asserting the constitutionality of the Social Security Act (1935), Supreme Court Justice Benjamin Cardozo, writing for the majority, proclaimed that "the hope behind this statute is to save men and women from the rigors of the poorhouse as well as the haunting fear that such a lot awaits them when the journey's end is near" (Haber and Gratton, p. 139).

To a large degree, many of the pension advocates had overestimated the impact of pensions on the lives of the needy elderly. Most had simply assumed that, with monthly annuities, individuals could live independently. They saw little reason to reform the poorhouse or support it with financial resources. A few, however, such as aging advocate Homer Folks, argued that only about 15 percent of the almshouse population were in the institution because of strict financial need. "The others," he explained, "are physically infirm and sick, and have various kinds of ailments that require personal attention of the kind that you could not get in an individual home; [they] require nursing or medical attention . . . in some sort of institution" (Thomas, p. 40). Nonetheless, the symbol of the almshouse was so powerful that Folks's argument had little public support. Despite its relatively small inmate population, the almshouse stood as a tangible sign of a despised welfare system. There seemed little doubt that it needed to be eliminated.



In eradicating the almshouse, therefore, pension legislation had an unforeseen consequence. By barring almshouse inmates from payments, aged individuals in need of long-term care were forced to seek shelter in private institutions. In Charleston, for example, while some of the almshouse residents were able to leave the institution and, with the support of pensions, live on their own, many were compelled to enter private, often unregulated, sanitariums. In some cases, such a move was more a change in name than in place. In Kansas, for example, immediately

following the enactment of Social Security, officials transferred well-established county homes into private control, although neither the residence nor its supervisors changed. Most importantly, however, the inmates could now be classified as recipients of private care, and the institution was able to receive residents' monthly annuities.

By the 1950s, the intent of policymakers to destroy the hated almshouse had clearly succeeded. Most poorhouses had disappeared from the landscape, unable to survive once their inmates no longer received federal annuities. As a result, and due to the lobbying of public hospital associations, Congress amended Social Security to allow federal support to individuals in public facilities. New legislation, including with the Medical Facilities Survey and Construction Act of 1954, allowed for the development of public institutions for the most needy older adults. For the first time, both public and private nursing-home residents were granted federal support for their assistance. As Homer Folks had predicted, not all elderly individuals could be supported in their own homes with monthly pensions; many incapacitated older adults required long-term care.

In 1965, the passage of Medicare and Medicaid provided additional impetus to the growth of the nursing-home industry, which, while it had been increasingly steadily since the passage of Social Security, grew dramatically. Between 1960 and 1976, the number of nursing homes grew by 140 percent, nursing-home beds increased by 302 percent, and the revenues received by the industry rose 2,000 percent. To a great extent, this growth was stimulated by private industry. By 1979, despite the ability of government homes to provide care, 79 percent of all institutionalized elderly persons resided in commercially run homes.

According to investigations of the industry in the 1970s, many of these institutions provided substandard care. Lacking the required medical care, food, and attendants, they were labeled "warehouses" for the old and "junkyards" for the dying by numerous critics. The majority of them, proclaimed Representative David Pryor in his attempt to initiate legislative reform in 1970, were "halfway houses between society and the cemetery" (Butler, p. 263). And, like the almshouses of old, people feared ending their days in the wards of these institutions and relatives felt guilty for abandoning their elders to nursing-home care.

Beginning in 1971, therefore, policymakers began to enact numerous government regulations in order to control the quality of long-term care. In 1971 the Office of Nursing Home Affairs provided a structure to oversee numerous agencies responsible for nursing-home standards. In 1972, reforms of Social Security established a single set of requirements for facilities supported by Medicare and for skilled-nursing homes that received Medicaid. Although this limited the ability of most individuals to enter skilled-nursing facilities, it increased the demand for intermediate-care facilities. Other amendments to the Older American Acts in 1973 and 1987 provided and strengthened statewide nursing home ombudsman programs. Nursing homes residents and their families now had a secure way of voicing any institutional complaints.

These policies, however, did not uniformly raise the standards of all nursing homes, nor did they eliminate the fear expressed by many of the older adults who faced nursing-home admission with dread. Yet, as the percentage of the population over eighty-five has continued to grow, nursing home care has become an increasing reality for many of the nation's oldest old. By 2000, nursing homes had become a 100 billion dollar industry, paid largely by Medicaid, Medicare, and out-of-pocket expenses; and although only 2 percent of all elderly individuals between sixty-five and seventy-four reside in such institutions, the proportion of those over eighty-five increased to 25 percent.

While these aging individuals no longer face the horrors of the almshouse, the development of the modern-day industry reflects its historical roots. In establishing monthly annuities for the old and disqualifying all residents of public institutions, the creators of Social Security took direct aim at the despised poorhouse. In their initial policies, New Dealers were anxious to sever the connection between old age and pauperism. In barring all residents of public institutions from receiving pensions, however, they clearly underestimated the proportion of elderly persons who required residential support. As a result, they did not initially provide for public asylums or regulate the quality of private care. Although recent legislation has attempted to control nursing homes, and federal funds such as Medicaid contribute to their assistance, the problems that face long-term care for older adults are clearly tied to their historical development. In shutting the almshouse door, policymakers gave birth to the modern nursing-home industry.

The Role of Nurses

The American Nurses Association recognizes and promotes the integral role of registered nurses in the care coordination process to improve healthcare consumers' care quality and outcomes across patient populations and health care settings, while stewarding the efficient and effective use of health care resources.

(1) Patient-centered care coordination is a core professional standard and competency for all registered nursing practice. Based on a partnership guided by the healthcare consumer's and family's needs and preferences, the registered nurse is integral to patient care quality, satisfaction, and the effective and efficient use of health care resources. Registered nurses are qualified and educated for the role of care coordination, especially with high risk and vulnerable populations.

(2) In partnership with other healthcare professionals, registered nurses have demonstrated leadership and innovation in the design, implementation, and evaluation of successful team-based care coordination processes and models. The contributions of registered nurses performing care coordination services must be defined, measured and reported to ensure appropriate financial and systemic incentives for the professional care coordination role.



The Affordable Care Act

This Act puts individuals, families and small business owners in control of their health care. It reduces premium costs for millions of working families and small businesses by providing hundreds of billions of dollars in tax relief – the largest middle class tax cut for health care in history. It also reduces what families will have to pay for health care by capping out-of-pocket expenses and requiring preventive care to be fully covered without any out-of-pocket expense. For Americans with insurance coverage who like what they have, they can keep it. Nothing in this act or anywhere in the bill forces anyone to change the insurance they have, period.



Americans without insurance coverage will be able to choose the insurance coverage that works best for them in a new open, competitive insurance market – the same insurance market that every member of Congress will be required to use for their insurance. The insurance exchange will pool buying power and give Americans new affordable choices of private insurance plans that have to compete for their business based on cost and quality. Small business owners will not only be able to choose insurance coverage through this exchange, but will receive a new tax credit to help offset the cost of covering their employees.

It keeps insurance companies honest by setting clear rules that rein in the worst insurance industry abuses. And it bans insurance companies from denying insurance coverage because of a person's pre-existing medical conditions while giving consumers new power to appeal insurance company decisions that deny doctor ordered treatments covered by insurance.

The Secretary has the authority to implement many of these new provisions to help families and small business owners have the information they need to make the choices that work best for them.

The Ethics of Keeping Someone Alive

Keeping Patients Alive a Few Weeks More: Is It Futile Care?

Hi. I am Art Caplan at the New York University (NYU) Langone Medical Center in the Division of Medical Ethics.

Futility. When should doctors even think about doing something that they believe to be futile? What I mean by “futility” is a belief that the treatment or intervention is not going to produce a benefit.

Medscape just conducted a survey of 24,000 doctors, and only 25% said they would not provide futile interventions. A very significant percentage, more than 30%, said that they would. The rest of those surveyed said they might, depending on the circumstances. That is a startling finding because the way we understand futility in ethics and in medical practice is “no benefit.” So why would you do things that don’t benefit the patient?

Part of the reason for the range of responses is that some doctors said, “Well, there might be a little benefit. Maybe you could keep someone going for a few weeks or a few months.” I understand that. I don’t think that is futile. That is a decision to provide a marginal benefit.



What counts as a significant or marginal benefit is partly up to the patient. We hear patients say in the intensive care unit, “I want to live so I can see my son’s wedding,” or “I want to live so I can get to my anniversary.” I have heard patients say, “I want to live so I can watch the Super Bowl.” Everybody has their own value system about what they think a few more weeks – a few more days, even – of life might mean to them. But I don’t consider that pure futility. So, if you are in that camp that says, “Well, I might do marginally beneficial things. I have to negotiate that with the patient, let the patient know that it will only be minimally helpful to them – another day, another week, or another month,” I understand that.

However, if you are going to follow that strategy, the patient needs to understand that the situation is still dire, that even if he or she receives the intervention (a little surgery, some medication for cancer, etc.) that this isn’t being provided in the hope that somehow he or she will get better or recover. By the time you

are having a futility discussion, you need to make it clear to the patient that we are really talking about managing their dying and extending that dying for some period of time, but that this is not a reversal of prognosis.

Some people said in the survey that they would provide futile treatments because there is always the possibility of a miracle. There is always a chance that something could happen. That is a troubling way to approach the subject of futility. It is true that miracles can happen, but for people who we know have end-stage lung cancer, liver disease, or pancreatic cancer, miracles don't come. The evidence says that we know what the prognosis is going to be.

So, although I certainly understand wanting to offer hope to people and give them emotional comfort, we are not doing them favors by saying, "You know, miracles happen; things happen out of the blue." Maybe that is something that the chaplain wants to say, but it isn't something that the doctor should be saying.

A better approach, or a substitute, is to offer people small hope such as, "Would you be comfortable if we said you might be able to see your family tomorrow? Does that give you hope and a reason to go on? Does it make you hopeful if we say there are small goals that we could reach together? You would have a chance to meet with friends and relatives and tell each other how you feel about one another."

Big hopes – miracles, miracle cures – are called miracles because it would be miraculous if they happened. Offering small hope instead of providing futile treatments is a more humane way to deal with the reality of death – small steps, small hopes. Patients understand. They usually know when they are in dire straits, and so do their families. They have the right to hope, but we ought to give them more short-term, reasonable things to hope for and not continue to give them hope that we absolutely know is futile at this point in their care.

The fact that a lot of doctors are still willing to give futile care is probably tied in with another reality, and that is fear about the law. People worry that "if somebody sues me, and I didn't do x, y, or z, then I'm going to be on the wrong end of a malpractice suit."

I have never seen it. I have acted as an expert witness. You don't lose those cases. If you say in good conscience, as a physician, as an expert, that I believed that doing something was futile and I didn't do it, and I talked about that with the patient – anybody can sue you at any time for anything – you are not going to lose that case because you are following the standard of care and what you believe to be true as the expert.

Using futile care as a way to stave off or avoid malpractice suits or litigation is not good for the patient, and in these kinds of situations, you want to do what is best for the patient. Prolonging suffering, causing the patient more harm – if that is part of what futility means, to have a false sense of security about a lawsuit – is not the way to go.

Futility is certainly complex, but let us not confuse it with marginally beneficial treatments or interventions. That is a different issue, and I fully understand why people would be inclined to negotiate that with the patient, to see what they want to do. Different people will answer differently. Let's not fool ourselves. We want to give hope. But let us not produce hope that isn't grounded in reality, and let us not use futility as a way to stave off fears about litigation. It doesn't work. You are going to be better off not providing the care, and explaining, if anybody challenges you, that continuing to provide that care is pointless, drives up the patient's bill, and probably causes more misery and suffering to the patient.

I'm Art Caplan at the Division of Medical Ethics at NYU Langone Medical Center. Thanks for watching.

REFLECT Post-Show Panel Discussions

Please join us for these free programs during the run of *Death Tax*.
No RSVP is required, but seating is limited.

REFLECT

Sunday, September 21 after 3pm matinee

Matters of the Heart: The Caregiver Connects

Our hospitals and hospices are filled with medical professionals who work tirelessly to deliver the best care possible. Who are these people, where do they come from, and what motivates them to take on this challenging job? How do they manage the stresses of consistent life and death decisions? How do caregivers also take care of themselves and their own loved ones?



Sunday, September 28 after 3pm matinee

Forever Young: America's Fear of Aging

America's focus on youth and independence has created a culture-wide fear of aging and dependence. New eldercare facilities have been created overseas so that we may send away any reminders of our mortality. What are the roots of our national fear of aging? How does this fear manifest – plastic surgery, overseas eldercare facilities, ageism, etc? Can we truly pluck, pull, and pill our way into immortality? How do other countries and cultures approach the aging and the elderly?



Sunday, October 5 after 3pm matinee

Grave Disagreements: How We Define Death

Countless advancements in biomedical care and technology have blurred previously understood lines between life and death. How do we currently define death from medical, legal, and cultural vantage points? How has this definition changed over time, societies, and cultures?



Sunday, October 12 after 3pm matinee

A Tale of Two Plays: Chicago Theatre and the works of Lucas Hnath

Chicago's theatrical institutions have embraced the words of budding playwright Lucas Hnath. Join us in a conversation between Heidi Stillman (Lookingglass Theatre Director, *Death Tax*) and Michael Halberstam (Writers Theatre Director, *Isaac's Eye*) as they discuss the similarities, differences, and shared themes of these Hnath plays, and why each story resonates for Chicago theatre-goers today.



PRE-SHOW LECTURE

Sunday, October 5 at 1:30pm

Dead or Alive: Taxed by Death

When we engage with rivals, we sometimes lose our best selves. In *Death Tax*, the central character challenges humanity's ultimate rival: death. What is permitted when good people seek to defeat death? What happens to relationships when the truth is expendable and money is no object? Don't miss this discussion between Director Heidi Stillman and Raven Foundation Founder Suzanne Ross about rivalry and self-deception in a play that begs the question: if you live your life in order to defeat death, are you as good as dead already?



THANK YOU TO OUR COMMUNITY PARTNERS:

THE RAVEN
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Resources

About Lucas Hnath

http://www.nytimes.com/2013/02/10/theater/lucas-hnath-on-his-comedy-about-isaac-newton.html?_r=1&

What is the Estate (Death) Tax?

<http://www.irs.gov/Businesses/Small-Businesses-&Self-Employed/Estate-Tax>

The History of Nursing Homes

<http://www.4fate.org/history.html>

The Role of Nurses

<http://nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/ANAPositionStatements/Position-Statements-Alphabetically/Care-Coordination-and-Registered-Nurses-Essential-Role.html>

The Affordable Care Act

<http://www.hhs.gov/healthcare/rights/law/index.html>

The Ethics of Keeping Someone Alive

<http://www.medscape.com/viewarticle/773985>