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## Older Clients with Questionable Legal Competence: Elder Law Practitioners and Treating Physicians

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Physicians

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## INTRODUCTION

Issues arise with some frequency in Elder Law practice,<sup>2</sup> as well as in legal practices wherein attorneys counsel parties who interact—or who contemplate interacting—with older persons, concerning the cognitive and emotional ability of an older individual to make legally significant decisions. Questions about a person’s legal competence<sup>3</sup> may arise regarding decisions to be made in a variety of both dramatic and everyday<sup>4</sup> factual contexts, most

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<sup>2</sup> For background information on the emerging professional field of Elder Law, see generally National Association of Elder Law Attorneys, [www.naela.org](http://www.naela.org) and the other essays in this Symposium.

<sup>3</sup> The terms “competence” and “capacity” frequently are used interchangeably in common parlance. However, the two terms technically refer to distinct concepts. As used in this essay, “competence” refers to a formal adjudication by a court or other authorized judicial or administrative body regarding the legal authority of an individual to make decisions with legal consequences. By contrast, “capacity” refers to a clinical, extralegal working impression concerning a person’s ability to engage in a rational decisionmaking process. “A capacity assessment is a clinical assessment.” Jason Karlawish, *Measuring Decision-Making Capacity in Cognitively Impaired Individuals*, 16 NEURO SIGNALS 91 (2008). See also American Law Institute-American Bar Association Continuing Legal Education, *Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers*, 6 ALI-ABA 115, 163 (2007) [hereinafter ALI-ABA].

<sup>4</sup> See James M. Lai & Jason Karlawish, *Assessing the Capacity to Make Everyday Decisions: A Guide for Clinicians and an Agenda for Future Research*, 15 AM. J. GERIATR. PSYCHIATRY 101 (2007).

importantly medical treatment choices,<sup>5</sup> other personal decisions such as where and with whom to reside, financial transactions,<sup>6</sup> and execution of a will or other estate planning instrument.

The physicians who have treated the person whose competence is being called into question (the “allegedly incompetent person”), and/or the medical records generated by those treating physicians,<sup>7</sup> often are sought by attorneys as sources of factual evidence regarding the physicians’ first-hand observations of the patient’s symptoms and behaviors, the clinical diagnoses made by the physicians, and the treatments offered and dispensed to the patient. The major medical conditions potentially complicating a patient’s mental competence—namely, dementia,<sup>8</sup> depression,<sup>9</sup> delirium<sup>10</sup> (the “three D’s), and various psychoses<sup>11</sup>—typically are seen and treated by the older person’s primary care physician.

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<sup>5</sup> See, e.g., Miriam B. Rodin & Supriya Gupta Mohile, *Assessing Decisional Capacity in the Elderly*, 35 SEMINARS ONCOL. 625 (2008) (discussing capacity assessment in the context of medical treatment decisions).

<sup>6</sup> See Daniel C. Marson et al., *Clinical Interview Assessment of Financial Capacity in Older Adults with Mild Cognitive Impairment and Alzheimer’s Disease*, 57 J. AM. GERIATR. SOC’Y 806 (2009).

<sup>7</sup> See generally S. Sandy Sanbar, *Medical Records: Paper and Electronic*, in LEGAL MEDICINE 347-356 (7<sup>th</sup> ed. 2007).

<sup>8</sup> See generally Richard H. Fortinsky et al., *Primary Care Physicians’ Dementia Care Practices: Evidence of Geographic Variation*, 50 GERONTOLOGIST 179 (2010) (“Dementia is a health problem of growing importance for primary care physicians (PCPs) who see older patients in ambulatory care settings.”); Cynthia M. Carlsson et al., *Dementia Including Alzheimer’s Disease*, in HAZZARD’S GERIATRIC MEDICINE & GERONTOLOGY 6<sup>th</sup> ed. ch. 65 (Jeffrey B. Halter et al., eds.), available at [www.accessmedicine.com/content.aspx?aID=5122625](http://www.accessmedicine.com/content.aspx?aID=5122625) (last accessed   ); ALZHEIMER’S DISEASE INTERNATIONAL, WORLD ALZHEIMER REPORT (2009), available at [www.alz.co.uk/research/files/world%20Alzheimer%20report.pdf](http://www.alz.co.uk/research/files/world%20Alzheimer%20report.pdf) (last accessed   ). For a comparative legal perspective, see Sanna Gevers, *Dementia and the Law*, 13 EUR. J. HEALTH L. 209 (2006).

<sup>9</sup> See generally Dan G. Blazer, *Late-Life Mood Disorders*, in HAZZARD’S GERIATRIC MEDICINE & GERONTOLOGY 6<sup>th</sup> ed. ch. 70 (Jeffrey B. Halter et al., eds.), available at [www.accessmedicine.com/content.aspx?aID=5122625](http://www.accessmedicine.com/content.aspx?aID=5122625) (last accessed   ).

In addition to the fact-provider role, the treating physician also may be solicited to provide, based upon that physician's direct experience with the allegedly incompetent person, an expert opinion regarding that person's present or previous<sup>12</sup> ability to make decisions<sup>13</sup> for purposes of having that opinion admitted and considered within a legal setting. Further, a treating physician's records may be sought by an attorney for use as a partial basis for the formulation of an expert opinion about the competence of the alleged incompetent person who was treated by the treating physician, when the expert opinion is to be rendered by a non-treating consulting physician explicitly employed by the attorney for forensic purposes.<sup>14</sup>

Attorneys' retention of expert consultants<sup>15</sup> specifically for the purpose of performing forensic evaluations (that is, specifically to generate expert opinion testimony for presentation to

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<sup>10</sup> See generally Katherine B. Auerswald, Peter A. Charpentier, & Sharon K. Inoue, *The Informed Consent Process in Older Patients Who Developed Delirium: A Clinical Epidemiologic Study*, 103 AM. J. MED. 410 (1997).

<sup>11</sup> See generally Danielle L. Anderson & Peter V. Rabins, *Schizophrenia*, in HAZZARD'S GERIATRIC MEDICINE & GERONTOLOGY 6<sup>th</sup> ed. ch. 71 (Jeffrey B. Halter et al., eds.), available at [www.accessmedicine.com/content.aspx?aID=5122625](http://www.accessmedicine.com/content.aspx?aID=5122625) (last accessed     ).

<sup>12</sup> Retrospective inquiry into a person's earlier mental state often takes place in the context of a will contest challenging a testator's testamentary capacity. See generally Thomas G. Gutheil, *Common Pitfalls in the Evaluation of Testamentary Capacity*, 35 J. AM. ACAD. PSYCHIATRY & L. 514 (2007); Kenneth I. Shulman et al., *Assessment of Testamentary Capacity and Vulnerability to Undue Influence*, 164 AM. J. PSYCHIATRY 722 (2007).

<sup>13</sup> Regarding the role of expert opinion evidence, see generally Harry A. Gair, *Selecting and Preparing Expert Witnesses*, 2 AM. JUR. TRIALS 585 (2009).

<sup>14</sup>The term "forensic" refers to the application of scientific (including medical) expertise, through the preparation of reports, to help resolve legal issues. See BLACK'S LAW DICTIONARY (8<sup>th</sup> ed. 2004) (defining "forensic" as "used in or suitable to courts of law or public debate").

<sup>15</sup> Psychologists as well as psychiatrists and other physicians frequently are hired by attorneys to perform the expert evaluator function. See, e.g., Sara Hone Qualls & Michael A. Smyer (eds.), CHANGES IN DECISION-MAKING CAPACITY IN OLDER ADULTS: ASSESSMENT AND INTERVENTION

the court or other legal forum) raises a panoply of challenges for legal practitioners<sup>16</sup> and the courts,<sup>17</sup> a comprehensive discussion of which would go beyond the scope of the present essay. Rather, this essay concentrates on the professional relationship present between the Elder Law attorney who is involved in a situation in which the decision-making competence of an older person is questioned, on one side, and the treating physician of the same older person, on the other. Competence is a “socio-legal construct”<sup>18</sup> and, within the boundaries of that construct, a competence determination involves the “intersection of legal doctrine, behavioral science research, and clinical practice.”<sup>19</sup> The attorney/physician interaction in this arena frequently is less than ideal;<sup>20</sup> this essay examines some of the reasons for such interprofessional friction and

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(2007). The pool of good potential expert witnesses is limited. *See* Kathryn Kaye & Michael Kenny, *The Business of Geropsychology: Billing and Preparing Legal Reports and Testimony*, in Qualls & Smyer, this note, at 299 (“Forensic evaluation [of decision-making capacity] is not for the faint of heart, nor is it a suitable choice for individuals who have an aversion to detail or a low tolerance for ambiguity.”); ALI-ABA, *supra* note 3, at 156 (“In major metropolitan areas lawyers are more likely to be able to identify internists, psychiatrists, and psychologists with relevant background. The reality is, however, that the number of professionals with ideal credentials is small.”).

<sup>16</sup> *See generally* Adam F. Streisand & James E. Spar, *A Lawyer’s Guide to Diminishing Capacity and Effective Use of Medical Experts in Contemporaneous and Retrospective Evaluations*, 33 AM. COLL. TRUST & ESTATE COUNSEL J. (ACTEC J.) 180 (2007).

<sup>17</sup> Kenneth C. Dudley & R. Turner Goins, *Guardianship Capacity Evaluations of Older Adults: Comparing Current Practice to Legal Standards in Two States*, 15 J. AGING & SOC. POL’Y 97 (2003).

<sup>18</sup> Andrea M. Newberry & Arlin K. Pachet, *An Innovative Framework for Psychosocial Assessment in Complex Mental Capacity Evaluations*, 13 PSYCHOL., HEALTH & MED. 438, 439 (2008).

<sup>19</sup> Michael A. Smyer, *Aging and Decision-Making Capacity: An Overview*, in Qualls & Smyer, *supra* note 15, at 5.

<sup>20</sup> *See* Jennifer Moye et al., *Clinical Evidence in Guardianship of Older Adults is Inadequate: Findings from a Tri-State Study*, 47 GERONTOLOGIST 604 (2007).

makes a few suggestions for productively addressing the tension in a manner likely to benefit the allegedly incompetent person.

Before proceeding with that discussion, however, an important caveat is in order. This essay does not at all purport to present the results of a rigorous scientific study, either quantitative or qualitative.<sup>21</sup> Rather, this essay offers one set of the author's own reflections and impressions formulated on the basis of his particular professional experience as an academic attorney who has worked for many years in medical educational environments, supplemented by his individual conversations with a small convenience sample of experienced physicians conducted for purposes of this project.<sup>22</sup> The explanations and suggestions that follow should be understood and evaluated with this caveat in mind.

#### EXPLANATIONS FOR THE INTERPROFESSIONAL TENSION

There is an array of plausible explanations for the frequent tension that develops between Elder Law attorneys and treating physicians in the sphere of decision-making competence determination. Perhaps most fundamental is the fact that attorneys involved in cases raising questions about decision-making competence identify the pertinent issues and objectives in a very different way than do the treating physicians of an alleged incompetent person.

Both relationships [physician-patient and attorney-client] require professionalism, ethical conduct, extensive skill and training, and confidentiality, yet they are

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<sup>21</sup> Regarding qualitative social science research techniques in a context with relevance to the legal profession, see Joshua Perry, *The Ethical Costs of Commercializing the Professions: First-Person Narratives from the Legal and Medical Trenches*, 13 U. PENN. J. L. & SOC. CHANGE 13 (2010).

<sup>22</sup> The author thanks the physicians who spoke with him about this project. Because these physicians spoke with the expectation that their comments would only be reported anonymously, they are not acknowledged here by name.

practiced in diametrically dissimilar fashions. Although this description is overly simplistic and entire texts have been devoted to both types of relationship, the physician's job is to prevent, diagnose, discover, and, if possible, remedy an illness and alleviate suffering. The legal system is based on an adversarial process; the attorney has an ethical duty to fervently represent a client and attempt to win the case or argument, which is often decided by a third unaffected party: jury, judge, or mediator. Winning may not be synonymous with truth or justice....Even though an argument could be made that neither relationship...is ideal or even just, it is telling that they are so different.<sup>23</sup>

Treating physicians normally are driven by, and organize the great bulk of their energies and activities around, a therapeutic model focused on the patient's medical welfare. Oriented thusly toward clinical consequences, treating physicians are generally tolerant of "bumbling through," even despite some legal ambiguity, and respecting the patient's autonomy so long as medical harm to the patient does not result. Efficiency and flexibility in responding to the medical immediacy of the patient's needs is important to accomplish the physician's patient care function. In the course of treating the patient, the physician ordinarily is not looking for, let alone collecting and documenting, legally admissible evidence, since the patient's legal status rarely will matter in carrying out the physician's job to make the patient "better;" hence, the physician may appear recalcitrant to the attorney not because the physician is intentionally behaving difficultly, but rather just because the physician does not possess the data necessary to answer the question posed by the attorney regarding decisionmaking competence.

By contrast, the elder law attorney likely is influenced by a more forensic, or legal authority clarification oriented, paradigm. This model basically entails a process orientation intent on obtaining absolute legal certainty regarding the rights and duties of all the respective parties to a medical, financial, or personal transaction, with that certainty achieved if necessary through the adversary system. Attorney bias in this direction is based heavily on Elder Law

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<sup>23</sup>Richard D. Zane, *The Legal Process*, 27 EMERG. MED. CLIN. N. AM. 583, 583-84 (2009).

practitioners' experience in working with a skewed sample in which legal bumbling through has not worked very well for vulnerable older clients and other parties with whom those clients have dealt.<sup>24</sup>

A second significant factor contributing to attorney/treating physician friction is physician apprehension that the physician's cooperation in a legal process (such as guardianship) that might have the ultimate effect of overriding or limiting the patient's stated wishes would be interpreted by the patient as a moral betrayal.<sup>25</sup> Physicians' worry that such perceived betrayal, especially when it entails the sharing of otherwise confidential patient medical information with third parties,<sup>26</sup> will engender a diminution of trust and thereby destroy or impair continuation of the beneficial physician/patient fiduciary relationship.<sup>27</sup> Additionally, physicians are anxious that their cooperation in a legal process that diminishes the patient's autonomy may be anti-therapeutic, hence offensive to the ethical principle of beneficence,<sup>28</sup> by helping to bring about a legal outcome that (from the patient's own perspective) makes the patient's life worse than it was before; for instance, the physician's assistance to an attorney in establishing a guardianship for a

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<sup>24</sup> The dichotomous differentiation of physicians as healers versus attorneys as adversaries, although generally accurate, is not inevitable and immutable. See Charity Scott, *Doctors as Advocates, Lawyers as Healers*, 29 HAMLIN J. PUBLIC L. & POL'Y 331 (2008).

<sup>25</sup> See Desla Mancilla & Sue Biedermann, *Health Information Privacy: Why Trust Matters*, 28 HEALTH CARE MANAG. 71 (2009). Cf. Dan R. Reilly, *Breaching Confidentiality and Destroying Trust: The Harm to Adolescents on Physicians' Rosters*, 54 CAN. FAM. PHYSICIAN 834 (2008).

<sup>26</sup> Regarding statutory permission for the physician to share patient information in the competence context, see, e.g., WISC. STAT. ANN. 905.04 (4) (a).

<sup>27</sup> Regarding the historic trust or fiduciary nature of the physician/patient relationship, see, e.g., JENNIFER JACKSON, *TRUTH, TRUST & MEDICINE* (2001); Mark A. Hall, *Law, Medicine and Trust*, 55 STAN. L. REV. 463 (2002).

<sup>28</sup> See generally EDMUND D. PELLEGRINO & DAVID C. THOMASMA, *FOR THE PATIENT'S GOOD: THE RESTORATION OF BENEFICENCE IN HEALTH CARE* (1988).

person who has no family but who vehemently wishes to remain in his or her own home despite deficits in Activities of Daily Living (ADLs)<sup>29</sup> might result in the guardian compelling the resisting person to enter an undesired nursing home.<sup>30</sup>

Another factor contributing to attorney/treating physician tension in this specific context is the fact that, in the modern frequently-fragmented, uncoordinated American health care non-system,<sup>31</sup> the primary care physician often does not interact with a patient to a great extent during the patient's times of substantial challenge and stress; during those most difficult situations, the patient's immediate care often is at least temporarily transferred to a medical specialist such as a hospitalist,<sup>32</sup> intensivist,<sup>33</sup> or nursing home Medical Director.<sup>34</sup> Thus, the primary care physician ordinarily has little reason to question, let alone to document, the patient's decision-making competence or patient behaviors that conceivably could reflect on the patient's competence during office-based encounters that are conducted for such routine purposes as monitoring the patient's blood pressure and lipid and thyroid levels. So long as the patient appears to be reasonably compliant with medical instructions (for example, appearing on time for scheduled appointments, independently or assisted by someone else, answering the

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<sup>29</sup> See generally M. Powell Lawton & Elaine M. Brody, *Assessment of Older People: Self-Maintaining and Instrumental Activities of Daily Living*, 9 GERONTOLOGIST 179 (1969).

<sup>30</sup> See Marshall B. Kapp, "A Place Like That": *Advance Directives and Nursing Home Admissions*, 4 PSYCHOL., PUB. POL'Y & L. 805 (1998) (discussing the resistance of many people to nursing home admission).

<sup>31</sup> See Gulshan Sharma et al., *Continuity of Outpatient and Inpatient Care by Primary Care Physicians for Hospitalized Older Adults*, 301 J. AM. MED. ASS'N 1671 (2009).

<sup>32</sup> Thomas E. Baudendistel & Robert M. Wachter, *The Evolution of the Hospitalist Movement in the USA*, 2 CLIN. MED. 327 (2002).

<sup>33</sup> See Gulshan Sharma et al., *Continuity of Care and Intensive Care Unit Use at the End of Life*, 169 ARCH. INTERN. MED. 81 (2009).

<sup>34</sup> James E. Finale, *The Nursing Home Medical Director*, 37 J. AM. GERIATR. SOC'Y 369 (1989).

physician's questions succinctly and affirmatively, and going along without complaint with laboratory tests and physical examinations), the primary care physician rarely generates and memorializes on an ongoing basis the sort of direct evidence regarding a patient's decision-making competence that an attorney would find useful in a legal proceeding.

As stated by one pair of commentators:

In the ideal case, the medical record contains a detailed, quantitative assessment of cognitive function on the date at issue. Unfortunately, such records are rare. Almost as useful is the medical record that contains multiple quantitative assessments of cognitive function prior to and after the date in question...But records of this type are also rare.<sup>35</sup>

Their inadequate professional education about the operation of the legal system generally, and particularly the lack of much or any systematized training to hone forensic diagnostic or documentary skills,<sup>36</sup> are additional factors cited by physicians to help explain their reluctance to get involved with attorneys in cases raising competence questions concerning present or former patients. Although for a number of years almost all medical schools and accredited medical residency programs have incorporated into their curricula substantial attention to the legal and ethical facets of informed patient consent for proposed medical interventions,<sup>37</sup> it is likely that most of that instruction pertains to the informed element of the consent doctrine,<sup>38</sup> with

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<sup>35</sup> Streisand & Spar, *supra* note 16, at 183.

<sup>36</sup> See, e.g., Ryan C.W. Hall et al., *Testamentary Capacity: History, Physicians' Role, Requirements, and Why Wills Are Challenged*, 17 CLIN. GERIATR. 18 (2009) ("Unfortunately, most doctors, even those who primarily see patients of advanced years, are not knowledgeable about key issues surrounding testamentary capacity.").

<sup>37</sup>S. M. Johnson et al, *Teaching the Process of Obtaining Informed Consent to Medical Students*, 67 ACAD. MED. 598 (1992).

<sup>38</sup>See, e.g., Tsiao Y. Yap et al., *A Physician-Directed Intervention: Teaching and Measuring Better Informed Consent*, 84 ACAD. MED. 1036 (2009); Heather B. Sherman et al., *Teaching Pediatric Residents How to Obtain Informed Consent*, 80 ACAD. MED. S10 (2005). Regarding the informed element of the informed medical consent legal doctrine, see, e.g., Jessica J. Finn,

particular emphasis on the tangible, written documentation of consent<sup>39</sup> and other risk management considerations.<sup>40</sup> Medical students and residents are—at best—only generally familiar with the element of informed consent that requires a competent decision maker, and likely receive scant if any structured instruction dedicated specifically to improving their knowledge or clinical evaluation skills in the arena of capacity/competence to give medical informed consent.<sup>41</sup> Even less attention is paid in most medical schools and post-graduate training programs to developing future medical practitioners' skills in assessing and documenting patients' decision-making competence for purposes besides obtaining informed consent to medical interventions.

A few limited exceptions to the foregoing general statements should be noted. A significant amount of instruction regarding both the theoretical and clinical assessment aspects of

*Personalizing Informed Consent: The Challenge of Health Literacy*, 2 ST. LOUIS U. J. HEALTH L. & POL'Y 379 (2009); Steven G. Rado, *A Patient's Right to Know: A Case for Mandating Disclosure of Physician Success Rate as an Element of Informed Consent*, 18 HEALTH MATRIX 501 (2008).

<sup>39</sup> Regarding the importance of written documentation of informed medical consent, see, e.g., Ctrs. for Medicare & Medicaid Servs., Dept. of Health & Human Servs., Revisions to Hospital Interpretive Guidelines for **Informed Consent**, S&C-07-17 9 (2007), available at <http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter07-17.pdf> (last accessed   ):

The **medical** record must contain a document recording the patient's **informed consent** for those procedures and treatments that have been specified as requiring **informed consent**. **Medical** staff by-laws should address which procedures and treatments require **written informed consent**. There may also be applicable Federal or State law requiring **informed consent**. The **informed consent form** contained in the **medical** record should provide evidence that it was properly executed.

<sup>40</sup> See, e.g., David E. Thiess, Justin A. Sattin & Daniel G. Larriviere, *Hot Topics in Risk Management in Neurologic Practice*, 28 NEUROL. CLIN. 429 (2010) (discussing the risk management value of documenting informed consent); Brendan G. Magauran, *Risk Management for the Emergency Physician: Competency and Decision-Making Capacity, Informed Consent, and Refusal of Care Against Medical Advice*, 27 EMERG. MED. CLIN. N. AM. 605 (2009).

<sup>41</sup> See, e.g., Karen L. McClean & Sharon Card, *Informed Consent Skills in Internal Medicine Residency: How Are Residents Taught, and What Do They Learn?*, 79 ACAD. MED. 128 (2004).

determining decisionmaking competence is woven into virtually all residency programs in the medical specialties of Psychiatry and Neurology,<sup>42</sup> and additional attention to this matter is devoted in geriatric, forensic psychiatry,<sup>43</sup> and geriatric psychiatry<sup>44</sup> fellowship programs. Additionally, in the last decade a number of substantial grants awarded by the Donald W. Reynolds Foundation<sup>45</sup> and the Association of American Medical Colleges (AAMC)<sup>46</sup> to American medical schools to enhance the level of geriatrics education for all of their students likely have had the effect of influencing the recipient schools to include more training regarding the clinical evaluation of decision-making capacity and competence in older patients. Despite

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<sup>42</sup>American Board of Psychiatry and Neurology, PSYCHIATRY AND NEUROLOGY CORE COMPETENCIES VERSION 4.1, III. A. 7 (“To communicate effectively and work collaboratively with other healthcare and other professionals involved in the lives of patients and families”) & VI. B. 2 (“In the community, physicians shall demonstrate knowledge of the legal aspects of psychiatric and neurological diseases as they impact patients and their families.”), *available at* [www.abpn.com](http://www.abpn.com) (last visited ).

<sup>43</sup>American Board of Psychiatry and Neurology, FORENSIC PSYCHIATRY CORE COMPETENCIES OUTLINE 2.1, I. B. 5 (“To conduct a forensic evaluation for non-treatment purposes of an individual and develop a well-reasoned forensic psychiatric opinion...”), II. A. 6 c & d (“Civil issues, including competency/guardianship/conservatorship & testamentary capacity”), II. A. 13 b (“Special consultations and investigations, including attorneys”), *and* III. A. 11 (“To communicate forensic data and opinions in written format through forensic reports and/or testimony”), *available at* [www.abpn.com](http://www.abpn.com) (last visited ).

<sup>44</sup> American Board of Psychiatry and Neurology, GERIATRIC PSYCHIATRY CORE COMPETENCIES OUTLINE 2.1, I. B. 4 (“Geriatric psychiatrists shall gather essential and accurate information through interviews with their geriatric psychiatric patients, family members, caregivers and other health professionals with attention to...[c]ompetency assessments (e.g., decisions regarding treatment, personal care, etc.”) *and* II. B. 10 c (“Geriatric psychiatrists shall develop and apply specific knowledge for education in geriatric psychiatry, including...[p]ractice related and policy and legal issues: [f]orensic issues”), *available at* [www.abpn.com](http://www.abpn.com) (last visited ); Susan J. Lieff, Paul Kirwin, & Christopher C. Colenda, *Proposed Geriatric Psychiatry Core Competencies for Subspecialty Training*, 13 AM. J. GERIATR. PSYCHIATRY 815 (2005).

<sup>45</sup>Donald W. Reynolds Foundation, [www.dwreynolds.org/programs/national/aging/aging.htm](http://www.dwreynolds.org/programs/national/aging/aging.htm) (last visited ).

<sup>46</sup>Association of American Medical Colleges, [www.aamc.org](http://www.aamc.org) (last visited ).

these important but limited exceptions, however, most treating physicians (particularly primary care providers) are quite uncomfortable with their low degree of educational preparation for the role of evidence supplier in legal contexts involving the questioning of a patient's competence.

Another serious source of attorney/physician tension in situations in which the physician's assistance in evaluating and proving a client/patient's decision-making competence is sought by an attorney is the set of anxieties that many physicians sense concerning their own exposure to legal liability for becoming involved in the competence determination process. To a large extent, these physician-held legal anxieties are free-floating and not firmly anchored to any specific, concretely identifiable reason; instead, fears derive from physicians' general distaste of attorneys, the adversarial system for resolving disagreements, and the process of cross examination in particular. Such fears are not exactly alleviated when attorneys, speaking for their profession, make such public assertions as: "Cross examination is about control...[T]he focus should not be on the witness, but on the attorney. The witness is nothing more than a trained monkey (a trained, talking monkey that is), confirming or denying the attorney statements."<sup>47</sup>

Stated a bit more diplomatically

The attorney, while presenting evidence, also presents witnesses whose opinions favor their argument in the case. The system is, by definition, adversarial, and therefore both sides collect and organize evidence as it is best presented to further their arguments, including diametrically divergent options from [witnesses]. Expert witnesses [especially] are often the focus of much scrutiny regarding their motivation and the lack of impartiality of their testimony.<sup>48</sup>

Finally (although the list of factors enumerated here in no way pretends to be comprehensive), most physicians consider the time commitment and emotional hassles that their

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<sup>47</sup> Streisand & Spar, *supra* note 16, at 193.

<sup>48</sup> Zane, *supra* note 23, at 589.

involvement with attorneys and the legal system generally entail to be an undesirable distraction from their important medical practices and the therapeutic patient benefit that those medical practices pursue. Practicing physicians are, and overwhelmingly characterize themselves as being, extremely busy and needing (in the words of one physician whom I interviewed) to “triage the paperwork to survive.” Making matters worse is the unavailability, in most situations, of meaningful financial reimbursement to physicians for the time expenditures and hassle-dealing efforts encountered in cooperating with an attorney for the purpose of helping the attorney to definitively clarify the patient’s legal status.

#### ADDRESSING THE INTERPROFESSIONAL TENSION

One possible reaction to the present state of affairs would be to maintain the status quo. Although the current level of interaction between Elder Law attorneys and treating physicians frequently is not ideal in the context of illuminating and clarifying the legal status of an allegedly incompetent person’s right to make particular kinds of legally significant decisions, both the medical and legal systems in the United States have somehow managed to bumble through for many years without unduly producing either anarchy or oppression.<sup>49</sup> The medical-legal tensions identified in this article are very real, but it still may be best—all things considered—to leave well enough alone.

Despite the inertial predisposition disfavoring a serious disruption of the present situation, improvement could be achievable. First, if an insufficiency of physician knowledge and skills regarding the assessment of patients’ decisionmaking competence is indeed a notable

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<sup>49</sup> Cf. Marshall B. Kapp, *Decisional Capacity in Theory and Practice: Legal Process Versus ‘Bumbling Through’*, 6 AGING AND MENT. HEALTH 413 (2002) (discussing the points pro and con for initiating formal guardianship proceedings for persons whose decisionmaking competence has been called into question).

problem, then medical schools and postgraduate medical training programs could be incentivized and assisted to include in the educational experiences they offer more focused attention on instilling in their students and trainees a better knowledge base and skill set in this sphere. Such efforts might entail development of model curricula and teaching materials and the working out of questions concerning who would implement the curricula, at what point in the student's or resident's educational career, and using which kinds of formats. Additionally, internal political questions within specific institutions would need to be addressed in order to carve out sufficient curricular time from already overloaded educational schedules and to allocate resources commensurably with the distribution of departmental responsibilities.

Even assuming *arguendo* that these kinds of programmatic details could be satisfactorily resolved, however, there are several reasons one might nonetheless doubt the efficacy of more formal medical education as a panacea for eliminating attorney-physician tension within the process of resolving the legal status of an allegedly incompetent person. To begin, when questions regarding an individual's decisionmaking capacity enter the legal arena (that is, once questions of capacity transform into issues of competence), particular court practices and procedures—as well as the practices and procedures of specific judges working within the same court system—vary enormously among<sup>50</sup> and within<sup>51</sup> different jurisdictions. No medical education curriculum could reasonably be expected to anticipate and prepare future physicians to

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<sup>50</sup> The specific judicial division with authority to adjudicate issues pertaining to individuals' decision-making competence varies depending on the specific jurisdiction. *Compare* FLA. STAT. 744-102 (placing the authority to hear and decide guardianship petitions in the state Circuit Court for each county) *with* 20 PA. C.S.A. § 5511 (placing the authority to hear and decide guardianship petitions in the Orphans Court Division of the state Court of Common Pleas for each county).

<sup>51</sup> *Compare* Carbon Co. O.C.R. 14.1, Lyc. Co. O.C. L14.1, Erie Co. O.C. 14.1.1, and Westmoreland Co. O.C. Rule W0501 (illustrating the differing guardianship adjudication procedures implemented by various counties within the single state of Pennsylvania).

respond precisely to such wide variations in judicial and administrative practice. Thus, generic medical education regarding attorney-treating physician interaction in the context of resolving a client's/patient's legal decisionmaking status has, even at its best, notable inherent limitations in its practical applicability. Moreover, imposing a mandate to include yet more curricular material in already overloaded training programs would (as noted above) potentially create additional political headaches for medical educators. Perhaps most importantly, one might well question the extent to which enhancement of training opportunities in this sphere will, by itself, be robust enough to overcome the several other, powerful obstacles outlined earlier<sup>52</sup> to a more productive attorney-treating physician interaction regarding resolution of an alleged incompetent person's legal decisionmaking status. Even if treating physicians possess better knowledge about how to be involved in this aspect of the legal process, how likely is it that they will *want* to be more involved?

If enhancement of medical, including postgraduate, education—however essential such enhancement may be—is not likely to be sufficient, and the other inhibiting factors cannot realistically be eliminated, how then can Elder Law attorneys in the future work usefully to improve the quality of attorney-treating physician cooperation in the context of resolving decisionmaking competence issues? One fairly easily implementable suggestion is that Elder Law attorneys develop a straightforward written glossary of relevant legal terms, attentive to the idiosyncrasies of each attorney's own jurisdiction, to make available to the treating physicians from whom they solicit client-specific information; with the help of such a resource, all of the involved professionals would be working with a shared vocabulary and a lot of initial confusion and cross-purpose efforts could be curtailed. State and local bar association Elder Law

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<sup>52</sup> See notes 23-35 and 47-48, *supra*, and accompanying text.

committees could use groundbreaking work done by the American Bar Association and its partners as a jumping off point for producing such materials.<sup>53</sup>

Another recommendation would be for the attorney to frame information requests to the treating physician that focus on decision-specific abilities of the alleged incompetent person (namely, Does the person meet the competence criteria for autonomously making the specific decision at issue?),<sup>54</sup> rather than querying the physician about the person's mental state in a global, open-ended sense. The attorney's inquiries crafted in terms of the precise areas of cognitive and emotional functioning<sup>55</sup> necessary to decide the question actually, contemporaneously confronting the alleged incompetent persons, geared to a specific set of circumstances and places, and accompanied by a clear explanation of why the competence inquiry is being posed right at this time, are more likely to produce physician responses with meaningful evidentiary value.<sup>56</sup>

Additionally, Elder Law attorneys should resist the natural inclination to ask treating physicians, even within decision-specific frameworks, for a single, all-encompassing clinical-legal conclusion. Instead, treating physicians' responses to attorneys' requests for opinions about a patient's decision-specific decisionmaking competence may be more worthwhile for the requesting attorney and the legal body resolving the matter when the attorney guides the physician to support conclusions with relatively brief answers to a series of questions that break

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<sup>53</sup> See AMERICAN BAR ASSOCIATION & AMERICAN PSYCHOLOGICAL ASSOCIATION, ASSESSMENT OF OLDER ADULTS WITH DIMINISHED CAPACITY: A HANDBOOK FOR PSYCHOLOGISTS (2008).

<sup>54</sup> See, e.g., Mathy D. Mezey et al., *Advance Directives: Older Adults With Dementia*, 16 CLIN. GERIATR. MED. 255 (2000) (discussing decision-specific mental capacity).

<sup>55</sup> Regarding the areas of cognitive and emotional functioning encompassed by the concept of decisionmaking competence, see, e.g., Karlawish, note 3, *supra*.

<sup>56</sup> ALI-ABA, *supra* note 3, at 160.

the competence evaluation into its separate data components, namely: the individual's ability to make and communicate any discernible choice; the individual's ability to comprehend his or her own specific situation; the person's ability to rational manipulate (reason with) the available information in reaching a decision; and the individual's ability to appreciate the probable and possible consequences of the alternatives being contemplated.<sup>57</sup> Many physicians may be better able, and more willing, to deal with attorneys at that concrete level of analysis and explanation than they would be to offer broad, undifferentiated conclusions regarding a particular patient's decisionmaking competence.

A further potential avenue of positive interprofessional synergy might entail attempts by attorneys dealing with questions of an individual's mental competence to use treating physicians to help pursue clinical or therapeutic interventions, as opposed to legal or adversarial ones, on behalf of the person about whom decisionmaking competence questions have been expressed.

There are many situations that are not adversarial, in which the attorney, client, and family are all seeking to serve the client's interests and to maximize capacity and autonomy. One important result of a capacity assessment may be specific recommendations for clinical interventions that may be recommended by the lawyer and pursued by the client and family to improve or stabilize the client's functioning. For example, in the case of the older client who has become delusional in the context of a hearing impairment, isolation, and anxiety, clinical interventions to address all three (hearing aids, more social contact, anti-anxiety medication) may very well reduce or eliminate delusions and restore the individual's capacity. In other situations, more frequent oversight and assistance with nutrition and medication may increase the client's lucidity.<sup>58</sup>

If these collaborative efforts are successful, the need for a formal competence evaluation by the treating physician, an expert consultant, and the court may be obviated or, at the least, delayed.

Fulfilling a therapeutic role on behalf of the individual patient is the natural historical fit for

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<sup>57</sup>See, e.g., Laura B. Dunn et al., *Assessing Decisional Capacity for Clinical Research or Treatment: A Review of Instruments*, 163 AM. J. PSYCHIATRY 1323 (2006).

<sup>58</sup>ALI-ABA, *supra* note 3, at 164.

treating physicians,<sup>59</sup> just as the costs and benefits of any contemplated intervention—that is, the net therapeutic impact—for each of the proper parties in a scenario should be a paramount consideration for the legal system and its cast of professional actors.<sup>60</sup>

## CONCLUSION

Whatever else might accurately be predicted about the practice of Elder Law in the next part of the twenty-first century, it will be imperative for attorneys in this developing professional specialty to learn to work more collaboratively with medical practitioners in a panoply of contexts that hold ramifications for the health and legal well-being of older people who are both attorneys' clients and physicians' patients. One of those contexts involves situations in which an older person's cognitive and emotional ability to make specific kinds of important, legally consequential life choices truly autonomously<sup>61</sup> has been called into question by someone with the right to raise that issue. The process for addressing the decisionmaking competence question is an interprofessional, medical-legal matter. It is in everyone's best interests, and especially that of the alleged incompetent person, that the quality of interprofessional interaction in this arena be improved. This essay offers some thoughts on the reasons for current tension between attorneys and treating physicians regarding the assessment and proof of an older person's decisionmaking competence, and sets forth a few preliminary ideas about improving or better capitalizing upon the quality of a much-needed interprofessional exchange between attorneys and physicians.

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<sup>59</sup>See JOHN H. WARNER, *THE THERAPEUTIC PERSPECTIVE: MEDICAL PRACTICE, KNOWLEDGE, AND IDENTITY IN AMERICA, 1820-1885* (1986).

<sup>60</sup>See Marshall B. Kapp, *A Therapeutic Approach*, in *THEORIES ON LAW AND AGEING: THE JURISPRUDENCE OF ELDER LAW* 31-44 (Israel Doron ed., 2009).

<sup>61</sup>The ethical principle of autonomy or self-determination lies at the core of the concept of valid adult decision making. See, e.g., ALASDAIR MACCLEAN, *AUTONOMY, INFORMED CONSENT AND MEDICAL LAW: A RELATIONAL CHALLENGE* (2009).