Representing a Client with Diminished Capacity: How Do You Know It *And* What Do You Do About It?

By
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Assisting clients with impaired capacity is traditionally thought of as the province of estate planners, elder law attorneys, or mental health lawyers. That association is no longer so true as we step into the twenty first century, because our nation's demographics are changing dramatically. We are becoming a much older society at an accelerated rate. As a consequence, an awareness of aging issues, even in the field of family law, has become essential to the practice of law. While the proportion of Americans marrying or divorcing after age 65 remains small compared to the aged population overall, the absolute numbers are growing, fueled by the inevitable crossing of the baby boomer bulge into old age.[1] According to the National Center for Health Statistics, there were 87,537 marriages and 30,143 divorces of persons 60 years of age and older in 1990.[2] Assuming marriage and divorce rates remain steady, these totals will more than double in the next 30 years.

One phenomenon correlated – though not *caused* by – older age is dementia. Dementia is a clinical syndrome characterized by loss of cognitive function sufficient to impair performance of

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1 *See* AARP, Profile of Older Americans: 1999, (May 22, 2000) <http://research.aarp.org/general/profile99.pdf>.

2 Centers for Disease Control and Prevention, National Center for Health Statistics, *Advance Report of Final Marriage Statistics, 1989 and 1990*, 43 (12) Monthly Vital Statistics Report (Supplement) at Table 8 (July 14, 1995); Centers for Disease Control and Prevention, National Center for Health Statistics, *Advance Report of Final Divorce Statistics, 1989 and 1990*, 43 (9) Monthly Vital Statistics Report (Supplement) at Table 5 (March 22, 1995).

everyday activities.[3] The label *dementia* implies no specific cause or pathological process, nor does it represent an inevitable part of normal aging. A wide range of diseases affecting the brain causes dementia – actually more than 55 diseases, some entirely reversible.[4] However, Alzheimer's disease is the most common cause, accounting for 60 to 70 percent of dementia cases.[5] The prevalence of dementia doubles every five years in the elderly, growing from a disorder that affects 1 percent of 60 year-olds to a condition afflicting approximately 30 to 45 percent of 85 year-olds.[6] In addition, other conditions such as depression or delirium (an acute confusional state) may mimic dementia in causing cognitive impairment. Yet, if recognized, these related conditions are reversible and manageable.[7]

The growing frequency of dementia demands specific attention by legal professionals. This article will review the lawyer's unique responsibilities and ethical dilemmas in identifying incapacity in Part I. Part II explains and clarifies the concept of decision-making capacity. Part III explains standardized screening mechanisms and suggests optimum steps for appropriate capacity screening in a legal practice. Finally, Part IV considers the range of protective actions that may be taken when the client no longer appears to be able to act in his or her own best interest.

I. The Attorney's Role

Although lawyers seldom receive formal capacity assessment training, they make capacity judgments on a regular basis. Practitioners by necessity make an initial determination of each client's capacity to engage in an attorney-client relationship, al-

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[3] University HealthSystem Consortium & U.S. Dept. of Veterans Affairs, DEMENTIA IDENTIFICATION AND ASSESSMENT: GUIDELINES FOR PRIMARY CARE PRACTITIONERS 1 (March 1997); David S. Geldmacher & Peter J. Whitehouse, Evaluation of Dementia, 335 NEW ENG. J. MED. 330 (1996).

[4] *Id*.

[5] *Id*. *See also* National Institute on Aging, National Institutes of Health, U.S. Dept. of Health & Human Services, PROGRESS REPORT ON ALZHEIMER'S DISEASE *1999*, NIH Pub. No. 99-4664 (1999); Peter V. Rabins, Constantine G. Lyketsos, & Cynthia D. Steele, PRACTICAL DEMENTIA CARE 16 (1999).

[6] University HealthSystem Consortium, *supra* note 3, at 1; Peter V. Rabins, et al., *supra* note 5, at 16.

[7] University HealthSystem Consortium, *supra* note 3, at 7.

though for the typical adult client, capacity will be presumed. It is only when signs of questionable capacity present themselves that an initial determination becomes deliberate. Subsequent assessments may be necessary because client capacity varies according to the nature of the particular decision.[8] A client may be capable of appointing someone as a substitute decision-maker but not of creating a trust document or agreeing to a complicated property settlement. Indeed, the law routinely distinguishes levels of capacity for a variety of legally sanctioned tasks.[9]

Lacking training in capacity assessment or other aspects of mental health, the average practitioner may argue that, as lawyers, we do not and should not perform capacity assessments. Instead, we should refer cases of questionable capacity to mental health professionals. The assertion is true as far as it goes, but it only goes so far. To decide whether a formal assessment is needed, the lawyer is already exercising judgment about the client's capacity on an informal or preliminary level. The exercise of judgment, even if it is merely the incipient awareness that "something is not right," is itself an assessment. It is better to have a sound conceptual foundation and consistent procedure for making this preliminary assessment than to rely solely on *ad hoc* conjecture or intuition.

The Model Rules of Professional Conduct only obliquely acknowledge lawyers' assessment functions. Rule 1.14, "Client Under a Disability," recognizes that a lawyer may take protective action with respect to a client "only when the lawyer reasonably believes that the client cannot adequately act in the client's own interest."[10] The Comment goes a step further in recognizing "intermediate degrees of competence," but nowhere is there any guidance for making a preliminary determination, other than rec-

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8 *See* Timothy A. Salthouse, *Commentary: A Cognitive Psychologist's Perspective on the Assessment of Cognitive Competency*, *in* OLDER ADULTS' DECISION-MAKING AND THE LAW 37 (1996); William M. Altman, et al., *Autonomy, Competence, and Informed Consent in Long Term Care: Legal and Psychological Perspectives*, VILL. L. REV., 1671, 1682 (1992).

9 *See* John Parry, *Decision-making Rights Over Persons and Property*, *in* THE MENTALLY DISABLED AND THE LAW 435-61 (Samuel J. Brakel, John Parry, and Barbara A. Weiner, eds., 1985).

10 Model Rules of Professional Conduct Rule 1.14(b) (1998) [hereinafter Model Rules].

ognizing that "[t]he lawyer may seek guidance from an appropriate diagnostician."[11]

The proposed final draft of the Restatement (Third) of Law Governing Law also recognizes the lawyer's assessment function in the Comment to section 35 "Client Under a Disability":

> When a client's disability prevents maintaining a normal client-lawyer relationship and there is no guardian or other legal representative to make decisions for the client, the lawyer may be justified in making decisions with respect to questions within the scope of the representation that would normally be made by the client. A lawyer should act only on a reasonable belief, based on appropriate investigation, that the client is unable to make an adequately considered decision rather than simply being confused or misguided. Because a disability might vary from time to time, the lawyer must reasonably believe that the client is unable to make an adequately considered decision without prejudicial delay.
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> A lawyer's reasonable belief depends on the circumstances known to the lawyer and discoverable by reasonable investigation. Where practicable and reasonably available, independent professional evaluation of the client's capacity may be sought. If a conflict of interest between client and lawyer is involved (see § 206), disinterested evaluation by another lawyer may be appropriate. Careful consideration is required of the client's circumstances, problems, needs, character, and values, including interests of the client beyond the matter in which the lawyer represents the client.[12]

Thus, the lawyer cannot avoid the task of making at least a preliminary assessment of client capacity related to the purpose of representation. The following section articulates a concept of capacity and its assessment tailored to the unique role of the attorney.

II. Decisionmaking Capacity

The functional activity at the heart of capacity for an individual receiving legal services is the ability to make and communicate decisions with respect to whatever particular legal task is at

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[11] Model Rule 1.14, Cmt. [5]. The Model Code of Professional Conduct does not address impaired capacity in the disciplinary rules. Ethical Consideration 7-11 and 7-12 simply recognize that the lawyer may have additional responsibilities, depending upon the client's mental condition.

[12] RESTATEMENT (THIRD) OF LAW GOVERNING LAW § 35, Cmt. d (P.F.D. No. 1, 1996).

hand.[13] Capacity is task-specific and time-specific, and despite continuous striving by the mental health professions for objectivity and consensus, no universal definition of decision-making capacity exists.[14] Nevertheless, the basic parameters of decision-making capacity can be described. Perhaps the clearest and most enduring articulation remains that of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, enunciated in their seminal 1982 report: "Decisionmaking capacity requires, to greater or lesser degree: (1) possession of a set of values and goals; (2) the ability to communicate and to understand information; and (3) the ability to reason and to deliberate about one's choices."[15]

The inclusion of a set of values and goals sets this definition apart from many other attempted articulations. Those values and goals establish a benchmark against which capacity can be assessed, for capacity must be judged according to a standard set by *that person's own habitual or considered standards of behavior and values*, rather than by conventional standards held by others.[16] This is a principle more easily respected in theory than practice, but it is fundamental to both theory and practice. Applying such a standard requires a more thorough knowledge of the individual than is normally feasible in a limited, one-time only encounter.

Lawyer-ethicist Nancy Dubler illustrates the importance of this knowledge in relating the quandary doctors faced when they evaluated her own mother after a fall: "[T]he doctors wondered, was she [her mother] uncooperative, cantankerous, and obstinate because her memory and mental function were impaired, or was she a woman who had spent a long lifetime being uncooperative,

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13 Stephen J. Anderer et al. DETERMINING COMPETENCY IN GUARDIANSHIP PROCEEDINGS 4 (American Bar Association, Division for Public Services, Public Service Monograph Series, Number 1) (1990).

14 *Id. See also* Charles P. Sabatino, *Competency: Refining Our Legal Fictions*, *in* OLDER ADULTS' DECISION-MAKING AND THE LAW 1, 4 (Michael Smyer, K. Warner Schaie & Marshall B. Kapp, eds., 1996).

15 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, VOL. 1, REPORT: MAKING HEALTH CARE DECISIONS: THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP 57 (1982).

16 Michel Silberfeld & Arthur Fish, WHEN THE MIND FAILS: A GUIDE TO DEALING WITH INCOMPETENCY 47-48 (1994).

cantankerous, and obstinate?"[17] As her daughter, Dubler had the knowledge to help them sort it out: "[S]he had always been obstinate, but being uncooperative and cantankerous were new characteristics, more than likely associated with her injury."[18] In other words, a person does not lack capacity merely because he or she does things that other people find disagreeable or difficult to understand. Indeed, a great danger in capacity assessment is that eccentricities, aberrant character traits, or risk-taking decisions will be confused with incapacity. A capacity assessment first asks what kind of person is being assessed and what sorts of things that person has generally held to be important.[19]

In everyday legal practice, capacity issues may arise with current or former clients with whom the lawyer has great personal familiarity or with new potential clients who are virtual strangers in need of legal services. The familiar client offers a clear advantage of knowledge and experience with the client's values and personality. The new or prospective client poses a threshold question of whether the person even has the capacity to engage the services of the lawyer. Most cases fall somewhere in the partially familiar middle ground. In any case, the practitioner needs an ethically and clinically sound process for making a preliminary assessment of capacity, compatible with the attorney's role and skills. The following section offers a framework and process.

III. Capacity Assessment

Capacity to perform most tasks is affected by countless variables: time, place, social setting, emotional, mental or physical state, etc.[20] Therefore, it is helpful in practice to approach capacity assessment in two stages – first take reasonable steps to optimize capacity; and second, perform a preliminary assessment of capacity. Remember, the emphasis in the second stage is on "preliminary," because the lawyer's role goes only that far. If doubts remain after a preliminary assessment, then the help of a

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17 Nancy Dubler & David Nimmons, Ethics on Call 209 (1992).

18 *Id.*

19 Silberfeld & Fish, *supra* note 16, at 47.

20 Altman, et al., *supra* note 8, at 1671.

mental health professional is clearly needed for further evaluation.

A. *Optimizing Capacity*

1. *Interview the Client Alone*

Family, friends, or caretakers commonly accompany older or disabled individuals to the lawyer's office. Indeed, these significant others may play an important role in providing essential background information relevant to the work to be done. However, the ethical starting point in the client-lawyer relationship remains the decision of the elder individual to retain the services of the lawyer and to decide the overall objectives of representation. Be clear from the beginning who the client is and the ethical implications of that relationship in terms of loyalty, confidentiality, and decision-making. Moreover, the initial interview should always include a time when the lawyer and putative client meet alone. This is important not only to confirm representation and its objectives but also to provide an opportunity if needed to assess capacity.

This one-on-one meeting request may cause apprehension among family members, including the elder person, but it is necessary to ensure that personal and environmental factors do not unduly influence the decision-making process. The 1993 Fordham Conference on Ethical Issues in Representing Older Clients explicitly recommended as a practice guideline that the lawyer "Speak with the client alone," whenever questioning client capacity for any specific purpose.[21] The recommendation is sound advice applied to all clients, not just those for whom the lawyer has capacity doubts.

2. *Adjust the Interview Environment to Enhance Communication*

Optimizing the interview environment and process serves all clients well. More importantly, it will optimize the partially impaired client's decision-making ability. Capacity deserves to be judged under the best circumstances possible. The range of phys-

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[21] *Proceedings of the Conference on Ethical Issues in Representing Older Clients—Recommendations of the Conference*, 62 FORDHAM L. REV. 991 (1994).

ical, social and temporal strategies available to improve client-lawyer communication provides a rich subject in itself. I will touch upon only a few basic parameters here and recommend that the reader use the valuable communication strategies enumerated in resources such as *Effective Counseling of Older Clients; The Attorney Client Relationship*.[22]

Impaired vision or hearing often produces non-responsive behaviors that may be wrongly interpreted as lack of mental capacity. Speaking slowly, conducting the interview in a quiet well-lit area, arranging furniture so as to avoid glare, and providing any necessary audio or visual amplification will facilitate communication and functioning.

Some elder clients need extra time to process the information regarding decisions at hand. Although the speed of cognitive processing may not be as fleet as that in younger persons, given more time, partially impaired elders will be able to understand the ramifications of each action under consideration.[23] Be willing to spend extra time explaining the nature and consequences of options and resist the temptation to equate the speed of the client's ability to process information with level of capacity.[24]

Meet with a client more than once to acquire a truer sense of the client's decision-making capacity. Greater familiarity engendered by multiple sessions may enhance the client's comfort level, confidence and trust in the attorney—all of which enhance the client's ability to function optimally. It also enables the attorney to see temporal variations in functioning. Inaccurate assessments due to fatigue may be avoided by scheduling shorter sessions at times when the client tends to be most alert. Keep in mind that temporary or fluctuating lucidity does not equate to total incapacity. Delaying determinations until the client is in a more lucid phase can enhance decision-making dramatically.[25]

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22 American Bar Association Commission on Legal Problems of the Elderly & Legal Counsel for the Elderly, EFFECTIVE COUNSELING OF OLDER CLIENTS: THE ATTORNEY-CLIENT RELATIONSHIP 15 (1995).

23 Marshall B. Kapp, *Decision Making by and for Nursing Home Residents: A Legal View*, 4 CLINICS IN GERIATRIC MEDICINE 667, 671 (1988).

24 *Id.*

25 *See* Daniel L. Bray & Michael D. Ensley, *Dealing with the Mentally Incapacitated Client: The Ethical Issues Facing the Attorney*, 33 FAM. L. J. 329,

Home visits are especially conducive to optimal decision-making for many clients. If, for example, the lawyer is determining whether the client needs to appoint a power of attorney for financial management, the elder may be able to demonstrate her banking skills best at her own desk with her own checks.

3. *Know the Client*

To restate, the standard against which capacity is measured is the standard set by the individual's own habitual or considered standards of behavior and values, rather than against conventional standards held by others. Without knowledge of this personal frame of reference, capacity judgements have insufficient anchor and are liable to be based on someone else's judgment of the propriety of certain behavior, clothed in the clinical language of incapacity.

For the long-time client whose functioning only recently appears to be slipping, the lawyer may already be familiar with the client's subjective frame of reference. Newer clients will require a more conscious inquiry — an effort that legal practitioners may be disinclined to pursue. Fortunately, it is not nearly as daunting as it might appear, since the lawyer's inquiry is limited to task-specific matters. Why does Mrs. Jones wish to forego this generous settlement offer and pursue litigation instead? An inquiry into the values, habitual patterns of behavior, and cultural factors that may authenticate such a decision is within the counseling/investigative skill of the lawyer. The more common shortcoming is the failure to make the effort to inquire far enough.

4. *Presume Capacity*

Merely raising the issue of capacity can be hurtful and damaging to the individual and to the client-lawyer relationship. And once begun, the process of assessing capacity involves an invasion of one's privacy that could ultimately result in a major intrusion into one's autonomy in the form of guardianship. Thus, the starting presumption should always be a presumption of capacity. This is a first principle of assessment, as well as of due process in

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336 (1999) (describing "windows of lucidity"); *see also* Lane v. Candura, 376 N.E.2d 1232 (Mass. App. Ct. 1978).

our western legal system.[26] For an assessment to take place, the concerned parties must overcome this presumption by substantiating evidence of impaired decision-making.

B. *Assessment*

If you have done everything practicable to optimize the client's opportunity to act with maximum capacity, you are ready to do a preliminary assessment. It may involve most or all five steps below, depending upon the point at which your conclusion is clear or professional referral is needed.

1. *Obtain Consent*

To the extent that capacity is implicitly tested by the normal questions that are posed to any client to ensure that the client understands his or her options and the consequences of those options, no special client consent is necessary. However, if the lawyer proceeds to the step of utilizing a formal screening test, or taking the step of referring the client for physical or psychological testing, then client consent is crucial. Obtaining consent not only keeps the lawyer on ethically sound ground, it also conveys respect of the client's privacy and the intent to protect the client's interests. Though persons with more advanced dementia may not be able to consent to the assessment, some experts suggest that the elder client be given the benefit of the doubt so as not to undermine residual capacity.[27]

If the client is unable to consent,[28] then consider whether a legally authorized surrogate is available, either pursuant to a du-

[26] The presumption of capacity has been incorporated into the Uniform Health Care Decisions Act (1993), § 11 ("An individual is presumed to have capacity to make a health-care decision, to give or revoke an advance health-care directive, and to designate or disqualify a surrogate."). The Uniform Guardianship and Protective Proceedings Act (1977) § 310 also reinforces a presumption of capacity by requiring "clear and convincing evidence" of incapacity and need before a guardian may be judicially appointed.

[27] Silberfeld & Fish, *supra* note 16, at 46-47.

[28] Capacity to consent to a medical evaluation, like many other capacities, has no universal definition. However, most states have a statutory standard of capacity for medical decisions fairly similar to that found in the Uniform Health Care Decisions Act (1993) § 1(3): "'Capacity' means an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision."

rable power of attorney or power of attorney for health care[29] or by operation of law under a state default surrogate law for health care decisions.[30] The Comment to Model Rule 1.14(b) acknowledges that the attorney may have to assume this decisionmaking role as a protective action. However, if one has reached the point of deferring to surrogates, then one has already come to the conclusion that impaired capacity justifies protective action, and the guidelines for taking protective action, discussed in Part IV, apply.

2. *Physical Exam*

It is sometimes surprising that, in the face of signs of dementia, so little attention is given to ruling out treatable physical or mental conditions. Family may assume that Mom's or Dad's forgetfulness or confusion is just part of getting old. The lawyer is in a position to ensure that alternate causes of incapacity have been ruled out. Deficiencies that appear cognitive are often caused by overmedication, toxic combinations of medications, poor diet, vitamin deficiencies, depression, infectious diseases, head trauma, poor eyesight, or other treatable conditions.[31] By discovering and addressing medically treatable conditions first, capacity issues may be rendered moot or at least diminished.[32]

3. *Standardized Screen*

Once some familiarity with the client has been achieved, the environment optimized, and client consent obtained, consider using a brief mental status questionnaire as a starting point, but only as a starting point. These screening tests are not capable of

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29 All states recognize some form of durable power of attorney for health care. *See* Myra G. Gilfix & Charles P. Sabatino, *Health Care Decision Making in an Elder Law Practice*, Portfolio 16, at 16-95 to -108, *in* The ElderLaw Portfolio Series (Harry S. Margolis, ed., 1997).

30 *See* Colleen M. O'Connor, *Statutory Surrogate Consent Provisions: An Overview and Analysis*, 20 Mental & Physical Disability L. Rep. 128-138 (1996).

31 Rabins et al., *supra* note 5, at 49-78; University HealthSystem Consortium, *supra* note 3, at 6-10; U.S. Congress, Office of Technology Assessment, Losing a Million Minds: Confronting the Tragedy of Alzheimer's Disease and other Dementias 8-13, OTA-BA-323 (Washington, DC: US Government Printing Office, April 1987).

32 *Id*.

dictating a conclusion about decision-specific capacity. Several brief mental status questionnaires have been developed, the most popular of which is the 30-item Mini-Mental Status Examination (MMSE), although others are widely used, too.[33]

The MMSE takes about ten minutes to administer and covers a wide sampling of cognitive abilities, including: an assessment of memory (i.e., delayed recall of three items and response to questions related to temporal orientation); language (i.e., naming common objects, repeating a linguistically difficult phrase, following a three-step command, and writing a sentence); spatial ability (i.e., copying a two-dimensional figure); and set-shifting (i.e., performing serial sevens or spelling the word "world" backwards). Scores on the MMSE range from 0-30, with scores below 24 generally regarded as abnormal, although advanced age and low education are associated with lower scores in the absence of a brain disorder.[34]

Another commonly used screening test is the Short Portable Status Questionnaire (SPSQ).[35] It is a 10-item test that primarily assesses orientation to time and place (i.e., date, day, place) and general and personal knowledge (i.e. president, mother's maiden name, telephone number). One question assesses concentration and set-shifting (i.e., counting backwards by threes). It is slightly shorter to administer than the MMSE and is scored by counting errors rather than correct responses.[36]

Table 1 provides a list of common tests and literature references. This genre of tests has enjoyed wide acceptance in clinical settings, mainly because of their brevity and simplicity in administering, scoring and interpreting. However, their weaknesses are many, including insufficient sensitivity and specificity with certain clinical populations; reliance on global estimates of cognitive status; high false-positive and false-negative rates; both ceil-

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[33] Marilyn S. Albert, Focus on Assessment Techniques, *in* 14 ANNUAL REVIEW OF GERONTOLOGY AND GERIATRICS, 93-106 (M. Powell Lawton & Jeanne A. Terisi, eds., 1994).

[34] *Id*. at 94-95; M. Folstein, S. Folstein & P. McHugh, *Mini-Mental State; A Practical Method for Grading Cognitive State of Patients for the Clinician*, 12 J. PSYCHIATRIC RES. 189-98 (1975).

[35] Marilyn S. Albert, *supra* note 33, at 97-98; E. Pfeiffer, *SPMSQ: Short Portable Mental Status Questionnaire*, 23 J. AM. GERIATRICS SOCIETY 433-41 (1975).

[36] *Id*.

ing and floor effects (i.e., does not distinguish well among those who score at the higher end, or conversely those at the lower end); narrow sampling of cognitive domains; lack of population-specific normative data; and confounding effects of age, education, gender, and ethnicity.[37] A thorough understanding of the proper administration and particular strengths and weaknesses of any mental status screening instrument used is necessary. Training is essential and usually available through formal continuing education in the health disciplines or through informal training by a clinical specialist.

The greatest danger in relying on a standardized screen is relying on it too much. Again, the results provide only a crude global assessment of cognitive functioning. A poor score does not rule out the ability to perform some decisionmaking tasks. Further inquiry is still necessary to examine the clients task-specific capacity.[38]

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[37] University HealthSystems Consortium, *supra* note 3, at 4. *See also* Thomas Grisso & Paul S. Appelbaum, *A Comparison of Standards for Assessing Patients' Capacities to Make Treatment Decisions*, 152 AM. J. PSYCHIATRY 1033 (1995).

[38] Robert P. Roca, *Determining Decisional Capacity: A Medical Perspective*, FORDHAM L. REV. 1177, 1182-83 (1994). Roca elaborates on one of the shortcomings of the MMSE: "It tests orientation, memory, attention and concentration, as well as language use, aptitude for serial subtraction, and the ability to copy a complex figure. Perfect performance earns thirty points. Scores below 24 are the rule in persons with dementia, and few demented persons score 24 or above. Persons with scores of 24 or above rarely are judged to have inadequate cognitive function for decision-making purposes. But many persons with scores below 24 are neither demented nor seriously impaired in their decision-making capacity. This is because dementia is not the only factor affecting scores on the MMSE. The greatest number of "false positives" occurs in persons who have limited formal education, particularly those whose schooling ended at or before the eighth grade. Over reliance on the usual "cut-off point" for the MMSE thus can lead to overestimation of the prevalence of dementia and of the severity of disability. In fact, no cut-off point perfectly distinguishes persons with and without decisional capacity. For this reason, the results of standardized tests best are regarded as simply one source of information about capacity. The final judgment must integrate data from many sources." *Id. See also* Marshall B. Kapp & Douglas Massmar, *Measuring Decisional Capacity: Cautions on the Construction of a "Capacimeter,"* 2 PSYCHOL. PUB. POL'Y & L. 73 (1996).

Table 1
Sample of Brief Screening Tests for Cognitive Function

1. **Alzheimer's Disease Assessment Scale (ADAS)**
   W.G. Rosen, R.C. Mohs & K.L. Davis, *A New Rating Scale for Alzheimer's Disease*, 141 AMERICAN J. PSYCHIATRY 1356-1364 (1984).
2. **Brief Cognitive Rating Scale** (BCRS)
   B. Reisberg, et al., *The Brief Cognitive Rating Scale (BCRS): Findings in Primary Degenerative Dementia (PDD)*, 19 PSYCHOPHARMACOLOGY BULL. 47-50 (1983)
3. **Blessed Dementia Rating Scale** (BDRS)
   G. Blessed, B.E. Tomlinson & M. Roth, *The Association Between Quantitative Measures of Dementia and of Senile Change in the Cerebral Gray Matter of Elderly Subjects* 114 BRITISH J. PSYCHIATRY 797-811 (1968).
4. **Cambridge Cognitive Examination (CAMCOG)**
   G. Blessed, S. Black, T. Butler & D. Kay, *The Diagnosis of Dementia in the Elderly: A Comparison of CAMCOG, the AGE-CAT Program, DSM-III, the Mini-Mental State Examination and Some Short Rating Scales*, 159 BRITISH J. PSYCHIATRY 193-198 (1991).
5. **Cognitive Capacity Screening Exam (CCSE)**
   J.W. Jacobs, M.R. Bernhard, A. Delgado & J.J. Strain, *Screening for Organic Mental Syndromes in the Medically Ill*, 86 ANNALS OF INTERNAL MED. 40-46 (1977)
6. **Dementia Rating Scale (DRS)**
   S. Mattis, DEMENTIA RATING SCALE (1988)
7. **Global Deterioration Scale (GDS)**
   B. Reisberg et al., *The Global Deterioration Scale for Assessment of Primary Degenerative Dementia*, 139 AM. J. PSYCHIATRY 1136-39 (1982)
8. **Legal Capacity Questionnaire (LCQ)**
   B.B. Brown, *Assessment of Capacity*, §§ 5.01 – 5.06, in MENTAL CAPACITY: LEGAL AND MEDICAL ASPECTS OF ASSESSMENT AND TREATMENT (A.C. Walsh et al., 1994).
9. **Mini-Mental Status Examination (MMSE)**
   M.F. Folstein, S.E. Folstein & P.R. McHugh, *"Mini-Mental State": A Practical Method for Grading the Cognitive State of Patients for the Clinician*, 12 J. PSYCHIATRIC RESEARCH 189-198 (1975).
10. **Modified MMSE (3MS)**
    E.L. Teng & H.C. Chui, *The Modified MMSE (3MS)*, 48 J. CLIN. PSYCHIATRY 314-318 (1987).
11. **Short Portable Mental Status Questionnaire (SPMSQ)**
    E. Pfieffer, *A Short Portable Mental Status Questionnaire for the Assessment of Organic Brain Deficit in Elderly Patients*, 23 J. AMER. GERIATRICS SOC. 433-441 (1975).
12. **The 7 Minute Screen**
    P.R. Solomon & W.W. Pendleburg, *Recognition of the Alzheimer's Disease Patient: The 7 Minute Screen*, 20 FAMILY MEDICINE 265-271 (1998). See <http://www.7minutescreen.com>.
13. **Telephone Interview for Cognition Scale (TICS)**
    J. Brandt, M. Spencer & M. Folstein, *The Telephone Interview for Cognitive Status*, 1 NEUROPSYCHIATRY, NEUROPSYCHOLOGY, & BEHAVIORAL NEUROLOGY 111-117 (1988).

4. *Task Specific Assessment*

The presence of some level of cognitive impairment does not tell us the degree to which individuals can still use their remaining limited abilities to act autonomously in their particular physical and social context and make decisions. Individuals adapt to limitations in countless creative ways. Therefore, the lawyer needs to consider the client's capacity related to the specific legal task at hand. Consider, for example, the different capacities needed to complete these tasks:

- Executing a power of attorney
- Executing a Will
- Executing a trust agreement
- Marrying or Divorcing
- Agreeing to a property division
- Executing a contract
- Donating a substantial asset or amount of money
- Agreeing to a new living arrangement
- Agreeing to the release of medical or other confidential records
- Agreeing to or refusing a medical treatment.

Baird Brown offers a useful structured questionnaire to examine a client's testamentary capacity.[39] Others have suggested more general guidelines for assessing capacity that may be flexibly adapted to whatever decision is in question. One paradigm of note is suggested by Prof. Peter Margulies and was adopted as a guideline in the recommendations of the Fordham Conference on Ethical Issues in Representing Older Clients.[40]

Margulies argues that a purely functional cognitive test of capacity has serious problems and that the substance of a decision and its values context have to be factored into the assessment:

> The flight from substance leads to a denial of context – a quest for some pure kernel of capacity free of the ambiguity of concrete situations. We tend to reify capacity – to make it into a thing to be discov-

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39 Baird B. Brown, Assessment of Capacity, §§5.01 - 5.06, *in* MENTAL CAPACITY: LEGAL AND MEDICAL ASPECTS OF ASSESSMENT AND TREATMENT (A.C. Walsh et al., 1994).

40 Peter Margulies, *Access, Connection, and Voice: A Contextual Approach to Representing Senior Citizens of Questionable Capacity*, 62 FORDHAM L. REV. 1073 (1994).

> ered. This view misconceives capacity. Rather than being a thing, capacity is a shifting network of values and circumstances.[41]

His foundation is a model of contextual capacity which integrates substantive and procedural concerns.[42] The framework of contextual capacity acknowledges both psychology's focus on cognitive processes and its interplay among personal, environmental and social factors.[43] Margulies suggests that the lawyer's questioning of the client focus on six factors, the first three of which are functional, the latter three of which are substantive in nature:

1. "Ability to Articulate Reasoning Behind Decision." The client's reasons may not be ones others would agree with, but their articulation demonstrates a level of cognitive functioning, as well as shedding light on two other factors — the client's appreciation of consequences and consistency with lifetime commitments.
2. "Variability of State of Mind." Does the client express the same wishes alone as with family members present? Are the client's wishes today the same as last week?
3. "Ability to Appreciate Consequences of Decision." Are crucial facts and likely consequences understood?
4. "Irreversibility of Decision." What exactly is at stake in the particular decision and can an error be rectified? Decisions to withhold or withdraw life-support illustrate the highest level of irreversibility.
5. "Substantive Fairness." Does the decision result in the injury or exploitation of someone?
6. "Consistency with Lifetime Commitments of Client." How does the decision stack up against the individual's own habitual or considered standards of behavior and values?[44]

The one factor above that is perhaps not self-explanatory is that of "substantive fairness." On first impression, it appears to invite the intrusion of the assessor's own value judgment of the outcome of the client's decision. However, Margulies argues that substantive unfairness is one factor that evidences whether "people are being taken advantage of or are being unduly influenced in ways that defeat their autonomy and values."[45] He agrees with the criticism that courts have been overly inclined to base

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[41] *Id*. at 1083.
[42] *Id*. at 1085.
[43] *See* Altman, et al., *supra* note 8, at 1686.
[44] Margulies, *supra* note 40, at 1085-90.
[45] *Id*. at 1088.

capacity findings solely on their judgment of a decision's outcome, but he adds emphatically that it is a mistake to go to the other extreme and ignore blatantly unfair transactions.[46]

Of the six factors, substantive fairness may be thought of as one of three substantive "levers" that modulate a kind of sliding scale of capacity. The *greater* the concerns under the latter three substantive variables (irreversibility, fairness, consistency with commitments), the *greater* the level of functioning demanded under the first three variables (ability to articulate reasoning and appreciate consequences, variability of state of mind).

The third factor — ability to appreciate the consequences of a decision – requires special caution in evaluating. More often than not, the gravamen of incapacity cases involves the claim of risk of harm posed by the likely outcome of the individual's decision. But an objective assessor must keep foremost in mind that risky conduct, as such, is not proof of incompetence. Silberfeld and Fish suggest the following self-reflection on alleged risk:

1. Is the risk new or old?
2. Are there concrete instances of failure?
3. How grave is the risk?
4. Is the risk imminent or remote?
5. What is the risk of harm to others?
6. How objective is the assessment of the risk?
7. Is the risk chosen or accidental?[47]

The last question – whether the risk is chosen or accidental — requires appreciation of a critical insight. Silberfeld and Fish remind us: "Incompetency is the inability to make choices. A competent person *chooses* to run risks; an incompetent person simply *happens to* run them."[48] Our culture is risk averse in its conventional caring for older persons. The result is that much of the risk assessment we as professionals, family, or friends do easily inclines towards trumping autonomy with safety.[49]

Consistent documentation of capacity is essential. It can be accomplished by recording of the lawyer's observations and discussion with the client using the six Margulies categories, and

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[46] Margulies, *supra* note 40, at 1088.

[47] Silberfeld & Fish, *supra* note 16, at 61-65.

[48] *Id*. at 65 (emphasis added).

[49] *See, e.g.*, Jan Ellen Rein, *Ethics and the Questionably Competent Client: What the Model Rules Say and Don't Say*, 9 STAN. L. & POL'Y REV. 241 (1998).

supplementing it with the MMSE or other standardized cognitive screen adopted by the practitioner. Though most lawyers record their conclusions in file notes or a formal memo, some firms audio or video tape interviews or document executions. Great caution should be exercised in audio or video taping. The practice of taping *only* questionably capable clients may invite challenge, while taping all clients is expensive and time consuming. Also, some clients may appear less lucid or capable on tape than in person. The lawyer who chooses to record the interview should be cognizant of lighting and auditory variables that may affect the quality of the tape and the impression of capacity conveyed.

5. *Consultation and Referral.*

In borderline situations, the lawyer may need to seek consultation from a medical or mental health expert. Comment 5 to Model Rule 1.14 recognizes the appropriateness of such consultations in authorizing the lawyer to "seek guidance from an appropriate diagnostician" even though "disclosure of the client's disability can adversely affect the client's interest."[50] However, the Rule gives little guidance as to the extent of disclosure permissible absent client consent. Rule 1.6(a) forbids disclosure without client consent unless it is impliedly authorized.

The ABA's Standing Committee on Ethics and Professional Responsibility in Formal Opinion 96-404, relies on the impliedly authorized language of Rule 1.6(a) to conclude that limited disclosure to the extent necessary to act in the client's best interest is impliedly authorized by the fact of representation:

> Such discussion of a client's condition with a diagnostician does not violate Rule 1.6 (Confidentiality of Information), insofar as it is necessary to carry out the representation . . . . For instance, if the client is in the midst of litigation, the lawyer should be able to disclose such information as is necessary to obtain an assessment of the client's capacity in order to determine whether the representation can continue in its present fashion.[51]

The opinion relies on the same implied authority to support consultation with family or other interested persons:

> There may also be circumstances where the lawyer will wish to consult with the client's family or other interested persons who are in a posi-

[50] Model Rules, *supra* note 10, Rule 1.14 Cmt. 5 (1998).
[51] ABA Formal Op. 96-404 (1996).

> tion to aid in the lawyer's assessment of the client's capacity as well as in the decision of how to proceed. Limited disclosure of the lawyer's observations and conclusions about the client's behavior seems clearly to fall within the meaning of disclosures necessary to carry out the representation authorized by Rule 1.6.[52]

The lawyer must be careful, however, "to limit the disclosure to those pertinent to the assessment of the client's capacity and discussion of the appropriate protective action."[53] This confidentiality exception "does not permit the lawyer to disclose generally information relating to the representation."[54] Note, however, that not every state permits this leeway under their ethical rules. For example, ethics opinions in California, Illinois, and Michigan, suggest tighter constraints on the disclosure of information, even where the lawyer believes protective action is appropriate.[55]

If referral for a formal assessment is desired, again, seek consent and cooperation of the client, recognizing that the experience of capacity testing may be felt as a serious blow to the client's self-image and a threat to the client's trust in counsel. The issue needs to be faced and worked through with professionalism and tactful consideration to facilitate a determination of capacity before proceeding with legal representation.

If a formal assessment is sought, whom do you use? The client's attending physician is an obvious starting point, especially if the physician and client have had a long-standing relationship. However, the attending physician's input may not be sufficient in itself, unless the physician is qualified by education and training credentials to do psychiatric/psychological assessments and has documented a thorough process of assessment. It takes some effort and experience to identify appropriate local assessment resources. Give preference to multidisciplinary geriatric assessment teams and be prepared to work with them to provide a clear picture of the nature and scope of the actual task or decision for which capacity is to be assessed.

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52 *Id.*

53 *Id.*

54 *Id.*

55 *See* Califormia Ethics Op. 1989-112 (undated); Illinois Ethics Op. 89-12 (1990); Michigan Informal Ethics Op. CI-882 (1983).

IV. Protective Actions.

In the absence of Rule 1.14, a lawyer whose client becomes unable to make decisions relevant to the representation would have to withdraw from representation. Model Rule 1.14(b) permits the lawyer to take protective actions in such situations, although it does not require it. Under Rules 1.16(b), withdrawal is ethically permissible as long as it can be accomplished "without material adverse effect on the interests of the client."[56] The reality in these cases, however, is that if the lawyer withdraws, the client may be left without help at a time when most vulnerable and in need of help. Consequently, the ethically preferred practice is to stay with representation, if possible, and seek appropriate protective action on behalf of the client.[57]

The north star in guiding the course of protective action is the principle of *least restrictive alternative action under the circumstances*. Although not explicit in Rule 1.14, the principle is expressly articulated in ABA Formal Opinion 96-404 and in a few state ethics opinions.[58] Too often practitioners think of guardianship as the first or sole option once they are persuaded that the client lacks capacity. Just as state guardianship law has moved toward favoring less intrusive interventions than plenary guardianship,[59] so too in exercising protective discretion, the lawyer should attempt less intrusive protective actions before considering guardianship. The Fordham Conference recommendations urge the following in this regard: "The lawyer should refer or petition for guardianship of the client only if there are no appropriate alternatives. The lawyer should act as petitioner only if

56 Model Rules, *supra* note 10, Rule 1.16(b).

57 ABA Formal Op. 96-404 states: "[T]he Committee believes the better course of action, and the one most likely to be consistent with Rule 1.16(b), will often be for the lawyer to stay with the representation and seek appropriate protective action on behalf of the client." Likewise, the Fordham Conference recommendations stated: "Where capacity comes into question, preference should be given to staying with the situation and taking protective action over withdrawal from the case." Fordham Conference, *supra* note 21 at 990.

58 Connecticut Inf. Op. 97-19 (1997); Pennsylvania Inf. Op 98-83 (1998).

59 *See* ABA Commission on the Mentally Disabled & ABA Commission on Legal Problems of the Elderly, GUARDIANSHIP: AN AGENDA FOR REFORM (1989). *See also* Erica Wood, *State Guardianship Legislation: Reform Directions in 1999*, 11 *Elder L. Forum* 11-13 (newsletter of AARP Foundation/Legal Advocacy Group) (Autumn 1999).

there is no one else available to act. The use of the guardianship system should be limited to the greatest extent possible."[60]

Identifying the least restrictive action under the circumstances is a challenge. It calls for a combination of risk assessment and creative problem solving skills. On a practical level, it will help to consider the following questions in developing a protective action strategy:[61]

1. What is the problem? Often by clarifying the problem people become aware of solutions to it that circumvent the feared risk or avoid a confrontation around competency issues. For example, if the problem is that the individual is unable to use a stove safely, perhaps replacing it with a microwave oven and using meals on wheels would alleviate the problem.
2. Is a voluntary solution practical? If the client will not agree to the course of action that most clearly seems to be in his or her best interest, will the client voluntarily agree to an intermediate action or agreement, even on an interim basis?
3. Whose interest is being served? This is often a morally ambiguous question and one easy to overlook in capacity assessment. Answering it can be extremely difficult for even a scrupulous and emotionally detached observer. Consider the case of an aging parent who resists the advice of an adult child caretaker who feels that placement in a nursing home is in the parent's best interest. Whether placement benefits the parent or child more may not be so easy to sort out. The aim, however, is not to eliminate conflicting motives but to better articulate and manage them. Silberfeld and Fish aptly note, "The search for a pure motive is often fruitless and paralyzing."[62]
4. What risks are involved in the present situation and are they sufficient to justify trumping the individual's autonomy? Risk assessment arises both in the capacity deter-

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[60] Fordham Conference, *supra* note 21, at 991. Also in accord is ABA Formal Op. 96-404: "The lawyer should, if time permits, explore the availability of such less restrictive actions before resorting to a guardianship petition."

[61] Based on Silberfeld & Fish, *supra* note 16, at 54-61.

[62] Silberfeld & Fish, *supra* note 16, at 60.

mination as discussed in Part III above and also in the determination of protective action.

The answers to these questions will provide you with a more realistic picture of the options you have and the trade-offs in terms of risks and benefits. But as you decide on some course of action, what exactly should your goals be? The Fordham Conference recommendations articulate an ethical gold standard for protective action:

> If the lawyer takes protective action under Model Rule 1.14(b), the lawyers action shall be guided by:
>
> 1. The wishes and values of the client to the extent known; otherwise, according to the client's best interest;
> 2. The goal of intruding into the client's decision-making autonomy to the least extent possible;
> 3. The goal of maximizing client capacities; and
> 4. The goal of maximizing family and social connections and community resources.[63]

The Fordham Conference provided several examples of less restrictive protective actions. Obviously, their availability and appropriateness depends on all the surrounding facts and circumstances. Possible protective actions include:

> a. Involving family members in the discussion;
> b. Creating or using durable powers of attorney or revocable trusts, if possible;
> c. Use of a "time out" to allow for cooling off, clarification, or improvement of circumstances;
> d. Referral to private case management;
> e. Referral to long-term care ombudsman (in situations involving the welfare of long-term care facility residents);
> f. Use of church or other care and support systems;
> g. Referral to disability support groups;
> h. Referral to social services or other governmental agencies, such as consumer protection agencies. However, the lawyer should carefully weigh the appropriateness and risk of agency referrals.[64]

Examples of protective actions that the lawyer may take in a litigation context include but are not limited to:

> a. Filing for injunctive relief;
> b. Requesting appointment of a guardian *ad litem*;
> c. Filing for a continuance so as to provide additional time to clarify the client's status and representation;

[63] Fordham Conference, *supra* note 21, at 990.
[64] *Id*. at 991-92.

d. Filing a petition for a protective order, or for limited or plenary guardianship;
e. Invoking regulatory or administrative remedies, for example, filing a separate consumer protection complaint with the appropriate state agency.[65]

A few state ethics opinions suggest similar types of interventions. At the less restrictive end of the scale, protective action may entail the notification of appropriate social welfare and medical mental health agencies for care or services to "enhance the client's capabilities" or "ameliorate feared harm,"[66] denying a client's request,[67] delaying the client's request until certain conditions are met,[68] or contacting an existing legal representative established under a durable power of attorney, revocable trust, or guardianship.[69] At the more restrictive end, Comment [2] to Rule 1.14 accepts the sometimes criticized notion that "the lawyer often must act as *de facto* guardian."[70] The Fordham Conference recommendations, however, admonish: "If the lawyer decides to act as de facto guardian, he or she, when appropriate, should seek to discontinue acting as such as soon as possible and to implement other protective solutions."[71]

If the lawyer concludes that some form of guardianship is the least restrictive action under the circumstances, the options for proceeding depend in part on the ethics rules of the particular state. Most states appear to comport with ABA Formal Opinion 96-404 which permits the lawyer to initiate a guardianship proceeding against his or her own client, but does not permit the lawyer to represent a third party in bringing the proceeding. However, some states are much more restrictive in the range of action permitted in this kind of situation. For example, California lawyers may not institute a conservatorship proceeding against an incapacitated client even if the lawyer believes that it would best serve the client's interests.[72]

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65 *Id.* at 992.

66 Connecticut Inf. Op. 97-21 (1997); Pennsylvania Inf. Op. 93-187 (1993).

67 Michigan Eth. Op. RI-51 (1990).

68 Michigan Eth. Op. RI-63 (1990).

69 Connecticut Inf. Op. 97-21 (1997); Pennsylvania Inf. Op. 96-97 (1996); Philadelphia Eth. Op. 91-3 (1991); Philadelphia Eth. Op. 96-12 (1996).

70 Model Rule 1.14, Cmt [2].

71 Fordham Conference, *supra* note 21, at 990.

72 California Ethics Op 1989-112 (undated).

V. Conclusion

If any lesson is to be learned in cutting through this ethical tangle, it is ultimately that the best strategy for dealing with capacity issues is a preventive one – one that may avoid the need to take control without client consent or direction. The American College of Trust and Estate Counsel (ACTEC) emphasizes this point in its Commentaries on the Model Rules of Professional Conduct:

> As a matter of routine, the lawyer who represents a competent adult in estate planning matters should provide the client with information regarding the devices the client could employ to protect his or her interests in the event of disability, including ways the client could avoid the necessity of a guardianship or similar proceeding.[73]

The most obvious methods to avoid the necessity of guardianship include the use of durable powers of attorney, advance directives for health care, and revocable trusts. However, these are neither fool-proof nor self-activating. Accordingly, the ACTEC Commentary offers the following strategy for the lawyer's consideration:

> A lawyer may properly suggest that a competent client consider executing a letter or other document that would authorize the lawyer to communicate to designated parties (e.g., family members, health care providers, a court) concerns that the lawyer might have regarding the client's capacity.[74]

Anticipating further confidentiality concerns, the commentary further suggests that a durable power of attorney could include an authorization for the attorney-in-fact to waive, on behalf of the client, the lawyer-client and physician-patient duties of confidentiality in appropriate circumstances.[75]

Although the commentary speaks directly only to estate planning, the graying of our population suggests a need to broach the topic in any representation that may involve significant personal or family decisions. Even this kind of preventive planning does not guarantee smooth sailing in all decisions, especially since voluntary advance planning mechanisms can be revoked by a client experiencing life's turmoil. Nevertheless, you will set a

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73 ACTEC Commentary on the Model Rules of Professional Conduct 1.14 at 216-17.

74 *Id.*

75 *Id.*

foundation that will best respect the wishes and values of the client, intrude least into the client's autonomy, maximize client capacities, and maximize family and social connection. A higher level of professionalism and service is not possible.