

# Older Clients with Questionable Legal Capacity/Competence: Elder Law Practice and Treating Physicians

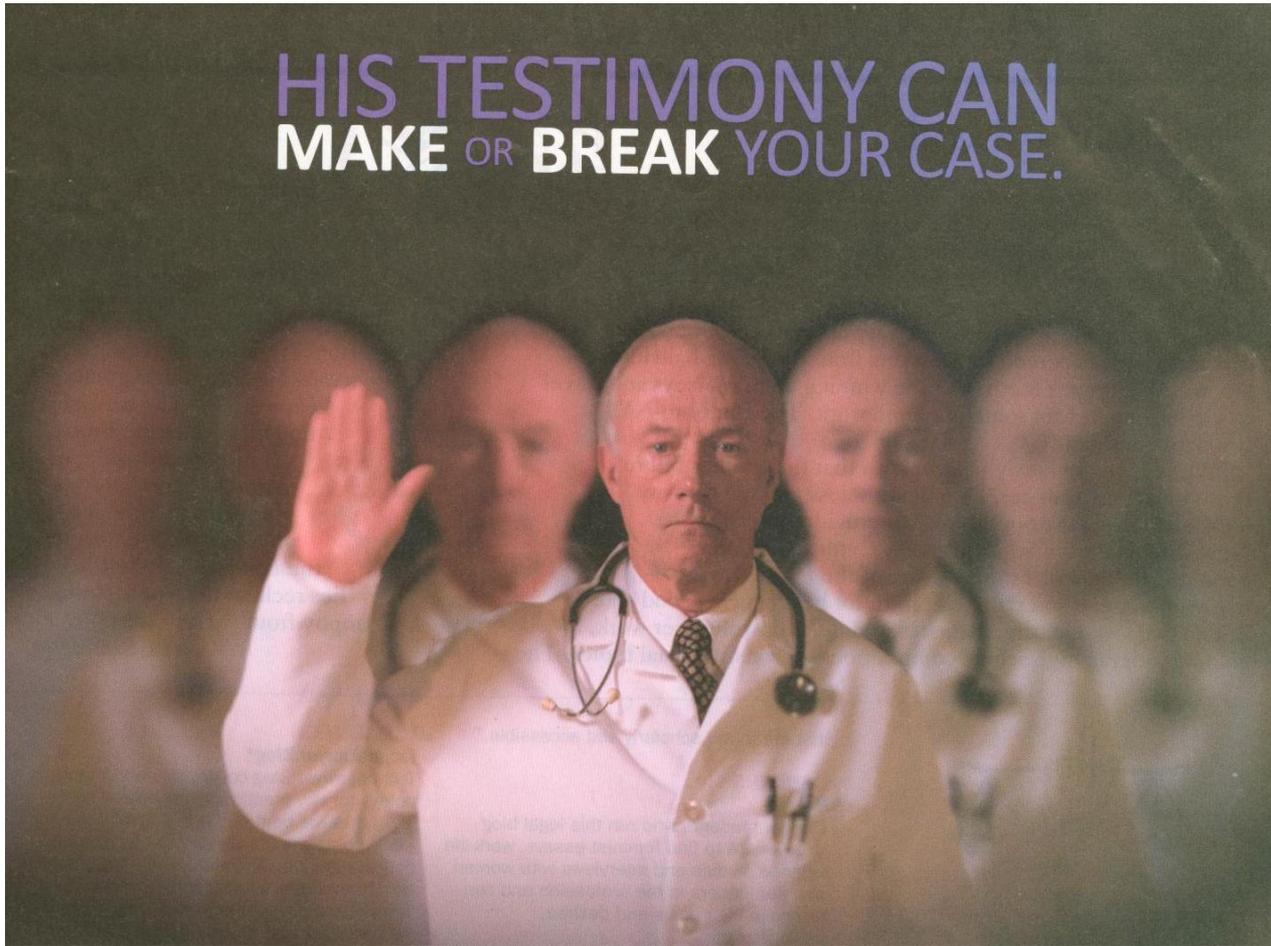
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# Introduction

- Issues often arise in elder law practice regarding cognitive and emotional ability to make decisions
  - Competence versus capacity
  - Medical decision making
  - Other personal decision making (e.g., residence)
  - Financial decision making
  - Testamentary capacity

HIS TESTIMONY CAN  
MAKE OR BREAK YOUR CASE.



- Treating physicians\* (and their records) are often sought as a source of both factual evidence *and* expert opinion, and as the basis for forensic consultants' opinions, regarding:
    - Present competence
    - Past competence
- \*Distinguish from evaluations/consultations requested specifically for forensic purposes (to generate expert opinion evidence)

– Competence affected by conditions seen by treating physicians

- Dementia
- Depression
- Delirium
- psychoses

- Competence determination involves the “intersection of legal doctrine, behavioral science research, and clinical practice” and “three interacting elements: the person, the process, and the context.”  
Competence is a “socio-legal construct.”

- The legal/medical interaction frequently is less than ideal
  - Why?
  - What to do about it?

# Caveats

- Not a scientific study
- Reflections and impressions based on conversations with a convenience sample of physicians

# Explanations for the Interprofessional Tension

- Different Issue Identification and Objectives
  - Therapeutic/capacity model (tolerant of “bumbling through, respect autonomy if no harm, result orientation). Treating docs are not looking for, or documenting, legally relevant evidence; legal status does not matter for making the patient better. Efficiency, flexibility in “getting the job done,” addressing medical immediacy. Docs do not have the data to answer the legal question.

- Forensic or Competence/Legal authority clarification model. Process orientation focused on obtaining certainty about respective rights and duties, through the adversary system if necessary. Attorney bias is based on experience with skewed sample of clients for whom “bumbling through” does not work.

- Physician fears harming the therapeutic relationship by betraying the patient
  - Loss of trust
  - Patient may be worse off because of legal intervention.

- In today's fragmented HC non-system, the primary care physician does not see the patient much during times of challenge and stress, has no reason to question (let alone document) decision making capacity/competence or patient *behaviors* during routine visits as long as the patient is reasonably compliant. Therefore, doc often does not have relevant evidence to present.

- “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.”

- Insufficient training in forensic skills
- Lots of medical student and resident education on the *informed* element of Informed Consent (with emphasis on documentation) and on the necessity for a capable patient or else an authorized surrogate, but very little training on clinical capacity/competency assessment skills (*how to do it*)

- Limited exceptions
  - Psychiatry residency programs and forensic and geropsychiatry fellowships
  - Geriatric fellowships
  - Neurology residency programs
  - Medical schools affected by geriatrician influence under grants from Reynolds Foundation and AAMC

- Physicians' legal anxieties
  - Free-floating
  - Confidentiality: What constitutes a waiver?
  - Liability risk for negligent evaluation, especially as the “state of the art” advances

- Distaste for the adversary system generally, and for cross examination particularly
  - “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.”

- Time, hassle, distraction from medical practice
  - “Forensic evaluation [of decisional 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.”
  - Physicians need to “triage the paperwork.”
  - Treating physicians do not get compensated for this task.

# Addressing the Interprofessional Tension

- Retain status quo?
- More training of physicians for this role?
  - ABIM and ABFM are developing geriatric competencies to “determine whether an older patient has sufficient capacity to give an accurate history, make decisions and participate in developing plan of care.”

- Is more training a panacea?
  - Variability in court practices?
  - What else to eliminate in curriculum?
  - Would it overcome the other impediments?

- Ask the physician *decision-specific* questions, not a global or open-ended question. What *specific* areas of *function* are at issue? In what circumstances and places? Why is the question being asked *now*?
- Develop a shared vocabulary

- Ask physician to support conclusion with short answers to a series of questions that break capacity evaluation into separate data components:
  - Communication ability
  - Comprehension of situation
  - Rational manipulation of information (reasoning)
  - Appreciation of consequences

- Use the treating physician to help pursue clinical, rather than adversarial, interventions. Clinical interventions may reduce or eliminate the incapacity and make a competence determination unnecessary.

# Conclusion