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LEGAL MEDICINE

Legal Medicine Issues in the Aging: Part One

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Part 1 presents an overview of elder rights, fiduciary physician's duties, capacity and competence, guardian, conservator, power of attorney, informed consent and refusal, and the older driver. Part 2 comprises End-of-Life legal issues.

Elder Law is a specialized area of legal practice that has evolved over the past 85 years. It has taken increased prominence during the Covid-19 pandemic beginning in 2020. *Elder Law* includes:

- Elder Rights
- Fiduciary Duties
- Capacity and Competency
- Guardianship versus Conservatorship
- Informed Consent and Refusal
- Powers of Attorney
- Abuse, Neglect, Fraud, and Discrimination
- Medical Malpractice
- Long-Term Care Planning
- Long-Term Care Insurance
- Nursing Home Issues
- Retirement Planning and Living
- End-Of-Life Issues and Advance Directives
- Disability Planning
- Estate Planning;
- Real Estate, Mortgage and Landlord/Tenant needs
- Family Issues - Children, Grandchildren

ELDER RIGHTS

The American elder (senior) citizens' rights are ***not*** recognized as a constitutionally protected class.

In 1935, President Franklin D. Roosevelt signed into law the *Social Security Act*. It was an insurance program against unemployment with three components: (1) retirement benefits, (2) survivors' benefits and (3) disability insurance.

In 1965, President Lyndon B. Johnson signed into law:

1. The *Social Security Amendments* which created *Medicare* and *Medicaid;* and
2. The *Older Americans Act (OAA)* which authorized grants to States for community planning and services programs, funding for research, and demonstration and training projects in the field of aging.
   - In 1972, the OAA was amended to add the National Nutrition Program for the Elderly.
   - In 2000, OAA was amended again to include the National Family Caregiver Support Program for family members struggling to care for their older loved ones who are ill or who have disabilities, such as dementia.
   - In 2020, Congress reauthorized OAA entirely through 2024.

Johnson also created the Administration on Aging (AOA), a division within the Department of Health and Human Services (DHS).

The *National Institute on Aging* (NIA) is one of the 27 Institutes and Centers of NIH, which leads a broad scientific effort to understand the nature of aging and to extend the healthy, active years of life. NIA is the primary current Federal agency supporting and conducting Alzheimer's disease research.

All States also have *Elder Law* statutes. In fact, the vast majority of elder protection comes from state laws.

Fiduciary Duties

The physician-patient relationship agreement binds the physician as a *fiduciary* whose duties include:

1. ***Confidentiality:*** The fiduciary discloses no medical information received in connection with treatment.
2. ***Care:*** The physician must be educated and informed about both the laws and issues regarding the procedures, conditions, and surgeries being administered.

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3. ***Prudence:*** The physician is required to act with care, skill and diligence when treating a patient.

4. ***Competence:*** The physician is required to be accredited, receive state and federally mandated education, stay up to date on licensing, and be current on new forms of treatment and new medications.

5. ***Loyalty and Exclusive Purpose:*** The physician must remain loyal to the patient's interests over one's own and is required to act exclusively in the patient's interest, benefit and safety.

6. ***Good Faith and Fair Dealing:*** The physician must avoid cheating the patient in any way, including charging fair market prices for procedures and avoiding ordering unnecessary procedures in order to increase insurance billing.

7. ***Act Within the Scope of Authority:*** The patient may either have expressly conferred authority on the physician, or the authority may be implied. The authority arises by consensual agreement. The physician is generally entitled to indemnity from the patient if he or she has acted within the scope of the actual authority. If the physician acts outside of that authority, he or she may be in breach of contract, and liable to a third party (e.g. insurance) for breach of the implied warranty of authority.

8. ***Conflicts of Interest:*** This duty varies widely and must be assessed with caution and care, for example business or sexual relationships. Another example, a physician may have developed a technique or treatment that is being marketed and sold. Is it a conflict of interest for that doctor to prescribe that technique or treatment to a patient and receive a royalty? If the physician is systematically recommending the technique or treatment and it is not done in the best interest of the patient, the answer is yes.

CAPACITY AND COMPETENCY

Legally, every elderly person, with or without cognitive impairment, is deemed *competent* and has a right to determine what shall be done with his or her own body.

Physicians deal with patient *capacity* on a daily basis. *Capacity* is not all-or-nothing. It may be specific, partial or total. For example, financial capacity and financial judgment often decline before other functions. *Capacity* (physical or mental) or lack thereof, *incapacity,* is generally determined by physicians, often psychiatrists.

Whether an adult of sound mind becomes *incompetent* and unable to consent is determined by a judge. However, the terms *incapacity* and *incompetency* are often used interchangeably by medical professionals.

By statute, for example in Oklahoma, an *incapacitated person* means any person eighteen (18) years of age or older:

1. Who is *impaired* by reason of mental or physical illness or disability, dementia or related disease, developmental or intellectual disability or other cause; and,

2. Whose ability to receive and evaluate information effectively or to make and to communicate responsible decisions is impaired to such an extent that such person *lacks the capacity* to manage his or her financial resources or to meet essential requirements for his or her mental or physical health or safety without assistance from others, or

3. A person for whom a guardian, limited guardian, or conservator has been appointed pursuant to the Oklahoma Guardianship and Conservatorship Act.

LETTER OF CAPACITY (COMPETENCY)

Primary care physicians, neurologists or psychiatrists who have seen their patient over the course of several years and are familiar with any changes in their baseline mental and physical health may be called upon to provide a *letter of capacity (competency)*. In some cases, obtaining this letter from a specialist in mental health and cognition, such as a psychiatrist or a neurologist, is important in situations where capacity is an issue such in a contested Will.

On the other hand, if the patient is already experiencing mild memory loss and has not had a primary care doctor for a decade, then a complete mental evaluation conducted by a specialist would be more credible compared to a mini-mental exam conducted by a new family doctor who is seeing the patient for the first time.

When attesting to a patient's mental capacity, the physician should provide on a letterhead:

1. The patient's name, date of birth and address,

2. Date the patient-physician relationship was established,

3. A statement testifying to the patient's ability or inability to make independent decisions regarding healthcare, finances and legal matters,

4. Relevant medical diagnoses and dates when the diagnoses were made, such as a stroke, Alzheimer's disease, and mental illness, and

5. The physician's contact information.

GUARDIAN VERSUS CONSERVATOR

A patient's *caregiver,* family or friend, might have to become that individual's guardian or conservator.

- A *guardian* has the legal authority to make decisions about the lifestyle and well-being of another person. The guardian's decisions include where a person may live, what care and medical treatment will be provided, and what religious and educational activities will be made available.

- A *conservator* has legal authority to manage another person's financial affairs.

INFORMED CONSENT AND REFUSAL

Before obtaining an informed consent, the physician should first determine whether the older patient has the capacity to *understand* the risks and benefits of and alternatives to those treatments, and the consequences of *refusing* treatment, then

proceed with the *informed consent*, treatment discussions or recommendations.

The patient's *mental capacity* should be tracked over time with repeat mental testing, at least annually. Often a psychiatric evaluation and a full Mini-Mental State Examination may not be required. Instead simple mental capacity tests can be used, for example:

1. ***Clock-drawing test:*** This is a standard geriatric where the patient is asked to draw a clock, with hour and minute hands to indicate a specific time.
2. ***Make-a-dollar test***: The patient is given three quarters, three dimes, and three nickels and is asked to make a dollar.
3. ***Three-in-one in two minutes test***: This involves naming three unrelated objects, then asking the patient to repeat them right away, one minute later, and again two minutes later.
4. ***Fact test:*** This involves asking the patient to name five of each of the following: foods, animals, cities in a state, and things that can be purchased at the mall. A perfect score is 20 out of 20. The test is objective, may track a patient's mental status over time, can be shown to the patient's family members, alerting them to cognitive deterioration, and the data is transferable from physician to physician.

Informed consent laws differ by state in the amount of information a healthcare provider must disclose to the patient. Generally speaking, physicians do well to provide patients with enough information to be able to make a fully informed decision about medical care. Exceptions to the informed consent requirement can be made for emergencies where the patient is unconscious and arrives at a facility needing a life-saving procedure. The physician should check state laws to find out what is required for informed consent discussions with patients.

In some states, the "*reasonable physician*" standard is employed, meaning a healthcare provider must provide the amount of information a reasonably prudent physician would provide in the same or similar circumstances. Other states use a "*reasonable patient*" standard, requiring that a physician provide information that a reasonable patient would need to make an informed decision. A handful of states, including Oklahoma, use the "*subjective patient standard*", which requires the physician to provide information that the patient would need to make an informed decision.

RECURRING TREATMENT

The capacity of elderly patients to make informed consent where recurring treatment is required poses special issues. Illnesses that require recurring treatments present unique challenges for physicians obtaining informed consent. Elderly patients are more likely to require recurring treatments such as dialysis, radiation, and chemotherapy. When a patient agrees to undergo these types of treatment, the initial informed consent process ideally covers the entire course of treatment. Patients are told they may question the treatment process, as well as each individual treatment. Informed consent may require more than one conversation, especially in the case of chemotherapy, radiation, or dialysis.

The physician should consider having an in-depth, detailed informed consent discussion with each patient before starting recurring treatments. The patient should sign an informed consent document acknowledging that discussion and the patient's consent to the course of recurring treatment. Verifying with the patient at each visit that he or she wishes to continue the course of treatment is a good idea, and that should be documented as verification in the medical record.

POWERS OF ATTORNEY (POA) AND DURABLE POWERS OF ATTORNEY (DPOA)

Seniors require 'agents' in place, referred to as 'power of attorney' and 'durable power of attorney', who would follow their wishes in the event of incapacity or death. Powers of attorney come in various forms. Limited, general, durable, and healthcare **POA** are the most common.

A **POA** is a document where a patient names an *attorney-in-fact ('agent')* to act on his or her behalf. The **POA** is usually a family member, a significant other or a friend who is not an attorney. The **POA** will usually outline the breadth of the agent's decision-making authority. Depending on the type of **POA** and how it is drafted, the *agent* may have very limited or virtually unlimited authority to make decisions on behalf of the principal.

- A **general POA** ends the moment the patient becomes incapacitated.
- A **DPOA** stays effective until the patient dies or until it is revoked by the patient.

Hence, the **POA** allows patients to give legal authority to their appointed agent to act on his or her behalf.

- A financial **POA** authorizes an agent to make financial decisions.
- A health care **POA** allows an agent to make medical decisions.

Whether the **POA** is used for financial or health care matters, seniors should, while competent, properly craft documents and find the right person(s) to hold that power. Elderly patients are more likely to present the physician with consent issues related to **POA**, guardianships, mental competence, etc. Who, if not the patient, do physicians need to obtain consent from for an elderly patient's medical care?

- **Healthcare POA** is often most straight-forward. It specifically outlines the healthcare decision-making authority granted to the agent by the patient. It also has a large impact on whether the individual named in the **POA** has the authority to make healthcare decisions on behalf of the patient. Physicians should read healthcare **POAs** carefully to determine the authority granted to the agent.

- **Non-healthcare POA** typically do not give the agent the authority to make healthcare decisions. Exceptions do exist.

If the healthcare decision-making authority is not specifically granted within a **POA**, physicians do not and should not make presumptions.

Physicians may encounter patients who, at some point, exhibit lack of mental capacity to continue to make healthcare decisions. Patients with dementia or Alzheimer's present consent issues that physicians should be ready to address, including family disputes, court orders, conflicting **POA**, or other documents that cloud the consent issue for a mentally incapacitated patient.

Physicians should establish consent when the patient is of sound mind, and determine if they have **POA, DPOA**, living will, or other documents outlining who has decision-making authority in the event they become incapacitated or otherwise unable to make decisions.

Finally, physicians should document in the medical records the decision-making authority for their patients, and review the documents with the patient periodically to ensure they are still current.

OLDER DRIVER SAFETY

More than 40 million older drivers are licensed to drive in America. Between 2007 and 2016, the number of older drivers increased 34 percent. On average, driver involvement in fatal crashes increases significantly after age 75 for women and after age 80 for men. During that 10-year period, the total number of traffic fatalities among the older population, who were 65 and above, increased by an average of 13 percent (4 percent in females and 20 percent in males).

The clinical risk factors for impaired driving include:

1. *Physical problems*, such as history of falls, impaired ambulation, problems with hearing, vision or function, and
2. *Cognitive impairment* such as decreased short-term memory, easily distracted, decreased way-finding, and difficulty learning new information quickly or recognizing unsafe conditions or situations.

The clinician's primary duty and responsibility is to protect the older patient's physical and mental health and safety. The clinician has a duty to advise older patients about their medical conditions and their medication which may adversely impair their ability to drive safely for example, older patients who are on sedatives, opioids, marijuana or antidepressants.

Communication is extremely important when caring for seniors. Elders with waning cognitive function or significant hearing loss should be encouraged to bring a family member, a representative or friend to the doctor's office. For example, advising elder patients to stop driving is difficult for physicians, but may be necessary in patients with dementia. The *duty to warn* the patient and third party (non-patient) states that a physician may be held liable for injuries to the patient and others involved in an auto accident if it can be established that the doctor knew the patient had a condition that made driving risky. Seniors often take multiple medications, which may cause adverse drug interactions and accidental overdoses.

The American Geriatrics Society and the National Highway Transportation and Safety Administration jointly provide detailed guidance in their publication, *Clinician's Guide to Assessing and Counseling Older Drivers*. The guide describes three clinical levels of care for prevention of driving disability:

- *Primary* prevention when the clinician intervenes to prevent the loss of driving ability.
- *Secondary* prevention addresses issues that have already caused the loss of driving skills, and an attempt is made to restore driving skills.
- *Tertiary* prevention identifies irreversible loss of driving skills.

The physician's legal obligations fall under 2 general categories:

1. Potential liability based on lawsuits filed by injured parties; and
2. Regulatory requirements due to laws governing driver's licenses.

Driver's licenses are issued by states, and each state has its own laws, regulations, and policies about:

1. Driving motor vehicles and
2. When and how impaired older drivers should be reported to state licensing authorities.

Clinicians must know the laws not only in the state where they practice, but also in the states in which their patients live. This is a challenge for clinics drawing patients from more than one state, for example in interstate telemedicine.

MANDATORY REPORTING

Six states require clinicians to report medically at-risk drivers to the licensing agency: California, Delaware, New Jersey, Nevada, Oregon, and Pennsylvania.

VOLUNTARY REPORTING

In most states, reporting of at-risk drivers is voluntary. However, clinicians may still have legal obligations to report.

LIABILITY FOR REPORTING

Some states provide civil immunity against lawsuits for clinicians who report an at-risk driver in good faith. Physicians should be aware that where reporting is mandatory, they may not necessarily have immunity.

The ***process of communicating*** the need to stop or limit driving is extremely important because of ethical and legal concerns surrounding the reporting of impaired older drivers.

- The clinician should first create a trusting relationship with the patient.
- All options should be explored in face-to-face conversations.
    - o Driving curtailment or cessation should never be discussed on the telephone or, worse, simply ordered in

a letter. That is likely to discourage the patient from returning for repeat examinations and follow-up.

- The clinician might recommend further treatment, such as driving rehabilitation, substance abuse treatment or occupational therapy.
- If changes in driving behavior are likely to improve safety, such as avoiding driving at night, during rush hour, or in bad weather, the physician can make the appropriate recommendations.
- If there are concerns that the older adult would not honor the restrictions, then driving cessation may be the best option.
- The physician should support the patient in making a safe transition, and empower them to find and use transportation alternatives, if needed.
- A conversation with the patient and, if possible, the family or other caregiver is paramount. Caregivers who are included in the discussion are more likely to assist the patient with the changes.
- Physicians should obtain the patient's permission before contacting others, and document the permission in the health record.
- If the patient maintains decisional capacity and denies permission, their wishes must be respected.
- Physicians should help caregivers focus on the older driver's functional abilities, not their age or disease.
- Finally, it is important for physicians to report at-risk drivers to the state licensing agency. If a patient ignores advice to discontinue or restrict (or modify) driving, it is both ethical and legally desirable to report them to the state licensing agency, whether or not such reporting is mandatory.

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