

Chapter 58

Geriatric Patients

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Elder Mistreatment
Guardianship and Its Alternatives
Research with Older Human Subjects

Financing Medical Care for Geriatric Patients
Elder Law as a Growing Specialty

Medical advances enable more Americans to live longer than their predecessors. The segment of our population that is over 65 years old continues to increase exponentially. According to the National Center for Health Statistics, "During 1950 to 2000, the U.S. population grew older. From 1950 to 2000, the percent of the population under 18 years of age fell from 31 percent to 26 percent while the percent 65–74 years increased from 6 to 7 percent and the percent 75 years and over increased from 3 to 6 percent. From 2000 to 2050 it is anticipated that the percent of the population 65 years and over will increase substantially. Between 2000 and 2050 the percent of the population 65–74 years of age will increase from 7 to 9 percent and the population 75 years old and over will increase from 6 to 12 percent. By 2040 the population 75 years and over will exceed the population 65–74 years of age."¹

A relatively small number (1.47 million, or 43 per 1000 population) of the over-65 population lived in nursing facilities and received their health care there in 1999. However, the likelihood of nursing home residency increased dramatically with age, ranging in that year from 194,000 residents 65–74 years old to 518,000 residents 75–84 years old and 720,000 residents aged 85 and older.²

The likelihood of developing chronic health problems increases sharply with age. Most older persons have at least one chronic condition and multiple conditions are not uncommon. The most common chronic conditions in persons aged 65 and older are arthritis, hypertension and other heart problems, sensory impairments, orthopedic impairments, sinusitis, and diabetes. Other problems include memory loss, dementia, and depression. Mental stress often creates serious physical complications in the aged. The major causes of death for older people are heart disease, stroke, and cancer.

Most of the generic chapters in this volume are fully pertinent to care of the elderly, although general medicolegal concepts frequently take on special nuances as applied specifically to older persons. For instance, the requirement of informed consent to medical interventions applies to persons of all ages, but when older persons are involved, special attention must be paid to issues of decisional capacity and (especially when the patient is institutionalized) the voluntariness of decisions.

The current chapter does not, however, comprehensively discuss the particular application of generic concepts to older persons. Instead, the purpose here is to outline a few selected topics involving the intersection of law and medicine in the care of the elderly population.

ELDER MISTREATMENT

Only in the last few decades have we been willing to publicly admit, let alone begin to address, the phenomenon of serious mistreatment of older persons both within home and community-based settings and institutional environments.³ The problem is a prevalent one⁴ and is by no means limited to the United States⁵ or to any particular racial or ethnic group.⁶

The definition of elder abuse and neglect is a matter of state law. Each state has enacted its own statutory schema in this arena, with substantial variation among particular definitions and procedures as a consequence.⁷

The National Research Council has described elder mistreatment as:

*(a) intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trusted relationship to the elder or (b) failure of a caregiver to satisfy the elder's basic needs or to protect the elder from harm.*⁸

These actions or inactions may take place in the elder's own home or that of a relative, at the hands of an informal caregiver,⁹ or in an institutional setting.¹⁰ A single incident may constitute abuse or neglect in most states, although usually a repeated pattern is discovered and in some jurisdictions it is necessary to meet statutory definitions of abuse and neglect. Random criminal assaults of older persons by strangers (e.g., in the context of a robbery) generally are excluded from the category of elder mistreatment as it is being considered in this chapter.

Among the different forms of elder mistreatment are: physical (e.g., assault, forced sexual contact, overmedication, inappropriate physical restraints); psychological or emotional (e.g., threats); denial of basic human needs by the caregiver (e.g., withholding indicated medical care or

560 Geriatric Patients

food); deprivation of civil rights (e.g., freedom of movement and communication); and financial exploitation.¹¹

In addition, a significant proportion of reported cases of elder mistreatment fall into the category of self-neglect by older persons living alone, without any informal (i.e., unpaid family or friends) or formal (i.e., paid) caregivers. Examples of self-neglect may include an individual's failure to maintain adequate nutrition, hydration, or hygiene, use physical aids such as eyeglasses, hearing aids, or false teeth, or maintain a safe environment for himself or herself. Self-neglect may be suspected in the presence of dehydration, malnourishment, decubitus ulcers, poor personal hygiene, or lack of compliance with basic medical recommendations.¹²

A few states have enacted distinct statutes dealing with cases of institutional abuse and neglect of older residents. Terms of these statutes may apply to nursing facilities, board and care homes, and assisted living arrangements. Even without such precisely focused legislation in a particular jurisdiction, resident mistreatment by long-term care institutional staff is condemned by federal regulations,¹³ including restrictions on the use of involuntary mechanical and chemical restraints,¹⁴ as well as by state institutional licensing statutes and common law tort standards.¹⁵ Also, a number of states explicitly lump together institutional and informal caregiver mistreatment in the same statutes, rather than legislatively handling them distinctly.

Every state has exercised its *parens patriae* power to protect those who cannot fend for themselves by enacting a statute dealing with the reporting of elder mistreatment suspicions by health care professionals to specific public welfare or law enforcement authorities.¹⁶ Some state statutes single out the elderly, while others just use age 18 and vulnerability to mistreatment as the criteria for reporting and intervention. Almost every state mandates reporting of suspected elder abuse and neglect, with criminal penalties and/or civil fines specified for noncompliance in most statutory schemes. A private tort action may also be brought by a mistreatment victim whose injuries were exacerbated by the professional's failure to report in timely fashion.¹⁷

The remaining jurisdictions make reporting a voluntary matter, with legislation stating that a report "may" rather than "shall" be filed. Whether reporting of mistreatment cases is required or only permitted, all of the statutes immunize the mandated or authorized reporters against any potential liability (e.g., for breach of the duty of patient confidentiality or for defamation) for making the report, as long as the report was made in good faith and without malicious intent.¹⁸

In recognition of the potential for elder abuse and neglect, the states have created a wide variety of programs under the general heading of Adult Protective Services (APS). The basic definition of this concept is a system of preventive and supportive services for older persons living in the community to enable them to remain as independent as possible while avoiding abuse and exploitation by others. Good APS programs are characterized by the coordinated delivery of services to adults at risk and the actual or potential authority to provide surrogate decision-making regarding those services.¹⁹

GUARDIANSHIP AND ITS ALTERNATIVES

Although the law presumes that adults are capable of making voluntary, informed, and understanding decisions that affect their lives, sometimes this presumption is not accurate.²⁰ A significant minority of older individuals have impaired ability to make and communicate their own choices about personal (including medical) and financial matters in a rational and authentic manner. The prevalence of dementia and other severe mental disabilities among the aged indicates the strong probability that this phenomenon will expand in the future. One important device within the legal system (both domestically and internationally)²¹ for dealing with the problem of cognitively incapacitated individuals, and the concomitant need for some form of surrogate decision-making on their behalf, is guardianship.²²

Guardianship is a legal relationship, established by the order of a state court under the authority of a state statute, between a ward (the person whom a court has declared to be incompetent to make decisions) and a guardian (whom the court appoints as the surrogate decision-maker for the ward). Terminology regarding this relationship varies among jurisdictions; in some states such as California, for example, this concept is referred to as conservatorship.

Judicial appointment of a guardian to make decisions on behalf of a person who has been adjudicated incompetent ordinarily occurs in response to a petition filed by the family, a health care facility, or an APS agency.²³ The legal proceeding involves review by the court of the sworn affidavit or live testimony of a physician who has examined the alleged incompetent person. An adjudication of incompetence means that the ward no longer retains the power to exercise those decisional rights that have been delegated to the guardian. The appointment of a guardian is an exercise of the state's inherent *parens patriae* power to protect from harm persons who are not able to care for themselves.²⁴ The performance of the guardian as a fiduciary or trust agent of the ward remains subject to continuing oversight by the appointing court.²⁵

The legal system historically has treated guardianship as an all-or-nothing proposition, global findings of incompetence being accompanied by virtually complete disenfranchisement of the ward. Lately, however, states have amended their statutes to recognize the concept of limited or partial guardianship, which accounts for the decision-specific nature of mental capacity and the ability of some people rationally to make certain kinds of choices but not others.²⁶ Because creating total or "plenary" guardianship usually entails an extensive deprivation of an individual's basic personal and property rights, the "least restrictive/least intrusive alternative" doctrine makes limited or partial guardianship preferred.

The modern trend in surrogate decision-making has been toward the substituted judgment standard. Under this approach, the guardian is required to make the same decisions that the patient would make, according to the patient's own preferences and values to the extent they can

be ascertained, if the patient currently were able to make and express competent decisions. The substituted judgment standard is highly consistent with respect for patient autonomy. When it cannot reasonably be ascertained what the patient would have decided if competent, the guardian is expected to rely on the traditional best interests standard. That test mandates that decisions be made in a manner that, from the guardian's perspective, would confer the most benefit and the least burden on the ward.

A number of alternatives to plenary, private guardianship exist for assisting older individuals with cognitive impairments to navigate through the vicissitudes of daily life. Some of these alternatives involve advance planning, while others are imposed on the individual in the absence of such planning.

A variety of legal and financial strategies have evolved that enable individuals, while still mentally and physically capable of rationally making and expressing their own choices, to plan ahead for the contingency of future incapacity. These advance planning mechanisms promote the principle of autonomy by permitting an individual to prospectively direct or shape subsequent personal decisions even if contemporaneous expression of wishes has become impossible.

Many of these devices pertain to prospective influence over monetary matters; they include joint bank accounts, automatic deposits, living trusts, personal money management services, powers of attorney, and durable powers of attorney. The chief advance planning mechanisms available for future medical decisions are the living will and the durable power of attorney for health care. These written directives are discussed in depth elsewhere in this text.

Although it usually works reasonably as intended, advance financial and health care planning sometimes goes badly awry. The geriatric clinician may become aware, for instance, of an agent named under a now-incapacitated patient's durable power of attorney who is misusing or exploiting the patient's finances, abusing the patient, or grossly neglecting the patient's medical needs. In such circumstances, the clinician confronts ethical quandaries about whether to initiate a guardianship proceeding or otherwise request court involvement. When the clinician sees no other effective, less restrictive means of dealing with such scenarios, referring the situation to the legal system, through official notification of the local APS agency, is probably the best course to follow.

There also is evidence that physicians not infrequently fail to honor patients' advance medical directives.²⁷ A number of initiatives have been launched in a concerted effort to educate both medical professionals and the general public about the significance and expectations of advance medical planning.

The majority of people who become decisionally incapacitated have failed to take advantage of the advance planning mechanisms just outlined. For this bulk of the cognitively impaired population, alternatives to standard plenary, private guardianship fall into two categories: alternative forms of guardianship (e.g., limited and/or temporary) and alternatives to guardianship.

For a growing number of older persons whose cognitive impairments would technically qualify them for guardianship, plenary or limited, the most pressing practical problem is the unavailability of family members or close friends who are willing and able to assume guardianship responsibilities. In the absence of a state public guardianship system, local volunteer guardianship program, or sufficient assets to hire a private, proprietary professional guardian, the cognitively incapacitated individual with no family or friends (the "unbefriended") often literally "fall between the cracks."²⁸ Important decisions, including those involving medical treatment, may by default go without being made until an emergency has developed and the doctrine of presumed consent applies.

Even in the absence of advance planning for incapacity by the individual, some form of official guardianship for the cognitively incapacitated older person is by far the exception rather than the rule. Unplanned alternatives to guardianship include representative payees for government benefit payments, adult protective services (APS) (including their emergency intervention powers), family consent statutes, and the informal but universally accepted practice of asking next of kin for authorization to provide or withhold specific interventions.

RESEARCH WITH OLDER HUMAN PARTICIPANTS

The generic legal aspects of conducting biomedical or behavioral research involving human participants is dealt with elsewhere in this volume. However, given the disproportionate prevalence of dementias and other severe mental disabilities among the elderly, the legal and ethical Catch 22 of conducting biomedical and behavioral research using older human participants who are severely demented or otherwise cognitively compromised presents a particular dilemma.²⁹ On the one hand, progress in developing effective treatments and cures for medical and psychological problems associated with dementia requires that research projects be done in which individuals suffering from the precise problems of interest be the basic units of study. At the same time, paradoxically, those very problems that qualify an individual for eligibility as a subject in such a research project often make it impossible for that person to engage in a rational and autonomous decision-making process about his or her own participation as a research subject.³⁰ This irony is exacerbated by the fact that research participants generally are more vulnerable to possible exploitation, and hence need more protection, than patients in therapeutic situations because of, among other things, the researchers' potential conflicts of interest.³¹

Federal regulations covering biomedical and behavioral research require that informed consent for participation be obtained from the "subject or the subject's legally authorized representative."³² However, a subject's legally authorized representative is defined in circular fashion to mean an "individual or judicial or other body authorized under applicable [presumably state] law to consent on behalf of a

562 Geriatric Patients

prospective subject."³³ Thus, state law, even when ambiguous or unspecific, controls in this arena.³⁴

A number of alternative possibilities for proxy decision-making in the research context have been identified. These devices include the durable power of attorney for research participation, reliance on family consent statutes, informal reliance on available family members as surrogate decision-makers, guardianship with specific authorization for research decisions, explicit prior court orders authorizing the incapacitated subject's participation in research protocols on a case-by-case basis, an independent patient advocate supplied by the organization sponsoring the research or by a government agency, and selection of a surrogate by the institutional review board (IRB) or a long-term care facility's resident council.

Some have suggested that special procedural safeguards are necessary to protect vulnerable, cognitively impaired human volunteers from injury due to research participation. These safeguards might encompass heightened IRB involvement in the protocol approval process, enhanced IRB activity in the postapproval ongoing monitoring and supervision phase of the research, including serving as a forum for appeals and objections, and requiring individual participant assent (i.e., giving participants a veto power) even when informed proxy consent to research participation has been obtained. An important question, especially since the participants of interest are mentally impaired, concerns the definition of assent to be used, namely, whether the failure to actively object to participation in a protocol is enough to be interpreted as a tacit or implied form of assent or whether some more affirmative indication of agreement is necessary.

FINANCING MEDICAL CARE FOR GERIATRIC PATIENTS

Medical care (acute and chronic) and long-term care³⁵ for geriatric patients is financed through a crazy-quilt combination of personal out-of-pocket payments, Medicaid (primarily for nursing facility care and home and community-based long-term care authorized under various state waiver programs), payments from private Medicare supplementary insurance policies purchased individually by the patient (i.e., "Medigap" policies), privately purchased long-term care insurance policies,³⁶ and Medicare. The traditional Medicare program, which was the only model available to Medicare beneficiaries until 1998, consisted of Parts A and B.³⁷ Medicare Part A mainly pays for inpatient hospital care and Part B primarily covers physicians' services.

A Medicare Part C was enacted by Congress as part of the 1997 Balanced Budget Act (BBA).³⁸ This new program created the Medicare + Choice Program (MCP), which was available to pay for an array of private health insurance options for Medicare beneficiaries. These options included health maintenance organizations (HMOs), competitive medical plans (CMPs), provider-sponsored organizations (PSOs), medical savings accounts (MSAs), and private fee-for-service (PFFS) plans. Under the BBA and implementing

regulations, each eligible older and disabled individual was afforded the right to choose between remaining in federally regulated Parts A and B or enrolling in one of the Part C Medicare + Choice market-oriented options available in the individual's local area. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) renamed Part C "Medicare Advantage" (MA) and created as Part D new private prescription drug plans that went into effect in 2006.³⁹ Part D beneficiaries can enroll in prescription drug plans (PDPs) and get all other Medicare benefits from the traditional fee-for-service (FFS) program, or they can enroll in MA plans, such as HMOs or regional preferred provider organizations (PPOs), that cover all Medicare benefits.⁴⁰

Earlier explicit suggestions that certain aspects of medical care be rationed categorically according to a patient's age⁴¹ have, in general, been soundly rejected in public policy debate. However, there is evidence that medical care actually is rationed by age de facto, in the sense that older people in many circumstances are treated less aggressively than younger counterparts from whom they cannot be distinguished in terms of prognosis or other relevant medical criteria.⁴²

ELDER LAW AS A GROWING SPECIALTY

Over the past three and a half decades, the field of elder law as a specialty of attorney practice has burgeoned.⁴³ Educational institutions offer specialized courses and other learning opportunities in this sphere for both attorneys and other professionals, focused textbooks and practice handbooks have proliferated, journals have arisen, and national and state organizations (such as the National Academy of Elder Law Attorneys)⁴⁴ devoted to the field have developed and grown.

The content of elder law is expansive. Matters falling within this area include, at least, advice to and representation of older persons, their families, and physicians and other service providers regarding: Social Security retirement and disability benefits; other federal and state benefits; Medicare and Medicaid (including asset sheltering and divestiture for eligibility purposes); housing issues, financial management (e.g., trusts), and estate planning; medical treatment decision-making and advance planning; judicial and nonjudicial forms of substitute decision-making; elder abuse and neglect; employment discrimination; and tax counseling. Elder law practice is necessarily interdisciplinary and interprofessional in nature, entailing cooperation among the attorney, physicians and other health and human services providers, governmental agencies, and nonlegal advocacy and support organizations.⁴⁵

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