2016

Running Past Landmines--The Estate Attorney's Dilemma: Ethically Counseling the Client With Alzheimer's Disease

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Recommended Citation

Joseph Karl Grant, Running Past Landmines--The Estate Attorney's Dilemma: Ethically Counseling the Client With Alzheimer's Disease, 24 Elder L.J. 101 (2016)

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RUNNING PAST LANDMINES—THE ESTATE ATTORNEY'S DILEMMA: ETHICALLY COUNSELING THE CLIENT WITH ALZHEIMER'S DISEASE

Joseph Karl Grant

This Article examines the ethical dilemmas faced by attorneys who represent clients suffering from Alzheimer's disease. To do so, this Article raises three (3) hypothetical case studies, and applies the ABA Model Rules of Professional Conduct, and the American College of Trust and Estate Counsel ("ACTEC") Commentaries, where appropriate, to those hypothetical case studies.

Additionally, this Article proposes initiatives to ameliorate the lack of awareness and discussion of Alzheimer's disease in the law school curriculum, and finally, modest initiatives that the practicing bar can embrace to further a discussion

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and awareness among practicing attorneys about the ethical dilemma attorneys face in their daily interaction with actual and potential clients suffering from Alzheimer's disease.

This article's objectives are twofold. First, the intention is to use this Article as a vehicle to expose law students, legal educators, practicing attorneys, policymakers, and layperson observers to the impact, medical symptoms and manifestations of Alzheimer's disease in accessible and easy to understand terms. Second, to use this Article as a tool for teaching, raising understanding, and providing guidance on a multitude of ethical considerations that law students (who will soon be lawyers) and practicing members of the bar should consider while being exposed to actual or potential clients who suffer from Alzheimer's disease.

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Introduction

After heart disease, cancer, chronic lower respiratory diseases, accidents (unintentional injuries), and strokes, do you know the sixth leading cause of death among adults in the United States of America? If you do not know: the answer is Alzheimer’s disease. Yes, Alzheimer’s disease is the sixth leading cause of death among adult Americans.¹ The average American citizen would fail the pop-quiz that I just presented, unless statistics and mortality rates somehow inform their daily lives. Actuaries need not apply! As one observer has astutely observed:

Current estimates approximate that the population over sixty-five years of age will increase from forty million in 2010 to 72.1 million by 2030. As society ages, the number of elderly with cognitive deficits [mainly Alzheimer’s disease] that impair decision-making abilities will also increase. This will place additional burdens on families and probate courts seeking to balance individual autonomy with necessary protections.²

Americans from all educational levels, racial, religious, economic, social, and cultural groups have not been immune from the cruel fate of Alzheimer’s disease. Prominent Americans have fallen victim to Alzheimer’s disease. In 1994, President Ronald Reagan issued a poignant open letter to American citizens informing the world about his Alzheimer’s diagnosis.³ Ronald Reagan’s long decline and death

1. See *Leading Causes of Death*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm> (last visited Mar. 20, 2016).

2. Jalayne J. Arias, *A Time to Step In: Legal Mechanisms for Protecting Those with Declining Capacity*, 39 AM. J. L. & MED. 134, 134 (2013).

3. See Letter from Ronald Reagan, President of the United States, to Fellow Americans (Nov. 5, 1994), <http://www.reagan.utexas.edu/archives/reference/alzheimerletter.html>. In 1994, President Reagan penned the following open letter to American citizens about his diagnosis with Alzheimer’s disease, known as his “Sunset of My Life” address:
“Nov. 5, 1994
My Fellow Americans,

from Alzheimer's disease may have begun during his term in office.⁴ Eddie Robinson, the legendary former head-football coach at the historically Black college, Grambling University in Louisiana, and the coach with the most victories in college football, publicly revealed his struggles with Alzheimer's disease in 2004 before his death from the disease in 2007.⁵ In 2002, iconoclastic actor and activist, Charlton Heston, informed the public about his battle with Alzheimer's disease.⁶ More recently, in 2012, legendary women's basketball coach,

I have recently been told that I am one of the millions of Americans who will be afflicted with Alzheimer's Disease.

Upon learning this news, Nancy and I had to decide whether as private citizens we would keep this a private matter or whether we would make this news known in a public way.

In the past Nancy suffered from breast cancer and I had my cancer surgeries. We found through our open disclosures we were able to raise public awareness. We were happy that as a result many more people underwent testing.

They were treated in early stages and able to return to normal, healthy lives.

So now, we feel it is important to share it with you. In opening our hearts, we hope this might promote greater awareness of this condition. Perhaps it will encourage a clearer understanding of the individuals and families who are affected by it.

At the moment I feel just fine. I intend to live the remainder of the years God gives me on this earth doing the things I have always done. I will continue to share life's journey with my beloved Nancy and my family. I plan to enjoy the great outdoors and stay in touch with my friends and supporters.

Unfortunately, as Alzheimer's Disease progresses, the family often bears a heavy burden. I only wish there was some way I could spare Nancy from this painful experience. When the time comes I am confident that with your help she will face it with faith and courage.

In closing let me thank you, the American people for giving me the great honor of allowing me to serve as your President. When the Lord calls me home, whenever that may be, I will leave with the greatest love for this country of ours and eternal optimism for its future.

I now begin the journey that will lead me into the sunset of my life. I know that for America there will always be a bright dawn ahead.

Thank you, my friends. May God always bless you.

Sincerely,

Ronald Reagan"

4. See generally Lawrence K. Altman, *Parsing Ronald Reagan's Words for Early Signs of Alzheimer's*, N.Y. TIMES (Mar. 30, 2015), <http://www.nytimes.com/2015/03/31/health/parsing-ronald-reagans-words-for-early-signs-of-alzheimers.html>; see also Ellie Zolfaghari, *Did Ronald Reagan have Alzheimer's while in office? Early signs of dementia are revealed in former president's speech*, DAILY MAIL (Mar 31, 2015), <http://www.dailymail.co.uk/sciencetech/article-3020517/Did-Ronald-Reagan-Alzheimer-s-office-Early-signs-dementia-revealed-former-president-s-speech.html>.

5. William N. Wallace & Frank Litsky, *Eddie Robinson, 88, Pioneer Grambling Coach, is Dead*, N.Y. TIMES (Apr. 5, 2007), http://www.nytimes.com/2007/04/05/sports/ncaafootball/05robinson.html?_r=0.

6. See Jeannie Williams, *Charlton Heston fears the worst: Alzheimer's*, USA TODAY, http://usatoday30.usatoday.com/life/2002-08-09-heston_x.htm (last visited Mar. 20, 2016). While President of the National Rifle Association (NRA), Heston made the following statement to members of the NRA:

Pat Summitt, resigned from her longtime position as head coach at the University of Tennessee due to her struggles with Alzheimer's disease.⁷ Even the Rhinestone Cowboy, legendary country music singer, Glen Campbell, took the public inside his own journey with Alzheimer's disease.⁸

"Increasingly, attorneys are asked to provide legal services to clients under circumstances that suggest that the client's mental capacity is diminished or absent."⁹ This Article examines the ethical dilemmas that face estate attorneys who represent clients who suffer from Alzheimer's disease. Part I explores the medical symptoms and manifestations of Alzheimer's disease to provide a basic understanding of the cognitive impact of the disease. Additionally, Part I places the societal and economic impact of Alzheimer's disease in perspective by looking at the statistics that characterize Alzheimer's disease. Part II explores practical ethical problems that estate attorneys face in representing clients with Alzheimer's disease through discussion on three hypotheticals, applications of the ABA Model Rules of Professional Conduct, and the American College of Trust and Estate Counsel (ACTEC) Commentaries,¹⁰ where appropriate, to those hypotheti-

"My dear friends, colleagues, and fans, my physicians have recently told me I may have a neurological disorder whose symptoms are consistent with Alzheimer's disease. I wanted to prepare a few words for you now, because when the time comes, I may not be able to.

I worked lived my whole life on the stage and screen before you. I found purpose and meaning in your response. For an actor, there is no greater loss than the loss of his audience. I can part the Red Sea, but I can't part with you."

7. See generally Pat Summitt, *Fast Facts*, CNN (June 2, 2015, 10:30 PM), <http://www.cnn.com/2015/01/06/us/pat-summitt-fast-facts/>.

8. See *Legendary singer Glen Campbell on living with Alzheimer's*, WGN (Aug. 29, 2015, 7:24 PM), <http://wgntv.com/2015/08/29/legendary-singer-glen-campbell-on-living-with-alzheimers/>.

9. Raymond C. O'Brien, *Attorney Responsibility and Client Incapacity*, 30 J. CONTEMP. HEALTH L. & POL'Y 59, 60 (2013). Professor O'Brien observes: "Examples would include, most commonly, the preparation and execution of a last will and testament. The formalities of due execution are easily and objectively satisfied by the seasoned attorney. However, particularly in regard to an aging population, the attorney must also confront the more subjective intention of the client: Whether the client has the necessary capacity for execution; whether the client is being unduly influenced by another; or whether the client is executing the last will and testament while under a delusion. Each of these subjective tests involving client capacity has a corresponding legal pedigree delineating what must be done to establish validity. Each requires the attorney to be sensitive to personality issues involving the client and often the client's family and beneficiaries." *Id.*

10. Susan N. Gary et al., CONTEMPORARY APPROACHES TO TRUSTS AND ESTATES 20 (Wolters Kluwer 2011). There is an explanatory relationship between the ABA Model Rules of Professional Conduct and the ACTEC Commentaries. As one authority observes: "The Model Rules, and the state rules adapted from them,

cals. Part III proposes initiatives to ameliorate the lack of awareness and discussion of Alzheimer's disease in the law school curriculum, and finally, offers modest initiatives that the practicing bar can embrace to further a discussion and awareness among practicing attorneys about the ethical dilemmas estate attorneys face in their daily interaction with actual and potential clients suffering from Alzheimer's disease.

This Article's objectives are twofold. First, this Article's intention is to serve as a vehicle to expose law students, legal educators, attorneys, policymakers, and layperson observers to the impact, medical symptoms, and manifestations of Alzheimer's disease in accessible and easy to understand terms. Second, this Article's intention is to serve as a tool for teaching, raising understanding, and providing guidance on a multitude of ethical considerations that law students and practicing members of the bar should consider while being exposed to actual or potential clients who suffer from Alzheimer's disease. My fervent desire is that this Article will spark exposure and discussion of a significant problem that will vex many segments of our society for many years to come until a cure or preventative measures are found to combat Alzheimer's disease.

Part I: The Signs, Symptoms, and Manifestations of Alzheimer's Disease

A. A Definition: What is Alzheimer's Disease?

A German physician, Dr. Alois Alzheimer, first identified Alzheimer's disease in 1906.¹¹ Dr. Alzheimer first noticed abnormal brain tissue in a postmortem exam of a woman who died as a result of a strange mental disease.¹² The abnormal clumps (known as amyloid plaques) and tangled fibers (known as neurofibrillary tangles) ob-

are general statements that apply to all areas of the law; they are not focused on any specific field of law. In an effort to provide guidance in the estate planning context, the American College of Trusts and Estate Counsel (ACTEC), a nonprofit organization whose members are involved in the trusts and estates area, has developed commentaries on the Model Rules . . . the ACTEC Commentaries give more specific guidance and adapt the general Model Rules to the particular problems encountered by estate planning lawyers."

11. See *Major Milestones in Alzheimer's and Brain Research*, ALZHEIMER'S ASS'N, http://www.alz.org/research/science/major_milestones_in_alzheimers.asp (last visited Mar. 20, 2016).

12. *Id.*

served by Dr. Alzheimer are now considered indicators or hallmarks of Alzheimer's disease.¹³ A postmortem examination of the brain is the only means to definitively diagnose Alzheimer's disease.¹⁴

Alzheimer's Disease is an irreversible and fatal form of dementia. Dementia is a widely used term that refers to neurological disorders, some which are reversible and others which are irreversible, whose symptoms leads to a loss of cognitive or thinking ability.¹⁵ There are well over fifty medically diagnosed and documented dementias. The common symptoms include a gradual loss of memory, problems with reasoning or judgment, disorientation, difficulty in learning, loss of language skills, and decline in the ability to perform routine tasks.¹⁶ These symptoms have an obvious effect on a client's ability to understand and work with an attorney.

In 2013, the Centers for Disease Control indicated that 84,767 Americans died from Alzheimer's disease.¹⁷ On average each year, approximately 700,000 people will die from Alzheimer's disease in the United States.¹⁸

Alzheimer's disease is on the rise in every nation with an increased life expectancy.¹⁹ The increase in the prevalence of Alzheimer's disease is not isolated to the United States alone. Worldwide, by 2030, it is estimated that 74.7 million people will be affected by dementia.²⁰ By 2050, the number of dementia sufferers could skyrocket to 131.5 million people.²¹

13. *Id.*

14. Charles L. White, *Autopsy for Dementia: Commonly Asked Questions*, U. TEXAS SW. MED. SCH., http://www.utsouthwestern.edu/edumedia/edufiles/departments_centers/neurology/alzheimers_disease_center/autopsy-dementia-faq.pdf (last visited Mar. 19, 2016).

15. See *What is Alzheimer's?*, ALZHEIMER'S ASS'N, http://www.alz.org/alzheimers_disease_what_is_alzheimers.asp (last visited Mar. 19, 2016).

16. *Id.*

17. See *Leading Causes of Death*, *supra* note 1.

18. See *2015 Alzheimer's Facts and Figures*, ALZHEIMER'S ASS'N, <http://www.alz.org/facts/> (last visited Mar. 19, 2016); see also WALTER F. BODMER, *THE BOOK OF MAN: THE HUMAN GENOME PROJECT AND THE QUEST TO DISCOVER OUR GENETIC HERITAGE* 144 (Oxford University Press 1977).

19. *Better Hygiene in wealthy nations may increase Alzheimer's risk, study suggests*, SCIENCE DAILY (Sept. 4, 2013), <https://www.sciencedaily.com/releases/2013/09/130904105347.htm>.

20. *World Alzheimer Report 2015: The Global Impact of Dementia*, ALZHEIMER'S DISEASE INT'L 1, 22 (Aug. 2015), <http://www.alz.co.uk/research/WorldAlzheimerReport2015.pdf>.

21. *Id.*

B. The Societal and Economic Impact of Alzheimer's Disease: A Statistical Overview

a. Approximately 5.3 million Americans of all ages have Alzheimer's disease.²² An estimated 5.1 million Americans with Alzheimer's are age sixty-five and older, while approximately 200,000 Alzheimer's sufferers are under age sixty-five.²³

b. One in three American senior citizens dies from Alzheimer's or another form of dementia.²⁴

c. In the United States, someone develops Alzheimer's disease every sixty-seven seconds.²⁵

d. Approximately two-thirds of Americans with Alzheimer's are women.²⁶ Of the 5.1 million sufferers over the age of sixty-five, 3.2 million are women and 1.9 million are men.²⁷

e. There are more non-Hispanic whites living with Alzheimer's and other dementias than people of any other racial or ethnic group in America. Older African-Americans and Hispanics are more likely than older whites to have Alzheimer's disease and other types of dementia.²⁸

f. The number of Americans affected by Alzheimer's disease will continue to grow rapidly—by 2025, the number of Americans with Alzheimer's disease is estimated to reach 7.1 million—which represents a forty percent increase from 2015 statistical levels.²⁹ By 2050, it is estimated that 13.8 million Americans could suffer from Alzheimer's disease,³⁰ barring breakthroughs in prevention and a cure for the disease.

g. In 2015 alone, an estimated 700,000 people aged sixty-five and older in the United States will die from Alzheimer's disease.³¹ As American citizens age, Alzheimer's disease³² is becoming a more common cause of death in the United States.

22. 2015 *Alzheimer's Facts and Figures*, *supra* note 18.

23. *Id.*

24. *Id.*

25. *Id.*

26. *Id.*

27. *Id.*

28. *Id.*

29. *Id.*

30. *Id.*

31. *Id.*

32. *Id.*

h. Although deaths from other major causes have decreased in the United States, official records and statistics indicate that Alzheimer's disease deaths are increasing significantly.³³

i. Between the years 2000 and 2013, Alzheimer's disease deaths increased seventy-one percent, while those attributed to heart disease (the leading cause of American deaths) decreased fourteen percent.³⁴

j. It is estimated that in 2014, friends and family of people with Alzheimer's disease and other dementias provided an estimated 17.9 billion hours of unpaid care, a contribution to America valued at \$217.7 billion.³⁵ To put this number into perspective, this number represents forty-six percent of the net value of Walmart sales in 2013³⁶ and nearly eight times the total revenue of McDonald's in 2013.³⁶

1. It is estimated that two-thirds of Alzheimer's caregivers are women and thirty-four percent are age sixty-five or older.³⁷

2. Forty-one percent of primary Alzheimer's caregivers have a household income of \$50,000 or less.³⁸

3. It is estimated, that over half of primary dementia caregivers take care of parents.³⁹

4. Estimates show that 250,000 children and young adults between ages eight and eighteen provide help⁴⁰ to someone with Alzheimer's disease or another dementia.

k. Alzheimer's disease is devastating to caregivers –forty percent of caregivers suffer from depression.⁴¹ It is estimated that due to the physical and emotional toll of caregiving to Alzheimer's disease patients, caregivers had \$9.7 billion in additional health care costs of their own in 2014.⁴²

33. *Id.*

34. *Id.*

35. *Id.*

36. *Id.*

37. *Id.*

38. *Id.*

39. *Id.*

40. *Id.*

41. *Id.*

42. *Id.*

1. It is estimated, that in 2015 alone, the direct costs to American society of caring for Alzheimer's disease patients reached a total of \$226 billion, with half of that cost borne by Medicare.⁴³

C. Signs and Symptoms of Alzheimer's Disease

According to the American Alzheimer's Association, there are ten warning signs and symptoms of Alzheimer's disease that should prompt someone to worry about having Alzheimer's disease.⁴⁴ Undoubtedly, these warning signs can affect a client's legal needs. The signs and symptoms highlighted by the American Alzheimer's Association include the following:

1. "Memory loss that disrupts daily life –One of the most common signs of Alzheimer's is memory loss, especially forgetting recently learned information. Others include forgetting important dates or events; asking for the same information over and over; increasingly needing to rely on memory aids (e.g., reminder notes or electronic devices) or family members for things they used to handle on their own."⁴⁵

2. "Challenges in planning or solving problems—Some people may experience changes in their ability to develop and follow a plan or work with numbers. They may have trouble following a familiar recipe or keeping track of monthly bills. They may have difficulty concentrating and take much longer to do things than they did before."⁴⁶

3. "Difficulty completing familiar tasks at home, at work or at leisure –People with Alzheimer's often find it hard to complete daily tasks. Sometimes, people may have trouble driving to a familiar location, managing a budget at work or remembering the rules of a favorite game."⁴⁷

4. "Confusion with time or place –People with Alzheimer's can lose track of dates, seasons and the passage of time. They may have

43. 2015 *Alzheimer's Disease Facts and Figures*, ALZHEIMER'S ASS'N 1, 45 (2015), http://www.alz.org/facts/downloads/facts_figures_2015.pdf.

44. 10 *Early Signs and Symptoms of Alzheimer's*, ALZHEIMER'S ASS'N, http://www.alz.org/alzheimers_disease_10_signs_of_alzheimers.asp#signs (last visited Mar. 19, 2016).

45. *Id.*

46. *Id.*

47. *Id.*

trouble understanding something if it is not happening immediately. Sometimes they may forget where they are or how they got there."⁴⁸

5. "Trouble understanding visual images and spatial relationships –For some people, having vision problems is a sign of Alzheimer's. They may have difficulty reading, judging distance and determining color or contrast, which may cause problems with driving."⁴⁹

6. "New problems with words in speaking or writing –People with Alzheimer's may have trouble following or joining a conversation. They may stop in the middle of a conversation and have no idea how to continue or they may repeat themselves. They may struggle with vocabulary, have problems finding the right word or call things by the wrong name (e.g., calling a "watch" a "hand-clock")."⁵⁰

7. "Misplacing things and losing the ability to retrace steps –A person with Alzheimer's disease may put things in unusual places. They may lose things and be unable to go back over their steps to find them again. Sometimes, they may accuse others of stealing. This may occur more frequently over time."⁵¹

8. "Decreased or poor judgment –People with Alzheimer's may experience changes in judgment or decision-making. For example, they may use poor judgment when dealing with money, giving large amounts to telemarketers. They may pay less attention to grooming or keeping themselves clean."⁵²

9. "Withdrawal from work or social activities –A person with Alzheimer's may start to remove themselves from hobbies, social activities, work projects or sports. They may have trouble keeping up with a favorite sports team or remembering how to complete a favorite hobby. They may also avoid being social because of the changes they have experienced."⁵³

10. "Changes in mood and personality –The mood and personalities of people with Alzheimer's can change. They can become confused, suspicious, depressed, fearful or anxious. They may be easily

48. *Id.*

49. *Id.*

50. *Id.*

51. *Id.*

52. *Id.*

53. *Id.*

upset at home, at work, with friends or in places where they are out of their comfort zone."⁵⁴

D. Progression and Stages of Alzheimer's Disease

As with most diseases, the severity and degree of Alzheimer's disease can be graded or qualified. Basically, Alzheimer's disease consists of three grades or levels of severity: mild; moderate; and severe.⁵⁵ Table One lists the three grades of Alzheimer's disease and describes the impact of the disease and its progression on the basic daily life activities of an individual with the disease.

TABLE 1: CHARACTERISTICS AND GRADING OF THE SEVERITY OF ALZHEIMER'S DISEASE⁵⁶

STAGE OF ALZHEIMER'S DISEASE	LIFE ACTIVITIES AFFECTED
Mild (Early-Stage):	<ul style="list-style-type: none"> • Problems coming up with the right word or name⁵⁷ • Trouble remembering names when introduced to new people⁵⁸ • Having greater difficulty performing tasks in social or work settings⁵⁹ • Forgetting material that one has just read⁶⁰ • Losing or misplacing a valuable object⁶¹ • Increasing trouble with planning or organizing⁶²
Moderate (Middle-Stage):	<ul style="list-style-type: none"> • Forgetfulness of events or about one's own personal history⁶³ • Feeling moody or withdrawn, especially in socially or mentally challenging situations⁶⁴ • Being unable to recall their own address or telephone number or the high school or college from which they graduated⁶⁵

54. *Id.*

55. *Stages of Alzheimer's*, ALZHEIMER'S ASS'N, http://www.alz.org/alzheimers_disease_stages_of_alzheimers.asp (last visited Mar. 19, 2016).

56. *Id.*

57. *Id.*

58. *Id.*

59. *Id.*

60. *Id.*

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.*

	<ul style="list-style-type: none"> • Confusion about where they are or what day it is⁶⁶ • The need for help choosing proper clothing for the season or the occasion⁶⁷ • Trouble controlling bladder and bowels in some individuals⁶⁸ • Changes in sleep patterns, such as sleeping during the day and becoming restless at night⁶⁹ • An increased risk of wandering and becoming lost⁷⁰ • Personality and behavioral changes, including suspiciousness and delusions or compulsive, repetitive behavior like hand-wringing or tissue shredding⁷¹
Severe (Last-Stage):	<ul style="list-style-type: none"> • Require full-time, around-the-clock assistance with daily personal care⁷² • Lose awareness of recent experiences as well as of their surroundings⁷³ • Require high levels of assistance with daily activities and personal care⁷⁴ • Experience changes in physical abilities, including the ability to walk, sit and, eventually, swallow⁷⁵ • Have increasing difficulty communicating⁷⁶ • Become vulnerable to infections, especially pneumonia⁷⁷

E. Risk Factors

The medical profession has not determined what causes Alzheimer's disease. Scientists are beginning to gain better insight and unravel some of the mystery surrounding Alzheimer's disease. A

65. *Id.*

66. *Id.*

67. *Id.*

68. *Id.*

69. *Id.*

70. *Id.*

71. *Id.*

72. *Id.*

73. *Id.*

74. *Id.*

75. *Id.*

76. *Id.*

77. *Id.*

numbers of factors may cause Alzheimer's disease. Biology, age, genetic, and environmental factors may explain the occurrence of Alzheimer's disease.⁷⁸ Amyloid plaques, clusters of protein fragments that accumulate around brain cells, are known biological markers for Alzheimer's disease.⁷⁹ Neurofibrillary tangles, clumps of altered proteins present inside of brain cells, are additional indicators of Alzheimer's disease.⁸⁰

Age is the most important risk factor associated with the contraction of Alzheimer's disease.⁸¹ As we age, our chances of developing Alzheimer's disease increase dramatically. For example, close to ten percent of individuals age sixty-five years of age or older have Alzheimer's disease.⁸² Close to fifty percent of individuals aged eighty-five years or older have Alzheimer's disease.⁸³ Table Two, below, provides a breakdown of the age groups most affected by Alzheimer's disease in the United States, and the projected growth of the disease.

TABLE 2: ESTIMATES OF PEOPLE WITH ALZHEIMER'S DISEASE BY AGE GROUP (IN MILLIONS)⁸⁴

Year	Age 65-74	Age 75-84	Age 85+	Total
2000	0.3	2.4	1.8	4.5
2010	0.3	2.4	2.4	5.1
2020	0.3	2.6	2.8	5.7
2030	0.5	3.8	3.5	7.7

Genetics plays a role in the development of Alzheimer's disease. "A family history of the disease is another known risk factor."⁸⁵ The children, siblings, other relatives, and offspring of Alzheimer's disease

78. *The Search for Alzheimer's Causes and Risk Factors*, ALZHEIMER'S ASS'N, http://www.alz.org/research/science/alzheimers_disease_causes.asp (last visited Mar. 19, 2016); *Risk Factors*, ALZHEIMER'S ASS'N, http://www.alz.org/alzheimers_disease_causes_risk_factors.asp (last visited Mar. 19, 2016); *About Alzheimer's Disease: Causes*, NAT'L INST. OF HEALTH, <https://www.nia.nih.gov/alzheimers/topics/causes> (last visited Mar. 19, 2016).

79. See *Risk Factors*, *supra* note 78.

80. *Id.*

81. *Id.*

82. *Id.*

83. *Id.*

84. Liesi E. Herbert et al., *Alzheimer's Disease in the US Population: Prevalence Estimates Using the 2000 Census*, 60 JAMA ARCHIVES OF NEUROLOGY 1119, 1121 (2003).

85. ALZHEIMER'S ASS'N MISS. CHAPTER, LIVING WITH ALZHEIMER'S 11 (2013), www.alz.org/ms/documents/ResourceGuide.pdf.

victims often develop the disease themselves. Scientists have isolated three genes that account for the rare condition of early-onset Alzheimer's disease, which occurs in individuals prior to the age of sixty-five.⁸⁶

Vascular risk factors, associated with the blood circulation system, have emerged recently as risk factors for developing Alzheimer's disease.⁸⁷ Individuals who suffer from high blood pressure or heart disease may have an increased risk for developing Alzheimer's disease.⁸⁸

F. Racial Disparities: Minorities and Alzheimer's Disease

"The literature shows consistent and adverse disparities among blacks and Hispanics compared to non-Hispanic whites in the prevalence and incidence of Alzheimer's disease, mortality, participation in clinical trials, use of medications and other interventions, use of long-term services and supports, health care expenditures, quality of care, and caregiving."⁸⁹ "The literature suggests numerous underlying causes, including factors related to measurement of the disease, genetics, socioeconomic factors, cultural differences, lack of culturally competent providers, and discrimination."⁹⁰

Statistics point to the fact that Alzheimer's disease is often misdiagnosed in minorities, particularly in African-Americans and Latinos.⁹¹ The percentage of minorities in the elderly population is expected to grow from a present sixteen percent to thirty-four percent in by 2050.⁹² "It can be safely assumed that there will also be an increase in the number of minorities who succumb to Alzheimer's during that time."⁹³ With the enormous demographic changes impacting Ameri-

86. *Id.*

87. *Id.*

88. *Risk Factors*, *supra* note 78.

89. Lisa M. Lines et al., *Racial and Ethnic Disparities Among Individuals with Alzheimer's Disease in the United States: A Literature Review*, RTI PRESS (Dec. 2014), https://www.rti.org/pubs/racial_ethnic_disparities_among_alzheimers_patients.pdf.

90. *Id.*

91. See *Alzheimer's and Public Health Spotlight: Race, Ethnicity & Alzheimer's Disease*, ALZHEIMER'S ASS'N (April 2013), http://alz.org/documents_custom/public-health/spotlight-race-ethnicity.pdf; see also Lines et al., *supra* note 89.

92. John Owens, *Culture Plays Role in Spotting Alzheimer's*, CHICAGO TRIB. (July 24, 2002), http://articles.chicagotribune.com/2002-07-24/news/0207240036_1_minorities-mr-ellis-gospel-music.

93. *Id.*

ca, particularly the increasing minority population and an aging population generally, it is increasingly important that law students and lawyers have the cultural competence⁹⁴ to deal effectively with increasing numbers of elderly minority clients.

In the United States, there are many gaps and disparities in the delivery of healthcare services between African-Americans, Latinos, and the majority population. As University of Oklahoma geriatrician, Vicki Lapley-Dallas, highlighted at the National Alzheimer's Disease Education Conference in Chicago, "African-Americans stand a greater chance of being misdiagnosed and mistreated by the very people who are supposed to help them, including physicians, nursing homes and community service providers[. . .]."⁹⁵

At a baseline, studies have noted a crucial racial disparity in diagnostic methods between African-Americans and Caucasians in diagnosing Alzheimer's disease.⁹⁶ The Mini-Mental State Exam (MMSE) is the most widely used test for screening Alzheimer's disease.⁹⁷ Early detection and proper diagnosis is key to the effective treatment of Alzheimer's disease. "Early diagnosis is important because doctors have time to administer drugs such as Aricept, which can help slow the progress of the disease."⁹⁸

The MMSE may result from an inadvertent cultural bias inherent in the test questions administered to patients suspected of having Alzheimer's disease. Typically, African-Americans receiving the MMSE are elderly (usually seventy to eighty years old) persons who are mostly the victims of Jim Crow-Era societal and educational discrimination. As Jennie Ward-Robinson, the Director of Medical and Scientific Affairs at the Alzheimer's Association, noted: "[t]his population was educated typically in rural areas, where the standards and

94. The National Center for Cultural Competence defines cultural competence as follows: "Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations." This definition is drawn from the seminal Cross et al. 1989 study on cultural competence. See Cross et al, 1989, NAT'L CTR. FOR CULTURAL COMPETENCE, <http://ncccurricula.info/culturalcompetence.html> (last visited Mar. 19, 2016).

95. *Id.*

96. *Id.*

97. *Id.*

98. *Id.*

entire quality of education were different than the standard that exists today."⁹⁹

Lawyers counseling clients from diverse populations with Alzheimer's disease must come to the representation with an awareness of cross-cultural differences that may impact their clients. Thus, in order to avoid conscious and unconscious bias law students and lawyers must gain awareness of the racial and cultural differences in fully grasping the impact of Alzheimer's disease on their legal representations.

Part II: Exploring the Ethics of Alzheimer's Disease through Hypotheticals

To magnify the bevy of troublesome ethical issues that estate planning attorneys face in dealing with clients who suffer from various stages of Alzheimer's disease, this Article presents three hypotheticals, which could potentially arise, to explore ethical dynamics faced by an attorney. In each hypothetical, first, we start with a narrative of a potential client engagement, then proceed to examine the ethical issues raised, and finally, apply the ABA Model Rules of Professional Responsibility and the ACTEC Commentaries, where appropriate, to each scenario.¹⁰⁰

A. Hypothetical A: The Geraldine Smith Estate Plan

One afternoon, while attending a bar association event, Barbara Jones, a prominent attorney in the legal community where you practice who knows that you practice in the area of estate planning, approaches you to get guidance and direction on planning her great-aunt's estate. Her great-aunt, Geraldine Smith, has been asking her great-niece to refer her to someone to assist with the planning of her estate. Your colleague's great-aunt is eighty-five years old, has never

99. *Id.*

100. Professor O'Brien notes: "An attorney's relationship with his or her client is governed by the rules of professional responsibility. Each state licenses its attorneys to practice and each state has its own rules of professional conduct. The American Bar Association publishes Model Rules of Professional Responsibility and these model rules illustrate the issues that arise in the context of an attorney and a client's capacity. Overall, the rules govern when an attorney may withdraw from providing services to a client, when an attorney for the client may consult with persons or entities able to take necessary action, issues of confidentiality, and making a good faith effort to apply the law to the needs of the client." O'Brien, *supra* note 9; see also MODEL CODE OF PROF'L RESPONSIBILITY (AM. BAR ASS'N 1980).

been married, has no biological children, and has never prepared a will or other estate planning documents. Over the past forty to fifty years, Ms. Smith has amassed a considerable fortune investing in rental real estate, her primary asset. She owns twenty single and double family houses valued conservatively at over \$2.5 million. Having no biological children, Ms. Smith's only lawful heirs under your state's descent and distribution statute would be your referring attorney colleague's mother and her sister. Attorney Barbara Jones mentions to you in passing, almost as an afterthought, that the family has noticed recently that Aunt Geraldine's memory and recollection have been, in her terms, "slipping" in the past year.

After getting Ms. Smith's telephone number, you call her to assess her needs, she indicates that she does not drive, but would like to set up an appointment to meet you in your office next week with her two biological nieces, who are her presumptive heirs. Ms. Smith and her two nieces show up at your office to discuss the nuts and bolts of planning her estate. You explain to Ms. Smith that she, and she alone would be your potential client, and you explain clearly to Ms. Smith's nieces that any potential attorney-client relationship exists between Ms. Smith and yourself, the estate planning attorney. In light of this disclosure, you ask Ms. Smith's nieces if they would wait in the waiting room section of your office while you discuss a client asset disclosure questionnaire you previously mailed to Ms. Smith after your initial phone call to her, in addition to taking the opportunity to talk to her about her assets and estate planning options.

Your one-on-one conversation with Ms. Smith lasts close to two hours. You ask Ms. Smith a number of questions about her background, familial status/structure, life accomplishments, wishes, aspirations, and intent with respect to her desired estate plan. In this discussion, you talk to Ms. Smith about current events in the news recently, and she appears to be in complete charge of her mental faculties. Indeed, she tells you that she would like for you to prepare a revocable trust and pour-over will as the principal documents in her estate plan, in addition to a general durable power of attorney, healthcare advance directive, and living will to round out her estate plan. Principally, Ms. Smith would like for the bulk of her property to be divided equally among her two nieces. She would also like to gift \$250,000 to her church, which she has been a faithful member of for the past fifty years. Ms. Smith tells you that she would like to retain

your services to act as her estate planning attorney. You execute a written fee/retainer agreement with Ms. Smith in your office. Ms. Smith agrees to pay your attorney fees upon delivery and final execution of her estate planning documents. You inform Ms. Smith that you will draft the estate planning documents she desires, and that you will come to her house in two weeks to review the draft documents that she requested that you prepare with her in detail, prior to their final execution.

Two weeks later, you arrive at Ms. Smith's doorstep, at the time you both previously agreed upon. She answers the door. Upon opening the door, Ms. Smith gets very agitated and asks you who you are, and what business you have showing up on her doorstep. Ms. Smith's nieces are at the house when you arrive, they are shocked by their aunt's behavior. After Ms. Smith's nieces calm her down, you talk to her again about her visit two weeks earlier to your office, and her instructions with regard to the preparation of her estate plan. Ms. Smith has no recollection of ever having shown up at your office, having any sort of discussion about estate planning with you, and no recall of her desired dispositive plan and final wishes. Ms. Smith's nieces inform you that last week their aunt's doctor diagnosed her with a moderate stage of Alzheimer's disease. Ms. Smith's nieces ask you if you would be willing to come back later, hopefully at a time when Ms. Smith's cognition and recall is better, to attempt to have her sign the estate planning documents that you have drafted for her in final form.¹⁰¹

What should the attorney do? What guidance do the American Bar Association's (ABA) Model Rules of Professional Conduct offer to you?

101. In my practice experience, I had a potential client engagement similar to the narrative that is recounted in Hypothetical A. Ethically, I deemed that I was unable to act further for the potential client in preparing their estate plan. From a legal perspective, in my professional judgment and discretion, I deemed the potential client was of "unsound mind" in accordance with my state's will execution statute. Unfortunately, this individual's symptoms and progression through the stages of Alzheimer's disease were very rapid. The family affected had no other alternative than to seek guardianship of the person and estate of their loved one. Subjectively, I was forced to make a professional judgment call regarding the potential client's mental capacity. This experience enabled me to gain firsthand exposure to the issues associated with counseling actual and potential clients with Alzheimer's disease. I began to explore objective assessment tools to aid in client capacity determination in future client engagements. In many ways, this challenging experience served as an inspiration and impetus to write this Article.

1. ETHICAL ISSUES RAISED IN THE GERALDINE SMITH HYPOTHETICAL

The first step in any potential client engagement is to define who the client really is. Notice in the narrative recounted in Hypothetical A, the attorney is extremely clear and transparent with Ms. Smith and her two nieces about who the client is (Ms. Smith), and moreover, about who the attorney-client privilege extends to as a result of any potential engagement. To completely preserve and not compromise the attorney-client privilege, the attorney rightfully asks Ms. Smith's nieces to leave his/her office before any substantive confidences or secrets between the client and attorney are revealed. This is an important and commendable practice that an ethical attorney should engage in as a matter of routine. This approach is consistent with the attorney's duties to their client under ABA Model Rule of Professional Conduct 1.6(c), which reminds attorneys of the following consideration:

- (c) A lawyer shall make reasonable efforts to prevent the inadvertent or unauthorized disclosure of, or unauthorized access to, information relating to the representation of a client.¹⁰²

102. MODEL RULES OF PROF'L CONDUCT r. 1.6(c) (AM. BAR ASS'N 1983); *see generally* MODEL RULES OF PROF'L CONDUCT r. 1.6 CMT.18 (AM. BAR ASS'N 1983) (stating "[p]aragraph (c) requires a lawyer to act competently to safeguard information relating to the representation of a client against unauthorized access by third parties and against inadvertent or unauthorized disclosure by the lawyer or other persons who are participating in the representation of the client or who are subject to the lawyer's supervision." *See* MODEL RULES OF PROF'L CONDUCT r. 1.1, 5.1, 5.3 (AM. BAR ASS'N 1983). The unauthorized access to, or the inadvertent or unauthorized disclosure of, information relating to the representation of a client does not constitute a violation of paragraph (c) if the lawyer has made reasonable efforts to prevent the access or disclosure. Factors to be considered in determining the reasonableness of the lawyer's efforts include, but are not limited to, the sensitivity of the information, the likelihood of disclosure if additional safeguards are not employed, the cost of employing additional safeguards, the difficulty of implementing the safeguards, and the extent to which the safeguards adversely affect the lawyer's ability to represent clients (e.g., by making a device or important piece of software excessively difficult to use). A client may require the lawyer to implement special security measures not required by this Rule or may give informed consent to forgo security measures that would otherwise be required by this Rule. Whether a lawyer may be required to take additional steps to safeguard a client's information in order to comply with other law, such as state and federal laws that govern data privacy or that impose notification requirements upon the loss of, or unauthorized access to, electronic information, is beyond the scope of these Rules. For a lawyer's duties when sharing information with nonlawyers outside the lawyer's own firm. *See* MODEL RULES OF PROF'L CONDUCT r. 5.3 cmt. 3-4 (AM. BAR ASS'N 1983). Interestingly, Comment 3 to ABA Model Rule of Professional Conduct 1.14 seems to provide a level of safe harbor in having the family members or associates of clients with diminished capacity present during discussions with the clients with diminished capacity. It reads as follows: "The client

The attorney must next make a determination regarding the mental capacity of the potential client. This may be done objectively and subjectively. Most often, the average estate planning attorney conducts a subjective assessment of the client's mental capacity. "Given its serious nature and potentially grave outcome, a capacity assessment must be performed and documented with care and caution."¹⁰³ With regard to cognitive assessment, the following considerations are important:

may wish to have family members or other persons participate in discussions with the lawyer. When necessary to assist in the representation, the presence of such persons generally does not affect the applicability of the attorney-client evidentiary privilege. Nevertheless, the lawyer must keep the client's interests foremost and, except for protective action authorized under paragraph (b), must look to the client, and not family members, to make decisions on the client's behalf." MODEL RULE OF PROF'L CONDUCT r. 1.14 cmt. 3 (AM. BAR ASS'N 1983). This approach to disclosure is consistent with the guidance highlighted in the ACTEC Commentaries. Particularly, ACTEC Commentary on MRPC 1.6 provides the following regarding disclosure when a client apparently has diminished capacity: "As provided in MRPC 1.14, a lawyer for a client who has, or reasonably appears to have, diminished capacity is authorized to take reasonable steps to protect the interests of the client, including the disclosure, where appropriate and not prohibited by state law or ethical rule, of otherwise confidential information. See *Commentaries on the Model Rules of Professional Conduct, Fourth Edition 2006*, ACTEC, <http://www.actec.org> (last visited Mar. 19, 2016); ABA, Informal Op. 89-1530 (1989); RESTATEMENT OF THE LAW (THIRD): THE LAW GOVERNING LAWYERS, § 24, § 51 (AM. LAW INST. 2000). In such cases the lawyer may either initiate a guardianship or other protective proceeding or consult with diagnosticians and others regarding the client's condition, or both. In disclosing confidential information under these circumstances, the lawyer may disclose only that information necessary to protect the client's interests. MODEL RULES OF PROF'L CONDUCT r. 1.14(c) (AM. BAR ASS'N 1983); see ACTEC Commentary on MRPC 1.6, ACTEC, <http://www.actec.org/publications/commentaries/#MRPC1.6> (last visited Mar. 19, 2016).

103. Lois M. Brandiet & Brian L. Thorn, *Determining Capacity: Is Your Older Client Competent?*, 14 UTAH B.J. 21, 24 (May 2001). With respect to objective assessment tools that an attorney may use, Brandiet and Thorn observe the following: "It is often helpful in the assessment process to incorporate data from objective tests designed to measure particular areas of functioning. A few screening instruments are simple to use and score with a minimal amount of training. When indicated, more comprehensive and reliable information may be gathered with the use of standardized tests for which specialized training is required to assure appropriate administration and interpretation procedures are followed. Psychologists are more likely to utilize such standardized tests as a core part of their clinical training is focused on testing. Neuropsychology is a specialization within psychology that emphasizes skills in cognitive and neuropsychological testing, including evaluation of dementia. The skills of a neuropsychologist may be particularly helpful when the pattern of cognitive impairment is atypical.

As mentioned above, some screening instruments are simple to use and may be helpful for attorneys to incorporate in their own process of deciding whether to refer a client for a capacity assessment. It cannot be emphasized strongly enough that one should seek appropriate training before using these tests. In order for the results to be reliable and valid, these tests must be administered under the right conditions and the scores must be interpreted in context. Otherwise, the results

A holistic assessment approach is recommended, with evaluation of cognitive, physical, psychological, functional, and emotional domains. A crucial point to consider is the general well-being of the proposed protected person and their capacity to meet their needs without risk to themselves or others. Only then can an accurate conclusion be drawn about capacity for decision-making.¹⁰⁴

The narrative recounted in Hypothetical A guides the ethical estate planning to one salient conclusion: subjectively, the potential client in the hypothetical suffers from a significant/severe cognitive impairment.¹⁰⁵ Subjectively speaking, it appears that the potential client might be suffering from a moderate-stage of Alzheimer's disease based on their age, and the events and facts discussed. Often, estate planning attorneys will need to have an ability to comprehend and access the degree of a client's cognitive impairment, based on the stages of Alzheimer's disease discussed *supra*, in Part I. Often, this ends up being a subjective judgment call that the attorney makes when engaging with each estate planning client on a case-by-case basis. Objectively speaking, however, with proper training and exposure, several helpful objective assessment tools and protocols exist to assess mental capacity objectively.¹⁰⁶ These include the MMSE,¹⁰⁷ the Short Portable

might overestimate or underestimate the individual's level of functioning. Unfortunately, it's beyond the scope of this article to provide such training. The Mini Mental Status Exam (MMSE), the Short Portable Mental Status Questionnaire (SPMSQ), and the Clock Test are examples of screening tests that are simple to use and can be administered in 15 minutes or less. Although useful as a brief screening device, none of these instruments provides enough information alone to constitute an adequate evaluation of capacity."

104. *Id.*

105. It is important to note that in analyzing Hypotheticals A, B, and C, *infra*, the Author assumes that the hypothetical attorney discussed in the narratives has NOT conducted any objective mental capacity assessments. Essentially, the assumption in each hypothetical in this Article assumes that the attorney in question has not employed a basic or brief objective mental capacity assessment tool as noted below in notes 106-109.

106. Commenting on objectivity, as Professor O'Brien highlights: "The first option available to an attorney is to establish an objective basis of the incapacity; the American Bar Association Model Rules only refer to incapacity as a result of "minority, mental impairment or for some other reason." And the American Bar Association offers only general advice to attorneys working with clients in their publication *Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers*. The Handbook suggests that attorneys use "markers" to establish an objective guideline to indicate emotional, cognitive, and behavioral signs suggesting diminished capacity." O'Brien, *supra* note 9, at 73 (internal citations omitted).

107. See *Mini-Mental State Examination (MMSE)*, UNIV. OF MASS. LOWELL, https://www.uml.edu/docs/Mini%20Mental%20State%20Exam_tcm18-169319.pdf (last visited Mar. 19, 2016). Attached hereto as Appendix A.

Mental Status Questionnaire (SPMSQ),¹⁰⁸ the Mini Cog Test,¹⁰⁹ and the Clock Test.¹¹⁰ For lawyers looking for easily understood and accessible objective assessment tools, these tests, included as appendices to this Article, may provide a helpful starting point. When it comes to identifying, classifying, and categorizing Alzheimer's disease, it is imminently difficult to draw a clear and discernable line in the sand without conducting hopefully both an objective and subjective mental capacity assessment.

As for the ABA Model Rules of Professional Responsibility, Rule 1.14 serves as a beginning point of departure when an attorney identifies and comprehends that a client may be suffering from diminished capacity or a cognitive impairment like Alzheimer's disease. Rule 1.14(a) informs the attorney that:

(a) When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, *as far as reasonably possible, maintain a normal client-lawyer relationship with the client.*¹¹¹

Comment 1 to ABA Model Rule of Professional Conduct 1.14(a) provides insight into how to maintain a "normal" client-attorney relationship. It reads as follows:

The normal client-lawyer relationship is based on the assumption that the client, when properly advised and assisted, is capable of making decisions about important matters. When the client is a minor or suffers from a diminished mental capacity, however, maintaining the ordinary client-lawyer relationship may not be possible in all respects. *In particular, a severely incapacitated person may have no power to make legally binding decisions.* Nevertheless, a client with diminished capacity often has the ability to understand, deliberate upon, and reach conclusions about matters affecting the client's own well-being. For example, children as young as five or six years of age, and certainly those of ten or twelve, are regarded as having opinions that are entitled to weight in legal proceedings concerning their custody. So also, it is recognized that some persons of advanced age can be quite ca-

108. See *Short Portable Mental Status Questionnaire (SPMSQ)*, UNIV. OF IOWA HEALTH CARE, <https://www.healthcare.uiowa.edu/igec/tools/cognitive/SPMSQ.pdf> (last visited Mar. 19, 2016). Attached hereto as Appendix B.

109. See *Mini-Cog™*, ALZHEIMER'S ASS'N, http://www.alz.org/documents_custom/minicog.pdf (last visited Mar. 19, 2016). Attached hereto as Appendix C.

110. *Id.*

111. MODEL RULES OF PROF'L. CONDUCT r. 1.14 (a) (AM. BAR ASS'N 1983) (emphasis added).

pable of handling routine financial matters while needing special legal protection concerning major transactions.¹¹²

The ACTEC Commentary to Model Rule 1.14 provides the attorney with insight into determining the extent of a client's diminished capacity. The ACTEC Commentary to 1.14 provides:

Determining Extent of Diminished Capacity. In determining whether a client's capacity is diminished, a lawyer may consider the client's overall circumstances and abilities, including the client's ability to express the reasons leading to a decision, the ability to understand the consequences of a decision, the substantive appropriateness of a decision, and the extent to which a decision is consistent with the client's values, long-term goals, and commitments. In appropriate circumstances,¹¹³ the lawyer may seek the assistance of a qualified professional.

Comment 1 reminds the attorney that diminished capacity is exhibited in varying forms and degrees of severity. "In particular, a severely incapacitated person may have no power to make legally binding decisions."¹¹⁴ Ms. Smith's lack of recognition of the attorney after such a lengthy initial discussion in the attorney's office manifests a severe incapacitation consistent with the cautions and insight of Comment 1 to Rule 1.14.¹¹⁵

To provide further illustration, Comment 2 to ABA Model Rule of Professional Conduct 1.14(a) notes:

The fact that a client suffers a disability does not diminish the lawyer's obligation to treat the client with attention and respect. Even if the person has a legal representative, the lawyer should as far as possible accord the represented person¹¹⁶ the status of client, particularly in maintaining communication.

The attorney in Hypothetical A should strive to treat Ms. Smith with the respect and dignity afforded to a client without diminished capacity consistent with the mandates of Comment 2 of Rule 1.14.¹¹⁷

What should the attorney do about Ms. Smith's nieces' request to come back at a different time? It is true that clients may experience "lucid intervals."¹¹⁸ "A person who is mentally incapacitated part of the time, but who has lucid intervals during which he or she meets the standard for mental capacity can, in the absence of an adjudication or

112. *Id.* at cmt. 1 (emphasis added).

113. *ACTEC Commentaries*, *supra* note 102.

114. MODEL RULES OF PROF'L CONDUCT r. 1.14 cmt. 1 (AM. BAR ASS'N 1983).

115. *Id.*

116. *Id.* at cmt. 2.

117. *Id.*

118. See generally RESTATEMENT (THIRD) OF PROP.: WILLS AND OTHER DONATIVE TRANSFERS § 8.1(c) (AM. LAW INST. 2003).

statute that has a contrary effect, make a valid will or a valid inter vivos donative transfer, provided such will or transfer is made during a lucid interval."¹¹⁹ Again, it appears that the issues of diminished capacity exhibited by Ms. Smith at her home are indicative of a severe incapacitation. With that in mind, it is questionable whether Ms. Smith may make legally binding decisions.¹²⁰ A red light should emerge for the attorney interacting with Ms. Smith. Professionally, it could be very damaging to act as the attorney scrivener of an estate plan for a client with severe mental incapacitation like Ms. Smith.

B. Hypothetical B: The Robert Jackson Estate Plan

Bill Jackson, a long-term client of yours in a variety of business matters, is at your office discussing a corporate matter. Near the end of your time together, Bill tells you that his mother would like for you to meet her at her home to discuss the possibility of preparing her husband's estate plan. Bill tells you that he will pay you to have his parent's estate plan prepared. Bill mentions to you that his father, Robert Jackson, has been diagnosed with Alzheimer's disease (Bill has not disclosed the stage or progression of his father's Alzheimer's disease) and is bed ridden. Additionally, Robert Jackson suffers from congestive heart failure and diabetes.

At the appointed time, you arrive at the Jackson family residence, Bill and his mother, Sofia, greet you at the door. After having a pleasant conversation, in which Sofia tells you she and Robert have been married forty-five years, and have three children including Bill (who has a brother and a sister), and what Robert has always said he would like to see done with his estate upon his death, you ask to meet Robert. Bill and Sofia lead you to a neatly kept upstairs bedroom, where Robert is laying in a hospital bed.

You observe that Robert can no longer feed himself, dress himself, nor provide for any of his basic needs. Sofia provides around the clock care for Robert. Robert pensively stares into space. You say hello to Robert, but he cannot audibly respond to you. Occasionally, he moves his head when Sofia speaks to him or rubs his head. After be-

119. *Id.* at cmt. M. See *James White Mem'l Home v. Haeg*, 204 Ill. 422, 68 N.E. 568 (1903); see also *In re Schmidt's Will*, 139 N.Y.S. 464 (Sur. 1912); *Carr v. Radkey*, 393 S.W.2d 806 (Tex. 1965).

120. See *supra* note 101.

ing unable to initiate conversation with Robert, you ask Bill and Sofia if you could return downstairs to the kitchen.

Bill and Sofia thank you for meeting Robert. Sofia asks if you will carry out the estate wishes that she informed you that Robert desires. Sofia has indicated that Robert told her in the past that he would want her to have the home they live in together, that he would like to see a beloved vacation home split equally among his three children, and finally that his extensive antique automobile collection be given equally to his two sons, Bill and Martin. Bill reminds you that he is willing to pay any fee that you deem appropriate to prepare his father's estate plan.¹²¹

Can you properly prepare Robert's estate plan? What ethical strictures would you potentially be violating if you prepared a last will and testament for Robert? Can you communicate with Peter about potential mental lapses that you have observed in John? If so, what could be the fall out of following such a course of disclosure?

1. ETHICAL ISSUES RAISED IN THE ROBERT JACKSON HYPOTHETICAL

First, the attorney contemplating representing Robert Jackson must make one thing clear: who the actual client is that he/she will be representing. The situation in this scenario becomes a little murky due to the attorney's long-standing representation of Bill Jackson in a variety of business matters over the course of time. Additionally, with Bill's mother, Sofia, in the picture, the stream gets muddier in terms of who the true client will be in the representation. As a baseline, before proceeding, the attorney in this situation would be well advised to consult ABA Model Rule of Professional Conduct 1.7, dealing with conflicts of interest before moving further. Rule 1.7 provides the following:

(a) Except as provided in paragraph (b), a lawyer shall not represent a client if the representation involves a concurrent conflict of interest. A concurrent conflict of interest exists if:

- (1) the representation of one client will be directly adverse to another client; or
- (2) there is a significant risk that the representation of one or more clients will be materially limited by the lawyer's re-

121. Similar to the experience expressed in *supra* note 101, I had a practice experience that closely mirrored the hypothetical narrative that forms the basis of Hypothetical B.

sponsibilities to another client, a former client or a third person or by a personal interest of the lawyer.

(b) Notwithstanding the existence of a concurrent conflict of interest under paragraph (a), a lawyer may represent a client if:

- (1) the lawyer reasonably believes that the lawyer will be able to provide competent and diligent representation to each affected client;
- (2) the representation is not prohibited by law;
- (3) the representation does not involve the assertion of a claim by one client against another client represented by the lawyer in the same litigation or other proceeding before a tribunal; and
- (4) each ¹²²affected client gives informed consent, confirmed in writing.

Additionally, the ACTEC Commentary to Model Rule 1.7 is very instructive for an attorney confronted with a situation where an existing client is attempting to pay for the legal services of that attorney to procure a will for someone else under which they will benefit. The ACTEC Commentary provides:

Existing Client Asks Lawyer to Prepare Will or Trust for Another Person. A lawyer should exercise particular care if an existing client asks the lawyer to prepare for another person a will or trust that will benefit the existing client, particularly if the existing client will pay the cost of providing the estate planning services to the other person. If the representation of both the existing client and the new client would create a significant risk that the representation of one or both clients would be materially limited, the representation can only be undertaken as permitted by *MRPC 1.7(b)*. In any case, the lawyer must comply with *MRPC 1.8(f)* and should consider cautioning both clients of the possibility that the existing client may be presumed to have exerted undue influence on the other client because the ¹²³existing client was involved in the procurement of the document.

The attorney in this situation needs to make it abundantly clear to Bill Jackson, and his mother, Sofia Jackson, that any potential attorney-client relationship would be solely for the benefit of Robert Jackson. It is likely and extremely possible that Robert Jackson's interests could be directly adverse to Bill Jackson's on a host of matters in any potential representation. At all times, the attorney must be able to act with competence and diligence on behalf of Robert Jackson.

As for the matter of payment of attorney's fees, the ABA Model Rules of Professional Conduct also provide us with some direct guid-

122. MODEL RULES OF PROF'L CONDUCT r. 1.7 (AM. BAR ASS'N 1983) (emphasis added).

123. ACTEC Commentaries, *supra* note 102.

ance. The attorney facing a similar factual scenario is wise to consult ABA Model Rule of Professional Conduct Rule 1.8(f). Rule 1.8(f)(1-3) provides the following guidance on the payment of attorney fees by someone other than the client:

(f) A lawyer shall not accept compensation for representing a client from one other than the client unless:

- (1) the client gives informed consent;
- (2) there is no interference with the lawyer's independence of professional judgment or with the client-lawyer relationship; and
- (3) information relating to representation of a client is protected as required by Rule 1.6.¹²⁴

As a general rule, Rule 1.8(f) cautions and admonishes the attorney not to accept compensation for representing a client from one other than the client unless three important preconditions are met.¹²⁵ First, a full and adequate disclosure must be given to the client regarding compensation, and the attorney must seek the client's informed consent.¹²⁶ Second, and perhaps most importantly, the attorney's independent professional judgment and the client-lawyer relationship must not be interfered with by the third party paying the attorney's compensation.¹²⁷ Thirdly, the attorney must safeguard and protect confidences gained about the client in accordance with the strictures of Rule 1.6, which speaks to maintenance of confidentiality.¹²⁸ Finally, in accordance with ACTEC Commentary 1.7, the attorney should caution the parties involved about the potential for undue influence claims regarding the procurement of the estate planning documents.¹²⁹

Again, the attorney faced with a situation like that outlined in Hypothetical B should be crystal clear on who their client truly is, and must maintain independence and not have a third party interfere with the representation purely because they are paying the attorney's compensation. This next turns our attention to an assessment of Robert Jackson's stage or level of suffering from Alzheimer's disease, and whether the purported estate planning desires of Robert Jackson, as

124. MODEL RULES OF PROF'L CONDUCT r. 1.8 (f)(1-3) (AM. BAR ASS'N 1983) (emphasis added); *Lobatz v. U.S. West Cellular of Cal., Inc.*, 222 F. 3d 1142, 1147 (9th Cir. 2000).

125. *Id.*

126. *Id.*

127. *Id.*

128. *Id.*

129. ACTEC Commentaries, *supra* note 102.

conveyed by his wife, Sofia, may be acted upon by the attorney to prepare Robert Jackson's estate plan.

A subjective assessment of Robert Jackson's mental capacity must be made by the attorney who has met with him in his bedroom. Having had some exposure to the types of life activities impacted by the varying stages of Alzheimer's disease, the attorney involved would be safe to believe that Robert Jackson is suffering a severe or late-stage form of Alzheimer's disease. Robert's cognition and ability to perform everyday life activities by himself has been substantially/significantly impaired. Robert's inability to feed himself, dress himself, and respond verbally or physically to the attorney raise insurmountable red flags for the attorney. In accordance with Rule 1.14(a), Comment 1, discussed *supra* in Hypothetical A, because of Robert's substantial impairment he no longer has the ability to make binding legal decisions.¹³⁰ The fundamental objective of any estate planning attorney should be to memorialize the final wishes and desires of their client, to effectively carry out the client's expressed intent with respect to the final disposition of their property. Having not had any opportunity to communicate directly and effectively with Robert Jackson, it would be improper for the attorney to substitute the purported values, wishes, judgments, desires, and intent expressed by Sofia to be representative of Robert's wishes as a true expression of Robert's own intent. In a "normal" client relationship, the client has the autonomy to make decisions that will further his/her best interests, values, utility, and well-being.¹³¹ Potentially, Sofia's articulation and expression of Robert's final testamentary wishes could be inconsistent with his true desires. Sofia's articulations and expressions of Robert's testamentary wishes amount to a form of substituted judgment.¹³² The attorney in this sort of situation should be extremely cautious to implement Sofia's suggestions in the absence of their articulation by Robert himself.

130. MODEL RULES OF PROF'L CONDUCT r. 1.14 cmt. 1 (AM. BAR ASS'N 1983).

131. MODEL RULES OF PROF'L CONDUCT r. 1.2 (AM. BAR ASS'N 1983).

132. See generally Ralph C. Brashier, *The Ghostwritten Will*, 93 B. U. L. REV. 1803 (2013) (examining substitute decisionmaking and the non-delegable duty of an individual's power to make, amend, or revoke their will).

C. Hypothetical C: The John Evans Estate Plan

Over the past twenty years, you have represented John Evans, who is seventy-five years old, and his numerous corporate entities in a variety of matters. John is a multimillionaire, with an estate currently valued at approximately \$4 million. You and John have had an extensive attorney-client relationship, in addition to a very close personal friendship for the past twenty years. At least twice each week for the past ten years, you and John have had lunch or dinner together. John, a widower, has one son, Peter Evans, who you represented seven years ago in the adoption of his minor daughter Janet. Additionally, you have a very close personal and social relationship with Peter. You and Peter regularly get together at least twice each month to play golf.

Ten years ago, you prepared a very extensive estate plan for John Evans, which includes an irrevocable life insurance trust, a revocable trust that holds several million dollars of real estate, and several smaller trusts that John has established for trusted long-term employees. The bulk of the assets held in the revocable trust are to go to Peter when John passes away.

Recently, at least over the past year in particular, you have noticed that John has become very forgetful, and that his long and short term memory have lapsed. In a recent conversation, about five months ago, John could not recall, Mary, his deceased wife's name. He literally drew a blank when you mentioned a memory about her. John, who is normally impeccably dressed, recently showed up at your office to have lunch with mismatched dress shoes— one black and the other brown. A month ago, when John was driving on the highway very close to his house, in a location he traveled often, he called you on his cellphone to tell you that he was lost. You were able to recognize his location from landmarks that he described to you. You stayed on the phone trying to direct John approximately two miles to his house. The phone call dropped, after repeated calls, you were unable to reach John again. A State Trooper called your phone number three hours later because you were the last listed number in John's phone, after discovering John disheveled and pulled off the highway on the median strip with his cellphone in his lap. The Trooper told you that John was forty miles away from his house, after checking John's driver's license to discern his home address, the of-

ficer took John to his house and had a tow truck take John's car to his house.

Last week, John showed up at your office unannounced to tell you that he felt like his son, Peter, was spying on him, and in his opinion was stealing money from him and trying to wrestle control of several of John's corporations from him. John was very angry, agitated and paranoid. Specifically, John accused Peter of converting \$50,000, which he felt was missing from his bank account. John told you last week that he, himself, wrote a \$50,000 check to a television televangelist. John pulled out the cancelled check alleging that Peter forged his name. The check was made out to Reverend C. Dollar and written fully in John's handwriting, whose handwriting you have known well for years. John tells you that he wants you to completely rewrite and amend his revocable trust to remove and disinherit Peter completely. Now, John wants to give all of his assets to Reverend C. Dollar to further his ministry, to Peter's complete exclusion.

You are tormented about what to do. Should you prepare the revisions to John's estate plan, essentially disinheriting Peter, in light of the facts you have been exposed to regarding John's recent behavior? Can or should you tell Peter about John's plan to disinherit him completely? In light of all the peculiar recent memory lapses in John's life, as his attorney, what can, should, or are you required to do to protect John's personal and financial wellbeing?

1. ETHICAL ISSUES RAISED IN THE JOHN EVANS HYPOTHETICAL

Based on the facts presented in Hypothetical C, subjectively speaking, it would appear John Evans is beginning to suffer from Alzheimer's disease or some other form of dementia. It is plausible that John's mental lapse, and perceived impairment, might be attributable to causes other than Alzheimer's disease that are unknown to the attorney. Having had such a lengthy relationship with John, and knowing his son, Peter, so well and the values and desires that John had previously professed in preparing his estate plan, in light of recent events, the attorney should proceed very cautiously.

The facts surrounding John's recent episode where he became lost on the highway close to his home leaves one concerned about John's personal wellbeing. The incident surrounding the \$50,000 check drawn to Reverend Dollar, by John, indicates that he may be placing his financial health and well-being in jeopardy. In considera-

tion of such troubling facts casting a negative light on John's mental capacity to safeguard his own personal and financial well-being, what options does the attorney have at his disposal?

First, the ethical analysis must begin with a consideration of ABA Model Rule 1.14(b) and (c). Rule 1.14(b) and (c) provide the following guidance to the estate planning attorney:

(b) When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian.¹³³

(c) Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, *but only to the extent reasonably necessary to protect the client's interests.*¹³⁴

Given the facts conveyed in Hypothetical A, the first practical consideration the attorney must consider is whether to comply with John's request to amend his estate plan and thereby disinherit John's son Peter. What is the attorney to do? The attorney must assess subjectively, and also hopefully objectively, John's mental capacity given evidence he may be suffering from diminished capacity. The ACTEC Commentary to Model Rule 1.14 is meaningful in this situation. It reads as follows:

Testamentary Capacity. If the testamentary capacity of a client is uncertain, the lawyer should exercise particular caution in assisting the client to modify his or her estate plan. The lawyer generally should not prepare a will, trust agreement, or other dispositive instrument for a client who the lawyer reasonably believes lacks the requisite capacity. On the other hand, because of the importance of testamentary freedom, the lawyer may properly assist clients whose testamentary capacity appears to be borderline. In any such case the lawyer should take steps to preserve evidence regarding the client's testamentary capacity.

In cases involving clients of doubtful testamentary capacity, the lawyer should consider, if available, procedures for obtaining

133. MODEL RULES OF PROF'L CONDUCT r. 1.14(b) (AM. BAR ASS'N 1983) (emphasis added).

134. *Id.* at (c) (emphasis added).

court supervision of the proposed estate plan, including substituted judgment proceedings.¹³⁵

Given the facts presented above, it would appear that John's mental capacity is particularly uncertain. Indeed, one could argue that John is substantially incapacitated. Given this state, the attorney should proceed cautiously. If the attorney determines that John's mental capacity is beyond borderline, and in his or her professional judgment, is severely compromised, the attorney should not prepare the trust amendment that John is seeking.

The analysis of Model Rule 1.14(b) does not end merely with the rule itself, the Commentary to Rule 1.14(b) provides illustrative highlight on how to implement and carry out the rule ethically. For example, Comment 5 provides the following insight.

[5] If a lawyer reasonably believes that a client is at risk of substantial physical, financial or other harm unless action is taken, and that a normal client-lawyer relationship cannot be maintained as provided in paragraph (a) because the client lacks sufficient capacity to communicate or to make adequately considered decisions in connection with the representation, then paragraph (b) permits the lawyer to take protective measures deemed necessary. *Such measures could include: consulting with family members, using a reconsideration period to permit clarification or improvement of circumstances, using voluntary surrogate decisionmaking tools such as durable powers of attorney or consulting with support groups, professional services, adult-protective agencies or other individuals or entities that have the ability to protect the client. In taking any protective action, the lawyer should be guided by such factors as the wishes and values of the client to the extent known, the client's best interests and the goals of intruding into the client's decisionmaking autonomy to the least extent feasible, maximizing client capacities and respecting the client's family and social connections.*¹³⁶

Additionally, Comment 6 to Rule 1.14(b) provides guidance to the attorney regarding considerations and factors in determining the extent of the client's diminished capacity. Assessing John's particular circumstances, the attorney should consider and balance the following factors articulated in Comment 6:

[6] In determining the extent of the client's diminished capacity, the lawyer should consider and balance such factors as: the client's ability to articulate reasoning leading to a decision, variability of state of mind and ability to appreciate consequences of a decision; the substantive fairness of a decision; and the consistency of a decision with the known long-term commitments and values

135. *ACTEC Commentaries*, *supra* note 102.

136. MODEL RULES OF PROF'L CONDUCT r. 1.14 cmt. 5 (AM. BAR ASS'N 1983) (emphasis added).

of the client. In appropriate circumstances, the lawyer may seek guidance from an appropriate diagnostician.¹³⁷

Finally, the attorney must use his or her professional judgment regarding how to proceed, and must consider the expense and trauma of pursuing a guardianship and other restrictive measures, and pursue the least restrictive action to maintain John's autonomy. For example, Comment 7 to ABA Model Rule 1.14 provides the attorney in John's case some guidance. It reads as follows:

[7] If a legal representative has not been appointed, the lawyer should consider whether appointment of a guardian ad litem, conservator or guardian is necessary to protect the client's interests. Thus, if a client with diminished capacity has substantial property that should be sold for the client's benefit, effective completion of the transaction may require appointment of a legal representative. In addition, rules of procedure in litigation sometimes provide that minors or persons with diminished capacity must be represented by a guardian or next friend if they do not have a general guardian. *In many circumstances, however, appointment of a legal representative may be more expensive or traumatic for the client than circumstances in fact require. Evaluation of such circumstances is a matter entrusted to the professional judgment of the lawyer. In considering alternatives, however, the lawyer should be aware of any law that requires¹³⁸ the lawyer to advocate the least restrictive action on behalf of the client.*

The attorney must next consider who to disclose John's recent mental capacity issues to and what type of information he should disclose to whom. In this regard, with respect to disclosure, Comment 8 to ABA Model Rule 1.14 provides the estate planning attorney with a level of guidance. Comment 8 to ABA Model Rule 1.14 reads as follows with regard to disclosure of information pertaining to a client with diminished capacity:

[8] Disclosure of the client's diminished capacity could adversely affect the client's interests. For example, raising the question of diminished capacity could, in some circumstances, lead to proceedings for involuntary commitment. Information relating to the representation is protected by Rule 1.6. Therefore, unless authorized to do so, the lawyer may not disclose such information. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized to make the necessary disclosures, even when the client directs the lawyer to the contrary. Nevertheless, given the risks of disclosure, *paragraph (c) limits what the lawyer may disclose in consulting with other individuals or entities or seeking the appointment of a legal representative. At the very least, the lawyer should determine whether it is likely that the person or entity*

137. *Id.* at cmt. 6 (emphasis added).

138. *Id.* at cmt. 7 (emphasis added).

consulted with will act adversely to the client's interests before discussing matters related to the client. The lawyer's position in such cases is an unavoidably difficult one.¹³⁹

Here, again, it is reasonable to believe that John has diminished capacity¹⁴⁰ and is at risk of substantial physical, financial, or other harm.¹⁴¹ In such circumstances, the attorney may take reasonably necessary protective action to protect John, including consulting with individuals and entities that have the ability to take action to protect John.¹⁴² Naturally, being concerned about John as a client and friend, the attorney is permitted to consult with "family members, using a reconsideration period to permit clarification or improvement of the circumstances, using voluntary surrogate decisionmaking tools such as durable powers of attorney or consulting with support groups, professional services, adult-protective agencies or other individuals or entities that have the ability to protect [John]."¹⁴³ In seeking to take protective action, the attorney should be aware of "such factors as the wishes and values of the client to the extent known, the client's best interests and the goals of intruding into the client's decisionmaking autonomy to the least extent feasible, [and of] maximizing client capacities and respecting the client's family and social connections."¹⁴⁴

The attorney may want to consider involving and engaging the services of a diagnostician to fully assess the level and extent of John's perceived diminished capacity. Perhaps, after accessing objectively and subjectively the nature and extent of John's perceived diminished capacity, the attorney may finally decide whether it is advisable to appoint a conservator or guardian for John. This should be a last resort decision. As Model Rule 1.14 and the associated Commentary reveal, a conservatorship or guardianship is expensive and traumatic.¹⁴⁵ However, this decision to seek a conservatorship or guardianship falls within the sound professional judgment and discretion of the attor-

139. *Id.* at cmt. 8 (emphasis added).

140. At least subjectively speaking, in assessing whether John has diminished capacity, the attorney should consider and balance such factors as: "the client's ability to articulate reasoning leading to a decision, variability of state of mind and ability to appreciate consequences of a decision; the substantive fairness of a decision; and the consistency of a decision with the known long-term commitments and values of the client. In appropriate circumstances, the lawyer may seek guidance from an appropriate diagnostician." *Id.* at cmt. 6.

141. See MODEL RULES OF PROF'L CONDUCT r. 1.14(b) (AM. BAR ASS'N 1983).

142. *Id.*

143. *Id.* at cmt. 5.

144. *Id.*

145. See *id.* at cmt. 7.

ney.¹⁴⁶ It is advisable that the attorney advocate and seek the least restrictive action to preserve John's autonomy.¹⁴⁷

The final consideration the attorney must ponder and pass decision on is the extent, if any, that information about John's perceived diminished capacity should be disclosed and revealed to Peter, John's son, by the attorney. As discussed above, ABA Model Rule 1.14(c) allows revelation of limited information about the client, "but only to the extent reasonably necessary to protect the client's interests."¹⁴⁸ Disclosure of evidence or perception of John's diminished capacity to Peter could potentially be adverse or detrimental to John's interests.¹⁴⁹ Armed with such information, Peter may likely attempt to commence an involuntary commitment proceeding, which would substantially impinge upon John's personal autonomy.¹⁵⁰ Generally, the attorney should not disclose information adverse to a client pursuant to Model Rule 1.6; however, attorneys may disclose necessary information to take protective action on behalf of the client.¹⁵¹ At least at this point, the attorney should tread lightly with respect to disclosure concerning John's decision to potentially disinherit Peter, and John's perceived diminished capacity and impaired condition to Peter. Disclosure on these two accounts is ill-advised. "The lawyer's position in such cases is an unavoidably difficult one."¹⁵²

Part III: Ameliorating and Addressing the Ethics and Challenges of Alzheimer's Disease in the American Law School and among Members of the Practicing Bar

As the hypotheticals presented above in Part II illustrate, servicing the needs of a client suffering from Alzheimer's disease requires an awareness of the manifestations of the disease, and cautiousness in adherence to ethical rules and standards that govern all lawyers. The demographic aging of the American populace will continue to create vexing and complex ethical problems for estate planning attorneys. Until a cure or preventative treatments for Alzheimer's disease are discovered, baring a major medical breakthrough, the number of Alz-

146. *Id.*

147. *Id.*

148. MODEL RULES OF PROF'L CONDUCT r. 1.14(c) (AM. BAR ASS'N 1983).

149. See MODEL RULES OF PROF'L CONDUCT r. 1.14 cmt. 8 (AM. BAR ASS'N 1983).

150. *Id.*

151. *Id.* See also MODEL RULES OF PROF'L CONDUCT r. 1.6 (AM. BAR ASS'N 1983).

152. MODEL RULES OF PROF'L CONDUCT r. 1.14 (AM. BAR ASS'N 1983).

heimer's disease sufferers will skyrocket if projections hold true. With this burgeoning and looming crisis on the horizon, the legal profession will be extremely wise and discerning to educate current and future members of the legal profession about the intricacies of dealing with the needs and ethical challenges presented by clients who suffer from Alzheimer's disease. The need for education in the legal community regarding the challenges of repressing clients with Alzheimer's disease is immediate—the problem will worsen as time passes—so the time for proactive initiatives is pressing. Education, awareness, and outreach about Alzheimer's disease is critically needed in two important segments of the legal community: 1) in the law school curriculum to raise the issue and prepare students for the practical challenges of servicing clients with Alzheimer's disease; and 2) among members of the practicing bar to familiarize and arm practitioners with a medical awareness of the manifestations of Alzheimer's disease, and the ethical considerations to avoid traps for the unwary and uneducated.

This Part's purpose is to briefly outline a handful of practical initiatives to engender and buttress a meaningful awareness of Alzheimer's disease in the law school/legal educational community and within the legal professional community. First, the focus will be on law school efforts that may be implemented to ameliorate the looming Alzheimer's disease crisis and its corresponding effect on client representation. Finally, consideration will be placed on how the practicing bar can become more aware of Alzheimer's disease in the existing and potential client population, while also fostering ethics and professional responsibility exposure to the challenges faced by practicing attorneys currently or when potentially representing clients with Alzheimer's disease.

A. Law School Efforts to Ameliorate the Looming Alzheimer's Disease Crisis

As outlined and discussed in Part I, *supra*, with an explosion in the number of American citizens suffering from Alzheimer's disease, law schools must expose students to the challenges and intricacies of interacting with future clients who actually or potentially could be suffering from Alzheimer's disease. As a first step, law professors, especially those teaching doctrinal classes like Estates and Trusts, Family Law, and Professional Responsibility must familiarize stu-

dents with the warning signs, symptoms, stages, and manifestations of Alzheimer's disease in a straight-forward and understandable fashion.

On an omnibus level, law professors must make it an imperative to devote meaningful discussion time to discuss demographic trends and raise the importance of the looming Alzheimer's disease crisis to law students. Every law professor understands the tension between allocated class meeting times, student contact hours, and curricular coverage priorities and time pressures. With this in mind, however, classroom discussion of Alzheimer's disease and its impact must move up the priority scale and have a place in the mix of topical coverage and in a professor's lecture and classroom discussion emphasis.

Additionally, a greater emphasis on ethical and professional responsibility considerations needs to be prioritized in leading casebooks in the estate and trusts universe. Unfortunately, many widely adopted casebooks offer, in my opinion, far too little space outlining and exposing students to in-depth consideration of ethical and professional responsibility cases and materials.¹⁵³ Law professors should consider integrating a meaningful discussion of important ABA Model Rules of Professional Conduct and ACTEC Commentaries that impact estate planners in the Estates and Trusts classroom. Next, hypothetical fact patterns that present real-life ethical and professional responsibility problems for consideration by students could aid student exposure and understanding of ethical quandaries associated with Alzheimer's disease. One key benefit of a hypothetical approach is that it allows students to ponder and consider complex factual situations in a safe environment where actual client interests cannot be harmed. Practice and exposure might not make one perfect, but it certainly will improve one's performance, perception, and adaptation skills when faced with the pressure of real-life situations.

To reiterate, my recommendations for law professors and the legal education community require little to no cost, and are as follows:

- a. Familiarize law students with the warnings signs, symptoms, and manifestations of Alzheimer's disease;

153. A good example to the point that I'm making is the widely adapted casebook *DUKEMINIER & SITKOFF, WILLS, TRUSTS, AND ESTATES* (Wolters Kluwer 9th ed., 2013). In this casebook, the authors discuss professional responsibility issues on pages 51-62, and only in principal cases within the context of the attorney's duty to intended beneficiaries and conflict of interest of the attorney to clients. *Id.* at 51-62.

- b. Incorporate and prioritize discussion about Alzheimer's disease into the curriculum and classroom environment in law schools;
- c. Integrate a meaningful discussion of the ABA Model Rules of Professional Responsibility and the ACTEC Commentaries that impact the ethical and professional conduct of estate planning attorneys, in particular, into the classroom; and
- d. Use and create real-life hypotheticals like the ethical and professional responsibility problems presented above in the classroom environment.

B. Efforts and Initiatives in the Legal Community to Address Ethical Issues Faced When Servicing the Needs of Clients with Alzheimer's Disease and Other Forms of Dementia

As discussed in the law school and legal education context above, familiarization and exposure of the practicing bar to issues surrounding Alzheimer's disease is imperative. As time passes, the practicing bar will be sure to face an explosion of clients with Alzheimer's disease who will present practical and ethical challenges in their representation. The time is now to make attorneys aware and prepared to handle and deal with the complex and vexing issues associated with representing current and potential clients with Alzheimer's disease. The time to ring the alarm is now. Attorneys will continue to run through a field populated with landmines.

The practicing legal community and the practicing medical community must unite to equip each other to better handle and deal with legal and medical needs of clients and patients suffering from Alzheimer's disease. With this understanding and cross-pollination, the legal and medical professions need to work together to educate each other about the legal and medical ethical issues that arise in servicing the needs of members of the populace who suffer from Alzheimer's disease. One practical initiative in this positive direction would be for specialty, local, county, and state bar associations to partner with doctors to expose their membership to accessible medical discussions on the warning signs, symptoms, and manifestations of Alzheimer's disease. This could be easily done by partnering with and allotting time for medical professionals to address attorneys at continuing legal education (CLE) events on the topic of Alzheimer's disease.

As a next step, in conducting CLE events generally on ethics and professional responsibility, special attention, focus, and emphasis should be directed towards moving Alzheimer's disease higher on the

discussion priority map. Generally, in CLE's on ethics and professional responsibility, Alzheimer's disease and its current impact and looming explosion should be advanced up the discussion ladder.

Next, as Alzheimer's disease gets discussed more in the legal CLE world, presenters should consider using hypotheticals and simulations based on ethical dilemmas estate planning attorneys face in planning for clients with Alzheimer's disease. This would serve to bring awareness to the issue of Alzheimer's disease, and expose, peek, and deepen the understanding of practicing attorneys to the bevy of ethical rules and considerations that could come to light when dealing with an actual or potential client who is suffering from Alzheimer's disease.

Conducting CLEs will not be the only answer to the looming impact of Alzheimer's disease on the typical estate planners practice. Invariably, as the prevalence of Alzheimer's disease continues to rise, attorneys will almost certainly encounter actual or potential clients who suffer from Alzheimer's disease. "As memory, judgment, and other cognitive abilities decline, compensatory mechanisms develop and serve to cover for such deficits."¹⁵⁴ "Remaining skills and abilities tend to be emphasized or overemphasized, so that deficits are not so readily observed."¹⁵⁵ "Simply stated, it is not always possible to accurately determine whether a person is capacitated (or incapacitated) during the course of normal conversations."¹⁵⁶ "While it is necessary to know when true incapacity exists, it is equally important to avoid declaring a client incapacitated if they are capable of making sound decisions."¹⁵⁷ "In your work with older clients, keep in mind that it may be difficult to make simple assessments of their cognitive capacity."¹⁵⁸ The attorney may desire to seek out the assistance of a qualified examiner or diagnostician who would be "able to assess overall capacity while accounting for specific neurological deficits and [to] . . . consider possible treatable causes of impairment."¹⁵⁹ In choosing a qualified examiner or diagnostician, it is suggested "that the most important consideration is whether the examiner has specialized training and experience in geriatric competency assessment in addi-

154. Brandriet & Thorn, *supra* note 103.

155. *Id.*

156. *Id.*

157. *Id.*

158. *Id.* at 22.

159. *Id.*

tion to an advanced clinical degree."¹⁶⁰ "Given that caveat, individuals from several different professions may provide quality evaluations."¹⁶¹ Physicians, psychologists, advanced practice nurses, and clinical social workers with the requisite training and experience may all bring particular strengths and perspectives associated with their respective professions."¹⁶² "It will be in your client's best interests for you to evaluate the credentials and experience of an examiner before making a referral for capacity assessment."¹⁶³

Both subjective and objective assessment of mental capacity must be conducted to determine an actual or potential client's mental capacity. In this vein, one commentator has astutely observed the following:

The outcome of a capacity determination can be very grave, possibly resulting in forced surrender of personal and/or financial decision-making rights. Thus, it is imperative that the assessment be accurate, complete, and performed and documented with care. Both objective and subjective assessment are components of a capacity evaluation. Standardized tests and measures are used to increase objectivity. As human evaluators, some subjective evaluation is inherent (which can be an advantage as not all human behavior can be objectively measured). Professional perspective of a person's capacity, though not necessarily the outcome, may vary depending upon the specific professional discipline of the evaluator(s).¹⁶⁴

160. *Id.*

161. *Id.*

162. *Id.* at 22-23.

163. *Id.* at 23.

164. *Id.* Additionally, it is recommended that capacity be assessed "holistically." Brandiet and Thorn observe the following regarding holistic assessment: "To increase the accuracy of a capacity evaluation, it is essential that the proposed protected person, along with their specific situation and living environment, be assessed "holistically" as opposed to consideration of only their mental or cognitive status. Assessing mental status is a necessity, but should never suffice as the entire evaluation. To illustrate, certain individuals may score very poorly on standardized mental status exams, yet function well, safely, and without putting themselves or others at risk (most decisions may be sound). Other individuals may score quite well on standardized tests, but subject themselves and others to risk on a daily basis (most decisions are likely poor) . . . Physical health, physical disability, functional ability (to do daily activities), nutrition, safety, sensory function, and emotional status must be determined in addition to mental status as each contributes to the ability (or inability) of a person to make sound decisions. If sensory loss, for example, was not considered, a person might be labeled as incapacitated due to unintelligible answers that were the result of deafness and the inability to hear what was being asked of them. Thus, failing to consider an individual in a holistic fashion could lead to an appointment of a guardian and conservator when the more appropriate provision for protecting the person might have been less restrictive." *Id.*

Again, to summarize, the practicing bar and legal professional community could be better served by considering the following efforts and initiatives to raise awareness of ethical and professional responsibility considerations in representing the needs of actual or potential clients with Alzheimer's disease:

- a. Partnerships and collaborative efforts uniting lawyers and doctors to educate each other on the medical and ethical issues in servicing the needs of Alzheimer's clients/patients should be fostered;
- b. Specialty, local, county, and state bar associations should consider inviting doctors to CLE events to present information on the warning signs, symptoms, and manifestations of Alzheimer's disease in straight-forward and accessible presentations on the topic;
- c. CLE events focused specifically on the importance and the rise of ethical and professional responsibility issues associated with servicing actual and potential clients with Alzheimer's disease should be prioritized and highlighted;
- d. CLE presenters should consider using hypotheticals to raise awareness and understanding of the multifaceted ethical and professional responsibility issues associated with representing actual and potential clients with Alzheimer's disease; and
- e. Attorneys who have questions about a client's mental capacity, within the context of an actual or potential estate planning client engagement, should seek the assistance of a qualified examiner or diagnostician to determine a client's subjective and objective mental capacity.

Conclusion

The impact and devastation associated with the rise and growing prevalence of Alzheimer's disease will be enormous and will uniquely affect an attorney's conduct with affected clients. Demographically, as the American society ages, more and more citizens and caregivers will be forced to stare the ravages of Alzheimer's disease in the face. Law students and attorneys will not be immune from having to eventually service the needs of a client with Alzheimer's disease at some point in their careers, especially current and prospective estate planning attorneys. There will be many landmines to run past and avoid ethically and professionally. These ethical and professional dilemmas will represent traps for the unwary legal practitioner. Many current and future lawyers will set off these proverbial landmines as-

sociated with ethical representation of clients with Alzheimer's disease.

At the outset, this Article's objectives were twofold. Exposure to a problem ideally brings about solutions. Hopefully, first, the symptoms, stages, and impact of Alzheimer's disease has been made accessible to a wider audience. Secondly, the awareness of Alzheimer's disease in the law school setting, and among members and policy-makers in the practicing bar has hopefully peeked. With exposure, we can begin to find ethical and professional guidance that steers attorneys beyond ethical pitfalls. Often, attorneys will find themselves forced to make subjective professional judgment calls regarding whether or not an actual or potential client has diminished mental capacity. The hope is that this Article will serve to provide a modicum of guidance and direction to attorneys forced to make these difficult professional judgments. Working together, the desire is that we find meaningful ways to ethically represent clients suffering from Alzheimer's disease and provide them with a level of autonomy and dignity in conducting their legal affairs.

Appendix A

Mini-Mental State Examination (MMSE)

Patient's Name: _____ Date: _____

Instructions: Ask the questions in the order listed. Score one point for each correct response within each question or activity.

Maximum Score	Patient's Score	Questions
5		"What is the year? Season? Date? Day of the week? Month?"
5		"Where are we now: State? County? Town/city? Hospital? Floor?"
3		The examiner names three unrelated objects clearly and slowly, then asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible. Number of trials: _____
5		"I would like you to count backward from 100 by sevens." (93, 86, 79, 72, 65, ...) Stop after five answers. Alternative: "Spell WORLD backwards." (D-L-R-O-W)
3		"Earlier I told you the names of three things. Can you tell me what those were?"
2		Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.
1		"Repeat the phrase: 'No ifs, ands, or buts.'"
3		"Take the paper in your right hand, fold it in half, and put it on the floor." (The examiner gives the patient a piece of blank paper.)
1		"Please read this and do what it says." (Written instruction is "Close your eyes.")
1		"Make up and write a sentence about anything." (This sentence must contain a noun and a verb.)
1		"Please copy this picture." (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.)
30		TOTAL

(Adapted from Rovner & Folstein, 1987)

Instructions for administration and scoring of the MMSE**Orientation (10 points):**

- Ask for the date. Then specifically ask for parts omitted (e.g., "Can you also tell me what season it is?"). One point for each correct answer.
- Ask in turn, "Can you tell me the name of this hospital (town, county, etc.)?" One point for each correct answer.

Registration (3 points):

- Say the names of three unrelated objects clearly and slowly, allowing approximately one second for each. After you have said all three, ask the patient to repeat them. The number of objects the patient names correctly upon the first repetition determines the score (0-3). If the patient does not repeat all three objects the first time, continue saying the names until the patient is able to repeat all three items, up to six trials. Record the number of trials it takes for the patient to learn the words. If the patient does not eventually learn all three, recall cannot be meaningfully tested.
- After completing this task, tell the patient, "Try to remember the words, as I will ask for them in a little while."

Attention and Calculation (5 points):

- Ask the patient to begin with 100 and count backward by sevens. Stop after five subtractions (93, 86, 79, 72, 65). Score the total number of correct answers.
- If the patient cannot or will not perform the subtraction task, ask the patient to spell the word "world" backwards. The score is the number of letters in correct order (e.g., dlrow=5, dlrow=3).

Recall (3 points):

- Ask the patient if he or she can recall the three words you previously asked him or her to remember. Score the total number of correct answers (0-3).

Language and Praxis (9 points):

- Naming: Show the patient a wrist watch and ask the patient what it is. Repeat with a pencil. Score one point for each correct naming (0-2).
- Repetition: Ask the patient to repeat the sentence after you ("No ifs, ands, or buts."). Allow only one trial. Score 0 or 1.
- 3-Stage Command: Give the patient a piece of blank paper and say, "Take this paper in your right hand, fold it in half, and put it on the floor." Score one point for each part of the command correctly executed.
- Reading: On a blank piece of paper print the sentence, "Close your eyes." In letters large enough for the patient to see clearly. Ask the patient to read the sentence and do what it says. Score one point only if the patient actually closes his or her eyes. This is not a test of memory, so you may prompt the patient to "do what it says" after the patient reads the sentence.
- Writing: Give the patient a blank piece of paper and ask him or her to write a sentence for you. Do not dictate a sentence; it should be written spontaneously. The sentence must contain a subject and a verb and make sense. Correct grammar and punctuation are not necessary.
- Copying: Show the patient the picture of two intersecting pentagons and ask the patient to copy the figure exactly as it is. All ten angles must be present and two must intersect to score one point. Ignore tremor and rotation.

(Folstein, Folstein & McHugh, 1975)

Interpretation of the MMSE

Method	Score	Interpretation
Single Cutoff	<24	Abnormal
Range	<21	Increased odds of dementia
	>25	Decreased odds of dementia
Education	21	Abnormal for 8 th grade education
	<23	Abnormal for high school education
	<24	Abnormal for college education
Severity	24-30	No cognitive impairment
	18-23	Mild cognitive impairment
	0-17	Severe cognitive impairment

Sources:

- Crum RM, Anthony JC, Bassett SS, Folstein MF. Population-based norms for the mini-mental state examination by age and educational level. *JAMA*. 1993;269(18):2388-2391.
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Appendix B

Short Portable Mental Status Questionnaire (SPMSQ)

Patient's Name: _____ Date: _____

Circle Appropriate SEX: M F RACE: White Black Other
Description: YRS OF EDUCATION: Grade School High School Beyond High School

Instructions: Ask questions 1 to 10 on this list and record all answers. (Ask question 4a only if the subject does not have a telephone.) All responses must be given without reference to calendar, newspaper, birth certificate, or other aid to memory. Record the total number of errors based on the answers to the 10 questions.

+	-	Questions	Instructions
		1. What is the date today? _____	Correct only when the month, date, and year are all correct.
		2. What day of the week is it? _____	Correct only when the day is correct.
		3. What is the name of this place? _____	Correct if any of the description of the location is given. "My home," the correct city/town, or the correct name of the hospital/institution are all acceptable.
		4. What is your telephone number? _____	Correct when the number can be verified or the subject can repeat the same number at a later time in the interview.
		4a. What is your street address? _____	Ask only if the subject does not have a telephone.
		5. How old are you? _____	Correct when the stated age corresponds to the date of birth.
		6. When were you born? _____	Correct only when the month, date, and year are correct.
		7. Who is the president of the United States now? _____	Requires only the correct last name.
		8. Who was president just before him? _____	Requires only the correct last name.
		9. What was your mother's maiden name? _____	Needs no verification; it only requires a female first name plus a last name other than the subject's.
		10. Subtract 3 from 20 and keep subtracting 3 from each new number, all the way down. _____	The entire series must be performed correctly to be scored as correct. Any error in the series—or an unwillingness to attempt the series—is scored as incorrect.

_____ Total Number of Errors

- 0 – 2 errors = Intact Intellectual Functioning
- 3 – 4 errors = Mild Intellectual Impairment
- 5 – 7 errors = Moderate Intellectual Impairment
- 8 – 10 errors = Severe Intellectual Impairment

(Allow one more error for a subject with only a grade school education. Allow one less error for a subject with education beyond high school. Allow one more error for African-American subjects, using identical educational criteria.)

Source:

Pratler E. A short portable mental status questionnaire for the assessment of organic brain deficit in elderly patients. *J Am Geriatr Soc.* 1976;23(10):433-41.

Appendix C

Instructions for Administration & Scoring

ID: _____ Date: _____

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are (select a list of words from the versions below). Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.^{1,2} For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Bonano	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Notion	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

Word List Version: _____ Person's Answers: _____

Scoring

Word Recall: _____ (0-3 points)	1 point for each word spontaneously recalled without cueing.
Clock Draw: _____ (0 or 2 points)	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.
Total Score: _____ (0-5 points)	Total score = Word Recall score + Clock Draw score. A cut point of ≥ 3 on the Mini-Cog [®] has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of ≥ 4 is recommended as it may indicate a need for further evaluation of cognitive status.

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v. 01/19/16

Clock Drawing

ID: _____ Date: _____

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1. Borson S, Scanlan JM, Chen PJ et al. The Mini-Cog as a screen for dementia: Validation in a population-based sample. *J Am Geriatr Soc* 2003;51:1451-1454.

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5. McCarten J, Anderson P et al. Screening for cognitive impairment in an elderly veteran population: Acceptability and results using different versions of the Mini-Cog. *J Am Geriatr Soc* 2011; 59: 309-313.

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