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Case Study

Into the Elder Law Trenches at Wake Forest University School of Law

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Objectives

1. Examine the benefits of a medical-legal partnership for training law students how to represent older clients.
2. Review common legal issues in the field of elder law.
3. Explore broader policy concerns facing an aging population.

Background

When it comes to learning, there's nothing like having real people with real problems seated across from you. They share their concerns, they ask questions, and they want results.

Recognizing this, in 1991, Wake Forest University School of Law

made a strategic decision. Students were clamoring for practical experience at the same time that the number of older adults was climbing. So, the school launched a clinical program in which upper-level law students would represent elders under the supervision of an attorney who was a faculty member. Fortunately, our medical school, at Wake Forest Baptist Medical Center, was starting a multi-disciplinary center on aging and welcomed the law school's new clinic to be a part of it.

Honestly, I had my doubts. As the attorney hired to start a new clinical program embedded in a large teaching hospital, it certainly sounded interesting. But I suspected the "multidisciplinary" approach would be more trendy than meaningful. I was wrong and here's why.

As you may recall, at that time an important medical-legal topic was in the news. In 1990, the first "right to die" case was decided by the U.S. Supreme Court. ([Cruzan v. Director, Missouri Department of Health](#)). Then, in 1991, when our clinic was launched, the federal Patient Self-Determination Act

went into effect. It mandated that hospitals provide patients with information about advance directives. The Elder Law Clinic got very involved in issues of living wills and health care powers of attorney. In return, our medical partners helped get me up to speed on issues of end-of-life care, including the terminology and the pros and cons of options such as artificial hydration and nutrition. Also, joining the medical center's ethics committee exposed me to complex issues faced by health care providers, such as surrogate decision-making and fear of legal liability.

There turned out to be two other areas, besides advance directives, where our "multidisciplinary partnership" has helped us train lawyers for older clients. First, the law students and I often work in other medical settings that elders interact with, such as nursing homes and assisted living facilities. Why is this important? All lawyers have learned civil and criminal procedure, but few lawyers understand "levels of care" or the procedures for discharge from a hospital to long-term care. They haven't a clue

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how long Medicare will cover rehab or what the asset limits are to qualify for Medicaid. But it is mainly health care settings, not courtrooms, which older clients and their families need help figuring out.

Second, many legal issues of older clients involve questions of mental capacity. Where better to learn the lingo of cognitive impairment than from geriatricians, neurologists, and psychiatrists? The law students learn how to interview a cognitively-impaired client effectively, which can terrify them more than standing up and speaking in a courtroom. They need to know the level of capacity required to sign a document. The students regularly handle court cases, guardianships, in which mental competency is the central issue.

Curriculum Format

Students in the Wake Forest Elder Law Clinic meet in class weekly. It is a four-credit hour course on the general civil practice of law with an emphasis on elder law, with two hours of lecture and eight hours a week in the clinic; the latter involves meeting with clients, drafting documents, doing research, going to court, and conducting a variety of client-related projects. The law students do not have classes or cases in common with medical students. Rather, there are a variety of collaborative efforts undertaken as needed. For example, to help law students understand the benefits of ECT (electroconvulsive therapy) for some older patients, I have arranged for them to observe it administered, to speak with the attending physician, and,

often, to speak with the patients themselves. A class that focuses on mental capacity issues and end-of-life care is taught by a member of the medical school faculty. Also, students interested in bioethics may accompany me to ethics consultation meetings. Finally, cases referred to us by our medical center are given priority, so we regularly have clients in the hospital and in post-acute care facilities. ABA-accreditation rules prohibit payment to the students. To learn more about the structure of the clinic, see Mewhinney (2006, 2010).

Wake Forest's unique partnership between the law school and the medical school strengthens our teaching and our legal work for older adults.

Case Study 1: Parenting a Parent

"Mrs. X needs a new power of attorney," it said on the application for services sent by Mrs. X's adult daughter. I assigned a law student named Brad Fleming to meet with Mrs. X. She was healthy-looking and friendly. But she was anxious and could not remember her daughter's name or the reason she was there. With Mrs. X's permission, Brad then met with her daughter, a busy nurse raising teenagers. The daughter had moved her mother to Winston-Salem from Georgia, due to signs of dementia. The daughter was patching together care at her home for the mother, including having the teenaged grandchildren pitch in. She wanted help figuring out what programs would be available when her mother was no longer able to live safely in the community with her.

Because the mother had some savings, Brad explained that she would be ineligible for North Carolina's Medicaid program that helps pay the cost of assisted living memory care units. One option would be for her to private pay the typical \$3,500 a month for this type of care, thereby quickly depleting her savings and becoming Medicaid-eligible. Brad suggested instead a written family care agreement. This way, the daughter could be paid for the care she was providing her mother. Then, when the mother needed 24/7 care, she would be eligible for government coverage through Medicaid. A simple transfer of the savings to the daughter, on the other hand, would have triggered a long period of disqualification.

Fortunately, Mrs. X had signed a financial power of attorney in Georgia. The relative there (named as agent under the document) was no longer willing to serve as her financial agent but was willing to sign a "family care agreement" with the daughter.

Discussion of Case Study 1

The case of Mrs. X and her overwhelmed and caring daughter raises many issues. Let's focus on three aspects: the lawyer's role in the process, the level of capacity needed to sign a power of attorney, and the health care policies implicated here.

Since a lawyer is an agent for a client, the first question in this case, as in many elder law cases, must be "Who is the client?" Even with very elderly and dependent prospective clients, the clinic students learn to start with a presump-

tion that the person has the capacity to be a client. Normally, where the older person's life or assets are central to the appointment, that person should be the client. In my state, North Carolina, legal ethics rules direct that, when preparing powers of attorney, the attorney must represent the principal (i.e., the person who would sign a power of attorney). This isn't necessarily the person who suggested the power of attorney, nor is it the person who first contacted the attorney on behalf of the elder (N.C. State Bar, 2003).

In Mrs. X's situation, there is another aspect of the lawyer's role that I teach about. The students learn that an attorney has the ethical duty to accommodate a client's impairments and, as far as reasonably possible, maintain a normal client-lawyer relationship with the client (American Bar Association, Model Rule 1.14). This means meeting at the time and place that is best for the client and proceeding at a pace and level of complexity that works for the client. Even though it may be more efficient just to take direction from adult children, this approach can lead to poor legal work, divided loyalties, and potentially invalid documents.

Because powers of attorney are sometimes used to exploit older people, it is particularly important in these cases for the attorney to be on the lookout for manipulation or coercion. I teach my students that they must diplomatically separate the client from the family members, so that they can assess the client's mental capacity and interest in even having a power of attorney. Sometimes the client sees the benefits of

having a power of attorney but would not choose as the agent the relative who initiated the process. (*For a good overview of undue influence and elder exploitation, see Pryor, 2016.*)

Years ago, I drafted a brochure entitled "Why Am I in the Lobby?" to give to the client's family members. It explains why they were not part of the interview process. Of course, after the key decisions are made by the client, if the client consents to sharing information with relatives (as most do), we can include family members in the meeting.

In summary, the first step in analyzing Mrs. X's case was to be clear about the lawyer's role. This analysis was informed by ethical standards and an understanding of the risk of exploitation of dependent elders.

Also, my student Brad picked up a drafting tip that may come in handy. The power of attorney that his client had signed in Georgia was still effective, but the agent/relative there wasn't willing to continue to act as agent. If the document had just contained a "power to appoint a substitute," the Georgia agent/relative could have simply appointed the Winston-Salem daughter to take over. As a young lawyer learns from experience, he starts to "practice" law and gain wisdom to better serve his next clients.

A second issue in this case was whether the client, Mrs. X, had capacity to understand and possibly sign a new power of attorney. This isn't always obvious. The law students learn interview techniques that elicit information about the

client's level of capacity. The setting is slow and friendly. The questions are simple. The explanations do not include legal jargon. These aren't just ethical rules but are fundamental skills for working with many older clients.

During the semester, the students get to observe at our medical center's geriatrics outpatient program. There, they see how an excellent skilled geriatrician's "bedside manner" can tease out mental impairments. Just as importantly, the students learn to modify how they present information, so that the cognitively-impaired client has a better chance of truly understanding it. Besides shadowing the geriatricians, we have a class session about cognitive issues taught by a member of the medical school faculty.

The third issue in the case involves the social and health care policies that have affected this family. The daughter's stress as a caregiver was evident, and the student and I discussed the lack of paid family leave policies. While there are some Medicaid-covered in-home programs, the waiting lists are extremely long and the services are limited. Medicare, too, offers no in-home services for beneficiaries like Mrs. X who need only custodial care. Fortunately, the Elder Law Clinic works regularly with other aging services providers, so we could recommend adult day programs, caregiver support programs, and other community services, some of which permit sliding-scale fees.

While in-home help from Medicaid and Medicare was not an option, we did look ahead for when the mother

might need care in locked memory care facility. Unlike many states, North Carolina's Medicaid program offers limited help for very low-income elders who need care in assisted living. The "Special Assistance" program, as it is called, limits a single person to having only \$2,000 or less in savings. Often, we advise our low-income clients that they can spend down excess savings on "non-countable" assets such as a car, a pre-paid irrevocable burial contract, or household goods. In Mrs. X's case, however, we recommended to her daughter that they sign a "family care agreement" whereby the mother's savings could be reduced by paying monthly to the daughter. Of course, the payment had to correspond to the fair market value of the daughter's services and the room and board she provided to the mother. Also, we told the daughter to consult her own tax advisor, as this would probably constitute reportable and taxable income for her.

This strategy allowed the mother, when she reached the point of being medically-certified as needing assisted living level care (probably in a secure memory-care unit), to qualify for Medicaid Special Assistance. As readers may know, many families run afoul of Medicaid "transfer of resources" rules by simply re-titling assets from the elder to their children. Generally, this is not permitted under the Medicaid regulations and results in a period of disqualification. However, there are some limited exceptions, so families should always consult with an experienced elder law attorney.

There was another legal policy that

proved to be helpful for this family. This is the Social Security "representative payee" rule, letting a surrogate be appointed to handle the payments if the beneficiary is incapable of managing their money. This is a user-friendly system. So, Mrs. X's daughter was at least able to handle on-going income for her mother's benefit.

Case Study 2: 98 Years Old and Living Alone

Living alone at age 98 is rare. And it is risky. A gentleman, call him Mr. Y, with no close family was doing so when his doctor reported him to the public agency that investigates neglected elders. Adult Protective Services (APS) filed a court case to have the man declared incompetent. My student, Matt Freeze, handled the case as the court-appointed "guardian ad litem." This means he had to communicate to the court what the client thought about having a guardian take over his decision-making. But Matt's other role was to be the "eyes and ears of the court" and make a recommendation as to what would be in the client's "best interests."

Mr. Y was adamant about staying in his second-floor rental apartment, where he'd lived for 37 years. He'd only been getting two hours of help each day from friends and this was about to end. Because of our partnership with the medical center, we arranged for him to receive a home visit by a geriatrician within a week, through the Sticht Center Geriatric House Call Program. The geriatrician was less sanguine than I was and had more concern than I did about Mr. Y's

cognitive condition. She was also dubious that in-home services could be arranged.

Nevertheless, for several weeks my student collaborated with APS to try to set up a new support system. But the client had significant challenges. Although we felt that his cognitive impairment was fairly mild, he was blind, had very limited income, and could move only a few feet and very slowly. Ultimately, we felt that the client's limitations made it too difficult for him to be safe at home. My student and I recommended that a guardian be appointed. The court agreed, appointing the Department of Social Services to serve as Mr. Y's guardian. They moved him to a good quality nursing facility that accepted Medicaid where, I later heard, he adapted well.

Discussion of Case Study 2

Mr. Y's case illuminates some of the common scenarios in elder law practice. Our students learn about the role and limits of social service agencies, the unique problems of the very old, isolated person, and the tension between protecting elders and allowing them to make poor choices.

In this case, the two friends who had been providing just a couple hours each day of help were no longer able to continue. Feeling too guilty to say so directly, they relied on DSS to be the "bad guy" and initiate a guardianship. DSS sometimes plays this role when it is the family who serve as caregivers, where guilt is even stronger. Also, family members often don't recognize that their impaired relative is

actually in need of much higher level of care than they are capable of providing.

Mr. Y became an “unbefriended elder” or “orphan elder.” With more money and a larger network of family and friends, he might have been able to live out his life in his dingy apartment. He said he preferred to remain there, but he seemed to adapt well to the living situation his guardian arranged.

Providing 24/7 services to frail, blind elders at home would be a tall order for any community. But it proved to be a challenge to find and coordinate even part-time services for this 98-year old that would have allowed him to stay in his apartment. It was to their credit that the Department of Social Services gave us a few weeks to try to put this together.

“Incompetency” determinations, for imposition of guardianship, often are largely a function of the strength of a person’s support network. With very few services available to help people age in place, older low-income adults are likely to be found “incompetent” and placed into “safe” environments. These housing options are generally more expensive than part-time in-home services would have cost. And they aren’t always so safe.

This case presented a real dilemma for us as guardian ad litem: should we advocate for his independence or lean towards emphasizing his safety? Mr. Y was clear about wanting to remain home, despite the risk. Whether he truly appreciated the risk was hard to determine.

In similar cases, we look at the client’s test results from commonly-used assessment tools such as the Montreal Cognitive Assessment (MoCA), the Folstein Mini-Mental State Exam (MMSE), or the Kohlman Evaluation of Living Skills (KELS). But as his advocates, we appreciated the value that “being independent” had to him. *(For a thoughtful examination of the “right” to opt for risk, see Mukerjee, 2015).*

Mr. Y pressed us on who had started the case and why. We explained that the county social services had started it out of concern for his safety. He wanted to know what business it was of the county’s. His interrogation continued: “And will the county love me the way my friends love me?”

Conclusion

Whether our communities truly love and will care for our frail elders is not clear. But at Wake Forest law school, we are doing what we can to provide them compassionate, ethical, and well-trained attorneys. These lawyers will have some familiarity with the medical environments and issues their clients face and the community resources available for elders and their families. We hope that our experiences in the Elder Law Clinic may inspire others to implement similar actions to benefit older adults.

Study Questions

1. In your work, have multidisciplinary approaches offered better solutions for older adults? If not, what collaborations might you explore

for the future?

2. Health care providers are often wary of lawyers and the legal system. In what ways and on what issues did these two professions interact at Wake Forest University to benefit older adults?
3. How far should our communities go in allowing frail older adults to live at home, despite increased risks associated with that choice?
4. Do courts in your jurisdiction give proper weight to the desires of older adults who are the subject of guardianship cases and is the process for determining “incompetency” fair?

References

- American Bar Association. (nd). Rule 1.14: Client with Diminished Capacity. www.americanbar.org/groups/professional_responsibility/publications/model_rules_of_professional_conduct/rule_1_14_client_with_diminished_capacity.html
- Mewhinney, K. (2006). Ideals and high heels: A look at Wake Forest University’s Elder Law Clinic. *North Carolina State Bar Journal*, Fall Issue, 20-24. Available at http://elder-clinic.law.wfu.edu/files/2014/02/N.-C.-State-Bar-Journal-Ideals-and-High-Heels-Fall_06.pdf
- Mewhinney, K. (2010). The human touch: The clinical teaching of elder law. *Stetson Law Review*, 40(1), 153-235.
- North Carolina State Bar (2003). Formal Ethics Opinion 7, www.ncbar.gov/for-lawyers/ethics/adopted-opinions/2003-formal-ethics-opinion-7/

Resources

Elder Law Clinic of Wake Forest University School of Law:
<http://elder-clinic.law.wfu.edu>.

Mukerjee, D. (2015). Discharge decisions and the dignity of risk. *Hastings Center Report*, 45(3), 7-8. Available at
<https://doi.org/10.1002/hast441>

National Academy of Elder Law Attorneys (NAELA):
www.naela.org

NAELA Aspirational Standards (2017): www.naela.org/Web/Members_Tab/AspirationalStandards/AspirationalStandards_Member_Page.aspx?New_ContentCollectionOrganizerCommon=3#New_ContentCollectionOrganizerCommon

National Center for Medical-Legal Partnership, <http://medical-legal-partnership.org>

National Elder Law Foundation:
www.nelf.org (to locate a board-certified elder law attorney)

Pryor, K. (2016). Averting financial exploitation and undue influence through legislation. *Age in Action*, 31(2), 1-6.

Virginia Bar Association, Elder Law Section
www.vba.org/?page=elder_law
(which has useful links to elder law resources)

Sticht Center for Healthy Aging and Alzheimer's Prevention, at Wake Forest Baptist Medical Center.

www.wakehealth.edu/aging_research/

Virginia Chapter of NAELA (VAELA): www.vacla.org

Virginia Poverty Law Center (VPLC): www.vplc.org/elder-law/

About the Author



Professor Kate Mewhinney is a Certified Specialist in Elder Law by the N.C. State Bar and the National Elder Law Foundation; a Certified Superior Court Mediator in North Carolina, with additional certification to mediate guardianship and estate disputes; and a Fellow of the National Academy of Elder Law Attorneys. She is also an Associate in the Wake Forest School of Medicine's Department of Internal Medicine (Section of Geriatrics and Gerontology). Contact her at mewhinka@wfu.edu.