No Help for the Helpless: How the Law Has Failed to Serve and Protect Persons Suffering from Alzheimer’s Disease

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I. Introduction

As human beings age, we often suffer memory lapses. Some of these lapses – like searching for your cell phone for several minutes only to discover you have been holding it in your right hand all along – are minor and even humorous. People often dismiss them as part of the aging process. However, some are far from minor, especially when they occur in the elderly. All too often, these lapses are symptoms of a more serious problem such as the onset of some form of dementia, specifically, Alzheimer’s disease, a thus-far incurable and irreversible disease of the brain. When people suffer from Alzheimer’s disease, they are at the most vulnerable point of their lives and need the protection of the law. Yet, too often, the law fails them at that critical time.

This Article will discuss three areas in which the law is failing Alzheimer’s patients: guardianship, tort law, and due process protections in court proceedings. The Article is divided into five parts. Part I will discuss dementia in general and Alzheimer’s disease in particular, including the causes of the disease, its symptoms, and its manifestations. Part II will discuss three areas of the law that do not adequately serve and protect Americans who have become vulnerable because of the onset of Alzheimer’s disease. This part will first discuss the shortcomings of guardianship law, then move on to tort law and, finally, due process protections in court proceedings. Part IV will propose solutions to the problem. Should the legal system adopt these solutions, the law would finally be able to adequately serve and protect Alzheimer’s patients. As this Part will indicate, the reform needed is not necessarily in the written law, but in the agents – lawyers, judges and court officials – who enforce the law. Part V, the Conclusion, will propose that the medical and legal fraternities combine forces to help the law better serve and protect America’s most vulnerable citizens.
II. Alzheimer’s Disease: Causes, Symptoms, and Manifestations

Alzheimer’s disease is a form of another condition called dementia.1 It is the most common form of dementia found in people age sixty-five and older.2 Although people often speak of dementia as a disease, it really is not. Rather, it is “the name given to a group of symptoms including memory loss, reduced ability to reason, impaired judgment, and progressive loss of ability to understand either spoken or written language.”3 Dementia could be likened to a headache: when someone says he or she has a headache, the headache itself is not a disease; rather, it is a symptom that the person is suffering from some disease. Indeed, the headache could be an indication that the person is suffering from one or more of several diseases. In the same way, when someone is diagnosed with dementia, the dementia itself is not a disease; rather, it is an indication that the person is suffering from a mind-affecting disease.

People suffering from dementia typically behave in ways others find irrational.4 For example, the patient may exhibit severe mood and personality changes.5 He or she may also be physically aggressive or may become easily agitated.6 Additionally, the person may hallucinate or hold misperceptions of reality.7 As the disease progresses, the patient may become disoriented in several ways, including not knowing the day of the week, date of month, or the current month.8 The patient may also be confused as to who he or she is, who anybody else is, or where he or she is.9

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3 See JAMES, supra note 1, at 4 (discussing the characteristics of Dementia); see also AMER. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS DSM-IV-TR 148-49 (Amer. Psychiatric Ass’n ed., 4th ed. 2000) (analyzing Dementia sufferers’ symptoms).
4 JAMES, supra note 1, at 4; see also Peter V. Rabins, Dementia and Alzheimer’s Disease: An Overview, 35 GA. L. REV. 451, 458-59 (2001) (describing “cognitive” and “non-cognitive” symptoms experienced by dementia and Alzheimer’s patients).
5 JAMES, supra note 1, at 4.
6 Id.
7 Id.
8 Id.
9 Id.; see also Marshall B. Kapp, Legal Standards for the Medical Diagnosis and Treatment of Dementia, 23
To diagnose someone as having dementia, the treating medical professional must find evidence for at least two types of impairments: (1) significant memory problems, and (2) impairment of at least one other cognitive function such as speech, the ability to think abstractly and exercise judgment, or the ability to articulate or manage previously learned information. Although relatively young people (i.e., those between forty and fifty years of age) are sometimes afflicted with dementia, the incidence and prevalence of the disease are more prominent in the elderly population. Almost five percent of persons age sixty-five and older are severely demented, with another ten percent of that group in the moderate dementia category. Among persons eighty-five and older, more than fifteen percent are severely demented.

These people suffer from a wide range of conditions – seventy-five in all – that comprise the “dementia group” of diseases. These include vascular dementia, Binswanger’s disease, dementia with Lewy bodies, Pick’s disease, and Alzheimer’s disease. Of all forms of dementia, Alzheimer’s disease is the most prevalent, accounting for more than two-thirds of all dementia cases.


See Margery H. Silver et al., Cognitive Functional Status of Age-Confirmed Centenarians in a Population-Based Study, 56 J. GERONTOLOGY 134, 134 (2001) (noting that some researchers predict everyone will have some form of dementia by age 100); What Is Alzheimer’s?, ALZHEIMER’S ASSN, http://www.alz.org/alzheimers_disease_what_is_alzheimers.asp (last updated Nov. 21, 2011) (stating that five percent of people with the disease suffer symptoms in their forties and fifties).

Kapp, supra note 9, at 366.

FEINBERG & YU, supra note 2 at 14 (explaining the prevalence of the disease in the elderly but noting Alzheimer’s is not an inevitable fact of aging); Kapp, supra note 9, at 366. However, the risk of becoming demented increases significantly as one ages. Kapp, supra note 9, at 366

See Rabins, supra note 4, at 452. Most of these diseases present specific syndromic patterns that permit clinicians to distinguish among them. Id.

FEINBERG & YU, supra note 2, at 51-55. Vascular dementia, Binswanger’s disease, dementia with Lewy bodies, Pick’s disease, and Alzheimer’s disease are the incurable forms of dementia. Id. at 51. In irreversible forms of dementia, the goal is to slow the progression of the disease and to treat the symptoms. Id.

Id. at 13 (explaining that Alzheimer’s is the most common form of dementia and that increases in life expectancy may account for the rise in its prevalence); NAT’L INST. ON AGING, U.S. DEPT OF HEALTH & HUMAN SERV., NIH PUB. NO. 03-3333, 2001-2002 ALZHEIMER’S DISEASE PROGRESS REPORT 2 (2003), available at http://www.nia.nih.gov/NR/rdonlyres/7049AF18-6827-4DCE-95FA-B853D171C974/0/20012002_ALZ_PR.pdf [hereinafter ALZHEIMER’S PROGRESS REPORT]. The number of people with the disease at any one time doubles every five years beyond age sixty-five. ALZHEIMER’S PROGRESS REPORT, supra, at 2. Researchers estimate that by 2050, 14 million Americans will have Alzheimer’s disease as long as current population trends continue and preventive treatments remain unavailable. Id.
A. Causes and Ultimate Effects of Alzheimer's Disease

Although scientists have been conducting research into Alzheimer's disease ever since Dr. Alois Alzheimer first identified it in 1906, no one knows for sure what causes the disease.\textsuperscript{17} Scientists believe that potential causes include genetics, aging, head injury, cardiovascular disease, and strokes.\textsuperscript{18} From a pathological standpoint, the disease is caused by the presence of beta amyloid plaques and neurofibrillary tangles in the brain.\textsuperscript{19} However, the scientists do not know what causes the build-up of these plaques and tangles.\textsuperscript{20} They do know, however, that regardless of the cause, Alzheimer's is a disease of the brain, and the plaques and tangles that give rise to its onset physically attack the patient's brain.\textsuperscript{21} Accordingly, the disease is irreversible.\textsuperscript{22}

Once it has struck, Alzheimer's begins to progress through the patient's brain. Over the course of its progression, the disease robs the patient of memory and cognitive skills, and causes him or her to have severe changes in personality and behavior.\textsuperscript{23} Although some people have lived up to twenty years with the disease, the average post-diagnosis lifespan for an Alzheimer's patient is eight to ten years.\textsuperscript{24}

B. Stages and Symptoms of Alzheimer's Disease

Because Alzheimer's disease resembles several other forms of dementia, no one knows for sure whether a patient is stricken with the disease. In fact, the only way medical professionals can be certain that someone \textit{has} Alzheimer's disease is to conduct

\textsuperscript{18} FEINBERG & YU, supra note 2, at 24-29.
\textsuperscript{19} \textit{Id}. at 22-24.
\textsuperscript{20} FEINBERG & YU, supra note 2, at 17.
\textsuperscript{21} Thies & Bleiler, supra note 17, at 210-211; \textit{see also} What \textit{Is} Alzheimer's?, supra note 11 (discussing plaques and tangles).
\textsuperscript{22} What \textit{Is} Alzheimer's?, supra note 11 (noting that Alzheimer's has no current cure).
\textsuperscript{23} Michael S. Maga et al., \textit{The Spectrum of Behavioral Changes in Alzheimer's Disease}, 46 Neurology 130, 130 (1996).
\textsuperscript{24} FEINBERG & YU, supra note 2, at 17.
a post mortem examination of the deceased person’s brain. Yet, using various tools at their disposal, medical professionals are now able to diagnose someone as having Alzheimer’s disease with ninety percent accuracy.

To make a diagnosis, doctors employ tools such as neurological exams, cognitive screening exams, blood tests, and brain scans. They also rely heavily on reports by the patient, family members, and close friends. These doctors must always bear in mind, however, that the development and progress of the disease varies from person to person. No two people have the same experiences, and no two people experience the same symptoms. Moreover, while the disease progresses rapidly in some people, in others it progresses slowly. What is common is that the disease progresses through stages.

Some scientists and healthcare professionals maintain that Alzheimer’s disease progresses through three stages – mild, moderate and severe. For several years, the Alzheimer’s Association has divided the progress into seven stages: no impairment, very mild cognitive decline, mild cognitive decline, moderately severe cognitive decline, severe cognitive decline, and very severe cognitive decline. However, on April 19, 2011, CNN reported that a new group of researchers, working with the blessings of the Alzheimer’s Association and the National Institute on Aging,

25 Thies & Bleiler, supra note 17, at 232 (discussing diagnostic challenges with Alzheimer’s disease).
26 Id. (noting that “more than 90 percent of patients diagnosed with [Alzheimer’s] are found to have it on autopsy”).
27 Id. at 233 (discussing diagnostic methods); Feinberg & Yu, supra note 2, at 46-49 (describing diagnostic medical evaluations).
28 Feinberg & Yu, supra note 2, at 45; see Thies & Bleiler, supra note 17, at 210 (noting that ideally family members and others close to the patient provide input).
29 Feinberg & Yu, supra note 2, at 32; see Thies & Bleiler, supra note 17, at 233. Cognitive function in healthy aging is affected by, among other things, a person’s education, family history, and other genetic factors. Thies & Bleiler, supra note 17, at 233. These factors affect how different individuals express dementia. Id.
30 Feinberg & Yu, supra note 2, at 32; see Thies & Bleiler, supra note 17, at 209 (noting that Alzheimer’s disease “can affect different people in different ways”).
31 James, supra note 1, at 25.
were announcing the introduction of three newly-named stages of Alzheimer’s disease.\textsuperscript{34} These three stages “would include even mild memory and behavioral symptoms” and would result in an increase in the number of patients receiving an Alzheimer’s diagnosis.\textsuperscript{35} The proposed three stages are: (1) preclinical Alzheimer’s disease; (2) mild cognitive impairment; and (3) dementia because of Alzheimer’s.\textsuperscript{36} The first stage, preclinical Alzheimer’s disease, is designed for research purposes only and will have no effect on the patient’s interactions with his or her medical provider.\textsuperscript{37} The second stage, mild cognitive impairment, occurs long before the person receives an Alzheimer’s diagnosis, but where he or she is “showing small changes in memory, behavior and thinking.”\textsuperscript{38} The third and final stage, dementia because of Alzheimer’s, is the point at which “memory, thinking and behavioral symptoms have become so damaged that the patient’s ability to function is hindered.”\textsuperscript{39}

Regardless of the number of stages one assigns to Alzheimer’s disease, the symptoms are basically the same. In discussing the disease and making its arguments, this Article will adopt the three-stage approach developed by some scientists and healthcare professionals, mild, moderate and severe. During the mild stage of the disease, as nerve cells begin to deteriorate, the patient may not exhibit any symptoms of Alzheimer’s disease.\textsuperscript{40} In fact, the patient may not even realize his or her brain is under

\textsuperscript{34} Madison Park, 3 Stages of Alzheimer’s Disease Introduced, CNN.COM (Apr. 19, 2011, 5:51 PM), http://www.cnn.com/2011/HEALTH/04/19/alzheimers.diagnosis.guidelines/index.html; see also Guy M. McKhann et al., The Diagnosis of Dementia Due to Alzheimer’s Disease: Recommendations from the National Institute on Aging and the Alzheimer’s Association Workgroups on Diagnostic Guidelines for Alzheimer’s Disease, 7 ALZHEIMER’S & DEMENTIA 263, 265 (2011) (discussing the rationale for each new stage and each stage’s possible symptoms).

\textsuperscript{35} Park, supra note 34; see also McKhann et al., supra note 34, at 264.

\textsuperscript{36} Park, supra note 34.

\textsuperscript{37} Id. (articulating this stage’s purpose of helping researchers ascertain whether Alzheimer’s causes a biological change which can be detected through various medical tests).

\textsuperscript{38} Id. Individuals in this stage do not experience a notable decline in their day-to-day abilities. Id. Persons diagnosed with Mild Cognitive Impairment may exhibit slight changes in their memory, behavior, and thinking. Id.

\textsuperscript{39} Park, supra note 34 (noting that symptoms expand beyond memory problems to include finding words, visual and spatial problems, impaired reasoning and judgment).

\textsuperscript{40} Park, supra note 34; see Reisa A. Sperling et al., Toward Defining the Preclinical Stages of Alzheimer’s Disease: Recommendations from the National Institute on Aging-Alzheimer’s Association Workgroups on Diagnostic Guidelines for Alzheimer’s Disease, 7 ALZHEIMER’S & DEMENTIA 280, 282 (2011), available at http://download.journals.elsevierhealth.com/pdfs/journals/1552-5260/PIIS1552526011000999.pdf (advocating an approach to understanding Alzheimer’s disease that distinguishes the underlying pathophysiological disease process from the outward clinical manifestations); Jeffrey L. Cummings, Alzheimer’s Disease, 351 NEW ENG. J. MED. 56, 57 (2004) (noting a ninety-seven percent failure rate amongst family members and physicians to recognize mild dementia
attacks. However, as the plaques and tangles build up in the brain and the destruction of the nerve cells worsens, noticeable changes in behavior occur.\textsuperscript{41} At this stage, the symptoms of the disease may include memory loss, difficulty reasoning, poor judgment, language difficulties, confusion about time and space, decreasing ability to interpret sensory stimuli, inability to concentrate, loss of initiative, extreme mood changes, and changes in personality.\textsuperscript{42} In addition to these symptoms, the patient may also begin exhibiting certain behaviors such as misplacing things or putting them in odd places (for example, putting a wallet in the freezer), repeating the same stories or questions (totally oblivious of the repetition), forgetting to eat, neglecting hygiene (for example, wearing the same clothes every day but insisting they are clean), and hoarding things of no value.\textsuperscript{43} 

In the moderate stage of the disease, the plaques and tangles affect more nerve cells and more parts of the brain.\textsuperscript{44} The patient develops new behaviors and exhibits more personality changes.\textsuperscript{45} The symptoms are so glaring, the patient’s thinking so hazy, and his or her sound judgment so diminished that family members recognize that something more than simple aging is affecting their loved one.\textsuperscript{46} Certain behaviors manifest themselves during this stage. For example, the patient may: have difficulty sleeping or, at the opposite extreme, sleep for extended periods; be unable to identify familiar objects and people (for example, the patient might think his wife is his sister, or his friend is his son); engage in inappropriate or unusual behavior such as accusing loved ones of doing wrong, making threats, or cursing in public; invent stories to fill gaps in his or her memory; or see, hear, smell, or taste things that are not there.\textsuperscript{47}

By the time the disease progresses to the severe stage, it has eroded the patient’s ability to think or reason.\textsuperscript{48} The patient then requires assistance for the most essential

\textsuperscript{41} Thies & Bleiler, supra note 17, at 7. 
\textsuperscript{42} FEINBERG & YU, supra note 2 at 33-37; see Thies & Bleiler, supra note 17, at 209. 
\textsuperscript{43} FEINBERG & YU, supra note 2, at 37. 
\textsuperscript{44} FEINBERG & YU, supra note 2, at 37; see Thies & Bleiler, supra note 17, at 210-11; Alzheimer’s Symptoms & Stages, AM. HEALTH ASSISTANCE FOUND., http://www.ahaf.org/alzheimers/about/symptomsandstages.html (last updated Sept. 21, 2011). 
\textsuperscript{45} FEINBERG & YU, supra note 2, at 37-38; see McKhann et al., supra note 34, at 265; AM. HEALTH ASSISTANCE FOUND., supra note 44. 
\textsuperscript{46} FEINBERG & YU, supra note 2, at 38; see McKhann, supra note 34, at 265; AM. HEALTH ASSISTANCE FOUND., supra note 44. 
\textsuperscript{47} FEINBERG & YU, supra note 2, at 38. 
\textsuperscript{48} FEINBERG & YU, supra note 2, at 38; see Jeffrey L. Cummings, Alzheimer’s Disease, 351 NEW ENG. J. MED. 56, 57 (2004) (explaining how Alzheimer’s disease deteriorates a patient’s ability to perform daily living activities); see also Alzheimer’s Ass’n, Late Stage Care: Providing Care and Comfort
tasks of daily living. In some cases the patient is bedridden. Common changes in the patient at this time include: complete memory loss, difficulty speaking and eating, repetitive crying out, frequent incontinence, difficulty or inability to walk or even stand unaided, seizures, frequent infections, and excessive sleep.

With all these changes in behavior and the inability to control his or her life and destiny, the Alzheimer’s patient needs protection from the law. Part II of this Article will discuss three areas of the law in which the Alzheimer’s patient needs this special protection. Alas, just when these vulnerable citizens need the law most, the law fails them.

III. Alzheimer’s Disease and the Law – No Help for the Helpless

A discussion of how the law has failed persons stricken with Alzheimer’s disease would consume volumes. This Article will limit itself to a discussion of three areas of the law that treat Alzheimer’s patients poorly: (1) Guardianship Law, (2) Tort Law, and (3) Due Process as relates to litigation involving Alzheimer’s patients.

A. Guardianship Law

Every state has enacted legislation authorizing guardianships. As regards the Alzheimer’s patient, the guardianship proceeding entails a court appointing someone to act on behalf of the patient who, because of his or her ailment, is unable to make “responsible” decisions. Inasmuch as the Alzheimer’s patient lacks capacity to even During the Late Stage of Alzheimer’s Disease 2-3 (2011), available at http://www.alz.org/national/documents/brochure_latestage.pdf (describing Alzheimer’s disease symptoms in the final stage).


FEINBERG & YU, supra note 2, at 39 (stating how a weak body from Alzheimer’s puts the individuals at a higher risk of obtaining illnesses).

Id. (delineating common changes in a final stage Alzheimer’s patient).

MARSHALL B. KAPP, THE LAW AND OLDER PERSONS: IS GERIATRIC JURISPRUDENCE THERAPEUTIC? 12 (2003); see, e.g., MASS. GEN. LAWS ch. 190B, § 5-106 (2008) (encompassing Massachusetts’ guardianship and conservatorship laws). “Guardianship is a court-supervised procedure for taking away authority from one person and placing it in the hands of another.” JAMES, supra note 1, at 116. Some states use the term “conservatorship,” but the procedure and result are the same. See KAPP, supra, at 12.

JAMES, supra note 1, at 118; see also KAPP, supra note 52, at 12-27 (discussing the presumption of
agree to the guardianship, the procedure is far from voluntary; rather, it is forced upon the incapacitated patient.\textsuperscript{54} By the time the proceeding is over and the court has appointed a guardian for the Alzheimer’s patient, that guardian has the authority to make decisions about the patient’s person (that is, his or her body and all that pertains to it, such as healthcare, place of residence, and daily routine), and property (such as his or her home, brokerage accounts, bank accounts, pension plans, certificates of deposit, and other assets).\textsuperscript{55}

Notwithstanding this result, the law begins by presuming that all adult individuals are legally competent.\textsuperscript{56} For someone to lose that status, a court of appropriate jurisdiction must decide that the person is mentally incapacitated.\textsuperscript{57} Although the various states define it differently, the term “mentally incapacitated” generally is used to refer to someone who lacks the capacity to make responsible decisions.\textsuperscript{58}

The test for responsible decision-making capacity does not ask whether the person’s decisions are in fact responsible, but instead whether the person has the capacity to make responsible decisions.\textsuperscript{59} A person has the right to make decisions that others may disagree with, or even deem foolish, without fearing that a court will declare him or her mentally incapacitated and place him under guardianship.\textsuperscript{60} For example,
members of the Jehovah’s Witnesses faith believe that the Bible prohibits the ingesting of blood and that Christians should therefore not accept blood transfusions or donate or store their own blood for transfusion. Based on this belief, an adult Jehovah’s Witness should have the right to refuse a blood transfusion and face certain death without fearing that a court would declare him mentally incapacitated and appoint a guardian for him.

While the devout Jehovah’s Witness does not need a guardian, the Alzheimer’s patient who gives away her property to friends and family because of or her disease does need one. To ensure that only truly-incapacitated people are subject to guardianship, some states have sought to define the term and to decree full guardianships for people who are totally incapacitated and limited guardianships for those who are partially incapacitated.

The Missouri statute defining the two types of people needing guardians is instructive:

(10) “Incapacitated person”, one who is unable by reason of any physical or mental condition to receive and evaluate information or to communicate decisions to such an extent that he lacks capacity to meet essential requirements for food, clothing, shelter, safety or other care such that serious physical injury, illness, or disease is likely to occur.

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(16) “Partially incapacitated person”, one who is unable by reason of any physical or mental condition to receive and evaluate information or to communicate decisions to the extent that such person lacks capacity

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62 See supra notes 60-61 and accompanying text.
63 See, e.g., OKLA. STAT. tit. 30, § 1-111(12), (22) (2011). Oklahoma defines an “incapacitated person” as someone who is eighteen years or older, who is impaired by a mental illness, retardation, physical illness or disability, or drug or alcohol dependency, and is unable to effectively receive and evaluate information to such an extent that said person cannot meet essential requirements for their physical health or safety or is unable to manage their financial affairs. Id. § 1-111(12). Comparatively, “partially incapacitated person” is an incapacitated person who is impaired only to the extent that without assistance that person is unable to meet essential physical health or safety requirements or is unable to manage their financial affairs. Id. § 1-111(22); 20 PA. CONS. STAT. ANN. § 5512.1 (2011) (distinguishing between guardian and limited guardianship if person is partially incapacitated); MO. REV. STAT. § 475.010(10), (16) (2010).
to meet, in part, essential requirements for food, clothing, shelter, safety, or other care without court-ordered assistance.\textsuperscript{64}

Pursuant to this statute, the court can appoint a limited guardian whenever the mental incapacity of a person is not complete.\textsuperscript{65}

On paper, all of this sounds good. In regard to the guardianship, the state is exercising its “inherent \textit{pares patriae} power to protect its citizens who cannot take care of themselves in a manner that society believes is minimally appropriate, even if that means protecting people from the folly of their own decisions and over their own objections.”\textsuperscript{66} That way, everyone is happy – the Alzheimer’s patient, his or her family members, the medical professionals, and the State. Yet, flaws exist in such a system. These flaws center on three main areas: (1) notice requirements, (2) choice of guardian, and (3) guardianship abuse.

1. \textit{Notice Requirements}

Guardianship presents several problems in providing meaningful notice to the Alzheimer’s patient who should be able to understand the nature of the proceedings from the notice. The ordinary person, unschooled in the law and its intricacies, can sometimes find it difficult to understand a summons or a petition. That task is virtually impossible for the Alzheimer’s patient who has cognitive impediments to understanding the import of the document.

Beginning in the late 1980s, states began reforming their guardianship laws, with a goal of “strengthening the substantive and procedural protections available to prospective and actual wards.”\textsuperscript{67} Prior to that time, a typical notice requirement statute read as follows:

Notice shall be given in writing to the alleged incompetent and to one or more members of his family, if other than the petitioner are known to be residing in the county, and to such persons as the court may

\textsuperscript{64} MO. REV. STAT. § 475.010(10), (16) (2010).
\textsuperscript{65} See \textit{id.} § 475.075. The petitioner has the burden of proof by clear and convincing evidence. \textit{Id.}
\textsuperscript{66} KAPP, \textit{supra} note 52, at 12.
\textsuperscript{67} KAPP, \textit{supra} note 52, at 15. Generally, a “ward” is someone whom “the law regards as incapable of managing his or her own affairs,” and for whom a court has appointed a guardian. 39 AM. JUR. 2D \textit{Guardian and Ward} § 1 (2008). Some jurisdictions limit use of the term to minors for whom a court has appointed a guardian. \textit{See, e.g.,} MASS. GEN. LAWS ch. 190B, § 5-101(25) (2008).
direct, notifying them that application has been made for an inquiry into either the mental or physical condition, or both, of the alleged incompetent and that a hearing on the application shall be held at the time and place specified on the notice.68

The notice mandated by these old notice statutes “was usually in small print and included little explanation of the rights at stake or how [the client should] respond.”69 Egregiously, some statutes did not even specifically require personal service.70

Following the onset of the “Guardianship Reform Era” in the late 1980s, states began changing their guardianship laws.71 These changes were recommended by the report, “Agenda for Reform,” issued by the participants of the Wingspread Conference held in Racine, Wisconsin, in 1988.72 The report called for the enactment by the various states of enhanced statutory due process requirements pertaining to guardianship proceedings including: (1) the use of simple but specific guardianship petition forms; (2) the potential ward’s right to timely notice; (3) the potential ward’s mandatory right to counsel and a hearing where the potential ward would be present; (4) a minimum standard of proof of clear and convincing evidence; and (5) the potential ward’s right to appeal any orders or judgments that were not in his or her favor.73 The other recommendations coming out of the conference “pertained to issues such as alternatives to guardianship, training for attorneys and judges, the use of public and private guardianship agencies, continuous monitoring of guardians’ performance . . . , and

69 Id.
70 John Parry, Incompetency, Guardianship, and Restoration, in THE MENTALLY DISABLED AND THE LAW 369, 380-81, (3d ed. 1985). In 1985, Alabama, Mississippi, and Louisiana did not statutorily require any notice to persons alleged to be incapacitated, although Due Process may have required some form of notice. Id.
71 KAPP, supra note 52, at 15.
72 See Am. Bar Ass’n. Comm. on the Mentally Disabled, Guardianship: An Agenda for Reform – Recommendations of the National Guardianship Symposium and Policy of the American Bar Association, 13 MENTAL & PHYSICAL DISABILITY L. REP. 271, 271-313 (1989); KAPP, supra note 52, at 15. The Wingspread Conference was a direct result of the publication of a set of revelations about abuses within the existing guardianship system revealed as part of a Pulitzer Price-winning Associated Press initiative on guardianship in the mid-1980s. KAPP, supra note 52, at 15. The conference was attended by 38 national experts invited by the conference’s conveners, the American Bar Association Commission on Legal Problems for the Elderly and Commission on Mental and Physical Disability. Id.
73 Id.; Am. Bar Ass’n. Comm. on the Mentally Disabled, supra note 72, at 282-86.
termination of unnecessary guardianships."\textsuperscript{74}

In response to the Wingspread recommendations, “virtually every state in the past two decades has modified its guardianship statutes, often quite extensively, in both substantive and procedural respects.”\textsuperscript{75} Substantively, many states have, for example, changed their definitions of incapacity to emphasize function rather than old age, and empowered their courts to consider appointing limited guardians with powers based on the potential ward’s specific deficits.\textsuperscript{76} As regards procedure, statutory modifications have included, among other things, the five due process and administrative provisions recommended by the Wingspread report.\textsuperscript{77}

For example, Virginia amended its statute to address the issue of adequate notice.\textsuperscript{78} The reformed statute provides that upon the filing of a guardianship petition, the court must “promptly set a date, time, and location for a hearing” and give the potential ward “reasonable notice of the hearing.”\textsuperscript{79} Further, at least seven days before the hearing, the petitioner must mail a copy of the notice, along with a copy of the petition, “to all adult individuals and to all entities whose names and post office addresses appear in the petition.”\textsuperscript{80} The notice to the potential ward must also “include a brief statement in at least 14-point type of the purpose of the proceedings” and must inform him or her of the right to be represented by counsel and of the right to a hearing.\textsuperscript{81}

The reformed Uniform Probate Code (“U.P.C.”) also makes provision for adequate notice. According to the U.P.C., notice of the hearing “must be given to the ward, the guardian, and any other person the court directs.”\textsuperscript{82} This notice “must be served personally on the respondent.”\textsuperscript{83} It “must include a statement that the respondent must be physically present unless excused by the court, inform the respondent of [his or her] rights at the hearing, and include a description of the nature, purpose, and consequences of an appointment” of a guardian.\textsuperscript{84}

\textsuperscript{74} KAPP, \textit{supra} note 52, at 15.
\textsuperscript{75} Id.
\textsuperscript{76} Id. at 15-16.
\textsuperscript{77} Id. at 15.
\textsuperscript{78} See VA. CODE ANN. § 37.2-1004 (2006).
\textsuperscript{79} Id.
\textsuperscript{80} Id.
\textsuperscript{81} Id.
\textsuperscript{82} UNIF. PROBATE CODE § 5-309(c), _ U.L.A. _ (2008).
\textsuperscript{83} Id. § 5-309(a).
\textsuperscript{84} Id.
Certainly, the changes to guardianship law would reasonably – if not adequately – protect a person who is partially incapacitated or whose incapacity is physical rather than cognitive. However, the provisions do nothing to protect the rights of the Alzheimer’s patient in the advanced stages of the disease. The reality is that it is only after the patient enters the advanced stages of the disease that family members consider guardianship as a viable alternative. At that point, a family member files a guardianship petition. Even if the patient receives a copy of the petition and notice of hearing, he or she will generally not be able to either read or understand them. Additionally, the patient will most likely not understand a thing that is said by the witnesses, argued by the attorneys, or determined by the judge, even though the statute compels him or her to be present at the hearing. By allowing these vulnerable people to “participate” in these guardianship proceedings where their very freedom is at stake – although they cannot advocate for themselves or assist their attorneys in representing them – the courts are failing them.

2. Choice of Guardian

Not only is the system flawed in terms of the notice requirement as applied to Alzheimer’s patients, but it is also flawed in terms of the process by which the courts choose guardians. Theoretically, anyone can petition a court of competent jurisdiction to have someone else placed under guardianship. In most cases, however, guardianship petitions are filed by spouses, children, relatives, friends or concerned

85 See id. § 5-102(4) (2008). Under the Uniform Probate Code, an “incapacitated person” is “an individual who, for reasons other than being a minor, is unable to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety, or self-care, even with appropriate technological assistance.” Id.


87 See James, supra note 1, at 134-35 (discussing factors influencing family members’ decision to seek guardian appointment).

88 See supra notes 46-51 and accompanying text.

89 See supra notes 46-51 and accompanying text.

90 See, e.g., VA. CODE ANN. § 37.2-1002 (2006) (“Any person may file a petition for the appointment of a guardian, a conservator, or both”) (emphasis added).
neighbors of the potential ward. The petition must nominate a potential guardian. Unless the court finds some reason not to do so, it will appoint the nominee as guardian. Of course, the petitioner normally nominates himself or herself as guardian. Even if the petitioner has a familial relationship with the potential ward, he or she may not be the best choice of guardian. Sometimes, the guardians turn out to be dishonest people who simply want to either place the ward in a nursing home or misappropriate and misuse his or her money and other property. In the final analysis, then, the court has no guarantee that the guardian will act in the ward’s best interests.

The issue of choice of guardian also comes into focus when the alleged incapacitated person has no living relatives. To address this, several states have devised some form of “public guardianship” system under which a government agency, acting either directly or through contract with a private not-for-profit organization, would be appointed to serve as such a person’s guardian. Outside governmental circles, some private corporations and non-profit organizations also offer their services to the courts,

91 See KAPP, supra note 52, at 13 (noting that a majority of guardians are relatives of the ward).
93 See id. § 5-310(a)(2). If the court does not appoint the nominee, it may choose from a number of alternatives in the following order of priority: (1) the allegedly incapacitated person’s agent under a durable power of attorney for health care; (2) the person’s spouse or someone nominated in a will executed by the person’s deceased spouse; one of the person’s adult children; one of the person’s parents or someone nominated by will or other signed writing of a deceased parent; or an adult with whom the person lived for more than six months before the filing of the petition. See id. § 5-310(a)(3)-(7).
95 See id. There is often an inability of direct relatives to separate their own interests from that of the ward and subsequently they may act primarily to secure the ward’s assets that they have a future interest in. Id.
96 See id. at 1828-30 (stating that conflicts of interests for guardians of wards can present issues in the way in which they receive care and appropriate their property consistent with their wishes); see also Courtney Hutchinson, Actor Mickey Rooney Granted Court Protection From Stepkids, ABC NEWS (Feb. 17, 2011), http://abcnews.go.com/Health/Wellness/mickey-rooney-90-victim-alleged-elder-abuse/story?id=12934033 (telling story of actor Mickey Rooney’s abuse at the hands of his stepchildren); see generally Elder Abuse and Neglect: In Search of Solutions, AM. PSYCHOLOGICAL ASSOC., http://www.apa.org/pi/aging/resources/guides/elder-abuse.aspx (last visited Sept. 7, 2011) (stating that often neglect and abuse in various forms occur under the care of family members and at home)
97 See supra notes 95-96 and accompanying text.
98 KAPP, infra note 52, at 13.
either on a *pro bono* basis or for a fee.\(^99\)

While these solutions provide guardians for persons allegedly needing one, the question remains: will these guardians, unrelated to their wards, act in the best interests of the Alzheimer’s patients, or will they simply view the guardianship relationship as a job or task? To the extent guardians adopt the latter attitude, they are not acting in the best interests of their wards, and Alzheimer’s patients are once again being ill-served by a legal system that should be protecting them. These guardians may be prone to misappropriate their wards’ funds, steal their money, and place them in substandard care facilities.\(^100\) Sometimes the guardians act out of their own biases, without regard to what would be best for the ward. For example, in *In Re Medworth*,\(^101\) the court found that the guardian (the ward’s nephew) did not act in her best interests or in consideration of her overall welfare when he decided to place her in an assisted living facility.\(^102\) According to the court, although the 87-year-old woman required twenty-four-hour medical services, her nephew’s decision to move her to the assisted living facility (as opposed to more preferable in-home nursing care) was based upon his own racial biases against the available in-home nurses.\(^103\)

\(^99\) *Id.*

\(^100\) See Luke Erburu Cocalis, *The Consequences of Choice: Does California Adequately Protect Choice of Residence for Individuals with Alzheimer’s?*, 19 S. CAL. REV. L. & SOC. JUST. 407, 412-15 (2010) (discussing the possibility that conservators may misuse a patient’s finances or place the ward in an institution or substandard residence); *Woman Stole Cash from Dying Mother*, THE DAILY TELEGRAPH (UK), Nov. 15, 2010, available at 2010 WLNR 22756726 (describing a woman who stole £60,000 from her mother who suffered from Alzheimer’s and spent the cash on traveling expenses and international rugby matches); Trisha L. Howard, *Woman is Charged with Stealing $250,000 from Elderly Neighbor: Nice Ended Caretaker Arrangement After Visits Revealed Inadequate Care*, ST. LOUIS POST DISPATCH (MO), July 25, 2002, at B1 (stating how the caretaker of an Alzheimer’s patient stole over $250,000 while acting as power of attorney); *Salem Nursing Home Owner Convicted of Stealing from Clients*, U.S. ST. NEWS, Jan. 22, 2009, available at 2009 WLNR 1413193 (explaining that 48 Alzheimer’s patients were moved to a different care taking facility after finding substandard care and allegations of abuse).

\(^101\) 562 N.W.2d 522 (Minn. Ct. App. 1997).

\(^102\) *Id.* at 525. Although Medworth was “deeply attached” to her home and she expressed a preference to remain there, the record demonstrates that (1) the conservator failed to consider seriously any housing alternatives; (2) there was no evidence as to the cost of making Medworth’s home safer; (3) the conservator only made one phone call to explore in-home care arrangements; (4) two doctors testified Medworth was capable of living at home; and (5) the social worker on the case testified that Medworth could receive care either at home or in a retirement center. *Id.* at 524-25. Failure to consider Medworth’s expressed wishes to remain in her home warrant an inference that relocation would not be in her best interest. *Id.* (addressing an argument based upon *In re Guardianship of Kowalski*, 382 N.W.2d 861, 867 (Minn. Ct. App. 1986)).

\(^103\) *Id.* at 526. Medworth’s conservator initially attempted to locate Caucasian caregivers based on
3. Guardian’s Abuse of Authority

Current guardianship law also fails persons stricken with Alzheimer’s by allowing too many guardians to abuse their authority and in the process, abuse their wards. Stories abound about such guardians. The most recent condemnation of guardians and the guardianship process came in a Government Accountability Office (“GAO”) report released in September 2010. The report noted that “[w]hile many guardians serve the best interests of the incapacitated people they are appointed to protect, others have taken advantage of these vulnerable individuals . . .” In summarizing its findings, the GAO stated that although it could not determine whether allegations of abuse by guardians were widespread, it was able to identify “hundreds of allegations of physical abuse, neglect and financial exploitation by guardians in forty-five states and the District of Columbia between 1990 and 2010.” In twenty selected closed cases, the GAO found that guardians stole or otherwise improperly obtained $5.4 million in assets from 158 incapacitated victims. The GAO also found that in some instances, guardians physically neglected and abused their wards.

The report also placed some blame upon the courts. It noted that in six out of Medworth’s alleged complaint about the African-American nursing home staff. Id. at 523. Once the Hennepin County Care Services informed the conservator that he would be unable to select a care provider by race, he quit his search for in-home providers and chose a congregate-living building which employed an all-Caucasian staff. Id. See, e.g., James Barron, Brooke Astor’s Son is Sentenced to Prison, N.Y. TIMES, Dec. 21, 2009, at A31, available at http://www.nytimes.com/2009/12/22/nyregion/22astor.html (detailing the sentencing of a son who siphoned millions from his wealthy mother while acting as her guardian in her final days); Jim Collar, Prosecutors Seek Delay of Jeffrey Schend Theft Trial: Former Guardian for State Set to be in Court Sept. 12, APPLETON POST-CRESBENT, Sept. 6, 2011, available at http://www.postcrescent.com/article/20110906/APC0101/109060404/Prosecutors-seek-delay-Schend-trial?odyssey=tab|topnews|img|FRONTPAGE (explaining the charges against a former state guardian accused of abusing his wards through financial exploitation); Randy Tucker, Legal Guardians Steal Millions from Elderly, Report Says: With Elderly Abuse Rising, Government and Courts Consider Stricter Guidelines, DAYTON DAILY NEWS, Oct. 28, 2010, available at http://www.daytondailynews.com/news/dayton-news/legal-guardians-steal-millions-from-elderly-report-says-987975.html (outlining report which found pervasive fraud and theft of millions from elderly persons for which they were legal guardians).


106 Id. at What GAO Found.

107 Id.

108 Id.
twenty cases, “the courts failed to adequately screen potential guardians, appointing individuals with criminal backgrounds or significant financial problems to manage high-dollar estates.” The GAO also found that “in eleven of twenty cases, courts and federal agencies did not communicate effectively or at all with each other about abusive guardians.” According to the GAO, this failure by the courts and federal agencies allowed guardians to continue to be abusive to their incapacitated victims.

The GAO found ten cases in which guardians abused, neglected or financially exploited their wards. Three of these cases stand out as gross examples of the failures of the system. First, in Missouri, a court appointed a former taxi cab driver as guardian of an eighty-seven-year-old man with Alzheimer’s disease. The cab driver was not related to the patient. Rather, he became acquainted with the senior while regularly transporting him from his home to various destinations. The guardian embezzled more than $640,000 from the Alzheimer’s patient, which he then used to purchase a Hummer and to make payments to exotic dancers, among other things. Shortly before his death, county workers found the Alzheimer’s-stricken man living in the guardian’s filthy basement wearing an old knit shirt and a diaper.

Second, a private agency in Alaska was serving as guardian of at least seventy-eight individuals. Over a four-year period, the agency’s management allegedly embezzled or stole at least $454,416 from the victims. The executive director used wards’ funds to pay his credit card bills, medical expenses, mortgage payments, and camp expenses for his children. Although the victims received partial repayment, the authorities brought no criminal charges against the agency or its executive director.

Third, a District of Columbia guardian delegated her caretaking responsibilities

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109 Id.
110 Id.
111 GAO REPORT, supra note 105, at What GAO Found.
112 Id. at 9.
113 Id. at 10.
114 Id. at 17.
115 Id.
116 Id. at 10, 17-18.
117 GAO REPORT, supra note 105, at 17. The guardian kept the ward confined in the basement. Id.
118 Id. at 11.
119 Id. at 11, 19-20.
120 Id. at 11, 20.
121 Id. at 11, 20. The wards received payments from a wards’ claim fund established through the agency’s bankruptcy proceedings. GAO REPORT, supra note 105, at 11, 20.
to her secretary, who then embezzled almost $50,000 from two elderly wards.\textsuperscript{122} The oldest victim was an 83-year-old mentally incapacitated woman.\textsuperscript{123} Although the elderly woman received $1,170 monthly income from both her federal pension and Social Security benefits, her guardian, who was also an attorney, never applied to become a representative payee, thereby shielding herself from federal oversight.\textsuperscript{124}

The GAO’s investigation also illustrated how easy it was for unscrupulous individuals to infiltrate the guardianship system. For example, using two fictitious identities (one with bad credit and one with the Social Security number of a dead person), GAO personnel obtained guardianship certification or met certification requirements in the four states where they applied: Illinois, Nevada, New York, and North Carolina.\textsuperscript{125} The GAO noted that although certification is intended to provide assurance that guardians are qualified to fulfill their role, none of the courts or certification organizations in those states checked the credit history or validated the Social Security number of the fictitious applicants.\textsuperscript{126}

As the GAO report indicates, guardians often abuse their authority and abuse their wards.\textsuperscript{127} Surely, this is not beneficial to the wards. If the law is to properly fulfill its role of protecting the most vulnerable people of our society, it must find a way to adequately protect these victims.

\textbf{B. Tort Law}

Over the past few years, legislators, the legal profession, and the general public have engaged in much discussion about tort reform.\textsuperscript{128} Little, if any, discussion has

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\textsuperscript{122} Id. at 22-23. The delegation was a breach of her fiduciary duties. Id. at 22. According to a probate court complaint, the guardian failed to pay one ward’s property taxes, causing the ward to lose her home. Id.

\textsuperscript{123} Id.

\textsuperscript{124} Id. However, with another ward, the attorney was listed as the ward’s representative payee for four years beyond discovery of the scandal. Id. at 23. The attorney’s license was later suspended for violating professional conduct standards by failing to cooperate in a disciplinary investigation. Id. The attorney was ordered by a probate court to pay restitution to the wards, but she was never criminally charged. \textit{GAO REPORT, supra} note 105, at 23.

\textsuperscript{125} Id. at 2-3, 24. These states did not require fingerprint background checks and were selected for this reason. Id. at 2-3.

\textsuperscript{126} Id. at 24. Case studies indicated that, although some states require a bond, the courts do not always confirm that an individual is bonded, missing a potential opportunity to discover an adverse credit history. See id. at 24-26 (table summarizing findings state-by-state).

\textsuperscript{127} See \textit{supra} notes 112-124 and accompanying text.

\textsuperscript{128} See generally Anita Bernstein, \textit{The 2x2 Matrix of Tort Reform’s Distributions}, 60 \textit{DEPAUL L. REV.}
centered on reforming tort law so that the law would protect individuals afflicted by Alzheimer’s disease.

Generally, torts are divided into two broad categories: intentional torts and unintentional torts (which, in turn, are divided into two subcategories: negligence and strict liability torts).

Intentional torts are intentional, voluntary misdeeds that one person commits against another. Unintentional torts are the result of actions or one’s failure to act as a reasonably prudent person would under similar circumstances, as a result of which another person suffers harm. Of the unintentional torts, negligence has the most significance for Alzheimer’s patients and their caregivers.

To prevail in a negligence suit, the plaintiff must demonstrate that the alleged tortfeasor (1) owed him a duty of care, (2) breached this duty of care, (3) the breach caused actual harm, and (4) the breach was the proximate or “not too remote” cause of the harm. These requirements have significant implications for Alzheimer’s patients, their family members, and their formal and informal caregivers. Under current law, Alzheimer’s patients can be found liable to the general public and their caregivers for either intentional or unintentional torts. Meanwhile, these caregivers, formal and informal, can be held liable to the patients for their negligent acts, and to the general public for both their own negligent acts and those committed by their patients.

1. The Alzheimer’s Patient’s Liability to the General Public

The Alzheimer’s patient’s tort liability to the general public can result from both

273 (2011) (analyzing the tort reform debate from the perspective of pro-plaintiff and pro-defendant); see also Steven M. Pavsner, Conflating Healthcare Reform with Tort Reform, 6 MOD. AM. 58 (2010) (focusing on the relationship between health costs, health claims and tort reform); Mark A. Hofmann, Tough Economy Raises Outlook for Tort Reform; Supporters Cite Legislative Success in Texas, Other States, BUS. INS., (July 3, 2011, 6:00 AM), http://www.businessinsurance.com/article/20110703/ISSUE01/307039974 (discussing legislative tort reform measures, with specific focus on reform in Texas).

129 See Staub v. Proctor Hosp., 131 S. Ct. 1186, 1191 (2011) (recognizing the intent distinction of intentional torts from negligent and reckless torts); see also JAMES, supra note 1, at 141 (discussing the two broad categories of torts).


131 See 43 CAL. JUR. 3D Negligence § 1 (noting that negligence is an unintentional tort).


133 See infra notes 134-210 and accompanying text.
intentional and unintentional torts. Because Alzheimer’s disease affects the patient’s cognitive functions, much of the existing jurisprudence on the tort liability of Alzheimer’s patients is built on insanity defense models. Under the early common law, a mentally disabled person was liable for his or her torts. The law has not changed. Hence, today, in determining tort liability for intentional torts, courts hold the mentally disabled to the same objective standards as those who have no mental disability. Thus, in cases where a mentally disabled person commits an intentional tort, such as striking someone and thereby causing him bodily harm, the court will hold the patient liable to the injured party regardless of any mental deficiency. No court has thus far made an explicit exception excusing Alzheimer’s patients for their intentional torts.

Regarding unintentional torts, an Alzheimer’s patient’s liability to the general public arises out of the duty not to harm one’s neighbors enunciated in Donoghue v. Stevenson. Accordingly, both the Alzheimer’s patient and his or her neighbors have a

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135 See Polmatier v. Russ, 537 A.2d 468, 469-70 (Conn. 1988) (explaining that the majority rule is that mental disability does not waive liability unless the actor is a child); see also Williams v. Kearbey, 775 P.2d 670, 674 (Kan. Ct. App. 1989) (holding a minor civilly liable for battery where the minor was insane when he shot two classmates). The insanity defense is insufficient in such a circumstance because “public policy favors placing the loss on the person who caused [the harm], whether sane or not.” Williams, 775 P.2d at 673.

136 See Berberian v. Lynn, 845 A.2d 122, 125-26 (N.J. 2004) (discussing how “a mentally deficient adult is liable for his torts”). Generally, the reasonable person standard applies to a mentally deficient person. Id. Unless the actor is a child, his insanity, or other mental deficiency does not relieve the actor from liability for conduct which does not conform to the standard of a reasonable man under like circumstances. RESTATEMENT (SECOND) OF TORTS § 283B (1965).

137 See Williams, 775 P.2d at 674 (listing decisions from several states holding insane tortfeasors civilly liable).

138 Donoghue v. Stevenson, [1932] A.C. 562 (H.L.) 564 available at http://www.bailii.org/uk/cases/UKHL/1932/100.html (appeal taken from Scot.) (U.K.). In Donoghue, Mrs. Donoghue was enjoying a drink of ginger beer at a bar in Paisley, Scotland, when, after having consumed some of the liquid, she discovered that a decomposed snail was inside the opaque bottle containing the ginger beer. Id. at 562-63. Mrs. Donoghue subsequently became ill – whether from her having consumed ginger beer contaminated with decomposed snail or from the realization that she had consumed decomposed snail, no one can tell – and sued the manufacturer of the ginger beer, Mr. Stevenson, for having caused her illness. Id. at 563. The case was decided by the British House of Lords. Id. at 562. The Lords agreed that Mrs. Donoghue had a valid claim. Id. at 599. Writing for the court, Lord Atkins argued that the law should recognize the principle that we all owe a duty of reasonable care to our neighbors. Id. at 580. Accordingly, he devised a new legal doctrine: we should not harm our neighbors. Donoghue v. Stevenson, [1932] A.C. 562 (H.L.)
general duty not to harm each other. Hence, if Kelleb is an elderly Alzheimer’s patient, Lindsay, his neighbor, and the owner of Rover, a ferocious pit bull, may not allow Rover to attack and injure the aged Alzheimer’s patient.\textsuperscript{139} Similarly, Kelleb has a duty to not drive his car into Lindsay’s wall or throw his baseball through the front window of her house.\textsuperscript{140} Now, should Kelleb negligently drive his car into Lindsay’s wall, his Alzheimer’s disease would not shield him from liability because traditional tort law does not allow mental or physical impairment as defenses to liability for a negligent accident.\textsuperscript{141} As far as the traditional law is concerned, if a driver’s impairment prevents him or her from controlling the car, the impaired driver should not be driving.\textsuperscript{142}

North Carolina, however, has carved out an exception to the general rule as it applies to Alzheimer’s patients. This exception exempts from tort liability those patients who suffer sudden incapacitation while driving. In \textit{Word v. Jones ex rel. Moore},\textsuperscript{143} an Alzheimer’s patient was driving a car that was involved in an accident.\textsuperscript{144} The driver of the other car sued the patient alleging that the patient was negligent by driving the car.\textsuperscript{145} The patient pled the affirmative defense of sudden incapacitation.\textsuperscript{146} Under North Carolina law, the sudden incapacitation defense requires that (1) the defendant was stricken by a sudden incapacitation; (2) this incapacitation was unforeseeable to the defendant; (3) as a result of the incapacitation, the defendant was unable to control the vehicle; and (4) the sudden incapacitation was the cause of the accident.\textsuperscript{147}

At trial, the defendant’s medical experts testified that the mental condition causing the incapacitation was either “(i) a sensory overload caused by Alzheimer’s

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\textsuperscript{140} See Widlowski, 562 N.E.2d at 968.
\textsuperscript{141} See Filip v. Gagne, 177 A.2d 509, 511 (N.H. 1962). As this case illustrates, the presumption of the ward’s liability is so strong that the court found the ward liable for injuries caused by his property when it was negligently maintained by his guardian. \textit{See id.} at 512.
\textsuperscript{142} Richards, \textit{supra} note 134, at 635.
\textsuperscript{143} 516 S.E.2d 144 (N.C. 1999).
\textsuperscript{144} \textit{Id.} at 145-46.
\textsuperscript{145} \textit{Id.}
\textsuperscript{146} \textit{Id.} at 147.
\textsuperscript{147} \textit{Id.}
\end{footnotesize}
disease; (ii) a transient ischemic attack . . . ; or (iii) a heart arrhythmia.” After the plaintiff lost and appealed to the North Carolina Supreme Court, the court upheld the trial court’s decision, explaining that the medical conditions presented to the trial court by the Alzheimer patient’s medical experts went directly to the elements of sudden incapacitation. Thus, at least in North Carolina, if the presence of Alzheimer’s disease causes a sudden, unforeseen incapacitation such as sensory overload, an Alzheimer’s patient causing a car accident has an established affirmative defense to a tort action brought against him or her upon the ground of negligence.

California and Wisconsin have also adopted the sudden incapacitation doctrine, but have not yet applied it to Alzheimer’s patients. In one Wisconsin case, Erma Veith, the insured, ran into the back of the plaintiff’s truck. At the time of the accident, she was suffering from an “insane delusion.” The insurer argued that Mrs. Veith should not be liable because her psychiatric condition came upon her without warning, and therefore fell into the sudden incapacitation exception. The plaintiff argued that precedent did not recognize mental illness as a defense to a negligence tort claim. The court distinguished this case from the precedent cases, which involved defendants with permanent insanity. The court then held that while permanent insanity was not a defense to tort actions, the sudden onset of incapacitating insanity could be.

In California, the courts have long recognized the sudden incapacitation
doctrine in relation to physical illness.\textsuperscript{158} In \textit{Bashi v. Wodarz},\textsuperscript{159} however, the California Court of Appeal refused to extend the application of the doctrine to mental impairment. In \textit{Bashi}, defendant Wodarz was involved in two automobile accidents in a period of minutes.\textsuperscript{160} She moved for summary judgment regarding the second accident, arguing that she had suffered a sudden mental incapacitation and thus was not responsible as a matter of law.\textsuperscript{161} The trial court granted her motion, and the plaintiff appealed.\textsuperscript{162} The court used the case as a test to determine whether California should extend its long-recognized sudden physical illness defense to a situation involving sudden mental impairment.\textsuperscript{163} After considering public policy concerns, the court rejected sudden mental impairment as a defense to a negligent tort and reversed summary judgment for the defendant.\textsuperscript{164} According to the rule established by this court, if an Alzheimer’s patient were involved in an accident because of his sudden incapacitation, a determination of his liability would rest on whether the sudden incapacitation was due to his physical condition or his mental incapacity.\textsuperscript{165}

The California rule leaves much to be desired. While traditional tort law does not excuse someone with a mental disability for torts he or she commits against a member of the general public, the sudden incapacitation doctrine provides an avenue to protect Alzheimer’s patients. Only North Carolina, however, has extended the application of the doctrine to Alzheimer’s patients. While California excuses people who suffer sudden incapacitation on account of their physical disabilities, it does not excuse a sudden incapacitation due to mental impairment. It is difficult, if not impossible, for California to reconcile the different treatment that it metes out to people who suffer from a similar crisis. The sudden incapacitation doctrine, as applied to persons suffering from Alzheimer’s disease, provides California with a way to correct


\textsuperscript{159} 53 Cal. Rptr. 2d 635 (Cal. Ct. App. 1996).

\textsuperscript{160} \textit{Id.} at 637. The defendant could only remember “ramming into the back of someone’s vehicle and then continuing east” and nothing more. \textit{Id.} During trial she recollected a family history of mental illness and stated that she may have “just freaked out” during the accident. \textit{Id.}

\textsuperscript{161} \textit{Id.} at 637.

\textsuperscript{162} \textit{Id.}

\textsuperscript{163} \textit{Bashi}, 53 Cal. Rptr. 2d at 638–639.

\textsuperscript{164} \textit{Id.} at 639–641.

\textsuperscript{165} See \textit{id.} at 641.
the inequity in its law. Indeed, not only California, but Wisconsin and all other states of the Union should adopt the sudden incapacitation doctrine as an available defense to Alzheimer’s patients involved in accidents while driving. While this would not erase the tort liability of all Alzheimer’s patients, it would protect those patients who are still able to function in society but whose disease causes them to unintentionally harm members of the general public.

2. The Alzheimer’s Patient’s Liability to Caregivers

Alzheimer’s patients may also be liable for harms they cause their caregivers. The liability issues are different depending on the identity of the caregiver — formal or informal. Formal caregivers are typically paid employees of health care facilities trained to provide care to their patients. Informal caregivers are typically family members volunteering their time to help a loved one. Usually, they have no training in caregiving.

(a) Liability to Formal Caregivers

The rule that Alzheimer’s patients are liable for all their torts is quite harsh. Apparently aware of this harshness, some jurisdictions have carved out an exception to the rule based on the nature of the care relationship between institutionalized patients and their caregivers. The exception holds that mentally incapacitated persons in nursing homes or convalescent centers owe no duty to their caregivers for injuries that their caregivers sustain while providing care.

The reason for this exception apparently lies in public policy justifications and the nature of the relationship between caregivers and their institutionalized patients. Some courts have held that the public policy reasons for holding mentally disabled persons liable for their torts are inapplicable to institutionalized individuals, and that it would be a grave injustice to hold them thus liable. As regards the relationship

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166 Richards, supra note 134, at 643-44, 648.
167 Id. at 647.
168 Id.
170 Creasy, 730 N.E.2d at 667.
171 See, e.g., Herle, 53 Cal. Rptr. 2d at 719; Creasy, 730 N.E.2d at 667; Gould, 543 N.W.2d at 286-87.
between the institutionalized patient and his or her caregiver, some courts have held that because a caregiver in an institutionalized setting is not a member of the public, he or she is able to foresee harm from Alzheimer’s patients who are usually combative by the time they are institutionalized.\textsuperscript{172}

In \textit{Creasy v. Rusk},\textsuperscript{173} the Indiana Supreme Court went further and enunciated several reasons for excusing the torts committed by Alzheimer’s patients against their caregivers. In \textit{Creasy}, an Alzheimer’s patient kicked a certified nursing assistant (“CNA”) while she was trying to put him to bed.\textsuperscript{174} The CNA brought suit to recover damages for the injuries she suffered when the patient kicked her.\textsuperscript{175} In holding that the patient did not owe a duty of care to the CNA, the court began by stating that the CNA was “not a member of the public at large, unable to anticipate or safeguard against the harm she encountered.”\textsuperscript{176} According to the court, the CNA knew of the patient’s violent history and “could have changed her course of action or requested additional assistance when she recognized [the patient’s] state of mind” on the evening he kicked her.\textsuperscript{177} As for the patient, the court reasoned that holding him liable for his action would place “too great a burden on him because his disorientation and potential for violence [was] the very reason he was institutionalized and needed the aid of employed caretakers.”\textsuperscript{178}

Thus, although the traditional common law rule provides no excuse for mentally disabled persons who injure others, the courts have recently taken a different view and are more willing to excuse such conduct when an institutionalized patient injures a formal caregiver.\textsuperscript{179} Yet, even in excusing the conduct, the courts consider each patient’s medical and behavioral history and the training received by the nursing home

\begin{footnotesize}
\textsuperscript{172} See \textit{Herrle}, 53 Cal. Rptr. 2d at 716 (holding that Alzheimer’s patient in convalescent hospital owed no duty of care to certified nurse’s aide because aide had been hired to protect patient from harming self and others); \textit{Creasy}, 730 N.E.2d at 667 (holding that Alzheimer’s patient did not owe duty of care to certified nursing assistant and noting that nursing assistant knew of patient’s “violent history” and inability to comprehend circumstances); \textit{Berberian v. Lynn}, 845 A.2d 122, 130 (N.J. 2004) (holding that Alzheimer’s patient, who lacked capacity to control his conduct, owed no duty of care to head nurse at long-term care facility).

\textsuperscript{173} 730 N.E.2d 659 (Ind. 2000).

\textsuperscript{174} Id. at 660-61.

\textsuperscript{175} Id.

\textsuperscript{176} Id. at 667.

\textsuperscript{177} Id.

\textsuperscript{178} Id. at 669 (quoting Gould v. Am. Family Mut. Ins. Co., 543 N.W.2d 282, 287 (Wis. 1996)).

\textsuperscript{179} \textit{Compare Kearby}, 775 P.2d 670, 673-74 (illustrating the traditional common law rule that insane persons are liable for their torts), \textit{with Colman v. Notre Dame Convalescent Home, Inc.}, 968 F. Supp. 809, 814 (D. Conn. 1997) (holding that an institutionalized patient owes no duty to his caregiver, even though adults with mental disabilities are liable for their negligent conduct).
\end{footnotesize}
employee involved. The courts are therefore better able to determine whether the employee was sufficiently aware of the hazard involved in caring for the patient who committed the injury. The question remains, however, as to whether non-institutionalized Alzheimer’s patients would have their tortious conduct excused by the courts.

(b) Liability to Informal Caregivers

Most non-institutionalized Alzheimer’s patients are cared for by family members – spouses, children or siblings of the patient. These informal caregivers can be subject to the same abuse their formal, institution-employed counterparts receive, but they rarely have the training or resources to respond as their professional counterparts would. Accordingly, “their only resort in severe cases is to call the police or emergency medical personnel.”

But this act of last resort would only create more problems. After all, when informal caregivers call the police or emergency medical personnel, the police may well arrest the patient. The police, however, do not have proper facilities to hold or care for Alzheimer’s patients. Considering this fact, the informal caregivers may very well choose to bear their burdens without seeking legal recourse. Meanwhile, these caregivers can, and are, sometimes held liable for the torts their patients commit against members of the general public.

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180 See, e.g., Creasy, 730 N.E.2d. at 669-70 (considering an Alzheimer patient’s mental capacity and the nature of his relationship to the nurse plaintiff to excuse the patient of his duty of care).
181 Richards, supra note 134, at 647.
182 Id. During a hearing before the Senate Special Committee on Aging, one person’s testimony cited a study that showed of 264 families that care for an individual with dementia, “90% had home safety issues, 64% had medical care issues, 48% had legal concerns, and 37% were not engaged in any meaningful activities.” Until There’s A Cure: How to Help Alzheimer’s Patients and Families NOW: Hearing Before the S. Special Comm. on Aging Forum, 11th Cong. 4-5 (2010) (testimony of Laura N. Gitlin, Director of Jefferson Center of Applied Research on Aging and Health), available at http://aging.senate.gov/events/fr229lg.pdf. Furthermore, the study found that 88% of the caregivers needed a referral for a resource, and 84% needed education about the disease. Id. at 4-5.
183 Richards, supra note 134, at 647.
184 Id. In some instances, the police may be required to arrest the patient because of certain abuse laws. Id.
185 Id.
3. Caregivers’ Liability to the General Public

Caregivers of Alzheimer’s patients can be held liable for negligent harm that their patients cause others.\(^{186}\) To a great extent, however, the law differentiates between formal caregivers and informal caregivers.\(^{187}\)

(a) Liability of Formal Caregivers

The law places the greatest legal burdens on the formal, or professional, caregivers.\(^{188}\) Here, the law is clear: as an initial matter, these caregivers are liable for injuries that their patients cause to third parties to the extent the caregivers owe the injured parties a duty.\(^{189}\) The most common example of this duty arises in an institutional setting: the caregiver has a duty to prevent a patient at the institution from injuring another patient.\(^{190}\) A determination of the caregiver’s liability in such cases depends on whether the caregiver knew of the patient’s propensity to harm others.\(^{191}\) For example, in \textit{Delk v. Columbia/HCA Healthcare Corp.},\(^{192}\) the court held that because the staff and management of Columbia Peninsula Center for Behavioral Health knew of her assailant’s history and past disturbing behavior, they had failed to protect Mrs. Delk from the sexual assault perpetrated on her by an adult male patient.\(^{193}\) Likewise, in \textit{Bradley Center, Inc. v. Wessner},\(^{194}\) the court found that a private mental hospital was civilly liable for the murder of a female patient by her husband.\(^{195}\) The evidence indicated that the hospital staff knew that if given the opportunity, the man would have caused his wife bodily harm.\(^{196}\) Yet, the staff issued the husband an unrestricted weekend pass

\(^{186}\) Id. at 658. “In general, the courts hold [Alzheimer’s patients] liable for their torts.” \textit{Id}. Courts do not hold caregivers liable as readily. \textit{See} Richards, supra note 134, at 658. However, when a caregiver knows of the dangerous propensities of the person in his or her care, or assumes a duty to prevent the dangerous activity, the caregiver will likely be liable. \textit{See id}.\(^{187}\) \textit{See id}. at 648-58 (explaining differences in professional and informal caregiver liability).\(^{188}\) \textit{See id}. at 638 (describing liability afforded to professional caregivers of patients with Alzheimer’s).\(^{189}\) \textit{Id}. at 648; \textit{see generally} Sylvester v. Nw. Hosp. of Minneapolis, 53 N.W.2d 17 (Minn. 1952) (patient injured by another patient who was visibly drunk); Freeman v. St. Clare’s Hosp. & Health Ctr., 548 N.Y.S.2d 686 (N.Y. App. Div. 1989) (patient raped while in restraints).\(^{190}\) Richards, supra note 134, at 646 n. 91.\(^{191}\) \textit{Id}.\(^{192}\) 523 S.E.2d 826 (Va. 2000).\(^{193}\) \textit{Id}. at 834.\(^{194}\) 296 S.E. 2d 693 (Ga. 1982).\(^{195}\) \textit{Id}. at 697.\(^{196}\) \textit{Id}. at 694.
privilege. While exercising his pass, the husband “obtained his gun, confronted his wife and her paramour and shot and killed both of them.”

Although the patients in Delk and Wessner were not suffering from Alzheimer’s disease, the principle enunciated by the courts in those cases apply equally well to caregivers of Alzheimer’s patients: if these formal caregivers are aware of the patients’ propensity to injure others, they are under a legal obligation to protect members of the general public from such harm, and are liable for damages to the people the patients do injure. However, the law applies different standards for holding informal caregivers liable.

(b) Liability of Informal Caregivers

Generally, if a caregiver knows of his patient’s propensity to engage in harmful conduct against members of the public, the caregiver has a duty to exercise reasonable care to control the patient and thus prevent him or her from injuring others. This rule applies to both formal and informal caregivers. Courts that have applied the principle to informal caregivers have focused on the caregiver’s reasonable anticipation of the patient’s harmful action. For example, in Bollinger v. Rader, the court held that the parents of a twenty-four year-old insane man who committed a homicide were not liable for their son’s act because they could not have reasonably anticipated that he would have killed the plaintiff’s daughter. On the day of the homicide, the son had been acting normally and had even attended church services. Likewise, in Fisher v. Mutimer, the court held that a father was not liable for his insane son’s homicidal act because he had used reasonable precautions in caring for his son and could not have anticipated the son’s killing of the victim. The court stated that the father would have been guilty of negligence if he had failed to do something that a prudent person would

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197 Id.
198 Id.
199 See Restatement (Second) of Torts § 319 (1965).
200 See id. § 319 cmt. A.
201 See, e.g., Bollinger v. Rader, 69 S.E. 497, 497 (N.C. 1910) (finding parents of insane child not liable for him committing homicide); Fisher v. Mutimer, 12 N.E.2d 315, 323 (Ill. App. 1938) (holding father of son who shot a girl after being sent home on parole was not liable).
202 69 S.E. 497 (N.C. 1910).
203 See id. at 497.
204 Id.
206 See id. at 323.
have done.\textsuperscript{207} However, the court found that the father had indeed acted reasonably and that the record contained no evidence of the son’s homicidal tendencies.\textsuperscript{208}

Although the patients in \textit{Bollinger} and \textit{Fisher} were not suffering from Alzheimer’s disease, because the law currently treats Alzheimer’s patients as it does mentally disabled persons, the same principles announced by the Restatement (Second) of Torts and the reasoning of the \textit{Bollinger} and \textit{Fisher} courts would apply in cases involving informal caregivers of Alzheimer’s patients. These caregivers would be held liable for injuries caused by Alzheimer’s patients in their care if they failed to act reasonably in protecting the public from harm caused by these patients.

This principle does not appear fair and just. After all, informal caregivers are the patient’s family members, friends, neighbors, or members of his or her faith community who volunteer their time to care for their loved one.\textsuperscript{209} Usually, they are learning about the disease even as they are caring for the patient.\textsuperscript{210} Accordingly, many of them would not know the nature of the abnormal behaviors they should anticipate if they are to protect themselves from tort liability. The precarious position in which informal caregivers find themselves is yet another example of how the law has failed, and is still failing, to help society’s helpless. If persons suffering from Alzheimer’s disease are to receive the true protection of the law, the law must be changed soon.

\textbf{C. Due Process Issues}

In addition to guardianship proceedings and tort actions, Alzheimer’s patients sometimes find themselves embroiled in other forms of litigation. Those cases often involve family matters, such as matrimonial actions, child custody actions, child support actions, and Social Security disability benefits disputes.\textsuperscript{211} During the course of such litigation, the Alzheimer’s patient, who lacks mental capacity, is often not afforded his or

\textsuperscript{207} \textit{Id}.
\textsuperscript{208} \textit{Id}.
\textsuperscript{209} See James, \textit{supra} note 1, at 226.
\textsuperscript{210} See \textit{id} at 232-234.
her full due process rights. Too often, notwithstanding the fact that the patient is sometimes unable to communicate and thus assist counsel with her case, the court behaves as if the patient is fully functional and proceeds with the case apparently oblivious to the fact that one party has no understanding of what is happening. Several possible reasons exist for this sad state of affairs. First, the judges before whom these Alzheimer’s patients appear could be uninformed about the nature of the disease and its effects on the patients’ cognitive functions. Second, the judges could be harried and simply want to move their dockets along. Third, the attorneys representing these patients could themselves be uneducated about the nature of the disease and its effects on their clients’ cognitive functions. Fourth, opposing counsel could be uneducated about the nature of the disease and its effects on the adverse party’s cognitive functions. Fifth, opposing counsel could well be aware of the nature of the disease and its effects on the adverse party’s cognitive functions, but could view this state of affairs as an advantage to be exploited during the proceedings.

Whatever the reason, Alzheimer’s patients typically receive little or no sympathy from the courts. Following is a section of a transcript from a matrimonial action wherein the wife is an Alzheimer’s patient and the husband is in good health, notwithstanding the wife’s condition, the court proceeded with the divorce and granted the husband’s petition for a divorce. However, by the time the matter went to trial, the wife had lost capacity, was unemployed, was receiving Social Security disability benefits and food stamps, and was living with her parents, who were caring for her.

In the following section of the transcript, the court is making determinations regarding the health insurance coverage for the wife and the couple’s minor child:

THE COURT: The parties will share their daughter’s unreimbursed health-care expenses of any nature whatsoever on a 90%/10% basis. The Plaintiff Husband will be responsible for 90% and the Defendant Wife is responsible for the 10% amount.

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212 See, e.g., Hezel v. Aon Corp., No. 93-2074, 1994 WL 320231 at *3 (4th Cir. Jun. 6, 1994). In Hezel, the court stated that it was not unsympathetic to the plaintiff’s claim. Id. at *3. The court acknowledged that Alzheimer’s disease, unlike an acute physical injury, is slow in progressing and may not be readily apparent to the afflicted individual. Id. However, the court ruled against Mr. Hezel, and instead advised the drafters of ERISA plans to consider and expressly provide for “the insidious nature” of such a disorder. Id.

213 See infra notes 216-218.

214 The author has personal knowledge of the facts of this case.

215 Id.
THE COURT: The parties have agreed that since Defendant Wife has medical coverage available to her, it is no longer necessary for her to remain covered under the Plaintiff Husband’s health-insurance plan; therefore, the parties have agreed that the Plaintiff Husband will immediately remove the Defendant Wife from his health coverage.

The Defendant Wife is already paying $96.40 a month for medical insurance, which is deducted from the disability payment she would otherwise be receiving in full.

* * *

THE COURT: Just so the record is clear, the health insurance available to the Defendant Wife is provided by the federal government as part of her disability situation.216

Apparently, the court was confused about the nature of the wife’s condition and of the source of her so-called health insurance. The court did not appear too familiar with the laws governing Social Security disability benefits.

The court next went on to discuss the child support obligations of the husband and wife. The court had previously awarded the wife – an Alzheimer’s patient being cared for by her aged parents – custody of the minor child:

THE COURT: Well, the parties have agreed, in terms of child support, that they will exchange W-2 Forms every two years.

* * *

THE COURT: Those W-2’s are to be exchanged within a week after receipt of the W-2 by each party every other year beginning in 2010; in

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216 This case occurred in the Supreme Court of the State of New York in 2009. The transcript of this case is on file with the author and the Journal of Health & Biomedical Law. For purposes of protecting the identity of the parties, this Article will not disclose the real names of the attorneys, judges, or other parties involved in this matter.
other words, with the W-2’s covering the Year of 2010.\textsuperscript{217}

The court had apparently still not yet understood that the wife was suffering from Alzheimer’s disease and was thus unable to work and would never be able to produce a W-2.

The proceedings took an interesting turn when the court swore in the wife and had her testify to her understanding of, and agreement with, the determinations arising out of the proceedings:

THE COURT: Did you hear the settlement that was just placed on the record?

WIFE: Yeah.

THE COURT: Do you understand it?

WIFE: Yeah.

THE COURT: Have you had sufficient time to discuss this agreement with your attorney and to think it over so as to be satisfied that you understand it fully?

WIFE: No.

WIFE’S ATTORNEY: Yes.

WIFE: Yeah.

WIFE’S ATTORNEY: Yes. She says yes.

THE COURT: Do you have any questions you would like to ask either your attorney or me concerning the terms and conditions of this agreement?

WIFE: No.

WIFE’S ATTORNEY: No.

\textsuperscript{217} Id.
THE COURT: Did you have full disclosure of your husband’s assets and liabilities before entering into this agreement so that you could enter into this agreement today?

WIFE: No.

WIFE’S ATTORNEY: Yes.

WIFE: Yes.

WIFE’S ATTORNEY: Yes.

Either because he did not know better or was in too great a hurry to bring this matter to a conclusion, the judge did not realize that the wife was unable to answer some simple questions and that her attorney was frequently “correcting” her answers. Ironically, as he ended the proceedings a few minutes later, the judge stated, “I hope this agreement helps to get both parties to a better place in their lives.”

That was quite a hope. If the judge had any understanding of Alzheimer’s disease, he would have known that the wife lacked capacity, would never regain it, and would never be able to fulfill the terms of the settlement he had read in open court.

In another case, a probate court was asked to decide who should be guardian of an 86-year-old woman suffering from Alzheimer’s disease. Using a durable power of attorney, the patient’s son had moved her from her home to a nursing home. He argued that the mother would be better off at the nursing home. The patient’s daughter (who appeared pro se) asked the court to allow her mother to continue living in her own home. She maintained that the mother would be happier in her own home and that she, the daughter, could adequately care for her mother with the help of

218 Id.
219 Id.
220 Id.
221 See JAMES, supra note 1, at 26-35 (outlining the various stages and symptoms of Alzheimer’s and the subsequent effects on mental capacity).
223 Id.
224 Id.
225 Id.
She provided the court with letters of support suggesting that she was a good caregiver of her mother. As the court disagreed. The court found that the Alzheimer’s patient was “now in such an extreme state of mental and physical debilitation that she must be maintained in a nursing home facility. . . .” As far as the court was concerned, the patient had reached the point where she will not be content or happy anywhere. Obviously, in making his decision, the judge ignored all the available research results indicating that living in their homes may be the best option for Alzheimer’s patients since they would most likely be less disoriented at home than if they were moved elsewhere.

In yet another case, the court had to decide whether a decedent, who died after suffering from Alzheimer’s disease, had left a valid will leaving his estate to his second wife with whom he had had an “arranged marriage.” On July 15, 2007, decedent executed an instrument purporting to be a last will and testament. However, the instrument did not comply with the provisions for a valid last will and testament under the Texas Probate Code because it was not signed by two witnesses. On June 26, 2009, decedent’s physician diagnosed him as suffering from Alzheimer’s disease. On December 16, 2010, decedent allegedly executed a new last will and testament leaving his estate to his (new) wife. In that new will, decedent placed a mark on the line above his name; he did not sign his name as he had done on the 2007 instrument. Without even addressing the issue of decedent’s Alzheimer’s disease, the court admitted the 2010 instrument into probate.

As these three cases illustrate, some courts are not acting in the best interests of Alzheimer’s patients and their loved ones. In some instances, the courts conduct “business as usual,” with no regard to the patients’ condition. In those cases where the

226 Id.
227 Id.
229 Id.
230 Id., supra note 1, at 183.
231 Estate of James Joseph Thornton, No. 7354 (Tex., Jim Wells County Ct., 2011).
232 Id.
233 Id.
234 Id.
235 Id.
236 Id.
patient has died, some courts disregard the effect of Alzheimer’s disease on the decedent’s mental capacity, while others issue rulings that ignore research results regarding Alzheimer’s patients and what would be best for them. By behaving in this manner, the courts are failing to protect and serve some of the most vulnerable members of our society. The next Part of this Article will make recommendations for arresting this sad state of affairs.

IV. Help for the Helpless – Recommendations for Better Serving and Protecting Alzheimer’s Patients

Surely, if the law is to serve its function, the current state of affairs vis-à-vis people suffering from Alzheimer’s disease must be changed. We as a nation can no longer afford to continue to deprive some of our most vulnerable citizens of basic legal protection. We must begin immediately to reform the guardianship process and tort law, and to ensure that Alzheimer’s patients are accorded the due process of the law. Anything short of this is unacceptable.

A. Reforming the Guardianship Process

For several years now, legal experts and others involved in eldercare have been advocating for guardianship reform. In response, most of the states have indeed amended their relevant statutes to facilitate such reform. The American Bar Association began tracking the passage of adult guardianship acts by the states in 1988. In 2001, sixteen states passed a total of twenty-six such acts; in 2002, at least ten states passed ten. Yet, in 2010, the GAO released a damning condemnation of the guardianship system. Surely, something is still wrong, not necessarily with the

239 KAPP, supra note 52, at 11-27.
240 See KAPP, supra note 52, at 11 (noting states’ attempts to constructively deal with challenges faced by elderly citizens).
242 KAPP, supra note 52, at 11.
243 See supra notes 105-124 and accompanying text.
statutes, but with the system on a whole. While guardianship reform focused on enacting statutes to make the process better – an effort in which these statutes have failed – the reform movement did nothing to change the system or educate the actors therein. Yet, this is the reform that is necessary if Alzheimer’s patients are to be treated fairly.

If guardianships are to protect and serve Alzheimer’s patients, the entire system must be overhauled. In particular, four things are absolutely necessary: (1) an upgrading of the courts with jurisdiction to hear guardianship matters, (2) promotion of the use by courts and the bar of guardianship alternatives, (3) efforts at educating the judiciary, bar, and general public about Alzheimer’s disease, its manifestations, and its legal implications, and (4) providing a mechanism to replace the ineffective notice requirements that currently exist.

1. Upgrading the Courts

Typically, guardianships are the province of probate courts. Alas, for too long probate courts have been looked down upon as inferior courts. In some jurisdictions the probate judges are not law school graduates, but are instead people from all walks of life elected by the general public voting along party lines.

This must change. Probate courts must be elevated to the stature worthy of their noble calling. Probate judges must be law school graduates well-schooled in the intricacies of probate and guardianship law. Also, if necessary, each county should have

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244 See KAPP, supra note 52, at 23-27. Although states have established comprehensive guardianship statutes, they may not be working effectively as a system because of their incompatibility with notions of autonomy and their failure to address all issues of guardianship. Id.

245 See supra notes 52-127 and accompanying text.

246 See discussion infra notes 247-251 and accompanying text.


248 48A C.J.S. Judges § 31 (2004). Some jurisdictions have constitutional provisions which expressly exempt probate judges from the requirement of being learned in the law. Id.; see e.g., ALA. CONST. art VI, §154 (“[J]udges of all courts of record shall have been citizens of the United States and of this state for five years next preceding their election or appointment, and shall be not less than twenty-five years of age, and, except judges of probate courts, shall be learned in the law.”). States are free to decide to elect, rather than appoint, state judges, but judicial candidates cannot be prohibited from expressing their views on political issues. 48A C.J.S. Judges §§ 22-23 (2004); see also Republican Party of Minn. v. White, 536 U.S. 765, 788 (2002) (holding state prohibition of political speech by judicial candidates violates First Amendment protections).
more than one probate judge. This will ensure that the judges are not harried and can give each case – and for our purposes, each guardianship petition – the full attention it deserves.

2. Use of Guardianship Alternatives

The various bar associations must also be involved in the makeover of the guardianship process. Lawyers must be taught and encouraged to counsel their clients to use guardianship alternatives — advance medical directives, durable powers of attorney, living wills, and revocable living trusts. Probate judges, meanwhile, should be taught the intricacies of these alternatives. Additionally, states that enacted guardianship reform during the “reform flurry” of the past two decades should now amend these statutes so that probate judges would have the power to lead parties in guardianship proceedings to better alternatives that would better serve the interests of Alzheimer’s patients.

3. Educating the General Population

Even as the judiciary and the bar educate themselves on true guardianship system reform, they must bring the public along. Bar associations and law schools must take the lead in educating the public about Alzheimer’s disease, its manifestations, and its legal implications. The Alzheimer’s Association estimates that by 2050, 106 million people worldwide will be suffering from Alzheimer’s disease. Of that number, 8.8 million will be living in the United States of America. Indeed, Alzheimer’s disease is this country’s next big health issue — if not epidemic. If the country is to weather that storm, the general public needs to be educated about the disease. Law schools need to add Elder Law to their curricula, and must then organize their students to go into their communities to educate the general populace about Alzheimer’s disease and all it entails.

4. Replacing the Current Ineffective Notice Provisions

Although most of the states amended their guardianship notice provisions

250 Id. (comparing the current statistic of over 3.1 million with the predicted 8.8 million).
251 See generally id. (discussing predicted increase in Alzheimer’s disease cases); Alzheimer’s Disease Program, TEX. DEPT. STATE OF HEALTH SERV., http://www.dshs.state.tx.us/alzheimers/default.shtm (last visited Nov. 26, 2011) (noting that Alzheimer’s is quickly becoming one of America’s major health problems).
following the release of the Wingspread report, these amendments do nothing to protect the rights of Alzheimer’s patients in the advanced stages of the disease. However, it would be difficult for any law to provide the protection these patients would need. What is needed, instead, is a combination of the law and widespread public education. Even as we adopt the recommendations of the Wingspread, we must educate people to the fact that if they want to ensure that people they trust become their guardians if they ever suffer from Alzheimer’s disease or otherwise become incapacitated, they should choose their own guardians while they have capacity. Hence, even with the ineffective notice requirements that currently exist, the only question at issue at a guardianship hearing would be whether the potential ward truly lacks capacity. The matter of who should be the guardian would already be decided. In fact, every person who is concerned about having a competent, trusting guardian, should develop a list of potential guardians so that if the first-choice predeceases the person, is unable to serve, or does not want to serve, there will be other people to choose from.

If these four steps are taken immediately, this country’s legal system will be on the path to bringing about meaningful change to the guardianship system as we know it.

B. Tort Reform with an Alzheimer’s Orientation

Current efforts at tort reform have focused on anything but protecting our vulnerable citizens suffering from Alzheimer’s disease. While this Article makes no judgment about or comments on these efforts, the Article proposes that the various legislatures should amend their tort laws as they pertain to negligence so that Alzheimer’s patients would no longer be liable for harms they cause unintentionally.

Under current law, but for two exceptions, mentally incapacitated persons are held liable for their torts. This is itself a very harsh rule, especially as it applies to an Alzheimer’s patient. The patient in the latter stages of the disease has no mental capacity. He or she does not understand anything. He or she does not understand right from wrong. He or she does not understand the elements of negligence. Hence, to hold someone who is suffering from moderate or severe Alzheimer’s disease liable for a harm caused to someone else is wrong. The states should all enact statutes outlawing this barbaric practice.

252 See Fraleigh, supra note 86 at 1103-04 (discussing problems with Michigan’s guardianship system).
253 See supra notes 138-150, 169-178 and accompanying text.
This does not mean that all Alzheimer’s patients will escape tort liability. Persons in the mild stage of the disease should be held liable for the torts that they commit. Although these patients exhibit symptoms including memory loss, difficulty reasoning, and changes in personality, they possess sufficient mental capacity to know right from wrong. Accordingly, they may be held liable for the torts they commit.

Even as true tort reform changes the law to excuse persons suffering from moderate and severe Alzheimer’s disease for their torts, the law should also expand on the currently-existing exceptions to tort liability. The current exceptions do not go far enough. For example, the first exception provides that Alzheimer’s patients are not liable for injuries they cause to their professional caregivers. Yet, the truth is that many Alzheimer’s patients are cared for at home by their loved ones. It is quite possible that these patients could engage in acts that harm visitors to their homes. Because these patients are not institutionalized and their torts are against non-caregivers, current tort law would hold them liable for the injuries they cause. This is grossly unfair. The various states need to move quickly to amend their statutes so that those stricken with moderate to severe Alzheimer’s disease are either immune from tort liability or are immune subject to some compensation scheme.

As regards the sudden incapacitation exception, only one jurisdiction – North Carolina – has applied it to Alzheimer’s patients. All jurisdictions need to follow North Carolina’s lead and adopt the exception so that Alzheimer’s patients who suffer from sudden sensory overloads will not be held liable for the results thereof.

Tort reform with an Alzheimer’s orientation should also reform current law regarding caregiver liability. Certainly, negligent professional caregivers should be held liable for the torts committed by the patients under their care. However, informal

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254 See supra notes 40-43 and accompanying text.
255 See supra text accompanying notes 169-178.
256 See Thies & Bleiler, supra note 17, at 217 (“Eighty percent of care provided at home is delivered by family caregivers”).
257 See Richards, supra note 134, at 639 (noting that patients can be dangerous to those around them).
258 See id. at 653 (discussing that Alzheimer’s patients, under the care of informal caregivers, are held liable for negligent acts to third parties).
259 See generally Sarah Light, Rejecting the Logic of Confinement: Care Relationships and the mentally Disabled Under Tort Law, 109 YALE L.J. 381 (1999) (advocating for total tort immunity for Alzheimer’s patients, but recognizing that there might be instances where the plaintiff may be due some compensation).
260 See supra text accompanying notes 143-149.
caregivers, untrained in providing this level of care and uneducated as to the nature and effects of Alzheimer’s disease, should be immune from liability for the torts of patients under their care unless, even with their limited training and limited knowledge of the disease, they knew or should have known of the patient’s propensity to harm others. Of course, should the patient commit the tort while living at the caregiver’s residence, the issue of tort liability may be of less significance for the caregiver since his or her homeowner’s liability insurance policy would likely compensate the tort victim for his or her injuries.261 This would be a better result to having the caregiver endure tort liability for an act he or she did not commit.

C. Resolving Due Process Issues – Education the Key

The due process issues faced by Alzheimer’s patients really have little, if anything, to do with the letter of the law. Instead, the unreasonable, harsh, and irrational treatment these patients receive from the courts are a direct result of a lack of education on the part of the judiciary and the bar. This Article has already proposed Alzheimer’s disease education for the judiciary and the bar. This education will enable judges and attorneys to recognize the presence of Alzheimer’s disease in a party to litigation and to either terminate the proceeding in which the patient is involved, have the judge make a determination that is read into the record that the individual lacks mental capacity because of Alzheimer’s disease (whereupon certain safeguards would kick in such as limiting or eliminating the person’s tort liability, closely scrutinizing documents allegedly executed by the person, and closely scrutinizing the person’s financial transactions), or call upon medical professionals (including psychiatrists and psychologists) to advise them on the medical issues as they relate to the law. Indeed, law and medicine can – and should – work together to arrest the current level of injustice endured by Alzheimer’s patients and ensure that our most vulnerable citizens are allowed to live the last years of their lives with a great deal of dignity.

V. Conclusion

It is true: today’s legal system renders no help to the helpless – the men and women suffering from Alzheimer’s disease. Yet, hope exists that this state of affairs can be reversed. If the legal and medical fraternities were to join forces and embark on a campaign to educate legislators, judges, members of the bar, and members of the general public about Alzheimer’s disease, all it entails, and the legal implications of an Alzheimer’s diagnosis for both the patient and his or her family, they would have gone a

long way to bringing help to the helpless. Let us pray that it happens soon.