

OLDER CLIENTS WITH DIMINISHING CAPACITY AND THEIR ADVANCE DIRECTIVES

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Editors' Synopsis: This Article examines the revisions to Model Rule 1.14, Client with Diminished Capacity, of the American Bar Association's Model Rules of Professional Conduct. The Article examines the initial contact with older clients in the context of elder law and estate planning, applying amended Model Rule 1.14. The Article then reviews legal documents, including advance medical directives, which can be used to develop and implement estate planning, asset preservation, and quality-of-life decisions.

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I. INTRODUCTION

In recent years, two areas of interest to elder law and estate planning and trust counsel have converged. The first area is the movement among the states to amend their codes of professional responsibility in accordance

with the changes in the American Bar Association's ("ABA's") Model Rules of Professional Conduct ("Model Rules"), as approved by the ABA House of Delegates in February of 2002.¹ This Article gives specific attention to Model Rule 1.14, Client with Diminished Capacity, and its impact on the operation of Model Rules 1.2, Scope of Representation and Allocation of Authority Between Client and Lawyer; 1.6, Confidentiality of Information; and 1.7, Conflict of Interest: Current Clients.

The second area of interest concerns a broad category of instruments known as advance medical directives, which are being created on advice of counsel by older clients with diminished capacity. The advance medical directives include the creation of a narrow group of trusts—for example, funded revocable trusts, custodial trusts, and irrevocable special or supplemental needs trusts—as part of planning by older clients who are anticipating life situations in which they will have a legal need for others to act on their behalf.

The convergence of these areas comes at a time when there has been a noted increase in civil litigation over the exercise of power and control by trustees and attorneys-in-fact, as well as over the validity of wills based on capacity and undue influence.² The ability of advance medical directives to eliminate the need for the more intrusive judicial processes of guardianship or conservatorship is well-known.³ However, the misuse and abuse of advance directives that grant attorneys-in-fact significant legal powers is equally well-known.⁴ Many attorneys-in-fact exercise the powers granted to them as if the assets they control are their own and with no regard to their fiduciary duties.⁵

This Article examines the initial contact with older clients, many of whom have diminished capacity, in the context of elder law and estate planning and trust law. It does not examine capacity as a separate subject. However, the Article describes the use and application of amended Model Rule 1.14 and its expanded comments when approaching the initial engagement and subsequent counseling of older clients with diminished capacity. The Article then reviews the legal documents, including ad-

¹ See MODEL RULES OF PROF'L CONDUCT (2002). The ABA House of Delegates approved the recommendations of the Ethics 2000 Commission, Report 401 as amended. See Am. Bar Ass'n, *Summary of House of Delegates Action on Report 401 during ABA Midyear Meeting in Philadelphia, February 2002* at http://www.abanet.org/cpr/e2k202report_summ.html (last visited Jan. 23, 2004).

² See generally ROBERT FLEMING & REBECCA C. MORGAN, UPDATE ON CASES RELATED TO ELDER LAW (citing an increase in cases dealing with advance directives); see, e.g., *Smith v. Lynch*, 821 So. 2d 1197 (Fla. Dist. Ct. App. 2002).

³ See Karen E. Boxx, *The Durable Power of Attorney's Place in the Family of Fiduciary Relationships*, 36 GA. L. REV. 1, 1-2 (2001).

⁴ See A. Frank Johns & Charles P. Sabatino, *Wingspan—The Second National Guardianship Conference: Introduction*, 31 STETSON L. REV. 573, 576-82 (2002).

⁵ See generally A. Frank Johns & Charles P. Sabatino, *Wingspan—The Second National Guardianship Conference: Recommendations*, 31 STETSON L. REV. 595, 598-600 (2002) (proposing recommendations to solve the identified problems of guardianship).

vance directives, available as options from which the client may choose as components in the development and implementation of estate planning, asset preservation, and quality-of-life decisions.

Where appropriate, noteworthy changes in the Model Rules are incorporated into the analysis.

II. CAPACITY AND THE INITIAL CLIENT CONTACT AS VIEWED BY THE LEGAL PROFESSION—GENERALLY

Whether the relationship is denominated lawyer-client or client-lawyer,⁶ the legal profession has proceeded at a snail's pace when it comes to including capacity in discussions about the initial client conference. Professor Morgan, writing about the representation of older clients, correctly states that "[a]lthough the *Model Rules of Professional Responsibility* . . . recognize the non-litigation roles of attorneys more explicitly . . . , the Model Rules still fail to provide adequate practical guidance to [elder law, estate planning and family law practitioners.]"⁷ Unfortunately, little is found outside the elder law construct to guide elder law attorneys through the rigors of confirming sufficient client competence or capacity at the initial contact, deciding whether to allow consultation, or determining what, if any, future legal services may be contracted.

A. Formation of Client-Lawyer Relationship

The legal profession first views the client-lawyer relationship based on the manifestation of the prospective client's intent. The relationship may arise when "a person manifests to a lawyer the person's intent that the lawyer provide legal services for the person."⁸ While intent requires

⁶ See 1 GEOFFREY C. HAZARD, JR. & W. WILLIAM HODES, *THE LAW OF LAWYERING* § 2.1 (3d ed. Supp. 2003) [hereinafter "The Law of Lawyering"] (explaining that four duties (competence, communication, confidentiality and loyalty) of the core principles of the law of lawyering run to the client, and noting that "[t]he Kutak Commission symbolized the primacy of [client interests] . . . by reversing the common reference to the 'lawyer-client' relationship"); see generally THE AMERICAN COLLEGE OF TRUST AND ESTATE COUNSEL, *COMMENTARIES ON THE MODEL RULES OF PROFESSIONAL CONDUCT* (3d ed. 1999) [hereinafter *ACTEC COMMENTARIES*].

⁷ William E. Adams & Rebecca C. Morgan, *Representing the Client Who Is Older in the Law Office and in the Courtroom*, 2 *ELDER L.J.* 1, 13 (1994) (citing Ronald C. Link et al., *Developments Regarding the Professional Responsibility of the Estate Planning Lawyer: The Effect of the Model Rules of Professional Conduct*, 22 *REAL PROP. PROB. & TR. J.* 1, 1-2 (1987)); see also Jeffrey N. Pennell, *Ethics, Professionalism, and Malpractice Issues in Estate Planning and Administration*, 2 (2002) (unpublished teaching materials from ALI-ABA Seminar—New Issues in Estate Planning) ("The lack of clear answers and direction in this area is because the ethics rules weren't written by or for estate planners.") (on file with the author).

⁸ *RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS* § 14(1) (2000). The comments of this section explain further:

The client's intent may be manifest from surrounding facts and circumstances, as when the client discusses the possibility of representation with the lawyer and

capacity, general legal texts addressing client-lawyer relationships focus on the client having fully informed consent, and on what the lawyer discloses to the client about the benefits, advantages, and conflicts of interest of the proposed representation rather than on capacity.

Any discussion of capacity merely focuses on those who are already incompetent and represented by a guardian or, if minors, by parents.⁹ Few general legal writings mention the attorney's need to assess the elderly client's competence from the outset or provide informed consent.¹⁰ In fact, the legal profession initially looks at competence only in terms of the lawyer's ability to deliver legal services. Consider Model Rules 1.2 and 1.16, bracketing the beginning and the ending of the client-lawyer relationship. These rules are concerned more with the lawyer's role and whether what the lawyer is being asked to do is moral or ethical, than whether the client has capacity.

B. The Lawyer's Duties to Prospective Clients

Even prior to engagement, the lawyer has duties to prospective clients that include protecting the client's confidential information, protecting property, and not to represent a client with interests materially adverse to those of a prospective client in the same or a substantially related matter if the lawyer received information that could be harmful to that person unless disqualification can be avoided.¹¹ Model Rule 1.18, which dis

then sends the lawyer relevant papers or a retainer requested by the lawyer. The client may hire the lawyer to work in its legal department. The client may demonstrate intent by ratifying the lawyer's acts . . . [or the] client's intent may be communicated by someone acting for the client, such as a relative or secretary.

Id. § 14 cmt. c.

⁹ See *id.* reporter's note, cmt. d (referencing case law addressing legally incompetent clients based on minority).

¹⁰ Cf. ERICA WOOD & AUDREY K. STRAIGHT, EFFECTIVE COUNSELING OF OLDER ADULTS 5 (1995) (explaining that age myths which stereotype older people as senile, confused, disabled, and the like, promote the dangers of "ageism" and noting that while some degree of short-term memory loss is part of normal aging, a significant, or complete failing in mental abilities is not a normal part of the aging process).

¹¹ See MODEL RULES OF PROF'L CONDUCT R. 1.18 (2002). The rule, entitled "Duties to Prospective Client," provides:

(a) A person who discusses with a lawyer the possibility of forming a client-lawyer relationship with respect to a matter is a prospective client.

(b) Even when no client-lawyer relationship ensues, a lawyer who has had discussions with a prospective client shall not use or reveal information learned in the consultation, except as Rule 1.9 would permit with respect to information of a former client.

(c) A lawyer subject to paragraph (b) shall not represent a client with interests materially adverse to those of a prospective client in the same or a substantially related matter if the lawyer received information from the prospective client that could be significantly harmful to that person in the matter, except as provided in paragraph (d). If a lawyer is disqualified from representation under this paragraph, no lawyer in a firm with which that lawyer is associated may knowingly undertake or continue representation in such a matter, except as

cusses these duties, should also emphasize the client's capacity. However, the Rules do not now generally address client capacity generally until the client-attorney relationship has been established.¹²

In summarizing the duties of the lawyer to the client over the course of representation, the Restatement (Third) of the Law Governing Lawyers ("Restatement Third") points out that general legal writings focus the scope of representation on how lawyers will (1) proceed in ways that their actions will be reasonably calculated to advance a client's lawful objectives within the consultative definition; (2) act with reasonable competence and diligence in adhering to client confidences and protecting property; and (3) avoid conflicts of interest and provide reasonable care.¹³

The Restatement Third separately treats the authority of the lawyer to make decisions for the client in a subsequent section.¹⁴ In this subsequent section, the Restatement Third examines concerns regarding the client under a disability, reflecting and applying Model Rule 1.14 and the mandate to maintain a normal client-lawyer relationship as long as possible when the client is impaired. Actions on behalf of the client, including making decisions for the client or seeking appointment of a person to make decisions on behalf of the clients, are also examined carefully within the scope of representation.

III. CAPACITY AND THE INITIAL CLIENT CONTACT AS VIEWED BY ELDER LAW AND ESTATE PLANNING AND TRUST LAWYERS —SPECIFICALLY

The very nature of elder law and estate planning practice requires attorneys to focus on capacity of the client at the initial client contact.¹⁵

provided in paragraph (d).

(d) When the lawyer has received disqualifying information as defined in paragraph (c), representation is permissible if:

(1) both the affected client and the prospective client have given informed consent, confirmed in writing, or:

(2) the lawyer who received the information took reasonable measures to avoid exposure to more disqualifying information than was reasonably necessary to determine whether to represent the prospective client; and

(i) the disqualified lawyer is timely screened from any participation in the matter and is apportioned no part of the fee therefrom; and

(ii) written notice is promptly given to the prospective client.

¹² See MODEL RULES OF PROF'L CONDUCT R. 1.14 (concerning clients with diminished capacity); RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS §§ 14, 24, 31 (2000) (concerning the formation of a client-lawyer relationship, a client with diminished capacity, and the termination of a lawyer's authority, respectively).

¹³ See RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS §§ 16-19 (2000) for a summary of the duties under a client-lawyer relationship.

¹⁴ *Id.* § 35 (concerning clients with diminished capacity).

¹⁵ While this may seem like ageism, see *supra* note 10, it is not. One cannot assume that simply raising the question of capacity answers that question. Attorneys must do more

While focus on capacity may not be a standard of practice in other legal specialty areas, experienced elder law attorneys often incorporate methods into their practices to assess client competence at the initial consultation and, if competence is confirmed, to agree to future legal services.

A. Formation of Client-Lawyer Relationship

Elder law and estate planning attorneys generally must deal with client competence, communication, confidences, and loyalty no differently than any attorney in the legal profession. However, these specialists also must assess the client's competence to hire counsel and must ensure that the client has sufficient informed consent to enter into a contractual relationship that delivers future legal services. When a lawyer finds that a client has diminished capacity, the lawyer should apply Model Rule 1.14 and its accompanying comment.

1. Revised Model Rule 1.14: Client with Diminished Capacity

Revised Model Rule 1.14 provides:

- (a) When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.
- (b) When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian.
- (c) Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests.¹⁶

B. Long-term Client-Attorney Relationship

Elder law and estate planning attorneys should include as an element

to confirm for themselves their clients' ability to enter the relationship, and thereafter to engage the attorneys for legal services. See generally JOHN J. REGAN, REBECCA C. MORGAN & DAVID M. ENGLISH, *Tax, Estate and Financial Planning for the Elderly*, Ch. 1, COUNSELING THE ELDERLY CLIENT (2003) (Chapter One is entitled "Tax Estate and Financial Planning for the Elderly.>").

¹⁶ MODEL RULES OF PROF'L CONDUCT R. 1.14 (2002).

of the scope of representation a reasonable calculation of client capacity within the consultative definition. These specialists should act with sensitivity, reasonable competence, and diligence when assessing client capacity, honoring client confidences and protecting client property. As these lawyers avoid conflicts of interest and provide reasonable care in doing so, they must determine whether there should be intervention or disengagement if client capacity declines to the extent that it impairs informed consent or some other aspect of legal representation.

IV. CAPACITY: THE GENERAL FRAMEWORK

A. Distinctions Between Incompetency and Incapacity

Incompetency is characterized as a judicial or legal determination.¹⁷ Incapacity is usually framed in a medical context.¹⁸ Comparison of the

¹⁷ See ARTHUR C. WALSH ET AL., *MENTAL CAPACITY: LEGAL AND MEDICAL ASPECTS OF ASSESSMENT AND TREATMENT* § 1.15 (2d ed. 1994).

¹⁸ See, e.g., John R. Murphy, *Older Clients of Questionable Competency: Making Accurate Competency Determinations Through the Utilization of Medical Professionals*, 4 GEO. J. OF LEGAL ETHICS 899 (1991) (discussing incapacity in a medical models context and incompetency in a legal context); Marshall B. Kapp, *Evaluating Decisionmaking Capacity in the Elderly: A Review of Recent Literature*, 2 J. ELDER ABUSE & NEGLECT 15, 16-17 (1990):

There is widespread acceptance by now of the concept that decisional capacity is a matter of the patient's functional ability to make decisions, rather than one that is automatically determined by agreement or disagreement with an outcome (that is, whether or not the decision itself is one that a 'reasonable' person would have reached) or the patient's status or membership in a particular 'vulnerable' class based on age or medical diagnosis. "The most important task for the legal standard of competency is to distinguish effectively between foolish, socially deviant, risky, or simply 'crazy' choices made competently, and comparable choices made incompetently. Although incompetent behavior may be restrained, identical competent behavior may not" (Tremblay, 1987).

Under the heading of functional assessment for decisionmaking purposes, four distinct but related standards are mentioned repeatedly (Appelbaum & Grisso, 1988; Stanley, Stanley, Guido & Garvin, 1988). First, is the patient able to evidence and communicate a choice, and one that is stable enough over time to permit its effectuation? Second, can the patient understand relevant information, both in terms of specific facts and the patient's own role in the decisionmaking process? This standard has the virtue of relatively easy testability, but depends heavily on the patient's verbal (rather than reasoning) skills. Third, what is the quality of the patient's thinking process; can the patient manipulate information logically? Is the patient able to weigh the decisional factors according to the values that the patient himself has assigned those factors? Is the outcome of the patient's decisionmaking exercise consistent with his starting premises? Fourth, does the patient appreciate the nature of his own situation (e.g., rather than denying a serious medical problem or risk) and the consequences of the decision for himself?

.....
 Broken down further, Beck's criterion of capacity for assimilating relevant facts requires that the patient be educated about, and aware of, pertinent facts but not that the patient agree with the clinician's interpretation of those facts. Put differently, the patient who says in effect, "I know what you say, but I do not

two is complicated by the notion that capacity is an objective phenomenon based on unchanging physical or mental attributes, which ignores the fluid dynamics of a client's physical and mental processes and the external factors surrounding client status.¹⁹

Black's Law Dictionary defines incompetency as:

Lack of ability, knowledge, legal qualification, or fitness to discharge the required duty or professional obligation. A relative term which may be employed as meaning disqualification, inability or incapacity and it can refer to lack of legal qualifications or fitness to discharge the required duty and to show want of physical or intellectual or moral fitness.²⁰

In comparison, incapacity is impairment by reason of mental illness, mental deficiency, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, or other cause (except minority) to the extent that the person lacks sufficient understanding to make or communicate responsible decisions.²¹ Careful attention should be given to state statutory language using one or the other term.

Competency and capacity are merged with the concept of informed consent to assess whether the client is able to understand documents and events. Informed consent is "[a] person's agreement to allow something to happen (such as a surgery) [or the signing of advance directives] that is based on a full disclosure of facts needed to make the decision intelligently: i.e., knowledge of risks involved, alternatives, [etc.] . . ."²²

B. Model Rule and Statutory Terminology Defining Informed Consent

When the ABA Ethics 2000 Commission revised the Model Rules, the Commissioners realized that the concept of informed consent permeated the practice of law and that they needed to develop an overarching definition of the term that would apply throughout the rules. The amended Model Rules provide such a definition in Model Rule 1.0(e): "'Informed consent' denotes the agreement by a person to a proposed course of conduct after the lawyer has communicated adequate information and explanation about the material risks of and reasonably available alterna-

agree," possesses decisional capacity.

¹⁹ See Adams & Morgan, *supra* note 7, at 19 n.97 (citing William M. Altman, et al., *Autonomy, Competence, and Informed Consent in Long Term Care: Legal and Psychological Perspectives*, 37 VILL. L. REV. 1671 (1992)).

²⁰ BLACK'S LAW DICTIONARY 765 (6th ed. 1990).

²¹ See *id.* at 760.

²² *Id.* at 537 (alterations in original); see also Judith F. Daar, *Informed Consent: Defining Limits Through Therapeutic Parameters*, 16 WHITTIER L. REV. 187, 187 n.1 (1995). Daar credits Justice Bray with the origin of the phrase "informed consent" from *Salgo v. Leland Stanford Jr. Univ. Bd. of Trs.*, 317 P.2d 170 (Cal. Ct. App. 1957). Daar also references a discussion of the development of informed consent doctrine in JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT*, 44-84 (1984); and RUTH R. FADEN & TOM L. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT*, 114-50 (1986).

tives to the proposed course of conduct.”²³

As shown below, the Model Rule definition of informed consent does not reference the cognitive or functional mental ability of the client to know and understand the proposed course of conduct.

1. *Derivation and Dual Nature of Informed Consent*

The legal doctrine of informed consent is based on two closely related English common law rules: (1) the client’s permission must be obtained before rendering treatment or delivering the service; and (2) the client’s permission must be based on a reasonable or appropriate explanation of the services to be rendered.²⁴ Informed consent is usually assessed in the medical and health care context, but in the legal context informed consent is assessed by analyzing the client’s cognitive function of understanding the client-lawyer relationship, acquiescence, and knowing execution of a document, whether it is a deed, power of attorney, trust, or will.

Informed consent may be assessed in two ways: (1) based on the cognitive and functional abilities of the client to know the effect of the legal document in question or the impact of a particular legal directive; and (2) based on the extent of lawyer disclosure to the client about the legal services or documents to be provided and their potential impact, both positive and negative. For example, the client may understand the basics of a power of attorney, but not the specifics such as the ramifications of a gifting clause that provides the attorney-in-fact with the power to gift to himself or herself.

2. *Informed Consent Compared in Law and Medicine*

Informed consent in the practice of law is predicated on whether or not clients have the cognitive ability to know what they are signing. Attorneys only recently have considered the broader perspective of the client’s cognitive ability to understand the client-lawyer relationship.²⁵ Informed consent in the practice of medicine and health care is predicated on disclosure and volition. Since the Nuremberg War Crimes Trials of Nazi doctors, informed consent in the medical or health care arena has had “three essential elements: (1) The patient must understand the medical procedure and, specifically, understand a description of the procedure, its risks, its benefits, and its alternatives; (2) consent must be voluntary; and (3) the patient must be mentally competent to give consent.”²⁶

²³ MODEL RULES OF PROF’L CONDUCT R. 1.0(e) (2002).

²⁴ See WALSH ET AL., *supra* note 17, § 2.12. Section 2.12 is entitled “Informed Consent Capacity” and cites the landmark case of *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972), and other sources, including W. Overman, Jr. & A. Stoudemire, *Guidelines for Legal and Financial Counseling of Alzheimer’s Disease Patient’s and Their Families*, 145 AM. J. PSYCHIATRY 1495, 1496 (1988) (citing *Schoendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92 (1914)).

²⁵ See generally WALSH ET AL., *supra* note 17, § 2.12.

²⁶ *Id.* (citing Jeffrey S. Janofsky, *Assessing Competency in the Elderly*, 45 *Geriatrics*

3. *Informed Consent in Statutory Law: The Uniform Probate Code*

The states that have adopted the Uniform Probate Code define the “incapacitated person” by addressing a legal rather than a decisional or functional term. An incapacitated person is “any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause (except minority) to the extent of lacking sufficient understanding or capacity to make or communicate responsible decisions.”²⁷

On the other hand, several states that have not adopted the Uniform Probate Code employ decisional or functional terms,²⁸ or they specifically conform statutory language to legal terminology.²⁹

V. CAPACITY ASSESSMENT IN THE INITIAL CONTACT WITH OLDER CLIENTS

A. Pre-Conference, Intake, and Appointment

The ABA’s Real Property, Probate and Trust Section, the American College of Trust and Estates Counsel (“ACTEC”), and the National Academy of Elder Law Attorneys (“NAELA”) provide numerous primers and published articles on structuring initial contact, intake, and the first consultation in an elder law or estate and trust planning practice.³⁰

Even with the initial call-in, legal staff should be carefully trained in what to say and what not to say. They should make certain inquiries to ascertain facts and elicit responses that will be helpful to assess the caller’s capacity. Legal staff should also be sensitive toward the callers, who are often experiencing crisis-oriented difficulties. Even in the initial call-in Model Rule 1.18, Duties to Prospective Client, comes into play.

Once an appointment is made, a good practice strategy is to send the client (1) a notice of appointment, (2) a one page, block-framed intake worksheet, and (3) a more lengthy legal and data information questionnaire and (4) request that the client fill out the worksheet and questionnaire and send them in at their earliest convenience.³¹ The prospective

No. 10 (Oct. 1990)).

²⁷ Compare UNIF. PROBATE CODE § 5-103(7) (1998), with UNIF. GUARDIANSHIP & PROTECTIVE PROCEEDINGS ACT § 1-102(5) (1997) (redefining an incapacitated person as “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 technological assistance.”), available at <http://www.law.upenn.edu/library/alc/ugppa/guardsh2.pdf> (last visited Feb. 12, 2004).

²⁸ See, e.g., N.Y. MENTAL HYG. LAW § 81.02 (McKinney 1996).

²⁹ See, e.g., 20 PA. CONS. STAT. ANN. § 5502 (West 1975).

³⁰ Reader can find more information at the ABA’s Real Property, Probate & Trust Section’s website at www.abanet.org/rppt/home.html (last visited Feb. 11, 2004); ACTEC’s website at www.actec.org (last visited Feb. 11, 2004); or NAELA’s website at www.naela.org (last visited Feb. 11, 2004).

³¹ Texts cited in this Article have countless options for developing data collection and

client may take the questionnaire to the initial appointment, but the pre-screen intake worksheet should be returned without delay and reviewed in advance of the consultation.

B. First Conference

For purposes of discussion, assume the completed prescreen worksheet raises the issue of the incapacity of the person who will be the subject of the conference. Often elder law attorneys are directed by the conferees to what the conferees believe is the primary issue to be discussed, and the question of capacity is circumvented or overlooked. No matter what the legal specialty, all lawyers should control the initial part of the first conference to determine client identity, client confidences, and client capacity.

1. Client Identity

The attorney must maintain initial control to identify the client. Unfortunately, identity problems are often created at the outset because the Model Rules do not clearly define "client."³² However, if client identity is not clarified at the beginning of the first conference, any further direction may be damaged by the realization that the client is someone other than the person the elder law attorney initially assumed the client to be from the initial consultation.

2. Client Confidences

Once the client is identified the lawyer must confirm the client confidences. This often becomes a sensitive situation. If the elderly individual was accompanied by others, usually his or her children, the children may need to be excused in order for the lawyer to discuss whether the prospective client wishes for confidential client information to be shared with the others. Depending upon who is present at the first conference, the situation may prove to be more complicated than this example. Sometimes the elderly individual or prospective client is not even present. How lawyers handle the conference thereafter, and gain an understanding of the client's capacity, can be troublesome.³³

questionnaires. NAELA's Practice Development/Management Special Interest Group also provides numerous samples in its resource bank, available at <http://www.naela.com/naela/sigareas.htm> (last visited Feb. 11, 2004).

³² See Adams & Morgan, *supra* note 7, at 13 (citing John E. Donaldson, *The Ethical Considerations of Representing the Elderly*, TR. & EST. J. July 1991, at 18).

³³ The first conference also may be where derivative or ancillary client relationships are either acknowledged or possibly limited. See A. Frank Johns, *Fickett's Thicket: The Lawyer's Expanding Fiduciary and Ethical Boundaries When Serving Older Americans of Moderate Wealth*, 32 WAKE FOREST L. REV. 445, 445-502 (1997); see also Bruce S. Ross, *Conservatorship Litigation and Lawyer Liability: A Guide Through the Maze*, 31 STETSON L. REV. 757, 757-89 (2002).

3. *Client Capacity*

When a question of capacity exists, the attorney should carefully examine the facts to determine whether the client has the capacity to engage an attorney or to grant to others the client's authority to engage an attorney. Releases, multi-disciplinary assessments, and screening indicators may also be needed. Releases should be signed by the prospective client at the initial conference, authorizing receipt of evaluations, medical records, and opinions of attending physicians, or related service professionals who can evaluate capacity or lack thereof for purposes of engagement and future legal services. If the lawyer finds that current and appropriate tests, assessments, or evaluations of the prospective client are not available, the lawyer should arrange for a multi-disciplinary geriatric assessment that includes health care or medical opinions regarding the prospective client's capacity and informed consent.

a. *Use of Screening Tools*

Many writers suggest that lawyers serving the elderly use their own simple screening tools to confirm for themselves whether a prospective client has sufficient mental capacity to exercise informed consent in making legal choices and decisions. Several instruments designed for medical and health care professionals have been targeted as instruments designed for non-medical, non-psychological, and non-health care professionals in recent years to screen or preliminarily assess the ability of a client or family member to exercise informed consent. The instruments qualify in broad categories the client's ability to exercise sufficient cognitive ability with the goal of maintaining a threshold level of capacity necessary to access alternatives to guardianship or conservatorship.³⁴ The

³⁴ However, some commentators believe that such a screening process or preliminary assessment is outside the realm of the practice of law and should not be a part of the attorney's office practice. Some have also criticized the instruments, specifically whether or not the screens and assessments sufficiently examine the ability of an individual to function or seek assistance to function in life. Regardless of the instrument used, attorneys may be too far out of their expertise to deal with such a complex area. Even psychiatrists and neurologists struggle with this area. See J. BROOKE AKER ET AL., *MENTAL CAPACITY: MEDICAL AND LEGAL ASPECTS OF THE AGING* 133-34 (Supp. 1993). Chapter 4, entitled "Diagnosis of Brain Damage" states:

Human behavior is an extremely complex multifaceted entity. The understanding of its disruption in brain disease has proved to be a substantial and often times frustrating problem to the clinician who is faced with the tasks of diagnosis and management. The patients with organically related changes in intellectual or emotional behavior unfortunately have often fallen just outside the limits of both psychiatry and neurology. Behavioral problems within this somewhat uncharted borderland have long been subsumed under the rubric of "the organic brain syndromes," a vague and overly inclusive term covering any possible behavior change from brain damage or dysfunction. The term has little utility for specific diagnosis, description, or patient management. In recent years, however, there has been a renewed interest in these organic mental syndromes and it is now possible to understand many of these conditions and to assign

instruments include the Client Capacity Indicator,³⁵ the Mental Ability Assessment, Functional Assessment and Safety Assessment,³⁶ the Legal Capacity Questionnaire,³⁷ the Mini-Mental State Examination,³⁸ the Client Capacity Screen,³⁹ and the Behavioral Dyscontrol Scale.⁴⁰

Once incorporated into a standard of practice by attorneys, the screens are easy to administer and retrieve.⁴¹ The screen should be kept in the client file so it can be used to corroborate an attorney's contention that the client had sufficient capacity to provide informed consent. When these

specific patterns of behavioral deficits to specific diseases or to damage in particular regions of the brain.

Id. (citing RICHARD L. STRUB & F. WILLIAM BLACK, *THE MENTAL STATUS EXAMINATION IN NEUROLOGY* 1 (1977)).

Cf. WALSH ET AL., *supra* note 17, § 7.06. The second edition of this authority provides:

An examination of mental status should be part of any thorough neurologic or psychiatric evaluation of the older adult. In the hands of a skilled examiner, the mental status examination can provide valuable information regarding such areas as an individual's ability to attend and concentrate, use speech and language appropriately, remember various types of information, perform visual and spatial activities, and access the higher cognitive functions involved in abstract reasoning, judgment, and mathematical calculations. Several short, compact forms of mental status exams have been introduced in recent years, and although these can be both efficient and effective diagnostically, an understanding of the basic steps involved in a more comprehensive examination is important.

³⁵ See LAURENCE A. FROLIK & MELISSA C. BROWN, *ADVISING THE ELDERLY OR DISABLED CLIENT* app. 2-3 at 2-24 (1992 & Supp. 1997). Professor Frolik's one page, six-section questionnaire concerning client capacity indicators is a good beginning.

³⁶ 1 HARRY S. MARGOLIS, *ELDERLAW FORMS MANUAL: ESSENTIAL DOCUMENTS FOR REPRESENTING THE OLDER CLIENT*, §§ 4.2-4.4 (1997) (Form 4.2 Functional Assessment, Form 4.3 Safety Assessment, and Form 4.4 Mental Ability Assessment are especially pertinent. Margolis has developed three simple assessment tools in the *ELDERLAW FORMS MANUAL* that construct questions, which look at mental ability, basic activities of daily living and self help determination, and concerns for physical safety of the client.).

³⁷ See Baird B. Brown, *Determining Clients' Legal Capacity*, *THE ELDERLAW REP.*, Feb. 1993, at 1-4 (providing a careful explanation of the Legal Capacity Questionnaire, a guide for giving it, and an answer sheet for scoring it); *see also* WALSH ET AL., *supra* note 17, § 5 (Assessment of Capacity).

³⁸ See Marshall F. Folstein et al., "*Mini-Mental State*": *A Practical Method for Grading the Cognitive State of Patients for the Clinician*, 12 *J. PSYCHIATRIC RES.*, 181, 189-98 (1975) (stating that the Mini-Mental State Examination has been identified as the most widely used test with excellent test and retest reliability).

³⁹ See Fox et al., *A Client Capacity Screen: A Tool for Evaluating Mental Capacity*, § 11 (1992) (unpublished material from the 4th NAELA Symposium, on file with author). The authors note that the client capacity screen is not a replacement for the use of medical professionals, but it provides a structure for assessment which assures relevant information will be gathered and provides the attorney with an easy and accessible method of documenting the file regarding such assessment.

⁴⁰ See Brown, *supra* note 37, at 3. Brown explains that the Behavioral Dyscontrol Scale is a standardized test designed to assess the integrity of the frontal lobes of the brain.

⁴¹ Attorneys may charge for the administration of the screen or assessment. Of course, the client should understand in advance that the test is not part of the primary consultation but is billed separately.

instruments are used regularly in an attorney's practice, the actual recollection by the attorney of his client's abilities and functions at the time in question becomes less important if questions regarding capacity are ever raised.

b. Objection to Screens

Objections to screening instruments or processes used by attorneys include the inaccuracy of these instruments, usage of the screens, and the so-called "snapshot" of informed consent and capacity.⁴² Medical and health care professionals have expressed concern that a onetime assessment of individuals to determine their capacity is inefficient and often inaccurate. The psychiatric community has criticized the screens, observing that competency is not a fixed state but may fluctuate as a natural course of an individual's illness, or in response to treatment or psychodynamic factors.⁴³

There are legitimate arguments for and against client capacity screens and other assessment instruments. If attorneys choose not to use a capacity screen, they should incorporate in their standard of practice consistent ways to resolve the issue of capacity and informed consent with each client.⁴⁴

4. Differences in Application

There may be a difference between the initial conference and subsequent engagement in terms of the requisite level of capacity. The difference in the requisite level of capacity may be evident in the area of practice in which the client is requesting legal services. An example of this is in the adjudication of incompetence, especially when the alleged incompetent person ("AIP") is seeking the engagement.⁴⁵

a. Threshold

Questions have been raised as to the mental capacity threshold necessary for an AIP to retain counsel to defend against an adjudication of

⁴² See *supra* note 34 (discussing objections to screening instruments).

⁴³ See Laura Coker & A. Frank Johns, *Guardianship for Elders: Process and Issues*, J. GERONTOLOGICAL NURSING, Dec. 1994, at 25, 28 (citing, P. Appelbaum & L. Roth, *Clinical Issues in the Assessment of Competency*, 138 AM. J. PSYCHIATRY, 1462-67 (1981)). Appelbaum and Roth recommend that in nonemergency situations more than one assessment of competency be conducted.

⁴⁴ See WOOD, ET AL., *supra* note 10, at 13.

⁴⁵ See generally A. Frank Johns, *Forays in Basic Guardianship and Conservatorship—Adjudication, Appointment, Administration and Accountability* (1998) (unpublished NAELA Elder Law Basics Symposium outline, on file with author) (analyzing a case study "She Was Crazy When She Hired Me, But Was She Competent to Engage Me?"). The case study analysis is based on a 1998 North Carolina ethics opinion. See Council of the N.C. State Bar, Rules of Prof'l Conduct, FEO 16 (1998), available at http://www.ncbar.com/eth_op/ethics_o.asp (last visited Feb. 12, 2004).

incompetence.⁴⁶ The client-lawyer engagement in this area has at least one strikingly different element compared to the screening analysis described above. In the case of engagement, there is a distinct possibility of immediate scrutiny and attack in the adversarial forum where the representation is sought. Thus, in addition to the screening described above, attorneys should consider strongly audio or video taping more than one interview of the AIP, at multiple locations and times of the day.

b. Scope of Representation

Under Model Rule 1.2, the scope of an attorney's representation and the duties in representing the AIP, once engaged, imposes on the lawyer the duty to abide by the AIP's decisions concerning the objectives of representation.⁴⁷ The comment to Model Rule 1.2 states, "In a case in which the client appears to be suffering diminished capacity, the lawyer's duty to abide by the client's decisions is to be guided by reference to Rule 1.14."⁴⁸ Simply stated, when a client's ability to make adequately considered decisions in connection with the representation is impaired, "[T]he lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client."⁴⁹ The attorney-client privilege deals with the disclosure of confidential information. If the lawyer representing the AIP is questioned about the AIP's disclosures, communications, production of documents, or anything else given within the scope of engagement or as a result of the engagement, the client-attorney privilege must be maintained.

Model Rule 1.6 states that a lawyer shall not divulge confidential information "unless the client gives informed consent, the disclosure is impliedly authorized in order to carry out the representation or the disclosure is permitted by [Rule 1.6(b)]."⁵⁰ Because the goal of the lawyer's representation of the AIP is to oppose the adjudication of incompetence,

⁴⁶ See Council of the N.C. State Bar, Rules of Prof'l Conduct, FEO 16 (1998) (examining the ethical difficulties surrounding the Clerk's appointment of a guardian ad litem, and the attempt by the respondent to hire her own counsel). The proposed opinion was crafted from letters of opinion written by Larry Rocamora, NAELA member, for North Carolina's Fiduciary and Estate's Section Ethics Committee and by Professor Kate Mewhinney, past NAELA Board member, NAELA Fellow and CELA, for the Wake Forest University School of Law and Elder Law Clinic.

⁴⁷ See MODEL RULES OF PROF'L CONDUCT R. 1.2 (2002).

⁴⁸ *Id.* cmt. 4 (dealing with clients with diminished capacity).

⁴⁹ See *id.* R. 1.14.

⁵⁰ *Id.* R. 1.6. In another North Carolina State Bar Ethics Opinion, RPC 157, a lawyer representing a person the lawyer believed to be incompetent was permitted to seek to have the person declared incompetent but could not disclose any information that the lawyer had obtained in her course of representation that would give rise to the attorney's belief that the client was incompetent. This is consistent with revised Model Rule 1.14. The rationale is that no exception exists to the limits on disclosure of confidential information. See Council of the N.C. State Bar, Rules of Prof'l Conduct, RPC 157 (1993), available at http://ncbar.com/eth_op/ethics_sel.asp?ID=157&LIST=number&BACK='ethics_o.asp' (last visited Feb. 12, 2004).

disclosure of any information obtained by the lawyer in that representation clearly would be contrary to the goals of the original representation. Under the standard rationale, the lawyer is unable to disclose the information.⁵¹ If ordered by the court, the lawyer should offer the testimony in camera, seeking guidance from the court regarding just what privileged information must be divulged on the record.

VI. CAPACITY ISSUES IN LONG-TERM RELATIONSHIPS WITH OLDER CLIENTS

A. Practice and Professional Dilemmas Related to Capacity

Attorneys have roles in assessing capacity and dealing with inherent dilemmas when relating capacity or incompetency to an ongoing client relationship.⁵² Many publications on elder law comment about capacity and the professional's relationship with the client. Elder law authors seem to agree that great care should be taken when an attorney confronts a client whose capacity has declined. Frequent interviews should address the relationship involved and declare the attorney's allegiance, undivided loyalty and command of confidentiality on behalf of the client as long as these tenets support the client's best interests.⁵³

The law presumes that all persons over the age of majority are competent. When the law's presumption of competency conflicts with facts arising during the course of representation, *de facto* incompetency may arise—an incompetent person yet to be adjudicated as such. When the de

⁵¹ See *Swidler & Berlin v. United States*, 524 U.S. 399, 406 (1998) (holding the attorney-client privilege continues after the death of a client). In N.C. RPC 206, it was assumed that the client impliedly authorized the release of confidential information to the person designated as personal representative in order that the estate might be properly and thoroughly administered. The RPC concludes:

Unless the disclosure of confidential information to the personal representative . . . would be clearly contrary to the goals of the original representation or would be contrary to express instructions given by the client to his lawyer prior to the client's death, the lawyer may reveal a client's confidential information to the personal representative.

Council of the N.C. State Bar, Rules of Prof'l Conduct, RPC 206 (1995), available at http://ncbar.com/eth_op/ethics_sel.asp?ID=206&LIST=number&BACK='ethics_o.asp' (last visited Feb. 12, 2004).

⁵² See James R. Devine, *The Ethics of Representing the Disabled Client: Does Model Rule 1.14 Adequately Resolve the Best Interest/Advocacy Dilemma?*, 49 MO. L. REV. 493, 513-14 (1984); J. Allee, *Representing Older Persons: Ethical Dilemmas*, 8 BIFOCAL 1 (ABA Commission on Legal Problems of the Elderly 1987).

⁵³ See generally PETER J. STRAUSS ET AL., AGING AND THE LAW 13-28 (1990); Lawrence A. Frolik, Melissa C. Brown, *Advising the Elderly or Disabled Client*, Ch. 2—*The Initial Client Interview*, Ch. 3—*Overview of Common Mental and Physical Impairments*, and Ch. 17—*Adult Guardianship and Conservatorship* (Thomson Prof. Pub., Inc. 2003); Louis Mezzullo, Mark Woolpert, Editors-in-Chief, *Advising the Elderly Client*, John E. Donaldson, contributing author, Ch. 2—*Ethical Considerations*; A. Frank Johns, contributing author, Ch. 34—*Guardianship and Conservatorship* (Clark, Boardman & Callaghan 1994) (Cum. Supp. 2003).

facto incompetent person is the client, does representation continue? Should it? Should the attorney rely on the person's consent? Is the person's consent legally effective?⁵⁴

B. Options if the Client's Capacity is Doubted

If client capacity is doubted, the lawyer has several options. First, the lawyer may act on the premise that the person is competent and has the ability to consent legally—informed consent. This option has the risk of consent being ineffective to consummate legal instruments that transfer the client's discretionary powers or assets.⁵⁵ Second, the lawyer may act on the premise that consent from family members is legally sufficient based on the principle of substitute judgment. In the past, this option has been viewed as legally sound, although it too has risks. The Model Rules comment that the negative consequences for a client in such a situation are significant and cautiously encourage practitioners to continue assisting the client while raising questions of competence.⁵⁶ Third, the lawyer may refuse to rely on the client's consent and seek adjudication of the person's incompetence and need for a court-ordered guardian.⁵⁷

C. Applying the Basics of Revised Model Rule 1.14

If readers have not worked with revised Model Rule 1.14, Client with Diminished Capacity, as it is currently written, a basic understanding may be gained from several sources published prior to the revision, but still applicable: (1) the Annotated Model Rules of Professional Conduct published periodically by the ABA;⁵⁸ (2) ABA Formal Ethics Opinion 96-404;⁵⁹ (3) the collective writing produced at the Fordham Conference on

⁵⁴ See generally Paul R. Tremblay, *On Persuasion and Paternalism: Lawyer Decisionmaking and the Questionably Competent Client*, 1987 UTAH L. REV. 515 (1987); Linda F. Smith, *Representing the Elderly Client and Addressing the Question of Competence*, 14 J. CONTEMP. L. 61 (1988).

⁵⁵ Continued representation of the client has long been the alternative promoted based on several factors: first, it may circumvent the undesirable incompetency proceeding; second, it encourages the family or friends to take care of the incompetent citizen; and third, it advances the well-accepted goal of the law—namely, to strengthen family unity and foster family reliance. Professor Turnbull wrote that this alternative “is well accepted, time honored, and not often abused. [I]t seems to be a good policy and one that the courts of this state might sanction if they are ever faced with the appropriate case.” H. RUTHERFORD TURNBULL, III, *THE LAW AND THE MENTALLY HANDICAPPED IN NORTH CAROLINA* 1-8 (2d ed. 1979) (footnote omitted).

⁵⁶ See MODEL RULES OF PROF'L CONDUCT R. 1.14 cmts. 2, 5 (2002); HAZARD & HODES, *supra* note 6, § 18.4; see also Comm. on Ethics and Prof'l Responsibility, ABA Informal Op. 89-1530 (1989) (stating that a lawyer may consult a physician about the client's medical condition without the client's knowledge or explicit consent).

⁵⁷ See ABA Comm. on Ethics and Prof'l Responsibility, Formal Op. 96-404 (1996).

⁵⁸ See ANNOTATED MODEL RULES OF PROFESSIONAL CONDUCT R. 1.14 at 231-46 (2003).

⁵⁹ See ABA Comm. on Ethics and Prof'l Responsibility, Formal Op. 96-404 (1996). The opinion has been a helpful guide for lawyers struggling with issues of client capacity.

Ethics and the Elderly;⁶⁰ (4) writings compiled by ACTEC in the ACTEC Commentaries;⁶¹ and (5) articles published in the last several years by Clifton B. Kruse, Jr., NAELA past president, mentor and author of the *Periapetetic Essayist*, which applies Model Rule 1.14 to elder law and estate and trust law practices.⁶²

In *Lessons Learned From Patch Adams*, Kruse discusses how the medical profession's edict "Do no harm" should be a cornerstone of any lawyer's practice.⁶³ He also directs our attention to the proposed comment regarding emergency legal assistance added to Model Rule 1.14 by the ABA Ethics 2000 Commission in February 2000.⁶⁴

VII. DEVELOPMENT OF THE REVISIONS TO MODEL RULE 1.14 AND THE RULE'S FUTURE APPLICATION

A. Scope of the Rule and the Actions a Lawyer May Take

The specific revisions to Model Rule 1.14 are set out earlier in this Article.⁶⁵ What follows is a review of how the revisions were developed and will be applied in the future. A primary revision to Model Rule 1.14 involved using more appropriate terms to refer to clients with diminished capacity. The prior rule referred to both a "client under a disability" and a "disabled client." The idea that client under disability actually fit the vast number of clients was clearly inaccurate. The phrase "client under a disability" created an assumption or inference that it referred only to clients who were truly "disabled," possibly to the extent that term is

⁶⁰ See generally Symposium, *Ethical Issues in Representing Older Clients*, 62 *FORDHAM L. REV.* 989, 989-92, 1003-14 (1994) (providing the recommendations of the conference for Model Rule 1.14 and the report of the working group on client capacity); see also Jan Ellen Rein, *Clients with Destructive and Socially Harmful Choices—What's an Attorney to Do?: Within and Beyond the Competency Construct*, 62 *FORDHAM L. REV.* 1101, 1101-76 (1994).

⁶¹ See ACTEC COMMENTARIES, *supra*, note 6, at 131-41. The main themes of the ACTEC Commentaries are:

(1) the relative freedom that lawyers and clients have to write their own charter with respect to a representation in the trusts and estates field; (2) the generally nonadversarial nature of the trusts and estates practice; (3) the utility and propriety, in this area of law, of representing multiple clients, whose interests may differ but are not necessarily adversarial; and (4) the opportunity, with full disclosure, to moderate or eliminate many problems that might otherwise arise under the [Model Rules]. *Id.* at 1.

⁶² See Clifton B. Kruse, Jr., *Model Rule 1.14—Lessons Learned From Patch Adams®—Ethical Issues Necessarily Considered When Working with Clients Under Disability*, NAELA Q., (Winter 2001), at 34 [hereinafter *Lessons Learned*]; see also Clifton B. Kruse, Jr., *Ethical Obligations of Counsel In Representing Clients Petitioning to be Appointed as Guardians of Others or of Their Estates, or Both*, NAELA Q., Spring 1995, at 13.

⁶³ See *Lessons Learned*, *supra* note 62, at 40.

⁶⁴ See *Lessons Learned*, *supra* note 62, at 40-41 (explaining that in 1997, paragraphs [6] and [7] were added to the Comment to Model Rule 1.14, addressing emergency situations); MODEL RULES OF PROF'L CONDUCT R. 1.14 cmts. 9, 10.

⁶⁵ See *supra* Part III.A.

defined in federal law.⁶⁶

Elder law and estate planning attorneys often saw clients with an initial diagnosis of symptoms consistent with Alzheimer's, beginning memory loss, or first phase dementia who presented some short-term memory loss. However, because these clients were not classified as disabled, they fell outside the language of the rule.

In an attempt to cover a broader range of clients, the revised Model Rule refers to clients with "diminished capacity." The new language gives lawyers guidance about how the rule would include the clients identified above. Diminished capacity refers to more than a reduction in cognitive function. Diminished capacity may include physical limitations and dysfunctions, such as incontinence, hearing loss, or vision impairment, if coupled with mental loss to the extent that it places the client at risk. The Model Rule's new focus on degrees of client capacity is clarified in comments 9 and 10.⁶⁷

Two additional revisions to Model Rule 1.14 describe the action a lawyer may take during representation of a client with diminished capacity.⁶⁸ The revisions guide the lawyer in taking reasonably necessary protective action, including consulting with individuals or entities that have the ability to act to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator, or guardian.⁶⁹ The changes offer lawyers greater flexibility and general guidance when clients face substantial risk of harm or when emergency legal intervention becomes necessary as described in comments 9 and 10.⁷⁰

Comment 7 provides that protection in the form of guardianship intervention is only appropriate when lawyers determine such protection is necessary after exercising their professional judgment.⁷¹ Comments 1 and 7 state that, while it "may" be necessary to have a legal representative appointed to complete a transaction, it is not ordinarily required to the extent that a client with some degree of capacity may be able to execute a power of attorney.⁷² Comment 5 explicitly provides that lawyers are to intrude "into the client's decisionmaking autonomy to the least extent feasible, maximizing client capacities and respecting the client's family and social connections."⁷³

⁶⁶ See, e.g., 42 U.S.C. § 1382(c)(3)(a) (2000) (defining "disabled" under the federal statute for funding means tested programs).

⁶⁷ See MODEL RULES OF PROF'L CONDUCT R. 1.14 cmts. 9, 10 (2002).

⁶⁸ These revisions addressed concerns voiced by the ABA Commission on Law and Aging, formerly known as the ABA Commission on the Legal Problems of the Elderly.

⁶⁹ See MODEL RULES OF PROF'L CONDUCT R. 1.14 cmt. 7 (2002).

⁷⁰ See *id.* cmts. 9, 10.

⁷¹ See *id.* cmt. 7.

⁷² See *id.* cmts. 1, 7.

⁷³ See *id.* cmt. 5.

B. Case Studies

1. *Father Knows Best*

The Jones family was a classic American family of the twentieth century. Tom and Linda Jones married in the 1940s and had three children. The children were good-looking, well-mannered, and overall above average. By the 1990s, Tom and Linda were in their late seventies and enjoyed retirement by traveling to and from one child's home to another to spend time with their seven grandchildren.

Tom had been involved in insurance throughout his professional career. He felt that he probably knew more about estate planning and arranging for legal things than lawyers who would only gouge him and attempt to sell him trusts he did not need. Healthy as an ox and quite proud of his youthful appearance, Tom considered himself "young-old" and thought little about the end of life. When such legal issues were raised in conversations with his children, Tom would give them an extensive song and dance about how he always took care of his family's business, and it was nobody else's place to ask. He would end each round with the declaration, "Father knows best!" Because Tom was a good provider, and Linda and the children loved and trusted him, they deferred a confrontation to sometime in the future. The situation continued for years into the twenty-first century.

As the years passed, Tom began keeping one dark little secret, a secret that grew so large that he could hardly hide it. Sadly, Linda was content in keeping Tom's secret as well, hoping beyond hope that it would correct itself as time passed.

Tom's secret did not go away and things grew much worse, escalating to a frightening intensity. It happened in the neighborhood in which Tom and Linda had lived for over forty years. Everyone in the neighborhood knew and loved the couple and were used to seeing them taking walks together in the late afternoons. While most of the time they went together, sometimes they walked separately. Lately, Linda would not let Tom go by himself. One day, Tom walked out while Linda was busy with laundry in the back of the house. Tom was found almost two days later wandering in a wooded area less than a half a mile from their home.

A week later, Tom had regained his memory and again argued with Linda that he did not need to see any professionals. Then one morning Tom walked out of the house and past a couple of houses up the block. In a split second, nothing was recognizable. It was a scene right out of the movie *On Golden Pond*. Extreme panic clutched at Tom, choking him in fear. Only by instinct, Tom turned and made it back to the house. Entering the door, Linda rushed to Tom only for him to stare at her and demand why

a strange woman was in his home. Then just as quickly, Tom remembered. He told Linda that he needed help.

Among the many professionals that Tom and Linda saw was an elder law attorney. At the time of the meeting with the lawyer, Linda explained Tom's dilemma. The lawyer focused her attention on Linda, giving little attention to Tom. When the lawyer turned her attention to Tom, she informally questioned him about which day, month, and year it was, as well as his age, the names of his children, and siblings. Tom answered many of the questions incorrectly. Finding Tom to be lacking in many areas, the lawyer concluded that Linda needed legal authority over Tom and that such authority could only be gained through guardianship.

Under current Model Rule 1.14, the lawyer's conclusion that Linda should pursue guardianship of Tom is reasonable. The lawyer reasonably believed that Tom could not adequately act in his own interest and that the lawyer could not assist Tom by maintaining a normal client-lawyer relationship.

The revised Model Rule 1.14 would not deny the lawyer her professional judgment or even assert that the lawyer's conclusion was wrong. However, the Comment suggests that the lawyer should have been more thorough in determining the extent of Tom's diminished capacity.⁷⁴ Although the lawyer interviewed Linda and questioned Tom, nothing suggests the lawyer went through the various factors raised in the Comment. The lawyer failed to assess Tom's ability to make a well-reasoned decision or the variability of his state of mind. None of the questions enlightened the lawyer as to whether Tom's decisions were substantively fair or consistent with his long-term commitments and values based on what the lawyer may have learned from Linda.

Capacity is a complex issue. In many instances, the lawyer may find that he is not able to assess a client's capacity to make legal decisions. In such case, it may be appropriate for the lawyer to seek guidance from an appropriate diagnostician.

2. SARS Covered Social Security Checks

Attorney *A* represents client *B* on a Social Security matter and determines from confidential communications with *B* that *B* is not competent to handle affairs in relation to the representation and that *B*'s actions in regard to the matters involved in the representation are detrimental to *B*'s own interest. For example, *B* refuses to cash checks from Social Security despite *B*'s obvious need for financial support. Client *B* declares to attorney *A* that the checks have been coated with severe acute respiratory syndrome (SARS). Attorney *A* believes that either a guardian should be appointed for *B* under state law or that a representative payee should be

⁷⁴ See *id.* cmt. 6.

appointed for *B* under federal Social Security law. *B* refuses to allow attorney *A* to seek the appointment of a guardian, the appointment of a representative payee, or even to discuss this problem with the client's family. Attorney *A* is of the opinion that client *B* lacks the capacity to form objectives necessary for a normal attorney-client relationship.

May the attorney seek the appointment of a guardian or a representative payee for the client? Under revised Model Rule 1.14, the answer is yes.⁷⁵ In this situation, the attorney asked how the client was going to pay for food, clothing, and shelter. The client's responses demonstrated an inability to articulate a well-reasoned decision, an irrational variability of his state of mind, and an inability to appreciate the consequences of the decision not to cash the checks.

VIII. CAPACITY AND SPECIFIC USE OF ADVANCE DIRECTIVES

A. Physical Barriers

Too often capacity is framed and examined only in a mental context. However, elder law attorneys provide services to many older clients who have physical limitations. Severe physical limitations hinder the elder law attorney's ability to discern the client's directives and determine competency and informed consent. Many older clients have mental capacity and the ability to offer informed consent, but have vision and hearing impairment, are nonverbal, or lack the fine motor skills to write or use a keyboard. Additionally, nonambulatory or incontinent clients may have such physical limitations that they may not be able to meet in the law office.

Although the Americans with Disabilities Act clearly mandates that the legal profession provide accessibility to clients, the legal profession does not specifically address accessibility to clients.⁷⁶ Whether relating to the initial consultation with a prospective client or in the ongoing relationship, the duties examined within the legal profession and the law governing lawyers do not speak to physical barriers and accessibility.⁷⁷ However, physical barriers in the courthouse and other additional barriers facing older persons may bar their participation in the judicial process.⁷⁸ These

⁷⁵ This case study is taken from NC RPC 157. See Council of the N.C. State Bar, RPC 157 (1993) (illustrating this case study and entering an affirmative decision of first impression); see also N.C. REVISED RULES OF PROF'L CONDUCT ANN. R. 1.14 (2003); N.C. State Bar, *The North Carolina State Bar Lawyer's Handbook*, N.C. ST. B. Q., Winter 1995, at 1, 100, 202-03.

⁷⁶ See 42 U.S.C. § 12181(7)(F) (2000). This section of Americans with Disabilities Act provides: "The following private entities are considered public accommodations for purposes of this subchapter, if the operations of such entities affect commerce [or] . . . office of an accountant or lawyer. . . ."

⁷⁷ See RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 14 (2000).

⁷⁸ See Erica Wood, *Toward a Barrier-Free Courthouse: Equal Access to Justice for Persons with Physical Disabilities*, in *COURT-RELATED NEEDS OF THE ELDERLY AND PERSONS WITH DISABILITIES: RECOMMENDATIONS OF THE 1991 CONFERENCE 69-83* (A.B.A. ed. 1991).

same issues confront elder law and estate planning lawyers in their offices.

B. Contracts

The capacity necessary to execute a contract is higher than that necessary to execute a will. Mutuality of assent, required to form a contract, constructs a back-and-forth relationship between two parties requiring greater cognitive ability and skill. Older clients not only must understand their status and desires, but they also must comprehend the consideration and what the other party to the contract expects out of the relationship.⁷⁹

The test for capacity to contract is the possession of sufficient mind to understand, in a reasonable manner, the nature and effect of the act.⁸⁰ Contractual capacity is found where the party is capable of making a rational judgment concerning a particular transaction.⁸¹

C. Trusts

Trusts are basically contractual in nature.⁸² Thus, the requirements of capacity for creating a trust may be the same as described above for contracts. However, some trusts activate certain other requirements when incapacity of the beneficiary occurs.⁸³

D. Advance Medical Directives

Advance medical directives encompass a host of legal and sometimes non-legal documents that enable an individual to exercise his or her right to accept or forsake medical care.⁸⁴ Advance medical directives generally include no code or do not resuscitate orders ("DNR Orders"), living wills, health care powers of attorney ("Health Care POA"), and durable general powers of attorney ("Durable POA").⁸⁵

⁷⁹ See 17A AM. JUR. 2D *Contracts* §§ 23-24 (1991). Mutuality of assent or promises requires the capacity of each party submitting to the promises such that they be binding on both. If a promise is void for incapacity, then the contract will not be upheld.

⁸⁰ See WALSH ET AL., *supra* note 17, app. D, at D4-5 (citing *Howard v. Howard*, 352 N.W.2d 280 (Mich. Ct. App. 1984), *Van Wagoner v. Van Wagoner*, 346 N.W.2d 77 (Mich. Ct. App. 1983), and *Star Realty Inc. v. Bower*, 169 N.W.2d 194 (Mich. Ct. App. 1969), *reh'g denied*, 303 Mich. 768 (1970)).

⁸¹ See *id.* at D-7 (citing *Harrison v. Grobe*, 790 F. Supp. 443 (S.D.N.Y. 1992), *aff'd*, 984 F.2d 594 (2nd Cir. 1993)).

⁸² See GEORGE GLEASON BOGERT, *HANDBOOK OF THE LAW OF TRUSTS* 1 (4th ed. 1963); see also BLACK'S LAW DICTIONARY 1513 (7th ed. 1999).

⁸³ See Janet L. Kuhn, *Using Trusts to Protect the Affluent Client in the Event of Incapacity*, *THE ELDERLAW REP.*, Jan. 1996, at 1.

⁸⁴ See ALAN D. LIEBERSON, *ADVANCE MEDICAL DIRECTIVES* § 1:1, at 2-3 (1992). Lieberson explains that

[a]dvance medical directives . . . [provide] a vehicle for competent declarants to make anticipatory medical decisions for the future, either through express directives to health care providers, as in a living will, or by the designation of an agent who knows and is sympathetic to their desires.

⁸⁵ See *id.*; see also ALAN MEISEL, *THE RIGHT TO DIE* §§ 9.4-9.10, 10.2-10.9, 12.6 (2d ed. 1995); FAY A. ROZOVSKY, *CONSENT TO TREATMENT* §§ 7.6.1-6.2, 7.8.1-8.4 (2d ed.

1. *Do Not Resuscitate Orders*

A DNR Order usually contains an instruction directing those who attend a person in severe medical distress to withhold medical intervention that would literally save the life of the patient or resident.

All too often, admission requirements of nursing homes and medical decisions in hospitals impress on the resident or patient the DNR Order, without their giving the directive. The directive exists based on the theory of substituted judgment.⁸⁶ However, the use of substituted judgment has also been described as invented consent, which is the

process of medical [and health care] decisionmaking whereby one orders care or discontinuance of care for another on a "ghost writer" basis. The order, perhaps to disconnect a feeding tube from an unconscious patient, issues from the patient's surrogate as if it were the command of the soon-to-be deceased. The order is, in reality, not authored by the patient, but ghost-scripted by the surrogate.

Born of a myth and employing a myth, invented consent is the practice of choice in many jurisdictions. The myth is this: a person incapable of choosing is capable of choosing.⁸⁷

Given the nature of the event, the patient or resident will be in such trauma that he or she is incapable of communicating decisions regarding medical care or treatment. The DNR Order usually is placed on the patient's or resident's admission documents, and staff are on notice and directed to respond accordingly. When the declarant lives at home, the risk that execution of the DNR Order may not be communicated is greater.

2. *Living Will*

The living will is a declaration addressed to health care providers generally rather than anyone specifically. Under statutes in all fifty states, the living will declaration authorizes providers to act, or not to act, with regard to life sustaining treatment of "terminal conditions." Most statutes dealing with living wills specify that death from a terminal condition must be imminent, or expected to occur in a "relatively short time" or "reasonably short period of time." Sometimes an immediate family member's recollection of the declarant's utterances, with no written declaration, will be sufficient evidence for a court to order the withholding of life-sustaining, invasive procedures.

The capacity needed to execute a living will is no different than that

1990).
⁸⁶ See Superintendent of Belcher Town State Sch. v. Saikewicz, 370 N.E.2d 417, 428-32 (Mass. 1977).

⁸⁷ James Bopp, Jr. & Daniel Avila, *Perspectives on Cruzan: The Sirens' Lure of Invented Consent: A Critique of Autonomy-Based Surrogate Decisionmaking for Legally-Incapacitated Older Persons*, 42 HASTINGS L. J. 779, 780 (1991) (footnotes omitted).

for other components of an advance medical directive. Statutes that address capacity require the declarant of a living will to be competent at the time of execution.⁸⁸ Many statutory living will forms require declarants to attest that they are of sound mind and acting freely when executing the instrument.⁸⁹

3. Health Care Powers of Attorney

The Health Care POA allows the principal to name an agent to make health care decisions for the principal when the principal lacks the capacity to make those decisions.⁹⁰ The Health Care POA is broader in scope and application than the living will in that it identifies a proxy, or a person to act as an intermediary with the medical or health care providers, executing agency directives on behalf of the principal.⁹¹

The capacity required for valid execution of a Health Care POA is no different than that for other components of an advance medical directive.⁹² The statutes that address the issue require the principal of a Health Care POA to be competent, although most of the attestation requirements of principals do not explicitly require principals to attest that they are “of sound mind and acting freely when executing the instrument.”⁹³

Capacity or competency and informed consent of the principal are necessary for a Health Care POA to have legal sufficiency. On the other hand, the Health Care POA usually will not activate until the principal is no longer capable of communicating his or her wishes and is in a situation that may be declared terminal by a physician.⁹⁴ In one recent case, failure of the state to follow a Health Care POA resulted in a violation of Title II of the Americans with Disabilities Act and section 504 of the Rehabilitation Act.⁹⁵

Health Care POAs often address more than just the withholding or withdrawing of life-sustaining measures. They often give the proxy or surrogate the duties and responsibilities of monitoring and advocating for the quality of life of the declarant with health care providers. Remember, however, the Health Care POA usually becomes effective only when the principal is incompetent. If the principal wants to ensure that the agent has the authority to act in quality-of-life situations when the principal is competent, the principal should execute a Durable POA, which activates upon execution and can include provisions that address the personal and

⁸⁸ See George J. Alexander, *Time for a New Law on Health Care Advance Directives*, 42 HASTINGS L. J. 755, 757 (1991).

⁸⁹ See, e.g., N.C. GEN. STAT. § 90-321(d) (2003).

⁹⁰ See, e.g., UNIF. HEALTH-CARE DECISIONS ACT § 1(12), 9 U.L.A. 1B (1999).

⁹¹ Compare *id.*, with N.C. GEN. STAT. § 90-321(d) (2003).

⁹² See generally MEISEL, *supra* note 85, at §§ 4, 5, 12.

⁹³ MEISEL, *supra* note 85, § 12.9, at 139.

⁹⁴ See *id.* at 133; see also Salkewicz, 370 N.E.2d at 428-32; WALSH ET AL., *supra* note 17; Lieberman, *supra* note 84.

⁹⁵ See *Hargrave v. Vermont*, No. 2: 99-CV-128, 26 MPDLR 32 (D. Vt. 2001).

health care needs of the principal. Many states provide for Durable POAs in their statutory law. When a statutory form is not available or is insufficient, counsel may provide the client with a customized Durable POA.

A continuing care trust is an option, other than a Health Care POA, which directs the trustee to focus narrowly on and implement the delivery of the continuing care of the beneficiary, with responsibility to have developed a quality care plan in the least restrictive environment affordable. This type of trust is appropriate in situations in which the quality of life of the person is paramount, and the person has serious reason to consider long-term care. However, the expense of the trust, as compared to the durable Health Care POA, makes the trust less attractive and, for older clients of modest means, the trust may be out of the question solely because of financial limitations.⁹⁶

E. Durable Powers of Attorney

Capacity is also necessary in the financial or estate planning context. Because Durable POAs may deplete the estate during the lifetime of the principal, they are significant documents.⁹⁷ Usually, if the principal can be shown to have understood that the instrument would allow the attorney-in-fact to transfer his bounty, then at a minimum, the principal or donor breaks the threshold of testamentary capacity. However, the capacity required for a testator to execute a will is still less than that which is required to execute a power of attorney. This capacity must be assessed on a case-by-case basis. Cases reviewed in the literature fall back on the elements of testamentary capacity.⁹⁸

F. Wills

There has been comprehensive treatment in the literature on the capacity required for execution of wills.⁹⁹

Generally, the elements for testamentary capacity are the same in most states. The elements include: (1) the testator must be of sound mind, and over the age of majority (18 in all states); (2) the testator knows the natural objects of his or her bounty (generally, his or her nearest kin); (3) the testator understands the nature and extent of his or her property; and, (4) the testator knows the manner in which he or she desires to dispose of his or her estate and realizes the effect that the manner of disposition will have upon his or her estate.¹⁰⁰

⁹⁶ See Kuhn, *supra* note 83.

⁹⁷ See Linda S. Whitton, *Durable Powers as a Hedge Against Guardianship: Should the Attorney-at-Law Accept Appointment as Attorney-in-Fact?*, 4 ELDER L. J. 39 (1994).

⁹⁸ Several cases are cited in the subsection on wills. See Brown, *supra* note 37.

⁹⁹ See generally Alison Barnes, *The Liberty and Property of Elders: Guardianship and Will Contests as the Same Claim*, 11 ELDER L.J. 1 (2003).

¹⁰⁰ See WALSH ET AL., *supra* note 17, app. B (providing references to every state and containing a headnote and case citation to precedent and other significant cases within the jurisdiction); see also *In re Will of Womack*, 280 S.E.2d 494, 496 (N.C. Ct. App. 1981),

Appellate level judicial decisions often publish the will contest or a caveat of a will. In recent years the number of published cases has increased and many of them focus on capacity.¹⁰¹

Capacity also relates to the examination of undue influence. To the extent it can be shown that the testator's capacity is in decline, influence unduly asserted by those immediately in contact with the testator may be sufficient to invalidate the will. Because testamentary capacity has a very low threshold to begin with, showing the testator's mental decline or dysfunction is often not enough. In almost all of the states, the presumption of the validity of the will is strong.¹⁰² Much like capacity, the number of published cases focusing on undue influence has increased in recent years.¹⁰³

IX. CONCLUSION

This Article examined the revision to Model Rule 1.14, Clients with Diminished Capacity and the broader application of the Model Rule in the context of the initial contact and ongoing relationships with older clients. The Article then reviewed legal documents, including advance directives, and the necessary elements in determining the client's capacity to execute them.

review denied, 285 S.E.2d 837 (N.C. 1981).

¹⁰¹ See generally *Horton v. Raspberry*, 852 So. 2d 155 (Ala. Civ. App. 2002); *Pyle v. Sayers*, 34 S.W.3d 786 (Ark. Ct. App. 2000); *In re Szewczyk*, 2001 WL 456448 (Del. Ch. Ct. 2001); *In re Estate of Herbert*, 979 P.2d 39 (Haw. 1999); *In re Estate of Farr*, 49 P.3d 415 (Kan. 2002); *Bye v. Mattingly*, 975 S.W.2d 451 (Ky. 1998); *McPeak v. McPeak*, 593 N.W.2d 180, 186 (Mich. Ct. App. 1999) (citing *In re Estate of Erickson*, 508 N.W.2d 181 (Mich. Ct. App. 1993)); *In re Probate of Alleged Will of Landsman*, 725 A.2d 90 (N.J. Super Ct. App. Div. 1999); *In re Clapper*, 718 N.Y.S.2d 468 (N.Y. App. Div. 2001); *In re Estate of Barber*, 2002 WL 818852 (Wis. Ct. App. 2002); *In re Estate of Persha*, 649 N.W.2d 661 (Wis. Ct. App. 2002); *In re Estate of Williams*, 1998 WL 514343 (Wis. Ct. App. 1998).

¹⁰² NAELA has provided several manuscripts and workshops that address testamentary capacity, will contests, and caveats. An excellent presentation on this subject was delivered by Jim Hill at the 1994 NAELA Institute in New Orleans, Louisiana. The presentation carefully laid out how to go through the trial. NAELA's past president Clifton Kruse gave a presentation on the language in a will at the 1997 NAELA Institute in Nashville, Tennessee. Contact NAELA publications by visiting the NAELA website at www.naela.org or by calling the NAELA office (520) 881-4005 to acquire manuscripts or audiotapes.

¹⁰³ See generally *Rudolf Nureyev Dance Found. v. Noreeva-Francois*, 7 F. Supp. 2d 402 (S.D.N.Y. 1998); *Sullivan v. Sullivan*, 539 S.E.2d 120 (Ga. 2000); *Succession of Lounsberry*, 824 So. 2d 409 (La. Ct. App. 2002); *In re Will of Sechrest*, 537 S.E.2d 511 (N.C. Ct. App. 2000); *In re Armster*, 2001 WL 1285904 (Tenn. Ct. App. 2001); *Dubree v. Blackwell*, 67 S.W.3d 286 (Tex. Ct. App. 2001); *Estate of Graham*, 69 S.W.3d 598 (Tex. Ct. App. 2001); *In re Estate of Barber*, 2002 WL 818852 (Wis. Ct. App. 2002).