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Elders Falling Through a Loophole in Quality: Impacts of “Off-Label” Drug Promotion
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Multidisciplinary Practice and Ethics, Part II
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INTRODUCTION

Until the 2005 passage of the Bankruptcy Abuse Prevention and Consumer Protection Act, and again in recent years, the number of annual bankruptcy filings has risen.1

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I. INTRODUCTION

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V. CONCLUSION
The rise has been particularly notable for the elderly and near-elderly. Despite the rise in filings by the elderly and near-elderly, however, the percentage of debtors aged 55 and higher who are filing for bankruptcy protection remains lower than for younger age groups. In a time of recession, however, mortgage foreclosures, job losses, and sub-prime lending crises the number of bankruptcy filings will almost certainly continue also thank the Hon. Paul Glenn, Chief Judge of the U.S. Bankr. Ct. for the Middle Dist. of Fla., for supporting this project, and the Stetson U. College of Law for its support of their research. Finally, they recognize the attorneys and experts who shared their insight with them through this research project.


John Golmant & Tom Ulrich, Aging and Bankruptcy, Am. Bankruptcy Inst. J. 26 (May 2007) (finding that filings by those ages 45 and older are increasing at a faster rate than other age groups, with an increase of approximately three percent from 1994 to 2002 in filings by filers over age 54, and approximately 20 percent by filers between ages 45 and 54, compared to a reduction in filings by those 44 and under); see also Institute for Financial Literacy, First Demographic Analysis of Post-BAPCPA Debtors (2006) (finding that “there appears to be a statistically significant shift in the age of bankruptcy debtors, the most dramatic of which is seen to be occurring with the population aged 65 and older”).

Ed Flynn & Gordon Bermant, Bankruptcy by the Numbers: Chapter 7 Debtors—from 19 to 92, ABI Journal, http://www.usdoj.gov/ust/oe/public_affairs/articles/docs/abi122002a.htm (accessed May 20, 2009). In their study, Flynn and Bermant concluded that “the ages of 25–44 are the peak years for filing bankruptcy.” Id.


Primarily a feature of mortgage lending, the number of subprime loans (loans given to the most risky of borrowers and with the highest interest rates) rose greatly during the decade leading to the current financial crisis. It appears that the increase could be as much as a five-fold increase in just eight years. Souphala Chomsisengphet & Anthony Pennington-Cross, The Evolution of the Subprime Mortgage Market, Fed. Reserve Bank of St. Louis Rev. 31, 37, http://research.stlouisfed.org/publications/review/06/01/ChomPennCross.pdf (January/February 2006) (calculating an increase from $65 billion in sub-
to increase. This increase will likely include an increase in filing among all age groups, including the elderly.

Although the elderly are significantly impacted by financial distress and are often not in a position to improve financially post-bankruptcy, they are rarely studied separately in bankruptcy. Recent research into — and discussion of — the causes of bankruptcy indicate that medical problems and job loss are primary triggers for bankruptcy filings. As the elderly are, in general, more susceptible to health issues and less likely to be employed, they face greater impact than the general population by these potential bankruptcy triggers. This article considers bankruptcy filings of the elderly and seeks to determine some of the reasons why the elderly file for bankruptcy protection. It makes recommendations for advising clients in financial distress and examines what the Federal Government must consider to stimulate the economy and trim the budget deficit.8

II. THE ELDERLY AND THEIR FINANCIAL AFFAIRS

A. The Baby Boomers

One reason why the elderly deserve a primary focus in the bankruptcy system is the simple reality that there are more elderly and near-elderly people today than at any time in recent history. The baby boomers — the generation consisting of those born between 1946 and 19649 — will classify as elderly in just a few years (using the age of 65 as “elderly”). The boomer generation will likely be very different from its predecessors — there are more people in this generation,10 they are expected to live longer than previous generations,11 and they grew up in different financial times. Credit, particularly in the prime loans in 1998 to $332 billion in subprime loans in 2003, but noting that the share of the total lending market occupied by subprime loans actually decreased slightly during that time). One study concluded that the elderly are more likely to take out subprime loans than other age groups, even when gender and race are accounted for. CONSUMERS UNION, ELDERLY IN THE SUBPRIME MARKET, http://www.consumersunion.org/finance/elderly-rpt1002.htm (October 2002).


10 The census bureau estimated 22,861,373 persons living in the United States were aged 45-50 as of July 1, 2007, the largest number for any five-year age cohort. ANNUAL ESTIMATES OF THE POPULATION BY SEX AND FIVE-YEAR AGE GROUPS FOR THE UNITED STATES: APRIL 1, 2000 TO JULY 1, 2007 (NC-EST2007-01), http://www.census.gov/popest/national/asrh/NC-EST2007-sa.html (accessed May 21, 2009); Robert Bernstein & Tom Edwards, AN OLDER AND MORE DIVERSE NATION BY MIDDLE CENTURY, U.S. CENSUS BUREAU NEWS (Aug. 14, 2008) (noting that by 2030 all baby boomers will be 65 or older and projecting more than doubling of the current elderly population by that time).

11 Someone born in 1930 was expected to live 59.20 years, while someone born in 1950 was expected to live 68.07 years, and someone born in 1970 was expected to live 70.75 years. Centers for Disease Control, LIFE EXPECTANCY BY AGE, RACE, AND SEX: DEATH REGISTRATION STATES 1900–1902 TO 1919–1921, AND UNITED STATES, 1929–1931 TO 2004, NATIONAL VITAL STATISTICS REPORTS, Vol. 56, No. 9, http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_09.pdf (Dec. 28, 2007).
form of unsecured credit, was easily available. But, while credit was readily available, the boomers faced hard financial times in their peak earning years. Many of them were in their 30s and 40s during the recessionary years of the 1980s. Studies suggest that most individuals reach their peak earning level at approximately 50 years of age. Unfortunately, at a time when they should have been financially comfortable, baby boomers were overrepresented in the bankruptcy system. While it seems likely that this generation will continue to work after age 65 in greater numbers than their predecessors, concern remains that this generation did not have an opportunity to save for retirement due to the financially precarious position some faced earlier in life. Indeed, the debt level for this

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13 Teresa Sullivan, Elizabeth Warren & Jay Westbrook, The Fragile Middle Class: Americans in Debt 39–40 (2000). The study noted that “[t]he 1980’s were a decade of pink slips—and not just for blue collar workers. Between 1984 and 1986, 600,000 mid- and upper-level executives lost their jobs.” Now, 20 years later, a significant portion of those mid- and upper-level executives (and undoubtedly many of the blue collar workers who also lost their jobs) are at or nearing retirement age, having gone through a period of unemployment and, presumably, a period of little or no saving for that retirement. One story in the study was particularly telling—a 62-year-old’s filing in the early 1990s, in which he notes that he was out of work for one year in the late 1980s. During that time, he depleted his savings account and tapped into his retirement account. Id. at 99–100 (discussing the story of Calvin Granger).


15 The Sullivan, Warren, & Westbrook study found that, while baby boomers made up just over 39 percent of the adult population in 1991, they constituted 55 percent of debtors filing for bankruptcy during that same time. Golmant, supra note 2, at 53 (citing Sullivan et al., supra note 13, at 39).

16 Alicia H. Munnell, Steven A. Sass & Jean-Pierre Aubry, Employer Survey: 1 of 4 Boomers Won’t Retire Because They Can’t, Issue Brief Series 6, Center for Retirement Research at Boston College, http://crr.bc.edu/images/stories/Briefs/wob_6.pdf?phpMyAdmin=43ac483c4de9f51d9eb41 (Dec. 2006). “If the survey results prove accurate, half of all Boomers who are currently in their 50s will lack the resources needed to retire at the same age as similar workers have in the past. This is bad news and concerns about their retirement prospects. However, an estimated 60 percent of these unprepared workers will want to remain on the job at least two years longer.” Id. at 6; see also Dan Muldoon & Richard W. Kopcke, Are People Claiming Social Security Benefits Later?, Issue Brief No. 8–7, Center for Retirement Research at Boston College, http://crr.bc.edu/images/stories/ib_8-7.pdf (June, 2008) (noting “long-term trend toward earlier retirement ages came to a halt in the mid-1980s, and labor force participation rates at older ages actually began to increase in the mid-1990s”).

age group was higher in 1998 — during their pre-retirement years — than for the elderly at that time. This suggests that as the baby boomers enter retirement, they may have at least as much debt as their predecessors, and potentially more. These factors leave some boomers no alternative but the bankruptcy system for protection in their “golden years.”

B. Sources of Income for the Elderly

In 2005, the median income for those aged 65 and older was $26,036. Approximately 10 percent of those aged 65 and older live in poverty. But many more are considered to have “low” incomes, defined as having no more than twice the annual income of the poverty level. The situation is bleaker for elderly women, who typically have about half of the income that elderly men have. Although the elderly receive income from a number of sources, the majority of senior income traditionally comes from savings, employment, retirement or other pensions, or government funding such as Social Security. Indeed, Social Security is the single
most important source of income for the elderly population.24 “Without Social Security benefits, the poverty rate would increase from 9.8 percent to 47.9 percent for all older persons and from 11.4 percent to 59 percent for those age 80 and older.”25 Highlighting the importance of Social Security for those with the lowest incomes, a recent study finds that those who leave the work force early, before becoming eligible for Social Security benefits, are significantly more likely to experience financial hardship than those eligible for Social Security after age 62.26

Social Security is not intended to be the sole source of retirement income, however.27 According to the Social Security Administration, retirement benefits replace about 40 percent of pre-retirement income, yet financial advisors indicate that a person needs 70 percent of pre-retirement earnings to live comfortably.28 This means that an individual’s retirement income needs an additional 30 percent of pre-retirement dollars from savings and pensions. So a person with Social Security and a pension still needs to save, and a person who does not have a pension needs to save even more.29

It appears, however, that the reduced availability of Social Security as a primary source of retirement income changes how the elderly and near-elderly approach retirement. An increasing percentage of the elderly continue to work full time every year to supplement Social Security income.30 At the same time, the elderly delay the onset date

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24 Key Indicators 2006, supra note 23, at Appendix A, Indicator 8 (indicating that 9.8% of older Americans were in poverty and another 28.1% were at low income levels in 2004). See also, Wu, supra n. 22, at 2 (indicating that while the poverty rate among those age 65 and older is lower than average, the percentage of the elderly “near poor” is higher than for any other age group); Wu, supra n. 17, at 11–12 (indicating that over 50% of households where an elderly person is the head-of-household have annual incomes below $25,000).

25 Wu, supra note 14, at 55.

26 Richard W. Johnson & Gordon B.T. Mermin, Financial Hardship Before and After Social Security’s Early Eligibility Age, Center for Retirement Research at Boston College (March 2009). The study concluded that early-eligibility Social Security benefits are particularly important for those with less education, as these workers are less likely to have high-paying positions and are more likely to have to reduce work hours should a medical condition arise because those positions frequently require physical abilities. Id. at 21–22.


28 Id.

29 Id.

30 In 2005, 67.9 percent of men and 54.8 percent of women aged 62–64 worked full time, up from 63.6 percent and 51.7 percent in 2000. For those aged 65–69, men increased from 46.7 percent working full time in 2000 to 54.2 percent in 2005, while women increased from 32.7 percent working full time in 2000 to 42.5 percent in 2005. And even the older elderly saw increasing full-time employment, jump-
of Social Security benefits.\textsuperscript{31}

The source of income varies substantially for those with the lowest overall income and those with the highest overall income.\textsuperscript{32} For example, the 20 percent of seniors with the lowest overall income receive over 80 percent of their income from Social Security.\textsuperscript{33} By contrast, the 20 percent of seniors with the highest overall income receive 40 percent of their income from earnings,\textsuperscript{34} 21 percent of income from pensions,\textsuperscript{35} and less than 20 percent of income from Social Security.\textsuperscript{36} Thus, the ability to supplement Social Security income is a key component for seniors in determining where they fall in the income continuum.

It seems altogether obvious that a lack of income is a primary factor in financial difficulty, but the lack of income is not the only contributing factor in a bankruptcy. Numerous people weather the storm of temporary unemployment, or the permanent unemployment of retirement, without filing for bankruptcy protection.\textsuperscript{37} Studies of bankruptcy filings from 35.3 percent to 37.3 percent from 2000 to 2005 for men and from 23.8 percent to 30.8 percent from 2000 to 2005 for women. Murray Gendell, \textit{Older workers: increasing their labor force participation and hours of work}, \textit{MONTHLY LABOR REVIEW} 41, 49 (January 2008). Muldoon & Kopcke, \textit{supra} note 16 (finding a steady decline in the percentage of persons taking the benefit when first eligible at age 62).


Pensions are significantly more common for near-retirees aged 55–61 who are the highest wage earners compared with the lowest wage earners. Irena Dushi & Howard M. Iams, \textit{Cohort Differences in Wealth and Pension Participation of Near-Retirees}, 68 \textit{SOC. SEC. BULLETIN} 3, 45–49 (2008) (noting that only 46 percent of those in the lowest fifth of earners participated in an employer-sponsored pension plan, while 83 percent of those in the highest fifth of earners did so). Although most older Americans have pension coverage, more than one-quarter of those aged 48 and above have no retirement plans. Verma, \textit{supra} note 34, at 7. Over 40 percent of those aged 65 and above lack any pension coverage. \textit{Id.} at 8.

Key Indicators 2006, \textit{supra} note 20, at Appendix A, Indicator 9. Interestingly, although pensions are not a significant income source for most of the population, most people aged 45 and older appear to have some pension income. AARP, 2003 \textit{Consumer Experience Survey: Insights on Consumer Credit Behavior, Fraud and Financial Planning} 34, http://assets.aarp.org/rgcenter/consume/cons_exp.pdf (Oct. 2003) (indicating that 60 percent of that population surveyed had a retirement, pension, or 401K plan). See also Ke Bin Wu & Economics Team, \textit{supra} note 23, at 6 (indicating that those with the lowest incomes received a substantial percentage of income from Social Security, while those with the highest income received the largest amount of income from earnings).

filings among the general population show that unemployment or under-employment are significant contributing factors in filing for bankruptcy protection, particularly when coupled with other factors such as lack of savings and high debt amounts. The same studies found that one of the most significant factors in avoiding bankruptcy or succeeding financially after bankruptcy lies in one’s ability to secure future employment at a sufficient salary. For the elderly, however, that safety net may not be feasible or desirable. Even in an era when age discrimination in employment is prohibited, it may be impossible for even the most able of elderly debtors to find a well-paying job, particularly if the debtor would need additional education in order to secure such a position. Thus, the lack of current income, combined with the inability to significantly increase future income, can create a spiral of debt from which many elderly cannot recover.

C. Expenditures

Nearly half of all those aged 45 and older report owing as much or more debt than their income will cover. This finding is significant for anticipating bankruptcy filings for today’s elderly, as well as filings that may occur when the youngest of that group reach their elder years. Studies from the 1990s found that the debt level for those aged 50 and above increased from 1989 through 1998, despite the relative prosperity of the mid-to-late 1990s, with the most significant increases in debt coming for the youngest of these elderly and near-elderly, and those of the lowest incomes.

38 The study concluded that job loss “is by far the most important cause of severe financial distress for middle-class Americans,” but also noted that having a job that does not pay enough can also be involved in bankruptcy filing. Sullivan et al, supra note 13, at 75–77. The study went on to consider the effect of unemployment or underemployment in conjunction with debt incurred before the job loss, noting that “bills that seemed reasonable on an income of $60,000 became insurmountable on a new income of $26,000.” Id. at 114 (discussing how credit card debt might be manageable if not for a job loss or pay reduction). See also, INSTITUTE FOR FINANCIAL LITERACY, FIRST DEMOGRAPHIC ANALYSIS OF POST-BAPCPA DEBTORS (2006) (concluding that “Overextended on Credit,” “Unexpected Expenses,” and “Reduction of Income” were each contributing factors in approximately 50 percent of bankruptcy filings studied, followed by “Job Loss” and “Illness/Injury” each contributing to approximately one-third of filings studied).


41 See, e.g., Robyn L. Meadows, Bankruptcy Reform and the Elderly: The Effect of Means-Testing on Older Debtors, 36 Idaho L. Rev. 227, 237 (2000) (discussing that “[e]lderly Americans have less ability to recover from financial setbacks because of shorter remaining life spans, and more importantly, fewer working years”). Interestingly, in the Sullivan, Warren & Westbrook study, although the percentage of elderly filers who reported a job-related reason for filing bankruptcy was less than for other age groups, it was still a significant percentage. Forty-one percent of the elderly (age 65 and older) reported job-related reasons for filing for bankruptcy. SULLIVAN ET AL, supra note 13, at 99 (concluding that the elderly are likely working during retirement).

42 AARP, 2003 Consumer Experience Survey: Insights on Consumer Credit Behavior, Fraud and Financial Planning, supra note 36, at 30 (indicating that 40 percent of those aged 45 and older cannot take on additional debt, and almost 10 percent are over-extended). While approximately 75 percent of seniors surveyed felt comfortable that they could pay for their home and basic expenses, there was more concern regarding major expenses like funerals, home repairs, emergencies, retirement, and long-term care. Id. at 34.

43 Gist & Figueiredo, supra note 18 (finding that debt almost doubled in size for these populations, but
1. Housing

For seniors, as with most populations, the most significant expense usually involves housing. The cost of housing alone, however, is not the primary concern. It is the percentage of income spent on housing that matters most.

The percentage of income devoted to housing expenses by seniors has risen in recent years. During the 1990s, the percentage of income spent on housing increased from nearly eight percent to over 11 percent for households with a head-of-household aged 50 or older. For earners at the lowest income levels, this increased housing cost could be devastating. In 1997, those with incomes in the lowest 20 percent spent just over 33 percent of total expenses on housing costs; by 2002, that number had risen to just over 40 percent.

Even those who own homes are not immune from debt; nowadays more elderly enter retirement or pre-retirement carrying a mortgage. There are a multitude of reasons why an elderly person would carry mortgage debt. Perhaps the elder bought a house later in life, either as a new home or as a first-home purchase. Maybe, the elder took out a mortgage on an already-paid-for or almost-paid-for home to finance a child’s college education or to pay other significant expenses. Or possibly an elder who already owned his or her home used the equity in the home to pay expenses through a “reverse mortgage.”

While useful, some have expressed concern over reverse mortgage lending due to the inherent potential for abuse and predatory lending practices. Because reverse mortgages are only effective if the borrower has significant equity in his or her home, the elderly and near-elderly are often targeted for these types of loans.

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that for those in the 50-64 age group, the debt was most widespread, with 75 percent of those in that group having some debt). Despite the increase in total debt, however, the study found that “nonhousing debt changed little over time,” minimizing the effect of credit card and medical debt in the total debt burden of the elderly and near-elderly. Id.

Housing expenses are defined as “mortgage payments (interest, property taxes, and insurance), rent, and utilities.” Key Indicators 2006, supra note 20, at Appendix A, Indicator 12.

The percentage increase can be seen across the board. Those with the highest incomes saw an increase from 20.5 percent in 1987 to 28 percent of total expenses in 2002. Key Indicators 2006, supra note 20, at Appendix A, Indicator 12.


A reverse mortgage is a loan arrangement in which the lender pays money to the homeowner on a regular basis, with each new loan being secured by a mortgage on the home. Loonin & Renuart, supra note 47, at 197–98.

Id. (noting “[r]everse mortgages are a particularly important but potentially dangerous product. . . . Although these can be attractive options for many elders, the reverse mortgage lending field is rife with the opportunity for fraud and financial abuse”).

Thus, many elderly find themselves entering retirement facing higher housing costs and mortgage debt than their predecessors, while also facing decreasing income and increasing costs in other areas.51

2. Medical Debt

One would expect that the elderly incur significant health care costs, and that those costs are rising. For those enrolled in Medicare, the average annual health care costs increased by almost 50 percent from 1992 to 2003.52 Thirty-five percent of those costs are related to outpatient services, including doctor visits. Inpatient hospital costs, costs for care in nursing homes and other institutions, and prescription medication expenses also contribute to the overall medical expenses of seniors, constituting 26 percent, 14 percent, and 14 percent respectively of the health care costs of seniors.53 Although prescription medications only account for 14 percent of the health care outlay of seniors, this is an increase from eight percent in 1992.54 For those elderly filling prescriptions, the aver-

Rowland, Defending the American Dream: Legislative Attempts to Combat Predatory Lending, 50 S. Tex. L. Rev. 343, 359–60 (Winter 2008) (warning that “[l]enders market these loans to the elderly by convincing them it will be the only way to avoid selling their home. In truth, it is almost never in the borrower’s interest to structure the loan this way because equity in the home will be lost each month, and in many cases the lender obtains the remainder of the equity in the home when the borrower dies, regardless of its value”).

51 For debtors living in Florida, the homestead exemption proved to be a significant factor in determining how to handle debt. Bankruptcy filers eligible to use the Florida homestead exemptions are eligible for a full exemption from levy by creditors of all of the equity held by the debtor in the homestead under Article X, § 4 of the Florida Constitution. However, under the BAPCPA amendments enacted in 2005, an individual filing for bankruptcy protection is only eligible to use the state’s exemption laws once the person has resided within the state for two years. 11 U.S.C. § 522(b)(3)(A) (2006). Also, even when the debtor is eligible to use Florida’s exemptions, and thus eligible for Florida’s homestead exemption, that exemption is capped at just over $136,000 for certain types of equity rolled into the house within 1,215 days before bankruptcy. 11 U.S.C. § 522(p) (2006). But once a debtor is eligible to use Florida’s homestead exemption, it may actually encourage the use of bankruptcy laws for an otherwise-solvent debtor, as evidenced by one attorney who participated in our survey. “I had an appointment today with a man’s children . . . father is severely in debt due to credit card and medical bills with a homestead equity of $150,000. They desire to move him to independent or assisted living but the house sale would expose the equity to creditors’ claims. They will likely encourage him to bankrupt so as to permit the post-bankruptcy extraction of the home equity for future living expenses.” E-mail from Gerald L. Hemness, Jr., Emma Hemness, Pa., to Rebecca Morgan, Prof., Stetson U. College of L. (February 7, 2006, 5:00 p.m. EDT) (on file with authors). But attorneys in the survey reported that if the elder wishes to remain in his or her house and that house is the primary asset of value, the elder debtor may often be able to avoid bankruptcy because he or she is often “judgment-proof.” In such cases, the primary motivation if a bankruptcy is filed may simply be to end harassment by the creditors. E-mail from Elaine Schwartz, to Rebecca Morgan, Prof., Stetson U. College of L. (February 5, 2006, 1:19 p.m. EDT); E-mail from Gerald L. Hemness, Jr., Emma Hemness, PA, to Rebecca Morgan, Prof., Stetson U. College of L. (February 5, 2006, 9:50 p.m. EDT) (on file with authors).

52 Key Indicators 2006, supra note 20, at Appendix A, Indicator 29.

53 Id. at Appendix A, Indicator 29.

54 Id. See also Clifford Binder, Leigh Gross Purvis, David J. Gross, Susan O. Raetzman & Stephen W. Schondelmeyer, Trends in Manufacturer Prices of Brand-Name Prescription Drugs Used by Older Americans—Second Quarter 2006 Update 4, 11, http://assets.aarp.org/rgcenter/health/dd146_drug prices.pdf (AARP Public Policy Institute 2006) (indicating that annual prescription costs for most
age number of prescriptions filled annually rose from 18.4 in 1992 to a staggering 32.1 in 2002.55 And many of these elderly do not have medical insurance coverage beyond Medicare.56

The increase in co-pays and premiums, as well as uncovered medical expenses, necessitates spending an increased percentage of individual income on health care.57 For those at or near the poverty level, nearly 28 percent of income is spent on health care, up from just over 12 percent in 1977.58 Added to the nearly 40 percent spent on housing,59 seniors in the most financial distress are spending roughly two-thirds of their income on housing and medical expenses. Since many seniors’ income is $25,000 a year or less,60 that leaves only $8,000 per year for other expenses such as food and transportation — not to mention taxes.

One of the best mechanisms for paying medical expenses for those at or nearing retirement is an employer-sponsored medical insurance plan. Despite a decrease over the last 20 years in the number of companies offering employee retirement health benefits,61 studies indicate that the number of retired or near-retired persons with employer-sponsored medical health insurance has not changed significantly in recent years — at least for those who are almost-elderly (55-64) or young elderly (65-70).62 While this is promising

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55 Key Indicators 2006, supra note 20, at Appendix A, Indicator 30. Those reporting at least five “chronic” medical conditions filled an average of 60.6 prescriptions in 2002. Id.

56 In 2003, 12.7 percent of the elderly had no additional medical coverage, while almost six percent had other public assistance and 9.6 percent had Medicaid coverage. Id. at Appendix A, Indicator 31.


58 Key Indicators 2006, supra note 20, at Appendix A, Indicator 32. See Eliot Fishman, Suzanne Tamang, and Dennis Shea, Medicare Out-of-Pocket Costs: Can Private Savings Incentives Solve the Problem?, www.commonwealthfund.org; search “Fishman” (March 2008) (indicating that “Medicare beneficiaries with an income less than 135 percent [of the federal poverty level] spend 33 percent of their annual income on out-of-pocket health care costs, on average” and that “beneficiaries of all incomes with fair or poor health status or age 85 and older spent almost 30 percent”). By comparison, those not near the poverty line saw an increase from 5.4 percent of income to eight percent of income spent on health care annually. Key Indicators 2006, supra note 20, at Appendix A, Indicator 32. See also Richard W. Johnson, The Urban Institute, Health Insurance Coverage and Costs at Older Ages: Evidence from the Health and Retirement Study, http://assets.aarp.org/rgcenter/health/2006_20_coverage.pdf (Sept. 2006) (reporting that nine percent of those between the ages of 55 and 64, and 16 percent of those 65 or older spent one-third of income on medical expenses in 2002).

59 Gist & Figueiredo, supra note 18, at 3.

60 Wu, supra note 19.

61 Johnson, supra note 58, at 3 [citing Kaiser Family Foundation and Health Research and Educational Trust 2005 (indicating nearly 50 percent reduction in percentage of companies with at least 200 employees offering retirement health insurance from 1988 to 1993).] However, after 1993, the decrease plateaued, leaving roughly the same number of elderly and near-elderly insured. Id.

62 Johnson, supra note 58, at i–ii, 7–8 (reporting that half of retired persons and over two-thirds of working persons between the ages of 55 and 63 have medical insurance from an employer or former employer, representing increases of four percent for each group over an eight-year period). The same study, however, found that among those over the age of 71 in 1995, just over half continued to have medical
news for those on the brink of retirement, it does not paint the entire picture. Although a significant portion of retirees or near-retirees have medical insurance through an employer, the out-of-pocket costs for these employees or retirees have tripled in recent years.63

3. Credit Card Debt

While rising housing and medical expenses present concerns for the elderly, unsecured credit card debt is an increasing concern as well. Indeed, studies have suggested that nearly 90 percent of debtors in bankruptcy carry credit card debt at the time of filing.64 The current elderly, having matured in an era not as credit-laden as today, may not appreciate the risks of revolving credit. Studies show that the elderly are less likely than their younger counterparts to understand credit.65 One study in particular suggests that the elderly are less savvy about the importance of credit scores.66

63 Johnson, supra note 58, at ii–iii, 15–17 (reporting that in eight-year period ending in 2002, premiums for employees and retirees aged 55–63 tripled after accounting for inflation; for those 65 and older, the premiums increased more than three-fold in just four years). The costs include not only premium payments, but also other out-of-pocket costs such as co-pays or costs for uncovered services. For these out-of-pocket costs, the increase was particularly stark for those under the age of 65, increasing by 60 percent after accounting for inflation; by contrast, the increase for those ages 65 and older was 25 percent during the same time period. Id. at iii, 18–20 (basing amounts on rising costs between 1998 and 2002); Id. at 4 (providing more specific numbers for individual years).

64 Sullivan et al, supra note 13, at 120 (finding that 88 percent of all debtors have credit card debt, and citing studies finding even higher percentages). See also Flynn & Bermant, supra note 3 (finding that levels of credit card indebtedness were significantly higher for those in their 60s and older than for any other age group).

65 While this section considers credit card debt that does not include predatory lending, those who study the credit industry recognize that the elderly are frequent targets of credit schemes that provide credit to groups like the elderly who are unlikely to be able to pay the high interest costs. Jean Braucher, Theories of Overindebtedness: Interaction of Structure and Culture, 7 Theoretical Inquiries in Law 323, 334–35 (July 2006) (referring to “reverse red-lining” as a practice of “targeting vulnerable populations such as … the elderly … in high-pressure marketing of very high cost credit that has a high likelihood of only being repaid by foreclosure on a home”).

66 Sharon Hermanson & Ann Jackson, Older Consumers’ Attitudes Toward the Use of Credit Scores, http://assets.aarp.org/rgcenter/consume/dd120_creditsscores.pdf (2006) (indicating that the elderly, defined as age 65 or higher, when compared with adults under the age of 65, were just over half as likely to report an understanding of credit scores, three times as likely to report “not knowing if credit scores are an accurate representation of creditworthiness” and two-thirds as likely to have actually determined their own credit scores). While there are a number of resources available to educate consumers about credit, at least one commentator has noted that, while education is helpful, “it is important to emphasize that prevention, including counseling and education, is never a substitute for strong regulation. Education is not a panacea as long as creditors are allowed to push dangerous, unaffordable credit on the most
Credit card debt is increasing in all populations. Studies cite the de-regulation of the credit card industry as a contributing factor to the increased availability of credit cards. One study indicated that the increase in credit card debt among the elderly is particularly staggering. The study, based only on self-reported data, found that the amount of credit card debt held by the elderly (age 65 or older) increased 89 percent from 1992 through 2001. The increase was more pronounced among the younger elderly (ages 65 to 69)—over 200 percent. By contrast, the credit card debt increase from 1992 through 2001 for all households was 53 percent.

Noting that “[t]he true financial impact of debt can be seen in the percentage of income people must spend servicing it,” the study found that 20 percent of the elderly with less than $50,000 in income were in “debt hardship,” spending at least 40 percent of income paying debt. For those with the lowest income, already spending 40 percent on housing and 28 percent on medical expenses, paying 40 percent of income servicing credit card debt leaves nothing for other essentials.

### III. The Literature Regarding Bankruptcy Filings

Before considering how many elderly file for bankruptcy protection, it is worth considering why someone who is elderly might file for bankruptcy protection. A debtor in bankruptcy may receive a discharge of some or all of his or her debt under the Bankruptcy

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68 See Sullivan ET AL., supra note 13, at 19 (citing Diane Ellis, The Effect of Consumer Interest Rate Deregulation on Credit Card Volumes, Charge-Offs, and the Personal Bankruptcy Rate, Bank Trends 98–105 (FDIC Division of Insurance March 1998) (regarding studies finding “repeal of usury rates as the triggering event for a glut of consumer credit”)).

69 Porter & Thorne, supra note 17 (citing Heather C. McGhee & Tamara Draut, Retiring in the Red: The Growth of Debt Among Older Americans, http://archive.demos.org/pubs/retiring_2ed.pdf (2d ed. 2004)). One theory about the reason for the increase in credit card debt is that it is easier to obtain money through a credit card than through a traditional loan. See Reginald H. Turnbull, Wiping the Slate Clean and Starting Over: Bankruptcy Basics for the Elder Law Practitioner, 16 WTR NAE LA Q. 16, 16 (Winter 2003) (citing Robert D. Manning, Aging into Debt: Crisis or Convenience in the Golden Years (2000)). Turnbull notes the changes in the credit situation, particularly the trend away from personal service that may make seniors unwilling to seek loans from banks. Id.


71 Tamara Draut & Javier Silva, Borrowing to Make Ends Meet: The Growth of Credit Card Debt in the '90s, http://archive.demos.org/pubs/borrowing_to_make_ends_meet.pdf (Sept 2003). See also Garcia, supra note 67, at 1, 5 (including updated data suggesting that overall credit card debt more than tripled from 1989 through 2006, with the average debt of individual households increasing by 89 percent during that time, and noting that the percentage of households with $10,000 or more of debt has increased from three percent in 1989 to 16 percent in 2004).


73 Id.

74 The authors recognize, however, that in some cases there may be overlap in these areas. For example, the medical debts may be put on the credit card, causing that debt to be counted in both areas.
Discharge occurs upon the successful completion of bankruptcy proceedings and prevents a creditor from collecting the debt once the bankruptcy concludes. Although there are several exceptions to the dischargeability of debt, the ability to discharge debt is one of the key incentives for filing for bankruptcy protection.

Yet, as noted, a substantial percentage of the elderly live below, or at least not very far above, the poverty level. These elderly may be widely viewed as judgment-proof, meaning that even if they owe money, they have few assets of value and very little income to pay debts. So why might someone who is elderly and, essentially, judgment-proof choose to use the bankruptcy mechanisms? The answer lies in the fundamental bankruptcy protection of the automatic stay. Section 362 of the Bankruptcy Code provides that, upon the filing of a bankruptcy petition, the debtor receives the protection of the automatic stay. Creditors may not institute or continue litigation, harass, or contact the debtor regarding the debt, or take any other action that may be seen as a collection effort. For the debtor who knows that he or she will never, in reality, be able to pay the debt, the ability to avoid contact from the creditor hoping to collect that debt may be invaluable.

While large-scale studies of the elderly in bankruptcy are not common, filings by the elderly have been considered. In 2001, researchers from the Consumer Bankruptcy Project considered the filing rates for all age groups, and found that baby boomers had a large impact on bankruptcy statistics. While finding that most debtors in bankruptcy are “middle-aged,” including the population known as the baby boomers, the researchers noted over a 200 percent increase in the percentage of elderly filing for bankruptcy protection in 2001 over the number filing for bankruptcy protection in 1991. Further, the near-elderly baby boomers had some of the highest bankruptcy filing rates, second only to middle- and late-middle-aged filers. One recent study considering bankruptcy in general found that credit card debt is significant in all bankruptcies; however, it comprises a substantial percentage of the debt owed in bankruptcy filings by the elderly.

76 Id.
78 S. Rep. No. 95-989 (noting “[t]he automatic stay is one of the fundamental debtor protections provided by the bankruptcy laws. It gives the debtor a breathing spell from his creditors. It stops all collection efforts, all harassment, and all foreclosure actions. It permits the debtor to attempt a repayment or reorganization plan, or simply to be relieved of the financial pressures that drove him into bankruptcy”).
80 Id.
81 Dr. Teresa A. Sullivan, Dr. Deborah Thorne & Prof. Elizabeth Warren, Young, Old, and In Between: Who Files for Bankruptcy? 9 NORTON BANKR. L. ADVISER 1 (Sept. 2001).
82 Id.
83 Id. (finding that the “younger Boomers” had the highest bankruptcy filing rate in each of 1991 and 2001, and the “older Boomers” had the second and third highest bankruptcy filing rates in those years, respectively).
84 Flynn & Bermant, supra note 3. This study of over 5,000 no-asset consumer bankruptcy cases (cases in which nothing was distributed to unsecured creditors) completed between 2000 and 2002 found that nearly half of the general unsecured debt of the bankruptcy filers was due to credit card debt, and that the average debt owed to credit card companies was over $17,000. But for elderly filers, that average credit card debt rose to $27,787, while it was $22,352 for the near-elderly. Id.
Studies have also considered what happens to debtors after bankruptcy ends. A study of filings from 2001 determined that approximately one-fourth of households filing for bankruptcy protection report having a worse financial situation after bankruptcy than before bankruptcy.\textsuperscript{85} When the study included debtors who reported being in the same situation after bankruptcy, the number rose to one in three households.\textsuperscript{86} While the study focused on debtors in general, it did find that older debtors were more likely than younger debtors to experience sustained financial distress post-bankruptcy.\textsuperscript{87} The study concluded that the primary factor affecting a household’s economic situation post-bankruptcy is whether the household income improves.\textsuperscript{88} Given that many of the elderly debtors cannot improve income post-bankruptcy, it is not surprising that elderly debtors were less likely to enjoy improved financial status post-bankruptcy.\textsuperscript{89}

\textbf{A. Methodology for This Study}

Data for this article was collected from bankruptcy filings in the Middle District of Florida\textsuperscript{90} for various periods of time during 2006–2008.\textsuperscript{91} The Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (BAPCPA) became effective on October 17, 2005. President George W. Bush signed BAPCPA into law on April 20, 2005, and some provisions became effective at that time. Thus, this study period involved roughly two years of BAPCPA data. Although BAPCPA’s enactment undoubtedly had some effect on bankruptcy filings during this time, the use of a time period more than a year after the effective date of the amendments ensured that the study included those who had not likely considered bankruptcy filing pre-BAPCPA.

Because petitions to file for bankruptcy protection do not require a debtor to disclose his or her age, determining whether a debtor qualified as “elderly”\textsuperscript{92} required some deductive reasoning from the petition and, more important, the bankruptcy schedules filed by the debtor. For each file, a review of the file turned up clues that might indicate the presence of an elderly debtor, including, \textit{inter alia}:

\begin{itemize}
  \item listing occupation as “retired” in schedule “I”
\end{itemize}

\textsuperscript{85} Porter & Thorne, supra note 17.
\textsuperscript{86} Id.
\textsuperscript{87} Id. For the general debtor population, one in three households reported either a similar or worse economic condition post-bankruptcy; for those age 55 or older, almost half indicated that the household financial situation had not improved post-bankruptcy. \textit{Id.} at 110–111.
\textsuperscript{88} Id. at 124.
\textsuperscript{90} Florida has an elderly population that makes up 16.8 percent of the state’s population. \textit{Key Indicators 2006, supra} note 20, at Appendix A, Indicator 1.
\textsuperscript{91} January through November 2006, July 2007 through January 2008; additional data collected for 2004–2006 for comparison purposes.
\textsuperscript{92} Of course, no common definition of “elderly” exists either, but the study used the traditional age of 65 for analysis purposes (though files of those nearing age 65 were also pulled for comparison purposes).
• listing Social Security income in schedule “I”
• listing pension or retirement income in schedule “I”
• listing grandchildren or adult children as dependents in schedule “I” or
• listing significant medical expenses in schedule “J”

Once identified as a potential elderly debtor’s file, the name and address of the
debtor was searched to determine whether an age could be found for the primary debtor. If confirmed to be below age 64, the filing was excluded from the study. Debtors who appeared to be aged 64 were included in the files due to the possibility that the debtor’s birth date would have fallen at a time that actually made the debtor 65 during the filing year. Although many of these indicators will be present in the filing for an elderly debtor, the collected files are both under- and over-inclusive. These factors fail to capture a segment of the elderly population — those who continue to work (or simply fail to list retirement in the schedule), receive no Social Security or pension, and are not burdened with significant medical expenses or dependents at home. At the same time, debtors who are not elderly may be included in the study — they have retired at a young age, receive Social Security due to a disability, had children at a young age so they have adult children and grandchildren at a young age, or have substantial medical expenses not related to advanced age.

Once the relevant files were collected, the following pieces of data were collected for each bankruptcy filing, if available:

• Primary debtor’s name
• Bankruptcy Chapter filed
• Whether debtor is solvent
• Filing date
• Amount due on credit card debt
• Amount due on medical debt
• Whether debtor listed dependents
• Social Security monthly income
• Gross income monthly from employment
• Retirement or pension monthly income

93 All official bankruptcy forms, including the official bankruptcy schedules, are available at http://www.uscourts.gov/bkforms/bankruptcy_forms.html (accessed May 22, 2008).
95 Individual bankruptcy filers may file under Chapter 7, Chapter 11, or Chapter 13 of the Bankruptcy Code. The vast majority of personal bankruptcy filings fall under either Chapter 7 or Chapter 13. With the exception of 2006, Chapter 7 bankruptcy filings have constituted at least 60 percent of the consumer bankruptcy filings in each quarter since 1994, and there have been at least 49,000 Chapter 13 filings and no more than 2,300 Chapter 11 consumer filings in each quarter since 1994. American Bankruptcy Institute, Quarterly Non-Business Filings by Chapter (1994-2008), http://www.abiworld.org/AM/AMTemplate.cfm?Section=Home&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=56825 (accessed May 22, 2009). Chapter 11 bankruptcy filings for individuals are typically reserved for the wealthiest individuals. Given their unusual nature, Chapter 11 filings were excluded from this study.
96 Solvency was determined using a “balance sheet” test. If debtor’s assets, as reported on the summary of schedules, equaled or exceeded debtor’s liabilities, also as reported on the summary of schedules, the debtor was deemed to be “solvency.”
97 To the extent that debt was both credit card debt and medical debt, it was listed as medical debt to avoid double-counting.
Today’s Elderly in Bankruptcy and Predictions for the Elderly of Tomorrow

Number 1

- Other monthly income
- Whether filing was joint filing
- Ages of debtors at the time of filing
- Monthly future medical expenses
- Other interesting miscellaneous information

In all, 2,399 bankruptcy filings were deemed likely\(^98\) to involve an elderly debtor. The filings were mixed between joint and single filings.\(^99\) A small percentage of the debtors listed dependents at home.\(^100\) The average age (of those whose age could be determined at the time of filing) was 73.

A review of the filings provided some general conclusions about the bankruptcy filings of “elderly” debtors, and in particular about the sources of income and the expenses of those debtors. But the review of the data created as many questions as answers. Perhaps, the most important question left was what was really precipitating the bankruptcy filing. Credit card debt appeared to be a more significant factor than medical debt in causing an elderly debtor to file for bankruptcy. But the fact that credit card debt exceeded medical debt nearly six-fold could be explained in any number of ways, and does not Perhaps, the elderly debtors were spending on luxury items. Maybe they misunderstood credit and did not realize that interest payments would add up. Possibly, they were using credit to purchase basic necessities like food and clothing.\(^101\) And if so, that could be at-

\(^98\) The study included 107 debtors determined to be age 64 and 39 debtors whose age could not be determined from Intellius. Of the remaining 2,253 debtors, the age distribution was as follows:

- 65 years old: 193 debtors
- 66 years old: 173 debtors
- 67 years old: 147 debtors
- 68 years old: 152 debtors
- 69 years old: 163 debtors
- 70 years old: 137 debtors
- 71 years old: 147 debtors
- 72 years old: 152 debtors
- 73 years old: 163 debtors
- 74 years old: 117 debtors
- 75 years old: 101 debtors
- 76 years old: 91 debtors
- 77 years old: 109 debtors
- 78 years old: 109 debtors
- 79 years old: 79 debtors
- 80 years old: 54 debtors
- 81 years old: 47 debtors
- 82 years old: 26 debtors
- 83 years old: 28 debtors
- 84 years old: 28 debtors
- 85 years old: 20 debtors
- 86 years old: 23 debtors
- 87 years old: 23 debtors
- 88 years old: 20 debtors
- 89 years old: 103 debtors
- 90 years old: 101 debtors
- 91 years old: 11 debtors
- 92 years old: 9 debtors
- 93 years old: 5 debtors
- 94 years old: 1 debtor
- 95 years old: 3 debtors
- 96 years old: 2 debtors
- 97 years old: 1 debtor
- 98 years old: 1 debtor
- 99 years old: 1 debtor
- 100 years old: 1 debtor

\(^99\) This study considered each filing, not each bankruptcy debtor, to determine the primary reason why the household filed for bankruptcy protection. In the case of a joint filing, the primary debtor was considered, because in most cases if one spouse is the primary earner for the house, he or she would be listed as the primary debtor. For a concise summary of the difficulties inherent in distinguishing between individual debtors and individual filings, see Sullivan et al., supra note 81 (noting “the statistics published by the Administrative Office of the United States Courts are overwhelmingly reported in terms of petitions filed, rather than number of petitioners filing for bankruptcy…. The number of petitions filed is an important benchmark for research and debate, of course, but it under-reports the number of adult Americans whose legal rights are altered through the bankruptcy system. When we discuss individual characteristics of the debtors such as age and sex, it is appropriate to look at all petitioners, not just those individuals who are listed as the ‘primary debtor.’ The difference can be significant…. . 38.7 percent of those [petitions] were filed jointly, … which means that the total number of petitioners in bankruptcy was … a number already in excess of a million long before the politicians seized on the magic ‘one million’ in discussion [sic] bankruptcy filings”). (emphasis in original).

\(^100\) There were 157 debtors who listed dependents living at home.

\(^101\) See National Consumer Law Center, Consumer Concerns for Older Americans: Advice for Older Con-
tributable to using disposable income to pay necessary medical expenses. Perhaps, some of the credit card expenses were to pay medical expenses directly.102

The next phase of the research involved sending surveys to understand individuals’ impressions of the reasons why the elderly file for bankruptcy protection. Surveys were sent to attorneys specializing in Elder Law in the Middle District of Florida, with inquiries focused on general impressions of the extent of and reason for financial difficulty for the elderly. The number of responses to the surveys was too small to be statistically significant,103 but the comments provided some additional insight into the problems faced by elderly filers.

IV. INITIAL FINDINGS

A. The Effect of Medical Expenses

Studies indicate that medical problems are a primary factor leading to bankruptcy filings.104 Combining that information with the fact that the elderly are likely to incur

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102 See Melissa B. Jacoby, Bankruptcy Reform and the Costs of Sickness: Exploring the Intersections, 71 Mo. L. Rev. 903, 905 (Fall 2006) (discussing the Sullivan, Warren, & Westbrook conclusion that medical issues play a prominent role in bankruptcy filings, but indicating that because the study included debt not owed to medical providers but linked to medical issues, it “produced higher estimates than prior studies of … ‘medical-related bankruptcy’”). See also Cindy Zeldin and Mark Rukavina, Borrowing to Stay Healthy: How Credit Card Debt is Related to Medical Expenses, http://www.demos.org/pubs/healthy_web.pdf (2007) (finding that medical expenses contributed to the credit card debt or nearly one-third of households with middle or lower income). The difficulty in assessing medical debt versus credit card debt was also recognized in the Sullivan, Warren, & Westbrook study: In the 1990s medical debt simply became too hard to identify… for many families, a serious medical problem will not result in bills that can be easily identified as medical in origin…. That $5,000 may have been used to pay doctors and hospitals, but nothing in the files explains where the money went. [The researchers] would have to classify the debt as “general” even though every penny might have been used to pay doctors and hospitals, sharply understating actual medical debt. Many providers now require payment at the time of service, so that many patients put their medical bills on an all-purpose credit card. As a result, a listing for credit card debt today may conceal ambulance costs, physicians’ bills, pharmaceuticals, home health care costs, medical appliance and equipment fees, and hospital charges. Nor will a home equity line of credit or a finance company loan on a bankruptcy schedule show a connection to earlier, substantial medical debts…. The discovery of medical debt as a cause of bankruptcy has likely proven elusive for other reasons. In addition to the problem of identification, where medical debt is camouflaged within another category, especially the ubiquitous credit cards category, it is possible that medical debt, like the “last credit card,” is often omitted from the debt schedules. Some families may be worried that a failure to pay their doctors or clinics may result in the loss of future services. Others may be so grateful for help that they are determined to pay regardless of the dischargeability of their debts. Still others may want to save face, hoping that their health care providers will not learn of their bankruptcy filing.

Sullivan et al, supra note 13, at 152–53.

103 A total of six responses were received.

104 Sullivan et al, supra note 13, at 142 (indicating that 20 percent of debtors listed medical issues as a contributing factor in bankruptcy filing). A study from Los Angeles concluded that approximately one-quarter of bankruptcy filings resulted from medical issues. Id. at 144. But see Igor Livshits, James Mac-
more medical expenses than other age groups of society, one would expect to see medical expenses playing a significant role in the bankruptcy filings of the elderly. Indeed, the study conducted by Sullivan, Warren, & Westbrook found that elderly debtors cited medical issues as a trigger for bankruptcy filing much more frequently than did younger debtors. An initial review of the bankruptcy filings of the elderly within the Middle District of Florida, however, did not indicate significant medical expenses leading to bankruptcy filings.

First, the debt was analyzed to determine whether any obvious medical expenses were listed. The debtors in the study averaged approximately $43,530.64 in credit card debt, with nearly 95 percent of the debtors holding some credit card debt at the time of the bankruptcy petition. By contrast, only one-third of the debtors listed debts clearly attributable to medical expenses, such as debt owed to a hospital or doctor’s office. Among those who included specific medical debts in their expenses, the average medical debt was just under $8,000. While $8,000 of medical debt is certainly a factor pushing debtors into bankruptcy, the initial review of this data indicates that credit card debt plays a much more significant factor in the decision to file for bankruptcy protection.

Note that some overlap exists between these figures, such as when a filer uses a hospital or other care provider’s credit card. For example, Mr. and Mrs. T, who filed in November of 2006, indicated that the credit card debt was incurred in part to pay medical expenses.
One explanation may be that, ironically, the elderly are less likely to be affected by one of the medically-related problems that plague other debtors faced with medical difficulties — that of job reduction. Unlike the elderly, many of whom already retired or planned to retire shortly, debtors who are younger planned on working at full capacity. For these debtors, the bankruptcy filing is not always caused by the medical expenses themselves, but by the reduction in pay that results when one cannot work as anticipated as a result of the medical condition. But for the elderly, medical conditions may not require a reduction in pay because their pay is already reduced (and, hopefully, that decrease in pay was planned for).

The other medical expense to consider is future medical expenses that will be incurred. Based again on the data regarding medical expenses of the elderly and the data regarding medical expenses among bankruptcy filers, one would expect that medical expenses would constitute a significant portion of the future expenses of debtors in bankruptcy. Fortunately, the bankruptcy schedules ask a debtor to predict his or her future monthly medical expenses. Among all of the debtors considered in the study, average monthly medical expenses of $139.20 were included, for annual medical expenses of approximately $1,670.40. Again, although these medical expenses are not minimal, the expense amount does not seem to support the concern that elderly bankruptcy filers are saddled with extraordinary medical expenses forcing them into bankruptcy. More notably, 362 debtors listed no future medical expenses on schedule “I,” indicating that any future medical expenses were not anticipated to be significant; those schedules that listed future monthly medical expenses varied from $3 per month to $3,800 per month.

Though the data does not clearly point to medical debt as an impetus to bankruptcy, attorneys reported situations in which medical expenses led to bankruptcy. Indeed, in the small survey of local Elder Law attorneys, health care bills were the most selected reason for debt. For example, one attorney reported that a “husband filed bankruptcy when his wife went into a nursing home and he lost the income of her Social Security.” The same attorney reported that another client suffered a heart attack and, as a result, was no longer able to work. One indicated that clients “are okay without the illness or [sic] a

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109 See Sullivan et al, supra note 13, at 144 (citing their own study and others to conclude that one-half to two-thirds of bankruptcy debtors who file for medical reasons do so because of the loss of income resulting from the medical event).

110 Studies suggest that the average medical debt of seniors is significantly higher than this reported monthly debt. See Porter & Thorne, supra note 17 (citing Heather C. McGhee & Tamara Draut, Retiring in the Red: The Growth of Debt Among Older Americans, http://archive.demos.org/pubs/retiring_2ed.pdf (2d Ed. 2004)). Other studies show that “[b]y 2000, senior citizens were spending on average $3,526 out-of-pocket on health care costs.” David Gross and Normandy Brangan, In Brief: Out-of-Pocket Health Spending by Medicare Beneficiaries Age 65 and Older: 1999 Projections (AARP Public Policy Institute 1999). The difference may suggest underreporting of medical expenses in Schedule I.

111 Five attorneys selected health care bills as a primary reason for debt, while three selected excessive spending/living beyond means, two selected credit card debt, and one selected each of lack of income, adult children, poor investment choices, and other. Financial Well Being of the Elderly, on-line anonymous survey, comment (Dec. 2008) (on file with authors).

112 E-mail from Richard Milstein, Akerman Senterfitt, to Rebecca Morgan, Prof., Stetson U. College of L. (February 6, 2006, 7:19 a.m. EDT) (on file with authors).

113 Id.
spouse or themselves, but have not planned for that eventuality.”\textsuperscript{114} Although the impetus for bankruptcy in each case was loss of income, that loss coupled with a medical situation. With the nursing home, the medical costs will continue, even if not reported as a medical expense, in the form of payment for the nursing home; for the heart-attack victim, the future medical costs associated with the heart attack are less certain.

B. The Effect of Credit Card Debt

Changes in the credit industry, including the combination of deregulation of the credit market and increased availability of credit for those deemed more risky borrowers, as well as the availability and attractiveness of bankruptcy as an alternative for financial distress, has likely affected bankruptcy filings over the past 25 years.\textsuperscript{115} Credit card debt accounted for an average of $43,530.64 of debt for each bankruptcy filing in this study. It is impossible to determine from the schedules alone what the debtors purchased with the credit cards.\textsuperscript{116} The possibilities are endless.\textsuperscript{117} Did the debtor purchase necessities like food or medical care? Did the debtor purchase luxury items? Or did the debtor purchase something that might not be an absolute necessity, but that most people would not consider being a luxury either, like a new sofa? Knowing that the debtors averaged nearly $44,000 in debt for credit card expenses provides very little insight into the cause of the spending and, thus, one of the causes of the bankruptcy filing.\textsuperscript{118}

C. Sources of Income

Where do elderly debtors find the resources to pay $44,000 of credit card debt and $8,000 of medical debt, while still maintaining payments to come in the future? Almost every filing reviewed included income from Social Security.\textsuperscript{119} Although the average amount received as gross income from employment was roughly half of the average received from Social Security,\textsuperscript{120} the number of filers receiving any income from employ-

\textsuperscript{114} Financial Well Being of the Elderly, on-line anonymous survey, comment (Dec. 2008) (on file with authors).
\textsuperscript{115} See Livshits et al, supra note 104, at 31.
\textsuperscript{116} The difficulty in identifying the effect of credit cards on bankruptcy is persistent. For example, Sullivan, Warren & Westbrook noted that, although close to 90 percent of debtors carry credit card debt, less than six percent identify credit card debt as the reason for filing for bankruptcy. SULLIVAN ET AL., supra note 13, at 132, 152–53 (finding that “[b]y the time a family files for bankruptcy, much medical debt is no longer clearly identifiable….We would have to classify the debt as ‘general’ even though every penny might have been used to pay doctors and hospitals, sharply understating actual medical debt”). The debtors may be opting to list whatever caused them to rely on credit cards to pay bills, rather than the credit cards themselves, as the impetus for filing.
\textsuperscript{117} See Loonin & Renuart, supra note 47, at 167 (witnessing that “[i]n rapidly increasing numbers, elders are using credit to pay for necessities like groceries, prescription drugs, and urgent house repairs”).
\textsuperscript{118} Interestingly, the large amount of credit card debt has been noted by bankruptcy researchers in the past, although the focus on medical debt has been more prevalent. See National Consumer Law Center, Consumer Concerns for Older Americans: Advice for Older Consumers About Bankruptcy, http://www.consumerlaw.org/issues/seniors_initiative/bankruptcy_advice.shtml (Aug. 2006) (citing Flynn & Bermant, supra note 3 (concluding that elderly typically have four times the credit card debt of very young bankruptcy filers)).
\textsuperscript{119} Income from Social Security, per schedule I, averaged $1,175.36 for the bankruptcy filers studied.
\textsuperscript{120} $579.05.
ment was significantly lower than the number receiving Social Security payments.\textsuperscript{121} Thus, the value of employment income for those who did receive it was substantial. Indeed, although Social Security should be just a portion of income for someone who is retired, among the elderly in the study, Social Security was the sole source of income for 585 debtors — nearly one-quarter of the study.\textsuperscript{122}

Social Security\textsuperscript{123} and current employment were not the only sources of income for these debtors. Pension payments,\textsuperscript{124} unemployment compensation, rent payments from tenants, veteran’s affairs benefits, food stamps, gifts from relatives, alimony, trusts, annuities, and other sources of income were also listed by debtors. The average amount received from income other than Social Security, retirement plans, and employment was the lowest form of income overall.\textsuperscript{125}

On average, each debtor received $2,355.74 per month from all sources of income combined, for an average annual income of $28,268.88. This number is very close to the average income of the elderly during the same time period.\textsuperscript{126}

V. Conclusion

There is no doubt that bankruptcy filings among the elderly are on the rise, and little doubt that this rise will continue. Attorneys specializing in protecting the rights of the elderly will need to consider how best to advise their clients regarding financial issues, both how to prepare for pressing financial obligations and how to deal with existing financial burdens. Materials are readily available with some basic advice for the elderly regarding financial obligations.\textsuperscript{127} Although advice regarding how to deal with financial difficulties

\begin{footnotesize}
\begin{enumerate}
\item Filers receiving Social Security income totaled 2,256, while only 748 filers received income from employment. Thus, while the average employment income was less than the average Social Security income overall, when adjusted for the number of recipients, those receiving Social Security averaged roughly $1,250 per month, while those receiving income from employment averaged over $1,850 per month. In addition, the highest monthly income from Social Security was $5,585, while the highest monthly income from employment was $35,454.\textsuperscript{122}

\item Thirty-one filings reported no income from either Social Security or employment.\textsuperscript{123}

\item One potential benefit for creditors in debt whose income comes primarily from Social Security is the ability to have those benefits exempt from collection from creditors. Commentators have noted, however, that “Social Security, Veterans Assistance, and other federal payments to the elderly are not as secure as they used to be. Changes in policy have eroded the assumption that creditors, whether government or private, could not touch these benefits.” Loonin & Renuart, supra note 47, at 186 (citing Huggins v. Pataki, 2002 WL 1732804 (E.D.N.Y. July 11, 2002) (allowing bank account including Social Security to be frozen), and 1996 Debt Collection Improvement Act (allowing benefits to be offset).\textsuperscript{124}

\item A total of 1,096 debtors listed retirement plan income. The average retirement income for all debtors was only $434.12, but when adjusted by the number of debtors receiving retirement income, the average almost doubled to $950.23 per debtor.\textsuperscript{125}

\item The 509 debtors who received other income (not including one whose additional income was listed in Euros) averaged $780.21; spread over all debtors in the study, the income from other sources totaled $167.21.\textsuperscript{126}

\item See supra note 19.\textsuperscript{127}

\item For example, the National Consumer Law Center published on the internet suggestions such as making the elder aware that he or she may be judgment proof to set his or her mind at ease, or, to the extent that an elder must file bankruptcy, explaining that bankruptcy is mentioned in both the United States Constitution and the Bible and noting some celebrities and well-known businesses that have filed for
\end{enumerate}
\end{footnotesize}
already in place is helpful, it helps to remember the old adage that “an ounce of prevention is worth a pound of cure.” Bankruptcy may be the best — or the only — option for some elderly debtors, but it is a cure fraught with moral dilemmas for the debtor who wants to pay back the debt, costs for the debtor and the creditors in going through the bankruptcy, societal costs for unpaid debt, and a host of other complicated issues. Given that medical expenses and credit card debt are both significant factors leading to the use of bankruptcy as a cure, it makes sense that the best option would be to control medical expenses and credit card spending. For those already deeply in debt, prevention may be a concept past its time. But for those counseling the elderly and, more importantly, the future elderly, time spent on financial advising today may prevent the need for such a cure tomorrow.

Unfortunately, the precarious financial position of the elderly is unlikely to end any time soon. The near-elderly and those who are middle-aged find themselves in a recessionary period during their prime earning years. One recent study suggests that “even if households work to age 65 and annuitize all their financial assets, … 44 percent will be ‘at risk’ of being unable to maintain their standard of living in retirement.”\(^\text{128}\) Perhaps, even more disheartening in this study was the conclusion that the rate of unpreparedness for retirement increased with younger generations.\(^\text{129}\) And when the increased medical needs of advancing age were included, the percentage of households unprepared for retirement increased even further.\(^\text{130}\) It is not surprising that younger generations have saved less for retirement; however, this study accounted for the time spent saving, and projected the amount that will be available for retirement for each household based on current savings patterns. This data suggests that future generations of elders will not be able to rely upon their own savings to support retirement, and may be even more reliant on other sources of income from earnings and government subsidy.

The nation is facing an economic crisis of incredible magnitude. Even those who have tried to prepare for retirement have found themselves facing a steep and unexpected plunge in the value of their retirement accounts and of their most valuable asset — their home. For those facing retirement within the next 10 years, there simply may not be

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\(^{128}\) Alicia H. Munnell, Francesa Golub-Sass, Mauricio Soto & Anthony Webb, *Do Households Have a Good Sense of Their Retirement Preparedness?*, Center for Retirement Research at Boston College Number 8-11 (August 2008). While the data suggests that one-third to one-half of each generation will likely be unprepared for retirement, families are generally aware of their own preparedness or unpreparedness for retirement. *Id.* at 5.

\(^{129}\) While 35 percent of early boomers (born from 1948–1954) were unprepared for retirement in the study, the number increased to 44 percent for late boomers (born from 1955–1964) and to 48 percent for Generation X (born from 1965–1974). *Id.* at 2.

\(^{130}\) *Id.* at 2, 5; Munnell et al, *Health Care Costs Drive up the National Retirement Risk Index*, Center for Retirement Research at Boston College Number 8-3 (February 2008) (noting both the February and August studies showed an increase from 44 percent to 61 percent overall, and an increase to 50 percent, 61 percent, and 68 percent for the early boomers, late boomers, and Generation X, respectively).
enough time to recover from this economic downturn. But individuals are not the only ones facing hard economic times. Federal and state governments face unprecedented deficits and need to cut costs in order to minimize additional deficits. In January 2008, the Director of the Congressional Budget Office estimated that health care expenses as a portion of the Gross Domestic Product would continue to rise, as would the federal allocation toward Medicare and Medicaid, and would become one of, if not, the most significant factors in the budget deficit:\(^\text{131}\)

In the years to come, federal spending on health care will rise sharply — mostly because of increasing costs per beneficiary but also because the aging of the baby-boom generation will significantly raise the number of beneficiaries. If health care spending grows as projected under current law, future budget deficits will rise to levels that will seriously jeopardize long-term economic growth unless policy-makers sharply reduce other projected spending, substantially increase revenues as a share of gross domestic product (GDP), or do some combination of the two.\(^\text{132}\)

At a time of fiscal conservatism, when there is temptation to cut spending, federal, state, and local governments will need to be mindful of the precarious position of the elderly and near-elderly (as well as of the middle-aged who are not able to start a solid retirement nest egg during their peak earning years) and the need for the government to help those who will not likely be able to support themselves in retirement.

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\(^\text{131}\) “CBO projects that, without changes in law, total spending on health care will rise from 16 percent of GDP in 2007 to 25 percent in 2025 and 49 percent in 2082. Federal spending on Medicare (net of beneficiaries’ premiums) and Medicaid would rise from four percent of GDP in 2007 to seven percent in 2025 and 19 percent in 2082.” Statement of Peter R. Orszag, Director, Congressional Budget Office before the Committee on the Budget of the United States Senate, *Growth in Health Care Costs* (Jan. 31, 2008).

\(^\text{132}\) *Id.* at 2 (recognized that “[t]he bulk of the projected increase in spending on Medicare and Medicaid is not due to demographic changes (such as increases in the number of beneficiaries) but rather to ongoing increases in costs per beneficiary”). Mr. Orszag suggests focusing on ways to decrease the cost of medical care such as limiting the use of costly medical care absent an indication of the effectiveness of that course of treatment. *Id.* at 16. In doing so, the government could avoid other ways of limiting government spending, such as transferring the cost to the patient or limiting the availability of federal assistance for medical expenses. *Id.*
Elders Falling Through a Loophole in Quality: Impacts of “Off-Label” Drug Promotion

By Prof. James T. O’Reilly

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I. INTRODUCTION

“We’ll try you on something else,” the physician says to the elderly patient. “I think it might work for you.” The hopeful patient smiles and leaves the office with a prescription that costs hundreds of dollars to fill. Hopefully, the drug works. Why would it not? Perhaps, because the physician has prescribed a drug for a condition that the drug was never proven to cure. How can that be? How can a physician prescribe a drug to treat an elder’s illness for which the drug has not been approved on the basis of its safety and effectiveness studies?

The answer is simple. Federal law permits a physician to prescribe any approved drug for a particular purpose or at a particular dose, even if that use has not been found to be “safe and effective” by the Food & Drug Administration (FDA). These are “off-label” uses of the approved drug. In many cases, the drug works fine. In other cases, however, the prescribed drug worsens the patients’ condition, and they suffer more harmful effects from the “cure” than from the ailment. Families may ask the prescriber, why was that

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1. 21 U.S.C. §§ 396, 355 (2006); these issues are covered in depth in JAMES O’REILLY, FOOD & DRUG ADMINISTRATION ch. 13 (3d ed, 2009 Supp.).
drug chosen when it has never won federal approval for use on this ailment? The honest answer might be: “That’s what I was told by the drug representative who handed me the company’s reprint showing the possible benefits from using this drug.”

Physicians are busy. Their economic incentive is to see as many patients as possible, which reduces their time for discernment and discriminating analyses of new drug developments. So they rely on drug information supplied by drug manufacturers. They are also greatly influenced by the “medical education agencies” that prepare selected articles for journal publication.3 Drug companies reproduce these articles and distribute them to physicians. The purpose is obvious: to sell doctors on a drug’s benefits by making claims that the FDA has never accepted as being supported by valid evidence. It is a high-stakes hustle, in which patients rarely know why they are being subjected to that drug’s higher risks for its uncertain benefits. Unlike double-blinded4 clinical studies, the only “blinded” person here is the patient. The FDA knows it is a problem. Federal prosecutors know it is a problem.5 Only the elderly and their families are out of the loop.

Information flow is crucial to successful choice of therapies by treating physicians. Today, however, distortions of that flow regularly occur. In some cases, physicians act on promotional information that later proves to have been unfounded or even wrong. So this article asks: If the elderly patient is harmed by that drug, what legal remedies should the elder have against a drug marketer if the drug company manipulated the loopholes in the FDA system in order to profit from the inappropriate use and sale of that expensive drug for that elderly patient?

II. FOLLOW THE MONEY

A newly developed prescription drug is approved by the FDA to enter the market for a specific medical indication, addressed on its label as a “labeled indication.”6 Drugs may be used for other purposes, however. These are not on the approved list of medical indications but are “off-label” indications, which the FDA does not usually allow to be promoted.7 The targeted marketing of non-approved uses for pharmaceuticals presents a billion-dollar societal conundrum. As individuals, we want faster access to effective drugs. We want their pricing to be fair. And we want the drugs to be verified by government experts as being reasonably effective and safe.8 We are a nation of health consumers

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3 In some cases, the journal articles are so selective in reporting tests of a drug, that they mislead the reader about the effectiveness of the drug.
4 The term refers to nondisclosure to a test subject or the physician investigator of the fact whether this patient had received the actual test drug; neither knows until after the test is over and the “blind” coded containers are disclosed, e.g. as a placebo or an actual drug.
7 Advertising or otherwise promoting a drug for off-label use is prohibited under the Food Drug & Cosmetic Act and its implementing regulations. In re Schering-Plough Corp, Intron/Temodar Consumer Class Action, 2009 WL 2043604 (D.N.J. 2009), citing 21 C.F.R. § 201.128 (2009) (intended use may be shown by the “labeling claims, advertising matter, or oral or written statements by such persons or their representatives”); 21 C.F.R. § 202.1(e)(4)(i)(a) (2009) (advertising “shall not recommend or suggest any use that is not in the labeling”).
8 Drugs are not required to be absolutely safe for all patients, of course; a balance of experimental data
who want it all, demanding the best medicine that costly lab work and expensive clinical trials can produce — and we want those cures to be found immediately, if not sooner.

Taxpayers and Medicare beneficiaries alike have an interest in removing those incentives for drug marketing practices that abuse the drug approval system in the search for short-term profits. It is important to distinguish between lawful yet exploitative practices, such as off-label promotion of a drug and outright fraud. Off-label promotion of a drug is not fraud because of a statutory loophole, discussed below. Nevertheless, the Justice Department has said that:

Off-label promotion of pharmaceutical drugs is a serious crime because it undermines the FDA’s role in protecting the American public by determining that a drug is safe and effective for a particular use before it is marketed. Off-label marketing created unnecessary risks for patients. People have an absolute right to their doctor’s medical expertise, and to know that their health care provider’s judgment has not been clouded by misinformation from a company trying to build its bottom line.9

Headlines in national news media of prosecutions and billion-dollar-plus fines against drug companies10 have made more lawyers aware of the illegal promotion of Medicare-reimbursed drugs. Prosecutors have brought criminal charges against drug marketing tactics that stimulate federal payment for drugs not proven to benefit patients.11 Some ex-employees of drug companies have reaped millions of dollars of rewards for “blowing the whistle” on intentional misstatements about the effectiveness of these drugs. This article is not about those criminal frauds, however. Nor is it about tort attorneys’ remedial options after injuries. Rather, this article addresses how an Elder Law attorney should respond when approached by an elderly client or a family member of an elderly person who has been harmed by a physician prescribing an “off-label” use for an FDA-approved drug. Do not rush to sue the physician; consider where else the inducements and incentives arose and whether liability may exist. In short, “follow the money.”

III. The Major Exception

Since 1938,12 labels of new pharmaceutical drugs have been closely regulated by the FDA. The labels on approved drugs are permitted to describe only those medical uses that the FDA has designated as “approved indications for use” based on the FDA’s review of rigorous tests of human health effects.13 A new drug can be marketed for those tested and cautionary labeling goes into each FDA approval decision, 21 U.S.C. § 355 (2006), 21 C.F.R. Part 314 (2009).

9 In addition to the $1.415 billion criminal and civil settlement, the company previously agreed to pay $62 million to settle consumer protection lawsuits brought by 33 states. Dep’t of Justice Press Release, Eli Lilly and Company Agrees to Pay $1.415 Billion to Resolve Allegations of Off-label Promotion of Zyprexa (Jan. 15, 2009).

10 One marketer paid $1.415 billion criminal and civil settlement with federal authorities and $62 million to settle consumer protection lawsuits brought by 33 states. Press Release, Dep’t of Justice, supra note 9.

11 Criminal prosecution issues are discussed at length in JAMES O’REILLY ET AL., PUNISHING CORPORATE CRIME (2009).

12 52 Stat. 1040 (1938).

medical uses in advertising, at professional meetings, in sales visits to doctors, and even in ubiquitous and quite annoying television advertisements.

An exception, however, allows individual doctors to prescribe a drug either for its FDA-approved use as indicated on the label or for a selected other “off-label use.”14 For example, anti-Leprosy medications are sometimes prescribed to treat acne. Complex cancer treatment “cocktails” are often used, including some powerful drugs that do not have FDA approval for a specific type of cancer. These are the paradigm models of “off-label” use that permit a drug to be used for specific patient circumstances. The doctor can choose to prescribe the drug for the patient without it having any proven effectiveness for that use and without any safety data cleared by the FDA.15 The drug manufacturer, however, cannot lawfully promote the drug for such off-label use.16

The question of drug choices by physicians leaps from the micro-level into the billions of dollars when considering the pattern of prescription drug marketing. Why did that doctor expect this drug to work for these indications in your elder client when the drug was never approved as being safe and effective for these uses? The answer is that a 1997 lobbying effort prevailed and resulted in amendments that allow drug marketers to promote (subject to certain conditions) an already-approved drug for an additional medical use before the drug is approved by the FDA as safe and effective for that use.17 This was a historic change specifically sought by pharmaceutical mega-firms as a means to expand the profitability of high cost, research-intensive drugs.

A. Why Care About This Exception?

Why should Elder Law attorneys consider FDA approval for a drug’s “on label” use to be important to their elderly clients? One hundred years ago, anyone could sell any drug for any purpose. However, deaths due to problems with drugs led to widespread public support for major controls in 1906, 1938, and 1962 legislation.18 Today, the protective benefits for consumers of the U.S. drug approval system make our system a paragon for the world. We, as taxpayers, have funded a federal medical bureaucracy that gives careful, skeptical scrutiny to industry testing results, and gives prior approval to our new drugs. As a result, our drug industry is inventive, energetic, and resourceful.

Drug makers have known since the 1938 drug law amendments that if they did not show sufficient data to the FDA to support approval for a particular disease they could not advertise or sell the drug for that indication.19 If a drug firm wanted to expand uses of an

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18 This history is ably covered in FDA: A CENTURY OF CONSUMER PROTECTION (Wayne Pines ed., Food & Drug Law Institute 2006).
approved drug, the firm would pay for tests, submit a supplemental application, and then
wait for FDA agreement.\footnote{20}{21 C.F.R. Parts 312, 314 (2009).} That long standing aspect of consumer protection was changed
with the loophole added in the 1997 amendments. That loophole has grown to resemble a
chasm, as more and more advertising dollars promote prescription drug use. The elder cli-
ent’s intake of prescribed drugs has been shaped by that loophole; the consequences may
be legally actionable if that promotional effort was the cause of patient death or serious
harm from prescribing a drug for an inappropriate use.

IV. Why the Drug Promotion Law Changed

The drug industry lobbied Congress for years to win the right to promote unap-
proved (off-label) uses of FDA-approved drugs. Their argument was sometimes wrapped
in “free speech” banners, but their economic claims were simple: it costs too much for
the drug company that has sponsored a new drug for one indication to wait for further
FDA approval of additional uses. They argued that the limited promotion of additional but
unapproved uses should be allowed with some constraints, thereby generating a stream
of income that would help finance the firm’s pharmaceutical research while the extra test-
ing and approval phases were underway to win FDA blessing for that new use. Congress
bought the argument.

The 1997 legislative compromise\footnote{21}{Codified as 21 U.S.C. § 360aaa (2006).} allowed the following pattern. Once a new drug
is approved for on-label indication X, its sponsor can easily obtain FDA clearance to con-
duct a small-scale patient test for off-label indication Y.\footnote{22}{Investigational new drug application, 21 C.F.R. Part 312 (2009).} The sponsor can submit to the
FDA the whole test and its original supporting protocol, ask the FDA to approve use Y
because of the test results, and quietly await the FDA’s approval for this use. These steps
would cost in the tens of millions of dollars while generating zero marginal income for
the drug company; Or the sponsor can use the 1997 loophole to run its test and arrange to
have its interpretation of the results published in a medical journal that is “peer reviewed.”
Next, the drug manufacturer will make certain that every doctor who might prescribe for
patients with disease Y receives a copy of the published article about the drug’s purported
benefits, as outlined in the article, for the test group of patients with disease Y.

Promotion to doctors of unapproved uses of drugs by the distribution of journal ar-
ticle reprints was a compromise allowed after the 1997 amendments.\footnote{23}{Pub. L. 105-115, § 401 (1997).} Industry lobbying
carved out a “safe harbor,” and the FDA implemented that exception.\footnote{24}{FDA Notice, 65 Fed. Reg. 14,286 (March 16, 2000).} The 1997 law had
a sunset provision,\footnote{25}{21 C.F.R. Part 99, expired Sept. 30, 2006.} but the compromise had consequences for the FDA and for drug mar-
keters that are very evident today: the non-binding FDA guidance document called “Good
Reprint Practices” allows the functional “safe harbor” exception to continue despite the
sunset of the express statutory provision.\footnote{26}{FDA, Good Reprint Practices supra note 14.}

The 1997 compromise has resulted in a flood of promotional efforts for the off-label
indications of new drugs. The promotional funding specific to these indications is not separately reported and may not be accurately known to anyone, but it is a large slice of the $8 billion spent each year on promotional efforts by the major drug companies. Some of the promotion crosses the line and is illegal. Some firms engaged in sales practices that resulted in large fines for their off-label promotional activities.  

How did this impact Medicare? The Federal Centers for Medicare and Medicaid Services (CMS) pays for about 29 percent of prescription drugs used in the United States. The expansion of sales for off-label use was part of the reason for the massive increase after 1998 and specifically for the increase of Medicare/Medicaid acquisitions of prescription drugs. Relevant statistics are not broken out, and we have also seen the enactment of Part D Medicare. Still it is reasonable to assume that the promotional effort for prescription drugs has had a significant fiscal impact on United States taxpayers. By following the money being invested in prescription drug promotional efforts, one can readily draw the conclusion that drug marketers have spent these vast sums on promotion of their drugs for additional unapproved uses because they know their off-label efforts generate significantly greater sales volumes.

A. What Practical Effects Have Resulted?

Sales representatives make frequent visits to physicians to explain the off-label advantages of drugs. The result is that a doctor may prescribe the drug for that unapproved use and may often meet with therapeutic success. The physician is, in effect, conducting an individualized experiment. Yet the physician has no way of testing whether the benefit provided by the drug exceeds the potential risk to the patient. If the doctor had extensive research time and resources, the decision to prescribe the drug for off-label use might have been different. Pharmaceutical use issues are about risk-benefit decisions, who can make them, and who bears the loss if the ultimate risk exceeds expectations. An individual physician is hardly in a position to make those decisions within the short time allocated by health insurers for individual patient visits.

Despite the uncertainty of the off-label use of drugs, practically no notice is given to patients that the choice being made was premised on promotion, rather than upon governmental scientific reviews. Virtually the only notice given to the patient about the status of the particular drug may be an oral message such as, “Although this is not an FDA approved use of this drug, field tests have shown that it may help treat the condition you have.” A more honest and literal statement could be: “I’m giving you a prescription for X, a $700-a-month drug that does not have government approval of its safety or its effectiveness for your illness. I just hope that it works for the problem you are experiencing. Let’s see if your results are like those of the 55 patients whose reports are described in a recent article in American Journal of Phrenology, which I learned about at lunch today from Mary Smiley, the sales rep for drug marketer Y.” Would too much truth turn  


28 See Center for Medicare Services, Table 4, NHE Fact Sheet, available at http://www.cms.hhs.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp#TopOfPage. (hereinafter “CMS Table 4”).
off the patients, and deter the doctors, from the current unfettered use of the product for an exceptional case?

1. Sales Growth, Public Costs

For the drug marketing company, off-label marketing means that sales of an existing drug are expanded at minimal marginal cost. As a result, the investors are happier because the sales opportunities for the drug maker are expanded without the cost of investing in the lengthy FDA approval process. One route is slow and uncertain, although sales may cover the costs eventually. The faster route is to take the approved product and sell it extensively off-label so that a stream of income arrives without the costs of actual preparation for a full new drug application. This tactic may be tried even after the FDA rejects the firm’s application for that particular approval.29

What does it all mean for Medicare and Medicaid and for taxpayers?

Of the estimated $66 billion spent on pharmaceutical purchases for the federal government programs for health care, including Medicare, Medicaid, veterans, military, civilian federal employees, and other programs, some unknown percentage goes for the drugs adopted by doctors as a result of off-label promotions. The expansion of sales for off-label uses was one of the several factors that resulted in an increase to $67,262,000,000 in 2007 from a 1998 figure of $15,663,000,000 in the Medicare/Medicaid acquisition of prescription drugs. The expansion of sales for off-label uses is not separately calculated, but certainly contributed to this estimated 329 percent increase in the 1998-2007 Medicare/Medicaid acquisition of prescription drugs.30

2. Legal Issues of Off-Label Promotion

Three legal issues arise with off-label journal article promotions: what is said by the marketer about the drug when delivering the article; whether information about the test is timely and factual; and what is slanted or omitted from the full context and content of the clinical experiment.

First, it has been alleged that drug sales representatives enhance the message in the article about that benefit. FDA Guidance tells the drug marketer very directly that the reprinted article “should not be the subject of discussion between the sales representative and the physician during the sales visit….”31 Ideally, sales training of manufacturer drug representatives would teach conservative “safe harbor” practices consistent with FDA Good Reprint Practices.32 The reality is quite different. To earn both commissions and advancement a sales representative will not be reticent to praise the manufacturers’ drugs for their off-label potential. The FDA cannot monitor oral presentations and rarely catches up with patterns of misconduct by sales representatives in doctors’ offices. Still, numerous whistleblower complaints have focused on consciously misleading sales train-

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29 Dep’t of Justice Press Release, United States Files Complaint Against Forest Laboratories for Allegedly Violating the False Claims Act (Feb. 25, 2009). Available at www.usdoj.gov/civil.
31 FDA, Good Reprint Practices, supra note 14.
32 Id.
Second, because evidence about an actively studied drug evolves faster than the publication cycle of peer reviewed medical journals, few marketers want to wait so long to announce their advantages. So the off-label “news” about human clinical trial results is usually presented as new, innovative and exciting. And the sales boost from off-label claims occurs even if experienced FDA reviewers disdain the quality of results, the degree of statistical certainty, or the relevance of the benefit that was actually shown in the clinical study. The FDA reviewers are silenced by federal confidentiality rules until after a future date when a supplemental New Drug Application (NDA) is granted and the public can read the summary review memoranda. (In an extreme case of false claims, the FDA could act against blatantly misleading claims if it so chose.)

Third, if the tested drug’s planned benefit never materialized and the test results showed a failure to prove the primary effect, creative editors in medical advertising agencies can still spin it into a success for some other indication or some lesser benefit claim. The published article then reads as if the test was a success and had always intended to find end point B instead of end point A. But there is folly in this spinning. The test may have figuratively sought a “gold standard” result, but instead it could only produce a “brass ring” of moderate benefit or lesser end point. The drug company’s medical sales staff, who needs to show better sales results, are supported by the company’s editorial staff or contractor who convinces a journal that these “brass” results are worthy of publication.

Secrecy rules adopted to protect the commercial value of medical research results bar the FDA from disclosing the protocol. This occurs despite the reality that details of the testing, if given to doctors reading the promotional reprint, may show that the reported clinical success had actually been a failure. Doctors would recognize a loss that was creatively “spun” in this direction in submissions to journals for publication. Salvaging some publishable results from a less than effective finding about a drug is a valuable “spin” skill, but it can alienate a skeptical FDA medical reviewer. The FDA cannot stop the dissemination of off-label claims based upon the use of the slanted result reports because their publication is literally true, and “sins of omission” about a drug test are hard to challenge without first disclosing confidential data about the proprietary details of the test.

3. What Impact Does Off-Label Use Have on Elders?

The good news is that the off-label use can be beneficial. For example, the off-label use of a “cocktail” of certain cancer drugs may benefit some cancer patients for whom regulatory delays of a combined drug therapy, while awaiting full FDA approval, could be fatal. But there are inevitable concerns about the insufficiencies of the research con-

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33 These False Claims Act cases are discussed at length in James O'Reilly et al., Punishing Corporate Crime (2009).
36 Promotional claims using reprints “should not discuss a clinical investigation where FDA has previously informed the company that the clinical investigation is not adequate and well-controlled.” FDA, Good Reprint Practices, supra note 14.
cerning such combined use of the drugs. Frail elders may need less of a dosage, and their body systems may have less tolerance for the active ingredients in some chemotherapies. Had there been FDA review, cautionary statements would have been compelled as part of the approval negotiations. This would have permitted the patients to make informed decisions about whether to accept the proposed treatment.

Decisions to accept these risks are stark choices for cancer patients. But decisions are less stark for diabetes, macular degeneration, and osteoarthritis patients whose off-label prescriptions may reflect the salesmanship of the drug sponsor, more than their clinical merits. Courts have upheld FDA requirements in the face of pleas from terminally ill patients seeking unapproved drugs.\(^{38}\) The difference in our situation is that these drugs have received a limited FDA approval to be on the market, so that they could thereafter be prescribed off-label at the physician’s discretion.\(^{39}\) The debate here is about promotion and its effects on the largest group of prescription drug users, i.e., the elderly.

When the doctors praise the drugs they prescribe for off-label use, it is perhaps too confrontational for a prudent patient to ask whether the doctors’ choices were influenced by the company’s campaign, or whether the prescriber had actually read studies for and against the use of that drug for this class of patients. “Don’t you trust me?” is not what ailing patients want to hear from their family doctor. The more intriguing question may be, “Don’t you trust the marketing companies that designed MegaPharma’s campaign for this off-label use and who gave me this reprint with the free lunch last week?”

The FDA recognizes that a risk/benefit balance is central to drug approvals, because no potent drug is free of some adverse effect risks. Congress, by adopting the 1997 amendments that liberalized off-label use, chose to expose more patients to more unknowns by granting permission for additional promotional efforts prior to FDA evaluation of the data. The FDA did not ask for the change in 1997, and has been uncomfortable with the amendment since that time, because of the incongruity of a statute that bans unapproved drug promotions but allows journal article promotions to be used to expand the markets for already-approved drugs.\(^{40}\)

Assertions about excessive risk usually draw close scrutiny from the FDA. When it comes to off-label use, however, the FDA is likely to be silent about the validity of a journal article because of the loophole. Only in rare cases will it find a clear violation that can be prosecuted.\(^{41}\) The absence of a patient advocacy counterweight to the current structure of drug promotion leaves the FDA in an awkward posture because although it is the regulator and gatekeeper for new drugs, it is constrained in its ability to police the marketing of these claims for certain new uses of the already-launched drug products. The effect is that the 1997 exception swallows the 1938 rule for new drugs, which is approvals first, advertisements later.

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40 Good Reprint Practices, supra note 14.
41 FDA can prosecute for misbranding, 21 U.S.C. §§ 331, 352 (2006), but cannot use its non-binding Guideline as a basis for prosecution.
4. Who Pays?

Prescription drugs for the elderly are paid for by the individual, by private- or employer-provided insurance, or by Medicare Part D.\textsuperscript{42} In general Medicare Part D will pay for off-label prescription drugs.\textsuperscript{43} For example, drugs for sexual dysfunction are normally excluded, but could be paid for by Medicare if there were another FDA-approved use for that drug.\textsuperscript{44} By reimbursing off-label use of drugs, Medicare and other third-party payors encourage such use of the drug, since neither the physician nor the patient has reason to complain absent the drug causing negative side effects.

States also pay for off-label use by virtue of their share of the growing costs for Medicaid prescription drug programs.\textsuperscript{45} In response to the fuzzy area of marketing promotions and sales-related payments to prescribers, some states are starting to rebel. New Hampshire and Vermont have recently banned the sale of doctor-specific prescribing records, which drug companies seek access to in order to monitor the effectiveness of their sales efforts.\textsuperscript{46} Other states are working toward full transparency of pharmaceutical firm payments to doctors. These state laws are a response to alarms about the rapid growth of spending for prescription drug promotions, and a response to suspicions that prescription drug “consulting” payments to high-prescribing doctors were not being paid for legitimate consultations. ‘Backlash’ is an apt term for these state drug promotion control measures.

5. Status Quo and Secrecy

Consider the relationship of drug marketing, wholesaling, and pharmacy profits. Sales growth and higher profits come from increased physician prescriptions of a drug. More prescriptions are written in response to the dissemination of more assertions of the drug’s benefit for more uses. The least costly route to this dissemination is through off-label promotions using the 1997 loophole.

Paying a medical advertising firm for its publication assistance can yield great rewards. Extraordinary financial incentives are used to selectively publish and promote off-label uses. Any attempt to move back to the pre-1997 norm of “remain silent until you prove valid results” would be vigorously resisted by drug companies because any change would hurt their profits. Today’s investors in drug stocks factor in the base line of projected sales for the drug’s approved use, and also add on the projected sales from off-label uses. Any disruption in that potential stream of profits would be vigorously resisted.

In some cases, a physician will prescribe a drug for off-label use to treat a symptom for which another drug has been approved by the FDA for treatment of that condition. On occasion the elderly patient who is taking a drug for its off-label benefits grows more ill rather than better because of side effects from the drug. Adverse effects or patient deterioration because a prescribed drug for off-label use did not work as intended are foreseeable consequences of overly aggressive promotional efforts. The FDA could act

\textsuperscript{43} 42 U.S.C. §§ 1395w-102(e); 1396r-8(d)(2) (2006).
\textsuperscript{46} IMS Health Inc. v. Sorrell, No. 1:07-CV-188 (D. Vt. April 23, 2009); IMS Health v. Ayotte, 550 F.3d 42 (1st Cir. 2008).
Elders Falling Through a Loophole in Quality: Impacts of “Off-Label” Drug Promotion

Number 1] 35 to stop the harm, but has rarely done so since the 1997 loophole was created.\textsuperscript{47} Medicare/Medicaid and the private health insurers bear the consequences of these misguided physician prescriptions, as they pay both for the prescribed drug and then for the remediating care necessary as a consequence of the harm done by that drug.

The use of prescription drugs by the elderly is more than three times higher than that of younger adults.\textsuperscript{48} The likely consequence is that the elderly are frequently prescribed drugs for off-label use. Exposure to drugs that cause more harm than good is a very real downside to such off-label promotional efforts. The prudent advice to an elderly individual whose physician has prescribed a drug is to ask, “Does the FDA-approved label for this drug say it is effective for my condition?” The internet will disclose this even if the patient did not ask at the time of the visit to the clinic. If the answer is no, the patient’s follow up questions should be, “Is there a specific reason for prescribing this product?” and “Is there another FDA-approved label drug for my condition?”

V. Two Different Restatement of Law Tests

Tort liability does not arise in a vacuum, but in a political and economic context. After very potent lobbying in the 1990s, the American Law Institute accepted a Third Restatement of Product Liability with a definite industry bias. Judges who are bound by that Restatement are not permitted to rule that a drug has a “design defect” if the drug has some therapeutic purpose for at least one medical indication.\textsuperscript{49} In this view, it would be reasonable to market a drug that worked only for a rare disease like leprosy, even if this injured patient had received the drug for use against acne. By analogy to malpractice claims, individual prescriber choices of this drug for this indication may be challenged when they vary from the medical uses listed on the label. But if defense witnesses assert that the choice of this drug was generally within the practice of other doctors in the community in a state that follows the Third Restatement, use of the drug is unlikely to be considered malpractice by a prescriber.

In states that have not adopted the Third Restatement, but look to the law as described in the Second Restatement of Torts, the absence of FDA approval for a drug might be a basis for malpractice and for strict liability claims. The principal defense of pharmaceutical makers under the Second Restatement is that their products are “unavoidably unsafe” in design when not used as directed.\textsuperscript{50} This “as directed” defense does not apply to off-label uses.

The second level defense, a claim of federal preemption of drug warnings-based tort actions by virtue of the FDA approval of the new drug label, is no longer operative after


\textsuperscript{48} Per person personal health care spending for the 65 and older population was $14,797 in 2004, which was 5.6 times higher than spending per child ($2,650 in 2004) and 3.3 times spending per working-age person ($4,511 in 2004). Data analysis must use per person figures because the elderly are such a small percentage of the population that as a group, they spend less on prescription drugs than children and working-age persons. See Center for Medicare Services, “U.S. Health Spending by Age: Highlights,” available at http://www.cms.hhs.gov/NationalHealthExpendData/04_NationalHealthAccountsAgePHCasp#TopOfPage.

\textsuperscript{49} RESTATEMENT (THIRD), PRODUCTS LIABILITY § 6 (1997).

\textsuperscript{50} RESTATEMENT (SECOND) OF TORTS § 402A (1965).
the 2009 Supreme Court decision in Wyeth v. Levine.\textsuperscript{51} Even if it were, preemption has a prerequisite of full compliance with federal standards, and the fact that the use was promoted by the defendant for an unapproved indication would render irrelevant a defense claim that the FDA had approved a label for some other uses of this drug.

A. The Role of Tort Law

After the FDA approves the new drug label submitted by the company,\textsuperscript{52} the federal government’s direct control is over. The product enters the market and the tort system then assumes a deterrent and compensatory role. Counsel for the injured patient must work with medical advisors to determine the potential likelihood of success in a tort claim. Plaintiff’s counsel must ask whether the prescribing doctor was aware of its lack of approval. The other questions to ask include: Was the doctor misled about its FDA status? Was the drug too dangerous to be marketed for its FDA-labeled indication, without adequate warnings? Was there a provable link between the marketer’s selective claims of benefit that induced the prescribing of that drug and this physician’s choice that caused harm? Did the off-label promotional effort expand the liability of the drug company, by exceeding the bounds set by Congress and the FDA?

The elderly will benefit when there is a proper match of the patients’ needs to a particular pharmaceutical drug’s risk/benefit ratio. If the risk of aspirin toxicity is $X$ serious adverse events per 100,000, and the undisclosed risk of a doctor using potent prescription drug $Y$ in lieu of aspirin is known by the marketer to be $5X$ per 100,000, then the patient who is harmed by drug $Y$ should have a tort remedy for inadequacy of warnings — unless, in some cases, the practice norms in the local medical community would have supported the selection of $Y$ in the particular instance. There is no express right to bring a tort “private cause of action” for the off-label marketing,\textsuperscript{53} but issues of breach of due care and inadequate warnings are likely to be raised. These details will vary according to state tort law and the industry’s success in winning “tort reform” immunities.

Tort lawyers know many of the questions to ask in depositions:

- How did this doctor come to choose drug $Y$?
- When this use was suggested to the doctor by the company, how did the sales representative “pitch” the reprint?
- Was it featured in a company promotional campaign?
- Was the promotional reprint an accurate report of the results intended for this testing of $Y$?

They also know the ultimate questions to bring to the jurors:

- Should the patient bear the costs of harm that come from the erroneous choice to prescribe $Y$?
- Should the drug maker bear those costs, as the price of distributing the costs of avoidable risks?

\textsuperscript{51} 129 S. Ct. 1187 (2009).
\textsuperscript{52} 21 C.F.R. Part 314 (2009); details are examined in 1 James O’Reilly, Food & Drug Administration ch. 15 (3d ed., 2009 Supp.).
\textsuperscript{53} Wolicki-Gables v. Arrow Intern., Inc. 2009 WL 2190069 (M.D.Fla. 2009).
• Is society paying more for the liability cost, in the consumer retail price of drugs or even in the lesser government acquisition price for drugs?

The first four are the kinds of questions that the deponent physician and the deponent company representative might not want to answer. The final three are the kind of open-ended policy considerations that matter to jurors, even though the defense will argue for hours about inadmissible or irrelevant opinions.

VI. Conclusion

The family of an injured or deceased client may ask the Elder Law attorney to discover why their parent had been harmed by a certain prescription drug. The trail of causation research and interviews ends with the lawyer finding out whether there was a basis for challenge to the doctor’s assessment of the safety of this drug for this patient. If malpractice claims are not welcomed in that state’s courts, product liability claims are possible. Since the labeling of the pharmaceutical drug did not mention the medical condition suffered by the victim, it was either malpractice or “mal-promotion” by the drug marketer.

Understanding the ways in which promotional efforts impact on the decision to prescribe certain drugs may facilitate the lawyer’s decision to take on the drug company’s practices. The 1997 loophole may be too broad to protect elderly ill persons; perhaps an alternative that more tightly controls off-label promotional activity would have been the right policy for the most vulnerable consumers. Absent a political action effort on behalf of elders, there is not likely to be a successful effort to close the promotional loophole. Until such change is forthcoming, the Elder Law attorney should be aware that the perceived umbrella of federal protection from drug-related harms has a large hole, with unpredictable consequences for the health of the individual elder client.
**FINANCIAL EXPLOITATION OF THE ELDERLY: IMPACT ON MEDICAID ELIGIBILITY**

*By Donald D. Vanarelli, CELA*

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I. INTRODUCTION

It is not uncommon for an elderly or disabled person to entrust his/her finances to a third party. For example, an elder may execute a power of attorney as a simple estate planning tool in order to ensure that his or her affairs are properly handled if the elder is unable to act due to illness, injury, incapacity, or other cause. In other cases, an elder who is becoming overwhelmed by day-to-day financial tasks may simply “hand over the checkbook” to a relative or a trusted friend.

But what happens when the person to whom the elder’s affairs are entrusted misuses that authority? As the elder population in the United States continues to increase dramatically, the financial exploitation of the elderly has become an increasingly serious problem.

The exploitation may arise in various contexts. The elder’s assets may be misappropriated by a family member or agent under a power of attorney, or by the guardian or conservator appointed to handle the elder’s affairs. The elder may even retain an attorney

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2 See Probate of Marcus, 199 Conn. 524, 509 A.2d 1 (Conn. 1986).
to file a Medicaid application on her behalf, only to have that attorney misappropriate her assets in the guise of a Medicaid “spend down.”

Liability may be clouded by issues of family relationships and trust between the victim and the abuser, ambiguities in powers of attorney or other instruments controlling the fiduciary’s authority, and varying levels of competency of the victim.

Adding to the dilemma of financial exploitation is the issue of Medicaid eligibility, and the impact of the exploitation on the victim’s eligibility for necessary public benefits. In particular, when a third party makes improper transfers of the elder’s property without the elder’s knowledge or consent, will those improper transfers negatively affect the elder’s eligibility for Medicaid?

II. THE MEDICAID PROGRAM

Medicaid is a joint federal and state program created under Title XIX of the Social Security Act of 1965 that covers long-term care for the aged, blind, and disabled individuals who qualify financially. Eligibility for Medicaid is based upon financial need.

With the enactment of the Deficit Reduction Act of 2005 (DRA ’05), Medicaid legislation now imposes a 60-month “look-back period,” during which, if a Medicaid applicant disposed of assets for less than fair market value, the applicant may be subject to a period of Medicaid ineligibility (a “penalty period”), based upon the value of the uncompensated transfer. Moreover, the penalty period imposed under the DRA ’05 does not begin until the applicant would be otherwise eligible for Medicaid “but for the application of the penalty period.”

What happens when the applicant’s resources are transferred by a third party without the applicant’s knowledge or consent?

A. Resource Transfer Rules

The Medicaid resource transfer rules provide a logical starting point for the analysis of a financial exploitation case. Federal regulation defines a “resource” as follows:

(a) Resources; defined. For purposes of this subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.

(b) Liquid resources. Liquid resources are cash or other property which can be converted to cash within 20 days...

(c) Nonliquid resources. (1) Nonliquid resources are property which is not cash and

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3 See In re Disciplinary Action Against Peterson, 718 N.W. 2d 849 (Minn. 2006).
which cannot be converted to cash within 20 days…. Examples of resources that are ordinarily nonliquid are … buildings and land.⁷

When evaluating a transfer of assets, those regulations further provide that:

Transfer of a resource for less than fair market value is presumed to have been made for the purpose of establishing … Medicaid eligibility unless the individual … provides convincing evidence that the resource was transferred exclusively for some other reason.⁸ (Emphasis added.)

A state’s Medicaid plan must include “reasonable standards … for determining eligibility … which provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant….”⁹

State Medicaid regulations, in turn, further impact the analysis of unauthorized transfers. Although Medicaid regulations vary by state, below is an analysis of New Jersey regulations, by way of example.

In New Jersey, “in order to be considered in the determination of eligibility, a resource must be ‘available.’ ”¹⁰ Mirroring the federal regulations, the New Jersey regulations define a resource as “available” if the applicant has “the right, authority, or power to liquidate” the resource.¹¹

According to New Jersey regulations, certain categories of resources are “excludable” and are not considered in the Medicaid eligibility determination. Among the categories of “excludable resources” are the “value of resources which are not accessible to an individual through no fault of his or her own.” (Emphasis added.)¹² The New Jersey regulation provides examples of such inaccessible resources, including real property that cannot be sold “because of the refusal of a co-owner to liquidate.”¹³

Practitioners are well-advised to pay particular attention to their state’s Medicaid regulations. In states with Medicaid regulations similar to New Jersey’s regulations, a strong argument can be made that funds or assets that have been improperly transferred by a third party are a classic example of a resource that is “not accessible … through no fault of [the applicant’s] own.” In fact, such a scenario is arguably more compelling than the example provided in the New Jersey regulation itself, in which a co-owner refuses to liquidate a property.¹⁴ An alternate argument could be that, as to the stolen resources, the applicant can rebut the presumption that the resources were transferred to establish Medicaid eligibility.¹⁵

Medicaid Communication No. 88-15 states that, when determining whether an “individual” has transferred resources, the “individual” shall be defined to include the eli-

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¹⁰ N.J.A.C. 10:71-4.1.
¹¹ Id.
¹³ Id.
¹⁴ Id.
ble individual, his/her spouse, or “any person acting for and legally authorized to execute a contract for the eligible individual.” (Emphasis added.) Of course, an agent’s theft of an individual’s resources falls well outside the scope of a power of attorney’s “legal authority.”

B. The Hardship Exception

In the event of a Medicaid denial as a result of an unauthorized transfer, another avenue of redress may be available to the applicant. The U.S. Code provides for states to make determinations that the denial of Medicaid eligibility “would work an undue hardship....”16 Again, by way of example, under the New Jersey hardship exception regulation:

Upon imposition of a period of ineligibility for long-term care level services because of an asset transfer...an applicant may apply for an exception to the transfer of asset penalty if he or she can show that the penalty will cause an undue hardship to him or herself.17

Undue hardship will be found to exist if the Medicaid penalty “would deprive the applicant/beneficiary of medical care such that his or her health or his or her life would be endangered,” or “would deprive the individual of food, clothing, shelter, or other necessities of life.”18

In order to prevail in a hardship exception request, the applicant must demonstrate that, “the transferred assets are beyond his or her control and that the assets cannot be recovered. The applicant/beneficiary shall demonstrate that he or she has made good faith efforts, including exhaustion of remedies available at law or in equity, to recover the assets transferred.”19 (Emphasis added.)

The hardship exception thus places the burden on the applicant, as in the cases discussed in Section V, infra, to pursue litigation if necessary to recover the transferred assets.

The small amount of reported New Jersey law on the hardship waiver demonstrates that the requirements for entitlement to the hardship exception are stringently applied.20

16 42 U.S.C. §1396p(c)(2)(D) (2006). See 20 C.F.R. § 416.1246 (2009); see also HCFA Transmittal No. 64, §3258.10(C)(4), 5 (“When application of the transfer of assets provisions ... would work an undue hardship, those provisions do not apply... Undue hardship exists when application of the transfer of assets provisions would deprive the individual of medical care such that his/her health or his/her life would be endangered. Undue hardship also exists when application of the transfer of assets provisions would deprive the individual of food, clothing, shelter, or other necessities of life.”)

17 N.J.A.C. 10:71-4.10(q).

18 Id.

19 Id.

Indeed, it appears that hardship waivers continue to be overwhelmingly denied in all states, based on states’ prohibitively restrictive definitions of “hardship.” Nevertheless, if a Medicaid applicant is found ineligible for Medicaid as a result of financial exploitation, seeking a hardship exception is an alternative strategy that should not be overlooked.

III. OBSTACLES TO ENFORCING ELDER’S RIGHTS

As mentioned above, cases involving the financial exploitation of the elderly present various unique issues. Liability may be clouded by issues such as family relationships and trust between the victim and the abuser (see IV: Unreported Decisions, Case 2, infra), whether the abuser was “authorized” to transfer the elder’s assets, and varying levels of competence of the victim.

A. Competence Issues

If the competence of the victim is compromised, it is vital that this issue be fully addressed by the advocate in order to ease Medicaid’s (or the court’s) reluctance to give proper weight to the issue. The competence of the victim may be a critical component of a Medicaid eligibility claim, affecting the evaluation of issues such as the promptness of the discovery of wrongdoing or the victim’s “right, authority, or power” over the assets in question. Too often, however, it appears that this issue is not fully developed by advocates, or is not afforded proper weight by courts.

For example, in Davis v. Monahan, on appeal from a partial summary judgment based upon the statute of limitations, the Florida Supreme Court refused to apply the doctrine of delayed discovery in order to permit an elderly woman suffering from dementia to file suit against family members based upon their alleged misappropriation of assets, despite the elder’s claimed recent discovery of the misappropriations.

In the Florida case of Bernau v. State, discussed infra, the State was ultimately unsuccessful in prosecuting a son for financially exploiting his elderly parents by endorsing a $847,000 check to himself. In “reluctantly reversing” the conviction, the court noted that the State’s case had been complicated by the parents’ mental status, finding that, although their mental status had apparently diminished rapidly during the course of events, the State had offered no evidence that they were incompetent.

In contrast, a Medicaid applicant’s competence proved to be the pivotal issue in I.L. v. Division of Medical Assistance and Health Services (DMAHS). In that case, a New Jersey state court relied upon New Jersey Medicaid regulations to find that when an individual is incapacitated and does not have a guardian in place, the individual’s assets may be “unavailable” because they are not accessible to the individual “through no fault of his or her own.”

22 See, e.g., Bernau v. State, 891 So. 2d 1229 (Fla. App. 2d Dist. 2005).
24 Davis v. Monahan, 832 So. 2d 708 (Fla. 2002).
25 891 So. 2d 1229 (Fla. App. 2d Dist. 2005).
26 Id. at 1230.
The *I.L.* case involved an 87-year-old nursing home resident with Alzheimer’s disease, who had been denied Medicaid eligibility twice. The first and second Medicaid applications had been denied because documentation required by Medicaid was not submitted. After the nursing home became involved and submitted the verification documents required, the third application was denied because the applicant owned insurance policies with cash surrender values. At the administrative level, the judge had found that the applicant lacked the mental capacity to surrender those insurance policies and, relying on a New Jersey Medicaid regulation, concluded that the resources were inaccessible through no fault of the applicant, that they were not countable assets for Medicaid purposes, and that, upon the appointment of a guardian, those policies would be surrendered and paid over to DMAHS as reimbursement.

The DMAHS Director had reversed the administrative law decision, concluding that the applicant’s dementia had no effect on her eligibility, and that nothing prevented the nursing facility or someone on the applicant’s behalf from liquidating the insurance policies:

> [T]he test is whether the individual has the “right, authority or power” to the resource pursuant to N.J.A.C. 10:71-4.1(c). See also 20 C.F.R. §416.1201. While N.J.A.C. 10:71-4.4(b)(6) provides that certain resources are excludable from determining eligibility including “the value of resources which are not accessible to an individual through no fault of his or her own,” there is no indication that there was a legal impediment preventing I.L. from accessing the resources.... Moreover, an individual’s mental or physical condition does not extinguish the individual’s right, authority or power to a resource. In *Chalmers v. Shalala*, 23 F.3d 752 (1994), the Third Circuit found that the phrase “right, authority or power” is disjunctive and refused to interpret the phrase as conjunctive. The court went on to find that the word “power” means not only a “mental or physical ability or aptitude,” but also “the legal authority” to liquidate resources. Id. at 755. Therefore, if the individual has the legal right to receive the money, any mental or physical disability is immaterial to the eligibility determination. Indeed, as the court noted, since many disabled individuals receive benefits, “such an interpretation would render the provision meaningless.” *Id.*

On further appeal, however, the Director’s decision was reversed. The Appellate Division in *I.L.* cited the New Jersey Medicaid regulation that includes among the categories of excludable resources “the value of resources which are not accessible to an individual through no fault of his or her own.” Noting that the applicant was incapable of managing her affairs, but that a guardian had not been appointed for her at the time, the court concluded that “the cash values of her life insurance, while theoretically accessible to I.L....

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28 *Id.* at *1.
31 *Id.* at *3.
32 389 N.J. Super. at 362 (citing N.J.A.C. 10:71-4.4(b)(6)).
through an appointed guardian, were not in fact accessible until the guardian’s appointment, a circumstance that existed ‘through no fault of her own.’”

B. Issues as to Whether Actions Were “Authorized”

Although not involving the issue of Medicaid, the case of State v. Kennedy\(^{34}\) explores the issue of “legally authorized” transfers, and assists practitioners in interpreting Medicaid Communication No. 88-15. Kennedy had obtained a power of attorney that was assumed to have been executed by the elderly victim, authorizing Kennedy to draw upon the victim’s bank accounts. Kennedy misappropriated most of the money in those accounts. The New Jersey Supreme Court affirmed a conviction of embezzlement. In so doing, it made the following comments regarding the abuse of a power of attorney:

> A power of attorney of course is not an instrument of gift. In itself, it is no more than the term, power of attorney, imports—an authorization to the attorney to act for the principal. Although as between the bank and the principal, the bank was relieved [by the terms of the power of attorney] to inquire as to whether any withdrawal was in the agent’s interest rather than the principal’s, the instrument did not authorize the agent to make off with the principal’s money. In short, the instrument was the means whereby the agent was able to get his hands on the moneys, but when the moneys were thus obtained, the agent received them as agent for the principal, and the fraudulent appropriation of the moneys thus obtained to his own use constituted embezzlement. In other words, it is no defense to embezzlement that the moneys reached the agent with the consent of the principal. On the contrary, such entrusting is the necessary setting for the crime…. [I]t is no defense to embezzlement that the victim trusted the culprit.\(^{35}\)

C. Litigation Costs

The practical issue of the cost of litigation may be magnified in this area of practice. Litigation of an elder abuse case may be time-consuming and costly. For example, if the victim of elder abuse had limited assets prior to the exploitation, or was pauperized by the exploitation, that victim may be left without funds necessary to pursue his or her rights to relief against the perpetrator, or his or her entitlement to Medicaid benefits.

The issue of litigation costs was highlighted in the California Court of Appeals case of Levitt v. Hankin.\(^{36}\) Levitt involved the appeal of an attorney’s fee award by attorney Marc B. Hankin, Esq., identified by the court as “a recognized leader in the field of elder law,” who had represented a professional conservator in two actions involving the financial exploitation of elders. In both cases, the attorney’s requested fee award was reduced based upon the modest size of the estates. The attorney had argued that his fees should be paid in full, regardless of the size of the estates, “to encourage attorneys such as himself to take cases of financial elder abuse.”\(^{37}\)

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33 389 N.J. Super. at 366.
34 61 N.J. 509 (1972).
35 61 N.J. at 512-513.
37 Id. at 546.
As the attorney noted, his intervention in the two cases protected not only the finances but also the health and safety of the elders. During one of the hearings, the court noted that the elder would be able to remain in the nursing facility in which he currently resided even if his estate was depleted, because “payments would be taken over by Medi-Cal.” Despite findings that the hours billed and the rate charged by the attorney were not objectionable, the court in both cases, based upon the size of the estate involved, reduced those fees.\textsuperscript{38} On appeal, the court took judicial notice of a September 12, 2000 Los Angeles County Board of Supervisors’ Order No. 14, stating that,

elderly persons with modest estates do not have ready access to legal advice and assistance, which would enable them to effectively redress the exploitation of their assets or obtain properly documented estate planning for their protection... County Counsel ... work with the State and County Bar Associations on specific legislative proposals that would help improve access to the justice system for elderly persons with modest incomes who have been victims of financial exploitation or need assistance in estate planning matters.\textsuperscript{39}

Nevertheless, the \textit{Levitt} appellate court affirmed the attorney’s fee awards, finding that the trial court’s consideration of the modest size of the estates was proper, and that the attorney’s dispute was an argument properly addressed to the Legislature. It concluded:

We expect that Hankin and other members of the elder abuse bar have coordinated efforts with offices of county counsel, public guardian, and adult protective services to work on specific legislative proposals to improve access to the justice system for victims of elder abuse, as suggested in the order of the Los Angeles County Board of Supervisors.... We commend their efforts.\textsuperscript{40}

\section*{IV. Unreported Decisions}

The author was informed of an unreported Minnesota case in which an elderly victim of financial exploitation was spared his Medicaid benefits thanks to the efforts of the University of St. Thomas law students’ Elder Law Practice Group. According to a \textit{Minneapolis-St. Paul Star Tribune} article,\textsuperscript{41} the elder, Donald Mayne, appointed his daughter agent under a power of attorney. She, reportedly, then stole approximately $60,000 from his bank accounts. Despite the fact that the daughter faced criminal charges of “theft by swindle,” Medicaid authorities attempted to strip the father of his Medicaid benefits. An administrative law judge found “no convincing evidence” that the transfer was not simply an attempt to hide Mr. Mayne’s assets and reportedly concluded that “[i]t does not matter that his daughter, who was his attorney-in-fact, made the transfers against his will and outside his control.” After that decision was appealed and the Minnesota Attorney General’s office became involved in the case, Mr. Mayne’s benefits were restored.

This author recently litigated two different cases in the Superior Court of New Jer-

\begin{thebibliography}{1}
\bibitem{38} \textit{Id.} at 547, 548.
\bibitem{39} \textit{Id.} at 549 n.2.
\bibitem{40} \textit{Id.} at 550-551.
\bibitem{41} See http://www.startribune.com/templates/Print_This_Story?sid=18751924.
\end{thebibliography}
Financial Exploitation of the Elderly: Impact on Medicaid Eligibility

A. Case 1: Exploitation By, and Criminal Judgment Against, Elder’s “Friend”

In one case, a non-relative “friend” took a frail, elderly widow into her home as a tenant. The elderly widow had no family in New Jersey. The friend acted as caregiver for the elder, and the elder eventually appointed the caregiver her agent under a power of attorney.

The caregiver met the elder’s personal care needs and handled all of the elder’s financial affairs. Unfortunately, the caregiver also financially exploited the elder. Over the course of about 11 months, the caregiver stole approximately $166,000 from the elder. Ultimately, the elder was removed from the caregiver’s home by Union County Adult Protective Services and placed in a local nursing home.

The caregiver was indicted, convicted, and eventually sentenced to serve seven years in prison. I represented the elder in a civil action against the caregiver, which had been stayed pending resolution of the criminal case. We ultimately obtained a civil judgment of $166,000 against the caregiver, based upon the criminal conviction. The elder, who is still residing in a nursing home, has been unable to recover any of this amount from the caregiver.

I also filed a Medicaid application on behalf of the elder victim. That application was approved.

B. Case 2: Exploitation By, and Civil Judgment Against, Elder’s Daughter

In another case, I was appointed by the court as counsel, and later as guardian ad litem, for an elderly woman who had been sued by the nursing home in which she was residing. The woman had lived with her adult daughter in the mother’s home in Elizabeth, N.J., before the daughter placed her mother into the local nursing home and then misappropriated her mother’s assets. The nursing home sued the mother and the daughter after providing care for the mother for several years without receiving payment.

This case presented interesting issues with respect to family relationships and trust between the victim and the abuser. The mother was elderly, blind, and hard of hearing, and her understanding of English was limited. When I first became involved, she did not cooperate in the defense of the nursing home’s claims, instead remaining silent and deferring to her domineering daughter. She said that she did not want me to represent her because her daughter was representing her interests. Upon advising the court of the mother’s stance, the court removed me as court-appointed counsel, but appointed me as guardian ad litem in the case. Interestingly, at some point in the litigation, the mother began to acknowledge that her daughter had exploited her, and thereafter, she participated in the case against her daughter.

As we alleged in our cross-claim against the daughter, after placing her mother in the nursing home, the daughter improperly used a power of attorney to mortgage her mother’s home and withdraw most of the equity value of the home. She then took the proceeds for herself and others. We also alleged in the cross-claim that the daughter used

her mother’s monthly Social Security and pension checks to pay her own personal bills.

After a trial, the court entered judgment in favor of the nursing home against the mother and the daughter on the main claim for $218,000, but in the cross-claim, the court found that the daughter was liable to her mother in the full amount of the debt owed by the mother to the nursing home.

I filed a Medicaid application on behalf of the mother. As discussed below, that application was denied.

C. Impact of Exploitation on Elder’s Medicaid Eligibility

As set forth above, I filed Medicaid applications for both victims of the financial exploitation, with two quite different results.

In the first case, involving the non-relative caregiver, Medicaid approved the application. In the second case, Medicaid denied the application based upon the failure to provide information about the stolen funds. However, in neither case was I able to provide Medicaid with concrete information about the disposition of the stolen assets.

In my opinion, there were two reasons for the differing results. First, a criminal conviction was obtained in the first case, which was likely a motivating factor behind Medicaid’s approval. In addition, the first case was not clouded by issues of the family relationship between the victim and the abuser, as was the second case.

These differing results spurred my interest in exploring the effect of financial exploitation on Medicaid eligibility.

V. CASE LAW AND ADMINISTRATIVE DECISIONS

A. Theories of Recovery in Financial Abuse Cases Generally

Unfortunately, there is a dearth of reported case law directly addressing the impact of financial abuse on an elder victim’s Medicaid eligibility. This problem is compounded by limited access to unreported decisions nationwide.

However, the case law that follows, involving general issues relating to financial abuse of the elderly, provides insight into potential theories of recovery in cases of abuse. These cases involve both civil and criminal actions; recoveries on behalf of the elderly and on behalf of Medicaid; and restitution awards ordered to be made directly from the perpetrator or from, for example, the bond company holding the surety bond for a wrongdoing guardian.

State v. Lehman\(^4\) involved an in-home caregiver employed by an agency. The caregiver, while acting as the caretaker for an elder with dementia, took the elder to her bank on numerous occasions and withdrew $95,752 from the elder’s account over time. The defendant was prosecuted under the Ohio criminal code for “theft from an elderly person or disabled adult.” She pleaded guilty to a lesser charge and was sentenced to 15 months in prison and ordered to make restitution to the elder in the amount of $94,752. On appeal, the sentence was affirmed, with the court commenting that the elder’s family was attempting to keep her at home rather than in an institution, and that because of the theft

she would no longer receive the quality of care that she had received before the theft.\footnote{44} The appellate court approved the trial court’s conclusion that, “if [the defendant] is not punished with a prison term, her actions are likely to be copied by others in her profession who are exposed to gullible, mentally incompetent people.”\footnote{45}

In the Florida case of \textit{Bernau v. State}, discussed \textit{supra}, although the son ultimately was acquitted of charges of financially exploiting his elderly parents by endorsing an $847,000 check to himself, the decision notes that a professional guardian previously had been appointed and had recovered approximately $380,000 of assets in a civil action against the son.\footnote{46}

In the Arizona case of \textit{Capitol Indemnity Corp. v. Fleming}, following the misappropriation of an elder’s assets by her conservator, the conservator was removed by the court and ordered to reimburse the elder’s estate for the amount misappropriated.\footnote{47} After the conservator was able to pay only a fraction of the misappropriated funds, the court ordered the surety bond company to reimburse the elder’s estate for the remaining amount. The bond company attempted to sue the conservator’s attorney and spouse for those damages based upon theories of negligence, but that suit was unsuccessful.\footnote{48}

In \textit{Persinger v. Holst}, the conservator attempted to bring a legal malpractice action against an attorney who prepared a power of attorney for an elderly widow after the agent under that power of attorney misappropriated funds.\footnote{49} The suit claimed that the attorney should have dissuaded the elder from appointing the wrongdoer as her agent, and that the attorney should not have permitted the client to execute the power of attorney because she lacked capacity. The court rejected these theories, however, finding that the attorney owed no duty to insure that a client appoints an appropriate agent, and that the attorney had executed reasonable judgment with regard to the elder’s capacity to execute the document.\footnote{50}

In Connecticut, a nursing home sued an elder’s son (and power of attorney) and the attorney who had been appointed as the elder’s conservator, alleging that the son’s acts/omissions resulted in the loss of Medicaid benefits in the amount of $115,639. In \textit{Glastonbury Healthcare Center, Inc. v. Esposito}, the court found that the son had filed a Medicaid application on behalf of his mother, an institutionalized elder suffering from Alzheimer’s disease.\footnote{51} He listed her sole asset as a $3,400 bond. He then transferred his mother to the plaintiff facility, and signed an Admission Agreement as his mother’s power of attorney. The Agreement named him as the “Responsible Party,” although he did not sign the Agreement in that capacity.\footnote{52} As “Responsible Party” to the Agreement, the son was required to take the necessary steps to ensure his mother’s prompt Medicaid eligibility. Because the son (and the son’s attorney, who had become the mother’s conservator) failed
to reduce the mother’s assets to $1,600 by a certain deadline, her Medicaid application was denied, and the denial was upheld upon appeal. In her Medicaid application was later approved when the conservator/attorney transferred the assets as requested by Medicaid.

The nursing facility settled with the conservator and the case against the son went to trial, alleging breach of contract, negligence, promissory estoppel and fraudulent misrepresentation. Although rejecting the fraudulent misrepresentation count, the court found in favor of the nursing facility on the other counts. It concluded that the son had failed to reduce the mother’s assets, as directed by Medicaid; persistently and unreasonably claimed that a $15,000 bank account was not his mother’s asset; and, as executor of the father’s estate, failed to distribute income to his mother pursuant to his father’s last will and testament. The court concluded that the facility lost the Medicaid payments that it would have received absent the son’s actions/inactions. Finding the son liable for that loss, the court entered judgment against the son in the amount of those payments.

In the unpublished decision of State v. Goulet, a son was criminally convicted of theft and abuse of a vulnerable adult, based upon his financial exploitation and failure to care for his elderly mother. During a period in which the mother was actually ineligible for Medicaid benefits because of her son’s improper transfers of the mother’s assets from a trust through a power of attorney, the mother had received Medicaid benefits. At a restitution hearing, the son was ordered to pay the State, which was considered a victim of the son’s theft, for the benefits incorrectly paid to his mother. In affirming the restitution order, the appellate court noted:

> Regardless of where her trust money went, [the mother] would have exhausted the trust and would have received essentially the same care. It is the State — which has paid expenses that rightfully should have been paid by the trust — that has been placed in a worse position as a result of [the son’s] thefts.

B. Financial Exploitation and Medicaid Eligibility

In a number of cases involving the exploitation of elders, the impact of the exploitation on Medicaid eligibility is raised but not decided. Among the limited administrative decisions or cases deciding the issue, there is support for the position that a Medicaid applicant

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53 Id. at *3.
54 Id. at *5.
55 Id. at *6.
57 Id. at ¶9. See also State v. Huffman, 154 N.H. 678, 918 A.2d 1279 (N.H. 2007) (concerning son’s conviction of “theft by misapplication of property,” where father was found eligible for Medicaid but son diverted $37,345.62 of his father’s income, which was properly payable to the nursing home, for his own use); In re Floyd, 359 B.R. 431 (D. Conn. 2007), reconsideration denied, 2007 WL 1114024 (D. Conn. Apr. 12, 2007) (bankruptcy adversary proceeding by nursing home to except embezzlement debt from bankruptcy discharge, based on debtor/grandson’s alleged embezzlement of Medicaid resident’s funds properly payable to the nursing home).
should not be penalized for the unauthorized transfer of the applicant’s assets. As illustrated below, although these cases do not always provide an in-depth analysis of these issues, the cases appear to turn on issues such as the applicant’s level of competence and involvement in the transfers (or lack thereof), the extent of control exercised by the wrongdoer over the applicant’s estate, and the efforts made to recover the transferred funds.

In New Jersey, the issue of third-party transfers and Medicaid eligibility was most recently addressed in the unpublished Superior Court, Appellate Division, decision of *A.H. v. DMAHS*. A.H. addressed transfers by a son of his parents’ assets under a power of attorney, and the effect of those transfers on his parents’ Medicaid eligibility.

In *A.H.*, the son, who was his parents’ agent under a power of attorney, applied for Medicaid benefits for his father. After initially being denied, the denial was appealed and the father was found to be eligible for Medicaid, with a retroactive eligibility date of March 2002.

Shortly thereafter, the son used the power of attorney to mortgage his parents’ condominium. He deposited the mortgage proceeds of $83,355.32 into his parents’ joint bank accounts, and then wrote a $35,000 check to himself from those funds. The day after he wrote the check to himself, the son applied for Medicaid on behalf of his mother. In the mother’s Medicaid application, the son failed to disclose her interest in the bank accounts. As the *A.H.* court noted, had the son disclosed the mother’s ownership interest in the accounts, Medicaid would have imposed a penalty period. Instead, her Medicaid application was granted.

Thereafter, the son wrote checks to himself totaling $24,250 from the parents’ accounts. Medicaid advised him in June 2003 that, because the son had failed to submit a plan to liquidate the parents’ condominium, their benefits would terminate on September 30, 2003. The son appealed and elected to continue Medicaid benefits pending the appeal. At the hearing, the administrative law judge concluded that the parents’ total resources exceeded the resource standard, and that a ten-month period of Medicaid ineligibility would be imposed with respect to Medicaid benefits that had been paid on behalf of the parents. The administrative law judge also ordered that the son would be personally liable for the repayment of $67,792 in Medicaid benefits. The Director of the New Jersey DMAHS adopted those findings, and the son appealed to the New Jersey Superior Court, Appellate Division.

The Appellate Division affirmed. The *A.H.* decision does not directly address whether the parents had knowledge of the transfers, but there is no reference to the parents’ involvement in these transfers, and it is clear that the court held the son responsible for the transfers. It reasoned that New Jersey Medicaid statutes authorize the imposition of liability upon “a recipient, legally responsible relative, representative payee, or any

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60 Id. at *1.
61 Id. at *1.
62 Id.
63 Id.
other party or parties whose action or inaction resulted in the incorrect or illegal payments [or] who received the benefit of the divestiture, or from their respective estates. The court concluded that “[the son’s] active role in dealing with his parents’ assets, in applying for benefits, and in personally benefiting from those assets while, at the same time, ineligible benefits were provided for the benefit of his parents, more than amply triggered [the son’s] personal liability for the repayment.”

In the case of In re Probate of Marcus, a ward’s conservators made unauthorized gifts to themselves and their family, depleting the ward’s estate. The conservators then applied for Medicaid on behalf of the ward. Medicaid notified the probate court (which handled the conservatorship) that the gifts had been made, a hearing was held, and the gifts were disallowed by the probate court as unauthorized. Thereafter, Medicaid denied the ward’s pending Medicaid application. On appeal, the hearing officer held that the probate court’s disallowance of the gifts rendered those funds “available” to the ward, even though the funds were no longer in the elder’s possession.

The Marcus case was further appealed to the Supreme Court of Connecticut, which held that, because the Medicaid applicant had an enforceable right against her daughters for the improper transfers, the funds would not be considered “available” to the applicant if she could demonstrate that those funds could not be recovered from the daughters (because, for example, the daughters were judgment-proof). The Marcus court found that the effect of the probate court’s disallowance of the gifts was that the conservators were personally liable for the return of the gifts. In other words, the ward’s estate had a legally enforceable right against the conservators for restitution. However, the court continued that,

[t]he mere fact that the conservatrices are personally liable for the unauthorized dispositions does not necessarily mean that these funds are “available” for purposes of determining eligibility for [Medicaid] …. The state would not be justified in denying benefits in the event that the conservatrices are unable to satisfy a judgment against them, or if for any other reason the funds due the estate are not actually available for the maintenance and support of the ward.

The North Dakota Supreme Court in Linser v. Office of Attorney General considered a Medicaid termination based on a guardian’s improper placement of funds into a special needs trust. The Linser Court cited the Marcus case and reasoned that “an asset to which an applicant has a legal entitlement is not unavailable simply because the applicant must initiate legal proceedings to access the asset.” Therefore, it concluded that:

It is appropriate for an agency to find that assets which the applicant has a legal entitlement to are actually available to him where the record fails to demonstrate the applicant would be unsuccessful in exercising a legal right to obtain them.

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64 Id. at 2 (quoting N.J.S.A. 30:4D-7(i)).
65 Id. at *2.
66 199 Conn. 524, 509 A.2d 1 (Conn. 1986).
67 509 A.2d at 3.
68 509 A.2d at 5.
70 Id. at 648. As to the issue of when assets are “available” to an applicant, see also Miranda v. Barnhart,
In a case in which a mother failed to pursue a cause of action against her daughter for “gifts” made under the daughter’s power of attorney, the transfers resulted in the mother’s Medicaid ineligibility. In the March 20, 2008, North Dakota Supreme Court case of Makedonsky v. North Dakota Dept. of Human Services, a mother was found Medicaid ineligible based upon transfers made by her daughter.\textsuperscript{71}

Notably, the Makedonsky court began its analysis by noting that, “at all times relevant to her claim for Medicaid benefits, [the Medicaid applicant] was mentally competent and capable of understanding her business affairs.”\textsuperscript{72} The transfers were made by the daughter (as attorney-in-fact under the mother’s power of attorney) to the daughter and her sisters. Although the transfers were made prior to the Medicaid “look-back” period, the mother signed a “statement of intention to gift” (stating that the transfers were gifts that she voluntarily made) during the look-back period. Thus, Medicaid eligibility depended upon the effective date of the transfers.

The North Dakota Supreme Court affirmed the administrative law judge’s holding that: 1) based upon the North Dakota statute, transfers made by a fiduciary that benefit the fiduciary are presumed to be the product of undue influence; 2) therefore, before the mother signed the “statement of intention to gift,” she had a legal cause of action against the daughter to return the “gifts”; 3) under Medicaid law, the mother was required to make a “good-faith effort to pursue available legal actions to have assets made available for purposes of Medicaid eligibility”; and 4) when she later signed the “statement of intention to gift,” she relinquished that legal right to sue for the return of the assets, and at that point made a disqualifying transfer. The date of that “statement of intention to gift” was deemed the transfer date, rendering the mother Medicaid-ineligible during the resulting penalty period.\textsuperscript{73} The Makedonsky court cited the Linser decision for the proposition that, an asset need not be in hand to be “actually available,” and an applicant may be required to initiate appropriate legal action to make the asset available.... If an applicant has a colorable legal action to obtain assets through reasonable legal means, the assets are available and the burden is on the applicant to show a legal action would be unsuccessful.\textsuperscript{74}

VI. Conclusion

Medicaid eligibility determinations involving financial exploitation of an applicant/victim will likely involve establishing the following elements during the application or appeal process: 1) the applicant’s knowledge of, or consent to, the transfer(s); 2) the applicant’s relationship to the wrongdoer; 3) the applicant’s competency at the time of the transfer(s); and 4) the steps taken by or on behalf of the applicant to recoup the transferred funds. Although eligibility determinations will be fact-sensitive, the foregoing legal au-

\footnotesize{\textsuperscript{71} 2008 N.D. 49, 746 N.W. 2d 185, 187 (N.D. 2008).}
\footnotesize{\textsuperscript{72} Id.}
\footnotesize{\textsuperscript{73} Id.}
\footnotesize{\textsuperscript{74} Id.}
Authority may be used to advocate in favor of eligibility (or in favor of granting a hardship exception, in the event of a Medicaid denial) on behalf of an elderly victim of financial wrongdoing.
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This is the second part of a two-part article examining the relationship of Elder Law attorneys and trust and estate lawyers with the medical profession. The first part appears at 5 NAELA JOURNAL 123 (No. 2, 2009). This second part of the article examines confidentiality. Subsequent articles in the series will examine doctors and lawyers and conflict of interest, and then focus on other multidisciplinary professional relationships including CPAs, financial planners, insurance professionals, psychologists and social workers.

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I. INTRODUCTION

The thesis of this two-part series of articles is based on the premise that the services and products provided to the elderly come from many different professions, including, but not limited to, accounting, insurance, finance, medicine, law, mental health, and social work. The involvement of those from different professions serving the same patient or client is termed “multidisciplinary practice.”¹ In addition to each profession having its own ethical code or guidelines,² each profession has a section addressing client confidentiality.³

Part I of this two-part series of articles compared the ethics of confidentiality in the medical and legal professions, focusing on ethical boundaries and black letter rules and summarizing their application. It reviewed the black letter rules on confidentiality in each profession related to privacy in the context of health care and the Health Insurance Portability and Accountability Act (HIPAA).⁴

This Part II examines articles, opinions, and decisions in the medical and legal professions, assessing several specific areas of confidentiality to determine if they clarify boundaries. Part II also examines differences between the professions that may be impediments to serving the same patient or client. The inquiry is prompted by the rising demographics of older adults in this society and by the increasing professional interplay between doctors and lawyers who are working with the same elderly patients or clients.

II. THE AMERICAN MEDICAL ASSOCIATION  
ETHICAL PRINCIPLE OF CONFIDENTIALITY AND ITS EXCEPTIONS

This Part II article first reviews several areas of the American Medical Association (AMA) Code of Medical Ethics (CME) promulgated by the AMA’s Council on Ethical

and Judicial Affairs (CEJA) that directly address the tension between protecting patient secrets and necessary disclosure within the core value of confidentiality.\(^5\) It then examines the primary principle of confidentiality as analyzed in one case that presents facts stemming from the relationship between a hospital and a law firm. It ends with an examination of the “harm or injury” exception to confidentiality.

The limited source of articles, opinions, and judicial decisions related to confidentiality of the patient-physician relationship led the author to interview Professor Jonathan M. Evans,\(^6\) a medical school professor who is experienced in private, academic, clinical, and institutional medical environments. His insight and perceptions will be noted in those areas on which he was requested to focus, addressing confidentiality generally and the exceptions to confidentiality specifically. Broadly, Evans described the secrecy apparent in the medical profession as logical inconsistency, with various governing bodies taking action but not venturing into on-going patrolling or enforcement of the medical profession.\(^7\)

A. Confidentiality Generally

The CME has 126 annotations relating to the general application of confidentiality.\(^8\) Even though there are no grievance decisions or formal ethics opinions in the annotations, they do reflect areas of concern that appear in published literature and judicial decisions.\(^9\) In the annotations related to confidentiality generally,\(^10\) one case, \textit{Biddle v. Warren General Hospital},\(^11\) stood out, bringing together medical and legal ethics within a multidisciplinary context. \textit{Biddle} involved a hospital and the disclosure of confidential patient information; a law firm and confidential information shared within an attorney-client relationship; the pursuit of SSI eligibility for patients who were not the clients of the law firm; and the issue of whether an independent tort existed for the unauthorized, unprivileged disclosure to a third party of nonpublic medical information that a physician or hospital learned within a physician-patient relationship.\(^12\)

The facts in \textit{Biddle} involve something surreptitious, bordering on sinister. A lawyer in the firm contrived a way for the hospital, on whose board a member of the firm sat, to be paid for uncollectible patient accounts by the firm filing for Social Security benefits, and in return for those legal services the hospital would pay a contingency fee to the firm.\(^13\) This was considered an inducement whereby both the firm and the hospital would gain financial benefit. For two and one-half years, the firm received all of the patient registration forms from the hospital without any direct contact with the

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\(^{5}\) \textit{See AMERICAN MEDICAL ASSOCIATION (2008–2009) [hereinafter ANNOTATED CODE OF MEDICAL ETHICS].}

\(^{6}\) Interview with Jonathan M. Evans, MD, MPH, Associate Professor, and Head of the Geriatric Faculty at the University of Virginia School of Medicine (Nov. 6, 2007, and Dec. 5, 2007.) [hereinafter Evans].

\(^{7}\) \textit{Id.}

\(^{8}\) \textit{See ANNOTATED CODE OF MEDICAL ETHICS, supra note 5, E-5.05 Confidentiality, at 149.}

\(^{9}\) \textit{Id.}

\(^{10}\) \textit{Id. at 142.}

\(^{11}\) \textit{Id. at 155–156, citing Biddle v. Warren Gen. Hosp., 86 Ohio St. 3d 395, 715 N.E. 2d 518 (Ohio 1999) (hereinafter Biddle).}

\(^{12}\) \textit{Id. at 523.}

\(^{13}\) \textit{See ANNOTATED CODE OF MEDICAL ETHICS, supra note 5, Prior History, at 3, 4.}
patients for their consent or authorization. When patients were singled out as candidates for Social Security benefits, they were contacted by the firm as if it were the hospital, explaining, “You might be entitled to Social Security benefits that might help you pay your medical bill.”

The Ohio Supreme Court appeared to draw the conclusion that the facts of the case were negative, finding it necessary to stop well into its analysis to again review those facts.\(^\text{14}\) In the review, the Court did little to hide its disdain when it wrote how the hospital handed thousands of patient registrations over to the law firm, which concealed its identity in order to solicit patients to hire the firm to file Social Security claims.\(^\text{15}\) The law firm had been counsel to the hospital, but was not its agent for the purpose of serving any of the hospital’s patients.

While the ethics violation was only directed at the hospital, the law firm had to struggle with the first and foremost question posed to lawyers at the inception of any engagement — who is the client? The law firm contended that the hospital was the client and that under that attorney-client relationship it had the right to receive confidential patient information. However, the law firm also acknowledged that it represented the patients in the Social Security hearings. The difficulty was how the firm solicited the patients through its relationship with the hospital. The Court ended with the observation that the hospital should have gained authorization from its patients.\(^\text{16}\)

Ohio was an early state to articulate the patient’s right to confidentiality, holding a third party liable for the inducement of unauthorized disclosure of medical information.\(^\text{17}\) Over 35 years later, Biddle was this country’s first decision to find that a law firm employed by a hospital is not considered an agent of the hospital and does not have the same duty of confidentiality to the patient because the law firm’s duty is to the hospital.\(^\text{18}\) Without a direct connection to the patients, the law firm was considered a third party and held liable for inducing disclosure.\(^\text{19}\) The decision declared that there was a common law tort for breach of confidences in Ohio.\(^\text{20}\) The law firm, supported by hospital and legal organizations, including the Ohio Bar, as \textit{amici}, argued that since the hospital was its client, and since the law firm had its own duty of confidentiality, the law firm should be under the same privilege as the hospital.\(^\text{21}\) With the hospital as its client, the law firm should have been able to receive confidential medical information from the hospital without obtaining prior patient authorization to do so.\(^\text{22}\) The Court determined that the registrations had been provided without authorization.\(^\text{23}\) Justice Stratton’s dissent in \textit{Biddle} argued in

\begin{itemize}
\item \textit{Id.} at 526–527.
\item \textit{Id.}
\item \textit{Id.} at 525.
\item See \textit{Biddle}, supra note 11, at 527.
\item \textit{Id.} at 523. The court recognized that other jurisdictions had slowly moved to the inevitable realization that there is a separate action for breach of confidence.
\item \textit{Id.} at 525.
\item \textit{Id.}
\item \textit{Id.}
\end{itemize}
simpler terms, concluding that the law firm was the hospital’s agent and not a third party, and as such the flow of confidential information between the hospital and the firm was not a tortuous disclosure.24

B. Confidentiality and Related Policies that Apply to Exceptions

The CME has an interesting structure. In addition to its declaration of principles, its introduction, and its terminology, it presents broad-based sections that overarch all other principles, including Opinions on Social Policy Issues,25 and Opinions on Professional Rights and Responsibilities.26

1. Opinions on Social Policy Issues

The Opinions on Social Policy section of the CME has 25 subcategories that the AMA saw fit to single out for commentary and opinion. Each subsection has either a short statement of position or guidelines, followed by applicable articles, opinions, and judicial decisions. Those subcategories that relate to this article are: (a) Abuse of Spouses, Children, Elderly Persons, and Others at Risk;27 (b) HIV Testing;28 and (c) Impaired Drivers and Their Physicians.29

a. Abuse of Spouses, Children, Elderly Persons, and Others at Risk

Physicians have a uniquely intimate relationship with their patients, examining all parts of their bodies and seeing all kinds of physical insults.30 With this intimate access comes the routine collection of medical history.31 On this professional foundation, the AMA Council on Ethical and Judicial Affairs published guidelines for detecting and treating family violence.32 The guidelines state that inquiry regarding physical, sexual, and psychological abuse should be routinely included in each patient’s medical history and that, because of this opportunity for detection, there is an obligation for physicians to “familiarize themselves with the protocols for diagnosing and treating abuse and with community resources.”33 The guidelines further emphasize this society’s misconception

24 Id. at 530–532. The Stratton dissent was framed in five bullet points: “1. An attorney-client relationship existed between the law firm and the hospital…. 2. Because an attorney-client relationship existed, the law firm was an agent, not a third party…. 3. The attorney-client privilege encourages the free disclosure of all information between the client and the attorney…. 4. The attorney is obligated to preserve all confidences of his or her clients…. 5. The hospital had a right to retain counsel for debt collection purposes.” Id.
25 See ANNOTATED CODE OF MEDICAL ETHICS, supra note 5, E-2.00 Opinions on Social Policy Issues, at 4.
26 Id. at E-9.00 Opinions on Professional Rights and Responsibilities, at 290.
27 Id. at E-2.00 Opinions on Social Policy Issues; E-2.02 Abuse of Spouses, Children, Elderly Persons, and Others at Risk, at 6.
28 Id. at E-2.23 HIV Testing, at 118.
29 Id. at E-2.24 Impaired Drivers and Their Physicians, at 120.
30 Id. at E-2.02 Abuse of Spouses, Children, Elderly Persons, and Others at Risk, at 6.
31 Id.
33 Id.
that abuse is a rare occurrence, that it does not happen to “normal” families, that it is private and should not have public scrutiny, and that victims are at fault.\textsuperscript{34}

The subcategory then provides guidelines for physicians to report abuse. Even with the dilemma of patients and offenders pleading for physicians not to report, and institutionalized elderly fearing reprisal in the form of more drastic treatment, the guidelines suggest compliance with reporting laws.\textsuperscript{35} Because of the need for physician involvement, there are few articles or decisions reported.\textsuperscript{36}

\textit{b. HIV Testing}

The concern that the medical profession has with HIV focuses on protection for health care providers and the public, while at the same time securing the patient’s informed consent and assuring patient autonomy and patient confidentiality.\textsuperscript{37} The report referred to in the subsection points to the need to test and to report under the exception to confidentiality “when necessary to protect individuals, including health care workers, who are endangered by persons infected with HIV.”\textsuperscript{38} If aware of a seropositive individual placing others at risk, the report instructs the physician “within the constraints of law” to attempt to get the infected person to stop endangering others, to notify authorities if the infected person is not persuaded, and to notify the person at risk if the authorities fail to act.\textsuperscript{39} Consider the following case study taken from published volumes addressing ethics law and medicine.\textsuperscript{40}

\textbf{Doctors: Case Study A — The Prostitute}\textsuperscript{41}

Prostitute P arrives at the ER after having been badly beaten. She is crying and incoherent. Dr. H attends to cleaning P. During an exchange, P reveals that she was beaten by G, manager of the curb market across from the ER. P mutters that G may have beaten her but that she bested him because she has AIDS and now “so will he.”

\textbf{Discussion Questions}\textsuperscript{42}

1. Does Dr. H have any obligation to offer HIV testing or counseling to P? Should he be required to inquire how she knows she is HIV-positive? Does he have an obligation to investigate further as to how P contracted HIV or whom she may have infected?

\begin{itemize}
\item \textsuperscript{34} \textit{Id.} at 7.
\item \textsuperscript{35} In this author’s opinion, this is hardly a mandate what with the important position of physicians in domestic and institutional advocacy for those most vulnerable in society. There should be more guidance for physicians serving as facility doctors in nursing homes.
\item \textsuperscript{36} \textit{See Annotated Code of Medical Ethics, supra} note 5, at E-2.02 Abuse of Spouses, Children, Elderly Persons, and Others at Risk, at 8–9.
\item \textsuperscript{38} \textit{Id.}
\item \textsuperscript{39} \textit{Id.}
\item \textsuperscript{40} \textit{See David M. Vuladinovich & Susan L. Krinsky, Ethics and Law in Modern Medicine: Hypothetical Case Studies, Ch. 2, Emergency Care and HIV, 17–28 (2001).}
\item \textsuperscript{41} \textit{Id.} at 18.
\item \textsuperscript{42} \textit{Id.} at 20.
\end{itemize}
2. Does Dr. H have an ethical obligation or a legal duty to keep P’s information confidential?

3. Does Dr. H owe a duty to G? If Dr. H has a doctor-patient relationship with P that requires him to keep P’s medical information confidential, are there any grounds upon which Dr. H may have an obligation to G that trumps his duty of confidentiality to P? What would be the effect of a specific state statute or the Tarasoff decision?

4. Assume G has been attended by Dr. H over the years, all in the ER and G has seen no other physician? G believes that Dr. H is his primary doctor. Is there a doctor-patient relationship? If there is, how does Dr. H handle his duty to P and to G?

**Analysis**

The medical perspective of the confidentiality duty is apparent in the way in which Vukadinovich and Krinsky focus their discussion questions. The authors go further by identifying role assignments for Dr. H, P, and G. In their assignment for G, they have G arguing that Dr. H is obligated to disclose any medical information about P that may be relevant to G’s health. They also suggest that G should argue that P is using HIV as a weapon and should not be protected by confidentiality. They then have P assert her right to confidentiality, and that G is not a patient of Dr. H and that G is at risk by his own actions. Regardless of the answers, what is significant is the discretion of the physician to disclose. Dr. H determines whether G is actually his patient; Dr. H determines whether P’s HIV is a threat that requires disclosure. There are sufficient facts in the case study for Dr. H to choose either option and not violate the CME. This is supported by the comments and opinion of Professor Evans describing how physicians deal with the practical realities of medical practice. How this compares to the attorney’s discretion to disclose will be examined later in this Part II article in the section on legal ethics and confidentiality.

c. **Impaired Drivers and Their Physicians**

The subsection on patients who drive while impaired is no stronger than the subsection on abuse. It gives a passive suggestion that physicians simply recognize driving impairments of patients. The published report instructs doctors to be watchful for those strong threats to public safety created by patient driving impairments that may have to be reported to the appropriate state agency. Like the subsection on abuse, this subsection requires no mandatory action by physicians. However, to its credit, the medical profession at least promotes recognition, awareness, and education about driving impairment.

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43 See supra note 61.
44 Vukadinovich & Krinsky, supra note 40, at 24–25.
45 Id.
46 See supra note 6.
47 See infra note 103, and accompanying text.
49 Id. at 111, citing Kanoelani M. Kane, Driving into the Sunset: A Proposal for Mandatory Reporting to the DMV by Physicians Treating Unsafe Elderly Drivers, 25 Haw. L. Rev. 59 (2002).
and the elderly. Unlike abuse and infectious diseases, impaired drivers have others that should take as much responsibility and be exposed to liability for harm or injury.\textsuperscript{50}

The report lists seven “shoulds” for physicians to consider doing: 1) Assess mental and physical impairment in relation to the effect on driving abilities; 2) Before reporting, have a careful discussion with patient and family; 3) Use best judgment as to when to report; 4) Adopt the role of reporter as required by law; 5) Explain requirement to report to patient; 6) Protect patient confidentiality by providing minimum information; and 7) Advocate with state and local groups to create necessary laws.\textsuperscript{51} The American Bar Association’s (ABA) Model Rules of Professional Conduct (MRPC) should do the same for attorneys.

A case study taken from the American College of Physicians (ACP) is examined in the section below discussing attorneys and legal ethics, and their duty to impaired clients and driving.\textsuperscript{52} It presents an assessment of how physicians would handle the situation and directs attention to studies that draw quite different conclusions when determining risk.\textsuperscript{53} The case study, assessment, and further comments by Professor Evans are developed in the law section because they provide continuity and convenience for understanding how different the lawyer’s ethical view of the risk is compared to that of the physician.\textsuperscript{54}

2. Opinions on Professional Rights and Responsibilities

Under the principle addressing professional rights and responsibilities, the CEJA again addresses infectious diseases and HIV infection.\textsuperscript{55} However, this section targets the problems when it is the physician who has the infectious disease or HIV infection.

C. Confidentiality and Specific Exceptions

As mentioned in the previous Part I article,\textsuperscript{56} both the medical and legal professions have approved policies\textsuperscript{57} or black letter rules\textsuperscript{58} that provide for exceptions to the general rules on confidentiality and the non-disclosure mandate in the patient or client medical or legal relationship.

In the Part I article,\textsuperscript{59} it was pointed out that the annotations examining the “harm or injury” exception to the confidentiality rule include areas of abuse,\textsuperscript{60} murder threats,\textsuperscript{61}

\textsuperscript{50} Id. citing Pat Martin, \textit{Who Will Take the Keys from Grandpa?} 21 T. M. COOLEY L. REV. 257 (2004).
\textsuperscript{51} Id.
\textsuperscript{52} See infra note 189, and accompanying text.
\textsuperscript{53} Id.
\textsuperscript{54} See infra note 189, and accompanying text.
\textsuperscript{55} See ANNOTATED CODE OF MEDICAL ETHICS, supra note 5, at 303, 304.
\textsuperscript{56} See supra note 4.
\textsuperscript{57} ANNOTATED CODE OF MEDICAL ETHICS, supra note 5, E-5.00 Opinions on Confidentiality, Advertising, and Communications Media Relations, at 125, 136.
\textsuperscript{58} See ANNOTATED MRPC, infra note 96, Rule 1.6(b)(1), at 89.
\textsuperscript{59} See supra note 4.
\textsuperscript{60} See ANNOTATED CODE OF MEDICAL ETHICS, supra note 5, IV Patient Confidences and Privacy, at xxxi, citing Maryland Att’y Gen. Opinion, 62 Op. Att’y Gen. 157, 160 (1977) (This actually dealt with child abuse, but for this paper, the discussion will address elder abuse.)
\textsuperscript{61} Id., citing Tarasoff v. Regents of Univ. of Calif., 17 Cal. 3d 425, 551 P.2d 334, 347, 131 Cal. Rptr. 14, 27 (Cal. 1976); at xxxiii, citing Rocca v. Southern Hills Counseling Ctr., Inc., 671 N.E.2d 913, 916 (Ind.
HIV infection, and impaired driving. As reviewed above, the CME has other code sections that come into play. As each of these excepted areas is examined, the applicable ancillary sections will also be applied.

1. Confidentiality — Abuse

Elder abuse has been described as a hidden epidemic. As noted by experts in the field, recognition of elder abuse lags years behind the recognition of other domestic violence victims, such as spouses and children. This may explain the dearth of articles or decisions in the annotations of the CME. Even with the lack of visibility, the CEJA sets out guidelines for physicians when confronting abuse. Admittedly, the guidelines are generic, spanning the spectrum of abused victims. With an understandable note of irony, the elderly are included in the class.

The medical profession expands this abuse exception to confidentiality with a bright line, marking the medical ethical boundary in a way that should put attorneys on notice when involved with the same patient. This conclusion is reached not from any opinion or decision, but from a comparison of the “harm or injury” exceptions found in both the CME and the MRPC.

The CME allows the communication of confidential patient information when it is legally justified because of overriding social considerations. The abuse exception is not found literally in Section 5.05, Confidentiality, but is engrafted into the general exception by the CME guidelines under Section 2.02, Abuse of Spouses, Children, Elderly Persons, and Others at Risk. The guidelines are discretionary and require physicians to comply with their state laws when reporting is mandated. The distinction here is that the CME directs physicians to consider actions taken against the patient, while the MRPC invites that consideration by attorneys only when certain actions are taken by the client.

App. 1996); at xliv, citing Roth & Levin, Dilemma of Tarasoff: Must Physicians Protect the Public or Their Patients? 11 LAW, MEDICINE & HEALTH CARE, 104, 106 (1983).


64 See supra notes 27 through 29, and accompanying text.


66 See Mary Twomey, Mary Joy Quinn & Emily Dakin, Courts Responding to Domestic Violence: From Behind Closed Doors: Shedding Light on Elder Abuse and Domestic Violence in Late Life, 6 J. CENTER FOR FAM. CHILD. & CTS. 73 (2005).

67 See supra note 32, at 6, 136.

68 Id.

69 Id.

70 See supra note 30 and accompanying text.

71 See infra note 77.

72 See ANNOTATED CODE OF MEDICAL ETHICS, supra note 5, E-5.05 Confidentiality, at 136.


74 Id.

75 See infra note 110, and accompanying text.
are also consequences for physicians not taking action.\textsuperscript{76}

When compared to the MRPC, the application of the CME ethics principle is strikingly different. For attorneys, there may be a state statutory law duty to report abuse, but they are neither trained, nor professionally involved with clients to recognize the results of physical abuse exacted on the clients.\textsuperscript{77} Even then, attorneys do not have guidelines by which they may be directed; on the contrary, they are given narrower and limited authority to disclose or report abuse against their clients.\textsuperscript{78} The MRCP, Rule 1.6, primarily focuses on the actions of the client. The attorney must be concerned or suspicious that the client is committing or about to commit such physical violence that it will end in death or substantial bodily harm.\textsuperscript{79} This narrow exception is tighter because the black letter of the rule only allows disclosure when it relates to the representation of the client, and only then to the extent that the lawyer reasonably believes necessary.\textsuperscript{80}

2. Confidentiality — Murder and Serious Bodily Harm

The greatest amount of attention to the “murder and serious bodily harm” exception has stemmed from difficulties with treating violent mentally ill psychiatric patients. In situations such as these, the CME is more closely aligned with the MRPC, addressing how the confidential nature of doctor-patient communications must yield when disclosure is necessary to protect an individual or community as a whole.\textsuperscript{81} When members of both professions are privy to communications that create credible threats of murder and serious injury, the cloak of secrecy and confidentiality must be broken and the professionals are admonished to warn individuals and the public.\textsuperscript{82}

3. Confidentiality — HIV and other Infectious Diseases

The most significant impact of the CME with regard to HIV and infectious diseases comes not from Section 5.05, Confidentiality, but from Section 2.00, Opinions on Social Policy Issues E-2.23 HIV Testing, discussed above. This has little practical effect on attorneys, but it does show the complexity and maturity that the CEJA provides in its published work to support and assist physicians in handling social conflicts that have an impact on patients.\textsuperscript{83}

4. Confidentiality — Impaired Driving

The CME treats driving and impairment the same way it does HIV. As discussed

\textsuperscript{76} See James T. R. Jones, Battered Spouses’ Damage Actions against Non-reporting Physicians, 45 DePaul L. Rev. 191 (1996).


\textsuperscript{78} See Annotated MRPC, infra note 103, at 94.

\textsuperscript{79} Id.

\textsuperscript{80} Id.

\textsuperscript{81} See Annotated Code of Medical Ethics, supra note 5, E-5.05 Confidentiality, at 138, citing Tarasoff v. Regents of Univ. of Cal., 17 Cal. 3d 425, 551 P.2d 334, 347, 131 Cal. Rptr. 14, 27.


\textsuperscript{83} See supra note 45.
above, guidelines are set out in Section 2.00, Opinions on Social Policy Issues, E-2.24 Impaired Drivers and Their Physicians, to help physicians deal with privacy, autonomy, and confidentiality of patients, while reminding them of state laws and societal protections that require disclosure when harm is likely.84

D. Confidentiality: Privacy and HIPAA

As summarized in the Part I article,85 medical and health care professionals are required to comply with Title II of the Health Insurance Portability & Accountability Act (HIPAA), which provides for “Protection of confidentiality and security of health data through setting and enforcing standards….”86 Under HIPAA, rules were published to ensure: 1) standardization of electronic patient health, administrative and financial data; 2) unique health identifiers for individuals, employers, health plans, and health care providers; 3) security standards protecting the confidentiality and integrity of “individually identifiable health information,” past, present or future; and, 4) sweeping changes in most health care transaction and administrative information systems.87

As noted in the Part I article, compliance resistance among medical and health care professionals has been one reason for so few published decisions enforcing HIPAA.88 Consider the scant numbers reported between 2006 and 2009. At the 14th National HIPAA Summit in 2006, the Med Law Blog reported the following statistics to reflect enforcement activities for 2006:89

<table>
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<tr>
<th>Complaints</th>
<th>Number</th>
<th>Percent</th>
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<td>Complaints</td>
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<td>100%</td>
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<tr>
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<td></td>
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<tr>
<td>Closed: Investigation</td>
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<tr>
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<td>24,360</td>
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</tbody>
</table>

84 See supra note 29, and accompanying text.
85 See supra note 4.
87 Id.
89 See Michael Cassidy, HIPAA Criminal Verdict and Enforcement, http://www.medlawblog.com/archives/compliance-hipaa-criminal-verdict-and-enforcement-statistics.html (last accessed July 5, 2009). Interestingly, 2006 seems to be the last time there was a National HIPAA Summit from which any statistics have been published to chronicle HIPAA enforcement.
The reference to only 39 case prosecutions out of a modest total of less than 25,000 complaints nationwide in 2006, confirmed how ineffective the privacy mandate of HIPAA was in medical practices at the time.\textsuperscript{90}

In October 2008, the Office of Inspector General (OIG) of the U.S. Department of Health & Human Services (DHHS) issued a report concluding that the Centers for Medicare and Medicaid Services (CMS) had no effective mechanism to ensure that covered entities were complying with the HIPAA Security Rule or that electronic health information was being adequately protected.\textsuperscript{91}

In addition to \textit{Biddle}, examined above,\textsuperscript{92} and \textit{U. S. v. Ferrer},\textsuperscript{93} examined in the Part I article, other published decisions highlight (among other issues) another significant impediment to HIPAA enforcement, namely that there is no private cause of action.\textsuperscript{94} The proof of this is found in research reflecting the sparse number of published decisions addressing HIPAA in any way.\textsuperscript{95} However, that is not where it ends. Further analysis of the cases reveals different results both in numbers and application of law, depending upon federal or state jurisdiction.\textsuperscript{96}

Examination of all cases referencing or citing \textit{Biddle} shows that when state-based statutory or common law confidentiality protections are joined with HIPAA, the courts recognize a private cause of action based on state statute, or, as fashioned in \textit{Biddle}, the common law tort of breach of confidentiality.\textsuperscript{97} This has been shown to be true even when the cases were decided in federal court.\textsuperscript{98}

However, federal courts have consistently barred a right of action to individuals who are using only HIPAA as the basis for an infraction related to confidential medical records.\textsuperscript{99} In \textit{Marsh v. County of San Diego}, the most recent decision addressing the issue

\textsuperscript{90} \textit{See} Evans, \textit{supra} note 6. This was confirmed by Professor Evans when he stated that only hospitals comply with HIPAA to the dismay of physicians. He mentioned that a hospital ER will send a patient out with no information. When contacted by the family physician, the hospitals will not disclose, claiming HIPAA confidentiality.


\textsuperscript{92} \textit{See} Biddle, \textit{supra} note 11.

\textsuperscript{93} \textit{See} No. 06-60261 CR-COHN (S.D. Fla. September 7, 2006).

\textsuperscript{94} \textit{See} Biddle, \textit{supra} note 11.

\textsuperscript{95} \textit{See infra} notes 97–98.

\textsuperscript{96} \textit{See infra} note 98.


of a private right of action, the United States District Court could find no decisions granting an individual such a right when it was the only basis on which the plaintiff asserted jurisdiction. In the Acara decision of the Fifth Circuit Court of Appeals, the court noted the fact that HIPAA gives the Secretary of DHHS the responsibility to enforce HIPAA infractions. While not expressing it directly, the courts have in essence mandated something similar to exhaustion of administrative remedies. The further restriction is that if the Secretary chooses not to act on an individual’s claim, the individual has no right to pursue the claim judicially under HIPAA.

III. THE AMERICAN BAR ASSOCIATION MRC CONFIDENTIALITY RULE AND ITS EXCEPTIONS

This section of the article examines the confidentiality rule of the MRPC. The way the model rules are designed, there is nowhere else to look. Everything in the Model Rules relating to confidentiality relates back to or is crossed referenced to Rule 1.6.

A. Confidentiality Generally and Related to Privacy and HIPAA

Within the general context of confidentiality, the concerns that attorneys have relating to disclosure may best be illustrated in the earlier discussion of the Biddle case. This context is also the best way to examine privacy and HIPAA as related to attorneys. The reason for the combination is that there are no published cases, ethics opinions, or grievance decisions applied to attorneys under the federal statutory authority of HIPAA.

In Biddle, the attorney and his law firm went to the hospital with a scheme to recap-

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See supra note 94, 470 F.3d at 571:

However, HIPAA limits enforcement of the statute to the Secretary of Health and Human Services. Id. Because HIPAA specifically delegates enforcement, there is a strong indication that Congress intended to preclude private enforcement. Alexander; 532 U.S. at 286-87 (“The express provision of one method of enforcing [a statute] suggests Congress intended to preclude others.”). Id.

102 Id.

103 ANNOTATED MODEL RULES OF PROFESSIONAL CONDUCT (hereinafter ANNOTATED MRPC) R. 1.6, 89–112 (ABA Ctr. for Prof. Resp., 6th ed. 2007).

104 Id.

105 See supra note 10, and accompanying text.

106 See supra notes 97, 98.
ture hospital losses for services rendered to Medicaid-eligible patients. The hospital gave each patient’s information to the law firm, from which the firm determined the viability of filing for disability. Only then did the law firm make direct contact with each eligible patient to explain what the firm would do to represent the patient in a disability claim. The Biddle Court did not actually examine the attorney’s ethical violation for what had been divulged. The Court focused instead on the hospital’s breach of medical ethics and HIPAA.

When comparing how the ethics codes of the medical and legal professions are applied, Biddle reflects the distinct difference between them on matters of confidentiality. The difference is not found in the actual language of the ethics codes, but in their application.

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107 See Biddle, supra note 11.
108 Id., 715 N.E. 2d at 523.
109 Id.
110 Compare Annotated Code of Medical Ethics, supra note 5, E-5.00 Opinions on Confidentiality, Advertising, and Communications Media Relation:

The information disclosed to a physician by a patient should be held in confidence. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential information without the express consent of the patient, subject to certain exceptions which are ethically justified because of overriding considerations.

When a patient threatens to inflict serious physical harm to another person or to him or herself and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, which may include notification of law enforcement authorities.

When the disclosure of confidential information is required by law or court order, physicians generally should notify the patient. Physicians should disclose the minimal information required by law, advocate for the protection of confidential information and, if appropriate, seek a change in the law. (III, IV, VII, VIII) Issued December 1983; Updated June 1994 and June 2007.

with Annotated MRPC, supra note 103, at 89:

Rule 1.6 Confidentiality of Information

(a) A lawyer shall not reveal information relating to the representation of a client unless the client gives informed consent, the disclosure is impliedly authorized in order to carry out the representation or the disclosure is permitted by paragraph (b).

(b) A lawyer may reveal information relating to the representation of a client to the extent the lawyer reasonably believes necessary:

(1) to prevent reasonably certain death or substantial bodily harm;
(2) to prevent the client from committing a crime or fraud that is reasonably certain to result in substantial injury to the financial interests or property of another and in furtherance of which the client has used or is using the lawyer’s services;
(3) to prevent, mitigate or rectify substantial injury to the financial interests or property of another that is reasonably certain to result or has resulted from the client’s commission of a crime or fraud in furtherance of which the client has used the lawyer’s services;
(4) to secure legal advice about the lawyer’s compliance with these Rules;
(5) to establish a claim or defense on behalf of the lawyer in a controversy between the lawyer and the client, to establish a defense to a criminal charge or civil claim against the lawyer based upon conduct in which the client was involved, or to respond to allegations in any proceeding concerning the lawyer’s
cation. Had the facts of *Biddle* been changed so that the law firm was sharing client information with the hospital to determine issues that were medical in nature, the registration information disclosed would probably not have violated the rule.\textsuperscript{111} Under MRPC 1.6 (a), the attorney may disclose to the hospital information related to obtaining Social Security disability because it is impliedly authorized to carry out the representation. However, based on the way in which the attorney held his firm out to be representing the hospital, and then surreptitiously switched representation to the patient, a conflict of interest was created under MRPC Rule 1.7 Conflict of Interest or Rule 1.18 Prospective Client.\textsuperscript{112}

**B. Confidentiality and Related Policies that Apply to Exceptions**

The MRPC has no black letter rules that address social or public policy similar to those set out in the CME.\textsuperscript{113} Instead, the first and foremost concern of the legal profession is the inviolate position of confidentiality as one of its core values.\textsuperscript{114} This is the reason for the ABA House of Delegates’ rebellion against the recommendations of its own task force on revising the MRPC.\textsuperscript{115} The social and cultural pressure on lawyers to address the direst situations in which confidentiality must be excepted finally prevailed on the ABA House of Delegates and the exceptions for “harm and injury” were incorporated into Rule 1.6 in 2003.\textsuperscript{116}

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\textsuperscript{111} Annotated MRPC, *supra* note 103.

\textsuperscript{112} The author contacted the Ethics and Grievance Section of the North Carolina State Bar for an opinion. Response referred to 2006 Formal Ethics Opinion 10, Safeguarding Confidential Health Information of Clients and Third Parties. The opinion declared “… a lawyer must use reasonable care under the circumstances to protect from disclosure a client’s confidential health information and is encouraged, but not required, to use similar care with regard to health information of third parties.” *Id.* (Abraham Johns’ phone and e-mail contact on December 10, 2007, with counsel to the North Carolina State Bar Alice Mine; phone and e-mail contact on December 19, 2007, with staff attorney to the North Carolina State Bar, Suzanne Lever. (E-mail response on file with the author.)

\textsuperscript{113} See *supra* note 110.

\textsuperscript{114} See Thomas L. Shaffer, *American Legal Ethics, Theology Today*, http://findarticles.com/p/articles/mi_qa3664/is_200210/ai_n9126519/pg_1. (First, “undivided loyalty to the client”; second, “independent legal judgment for the benefit of the client”; third, “the lawyer’s duty to hold client confidences inviolate”; and fourth, “the lawyer’s duty to promote access to justice.”) *Id.* at 7.

\textsuperscript{115} See ABA Center for Professional Responsibility, http://www.abanet.org/cpr/e2k/home.html. The legal profession was as conflicted as the medical profession as it struggled with the revision of Rule 1.6 that allowed exceptions to confidentiality. In 2001, there was a division between the House of Delegates of the ABA annual meeting and the revision proposed by the ABA Ethics 2000 Commission. The House of Delegates could not follow the Commission’s recommendation for substantial expansion of the grounds for permissive disclosure under Rule 1.6. Such significant erosion of the legal profession’s commitment to the core value of confidentiality was too high a price to pay in the Delegates’ opinion. The Commission asserted the overriding importance of human life and the integrity of the lawyer’s own role within the legal system, agreeing with critics that Rule 1.6 was out of step with public policy and the values of the legal profession. Regardless, the House voted not to change, embracing anew one of its primary core values. It was brought back before the House of Delegates in 2003 and adopted. *Id.*

1. General Duty of Confidentiality

As mentioned above, the nature and origin of the duty of confidentiality is similar in intensity to the CME’s principle of confidentiality of medical records. This general duty includes the relationship of Rule 1.6 to the attorney-client privilege and disclosures of general information related to client representation.

a. Attorney-Client Privilege

The MRPC Rule 1.6, Comment 3, identifies the attorney-client privilege as one of the related bodies of law that gives effect to attorney-client confidentiality. It also explains that when the attorney-client privilege and the attorney work-product doctrine are narrowly applied “in judicial and other proceedings in which a lawyer may be called as a witness or otherwise required to produce evidence concerning a client,” the rule of attorney-client confidentiality goes further, beyond matters communicated in confidence by the client, to anything from any source related to the representation.

The attorney-client privilege is comparable to the doctor-patient privilege. Under the doctor-patient privilege, the physician must refuse to testify in a trial or other legal proceeding about any comment, communication, or statement made by the patient to the physician. The attorney-client privilege narrowly protects clients against disclosure of the substance of an attorney-client communication in a legal proceeding. The communication must be within the framework of the attorney giving advice or assistance and the client giving or receiving it. While the rules of ethics do apply, the determination of the attorney’s required testimony will turn on the rules of evidence. Further, the attorney must not give the privileged testimony until ordered by a court to do so, and even then must only divulge that which the court requires.

For Elder Law attorneys, the attorney-client privilege comes into play at the initial conference when one or more persons other than the client are present and confidential communications occur that would be privileged but for the presence of the third person. However, the third party may have an agency or other special relationship with

117 See Annotated Code of Medical Ethics, supra note 5.
118 See Annotated MRPC, supra note 103, at 94.
119 Id. at 95.
120 Id. at 90.
121 Id.
122 Id.
125 See Annotated MRPC, supra note 103, at 94.
126 Id.
127 Id.
129 Id.
130 See Steven K. Mignogna, The Continuing Erosion of the Attorney-client privilege in Trust and Estate
the client that would include that party within the privilege. The probable extension of the privilege beyond patient and doctor is when the patient signs a health care advanced directive.

b. Disclosures of General Information Related to Client Representation

The general prohibition is succinct and clear: an attorney must not disclose “any information related to the representation.” This bar is so broad that it has been applied when an attorney simply discussed client information with the client’s roommate, or when the attorney gave a client notes that had notes related to other clients on the back.

While the doctor-patient protections are expansive, they do not reach the broader scope of protection in the legal profession, in large part due to the complexities associated with litigation. The blanket of protection in the attorney-client representation covers the identity of the client or of the client’s whereabouts when connected to representation, the information contained in documentation of billing matters, any form of communication or documentation that would lead to the discovery of client information that is confidential, or even documents, information, or communications previously disclosed or publicly available.

c. Disclosures Express or Implied

The complexities of confidentiality within the attorney-client context allow lawyers to take action within the attorney-client relationship necessary for the lawyer to carry out the representation. This implied representation may include the lawyer divulging facts and disclosing certain admissions without client authorization. Implied consent is also found when a lawyer must act to protect a client with diminished capacity. Although driven by MRPC 1.14, the amount of information is controlled by MRPC 1.6 to the extent that only sufficient information may be given by the lawyer necessary to protect the client’s interests. When the lawyer is ordered to disclose information related to the attorney-client relationship, without the client’s consent, the lawyer must resist divulging any information not otherwise authorized by the order. Unless there is express or implied

\[\text{Litigation, ALI-ABA Course of Study (February 10–11, 2005).} \]
\[\text{131 See Flowers, supra note 123.} \]
\[\text{132 See ANNOTATED CODE OF MEDICAL ETHICS, supra note 5, at 136.} \]
\[\text{133 See ANNOTATED MRPC, supra note 103, at 95.} \]
\[\text{134 Id. at 95, citing People v. Hohertz, 102 P.3d 1019 (Colo. O.P.D.J. 2004).} \]
\[\text{135 Id. at 95, citing Statewide Grievance Comm. v. Paige, No. CV030198335S, 2004 WL 1833462 (Conn. Super. Ct. 2004).} \]
\[\text{136 Compare ANNOTATED CODE OF MEDICAL ETHICS, supra note 5, at 4, 136, with ANNOTATED MRPC, supra note 103, at 95–98.} \]
\[\text{137 See ANNOTATED MRPC, supra note 103, at 95.} \]
\[\text{138 Id. at 96.} \]
\[\text{139 Id. at 97.} \]
\[\text{140 Id.} \]
\[\text{141 Id. at 98.} \]
\[\text{142 See ANNOTATED MRPC, supra note 103, R. 1.6, at 99; R. 1.14 Client with Diminished Capacity, at 214.} \]
\[\text{143 Id.} \]
\[\text{144 Id. at 109.} \]
authorization, disclosure of confidential client information must be based on the client’s informed consent as redefined and applied to all rules.\textsuperscript{145} The lawyer’s duty of confidentiality generally applies before confirmation of the client as client (i.e., the prospective client),\textsuperscript{146} applies after the end of the representation,\textsuperscript{147} and applies to former clients.\textsuperscript{148}

2. Death or Substantial Injury Exceptions

The Part I article of this two-part series explained the 2002 revision to MRPC 1.6, which broadens the scope of the lawyer’s discretion to act when death or substantial injury are reasonably certain.\textsuperscript{149} The following discussion applies this new realm of confidential disclosure to those situations discussed earlier under the CME.

\textit{a. Confidentiality — Abuse}

Abuse is not as readily apparent in the legal profession as in the medical profession, as discussed above.\textsuperscript{150} However, experienced Elder Law attorneys are in a better position to recognize the abuse of elderly clients than other attorneys in the legal profession.\textsuperscript{151} Because of the relative newness of the “death or substantial injury” exception to MRPC 1.6, there are no known judicial opinions or ethics opinions. The following case study provides the basis for analysis.

\begin{flushleft}
\textsuperscript{145} Id. at 100, R. 1.0(e) Informed Consent.
\textsuperscript{146} Id. at R. 1.18, Duties to Prospective Client, at 261.
\textsuperscript{147} Id. at R. 1.16, Declining or Terminating Representation, at 237.
\textsuperscript{148} Id. at R. 1.9, Duties to Former Clients, at 153.
\textsuperscript{149} See A. Frank Johns, \textit{Multidisciplinary Practice And Ethics, Part I – Lawyers, Doctors And Confidentiality}, 5 NAELA J. 123 (No. 2, 2009); ABA Center for Professional Responsibility, http://www.abanet.org/cpr/e2k/home.html (last accessed December 27, 2007). The legal profession was as conflicted as the medical profession as it struggled with the revision of Rule 1.6 that allowed exceptions to confidentiality. In 2001, there was a division between the House of Delegates of the ABA annual meeting and the revision proposed by the ABA Ethics 2000 Commission. The House of Delegates could not follow the Commission’s recommendation for substantial expansion of the grounds for permissive disclosure under Rule 1.6. Such significant erosion of the legal profession’s commitment to the core value of confidentiality was too high a price to pay in the Delegates’ opinion. The Commission asserted the overriding importance of human life and the integrity of the lawyer’s own role within the legal system, agreeing with critics that Rule 1.6 was out of step with public policy and the values of the legal profession. Regardless, the House voted not to change, embracing anew one of its primary core values. It was brought back before the House of Delegates in 2003 and adopted. \textit{Id.}
\textsuperscript{150} See supra note 30, and accompanying text.
\textsuperscript{151} See supra note 82. Most experienced elder law attorneys have attended state bar or National Academy of Elder Law Attorneys (NAELA) programs, symposiums, and institutes that have highlighted the elder abuse issue.
\end{flushleft}
Lawyers: Case Study A — Attorney Action and Client Reaction

Attorney (A) represented Mother (M) for several years. In the last several conferences, A sensed that daughter Debbie (D) was unduly influencing M’s decisions. While in conference with M present, D insisted that A make D attorney-in-fact on all of M’s advanced directives, make D trustee of M’s trusts, and generally was more confused, disheveled, and unclean. A saw what he was certain were bruises on M’s arms and neck and around her forehead. When A asked what was going on, M said “nothing;” and as D explained that because of what with M’s frail health and instability, she kept falling and was unable to handle simple hygienic tasks.

At the most recent meeting when D brought M to see A, over D’s objection, A talked to M in private. During the talk, M broke down, crying and telling A that D practically had her imprisoned in her own home, that she was unable to make or receive any calls from the other children. When asked about the bruises, M said that D beat her when she would not do what D wanted, which was to make D the executor and sole beneficiary of M’s will, excluding several other children of M. M agreed to all of this in previous meetings with A because D was present.

A insisted on calling M’s other children, but M vehemently opposed communication to anyone else, demanding that everything be kept confidential. M left with D. From her office window, A could see the firm parking lot where she saw D arguing with M. As D shoved M into the car, M hit her head on the corner of the door. D recklessly raced the car out of the lot and down the street. Believing the state legal ethics rules required it, A did as M insisted — communicating nothing to the other children or to the county Adult Protective Services (APS). There is no mandatory adult abuse reporting in the state.

Analysis

Experienced Elder Law attorneys have seen similar situations, although few this severe. Parent-child problems, including elder abuse, are at times present and always messy.

A and M were in agreement that A was not representing D or the other children. In such ongoing attorney-client situations, the MRPC provides lawyers with discretion to reveal or disclose information in those situations specifically expressed in the black letter of the ABA Model Rules. In this case study, MRPC 1.6(b)(1) is applicable insofar as A could have concluded that she should divulge confidential client information to the other children and to APS “to prevent reasonably certain death or substantial bodily harm.” However, Comments 14 and 15 to Model Rule 1.6 impress on A the suggestion that diversionary measures be taken before exercising the discretionary exception, thereby

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152 This particular case study with accompanying analysis (revised and edited) was previously published with Bernard Krooks. See A. Frank Johns and Bernard Krooks, Alive, Kicking and Incapable, 143 TRUSTS & ESTATES MAG. 59 (November 2004); A. Frank Johns and Bernard Krooks, The New Wrinkled Faces of Capacity: The Older Client with Diminished Capacity, 30 ACTEC J. 301 (Spring 2005); A. Frank Johns and Bernard Krooks, Elder Clients with Diminished Capacity: NAELE’s Response to Specific Case Applications and its Development of Aspirational Standards that may Cross Professional Organizational Boundaries, 1 NAEELA J. 197 (Fall 2005).

153 See ANNOTATED MRPC, supra note 103, R. 1.6.

154 Id.
qualifying A’s discretion. Based on the qualifications suggested in the Comments, A could have spoken to the other children, divulging enough of M’s confidential information to allow intervention based on the belief that discretionary disclosure would prevent M from suffering physical abuse at the hands of D resulting in substantial injury. As a diversionary measure, A could have called M and explained that she felt it necessary to contact M’s son, asking for her authorization to divulge confidential information and to allow the son to be named attorney-in-fact in new advance directives. As egregious as these facts are, A could probably still disclose even if M said “no.”

Since the revisions to Rule 1.6, the differences between the medical and legal professions codes of ethics have greatly diminished. Both professions guard against disclosures of confidential patient/client information, but understand the duty to protect patients/clients and society from substantial harm or injury when communication or information from the patient/client places the physician or attorney on notice. However, attorneys are put to more stringent compliance in that they must disclose only enough to confront the harm or injury, and no more.

b. Confidentiality — Murder and Serious Bodily Harm

As discussed above, physicians, especially psychiatrists, are more likely to experience situations in which their patients are threatening to murder or inflict serious bodily harm on themselves or others. Under the relatively new addition to MRPC Rule 1.6, lawyers in most jurisdictions are given the discretion to report that a client has communicated the intent to kill or seriously injure themselves or others. The annotations to the MRPC note that several jurisdictions actually have mandatory reporting provisions, referencing cases from Massachusetts, Washington, Rhode Island, and Oregon. For Elder Law attorneys, the communication of such dire acts may be veiled and go unnoticed. Consider the following case studies.

Lawyers: Case Study B — W is the Client

Elder Law Attorney (ELA) is hired by Wife (W). At the time of the engagement, W was alone and made clear to ELA that he was to represent only W. W further instructed ELA to say nothing to her Husband (H) or their children. ELA agreed. W then told ELA

155 Id.
156 Annotated MRPC, supra note 103, R. 1.6(b)(1) at 101.
157 Id.
158 See supra note 110.
159 Id.
160 Id.
161 See supra notes 60, 61 and accompanying text.
162 See The Law Governing Lawyers, supra note 116, Ch. 5 Confidentiality.
164 These case studies were taken from the author’s previous writing. See A. Frank Johns, Revised ABA Model Rules of professional Conduct Applied in Elder Law: The Basics Framed in Core Values Get Complicated Fast—Part One of Three Parts MRCP 1.0 –1.6, 1 NAELA J. 59 (2005).
that H was diagnosed with Alzheimer’s disease several years earlier, and he had declined drastically in the last year. W goes on, telling ELA that she and H already saw a lawyer over a year ago to execute advance directives and mirror wills. W says she has been acting as H’s attorney-in-fact and has transferred all assets out of H’s name. She also confides in ELA that she called Adult Protective Services, complaining that H has become too aggressive and that even with medication, H has been physically beating and fighting with W. W whispers quietly that she has been provoking H all along so that H is constantly aggressive when she is in his presence. W said she did this in order to get H placed in an assisted living facility over his objection.

W instructs ELA to create a new will for her, without H as a devisee and including her illegitimate child unknown to H or their children. W also tells ELA that she has engaged another lawyer to initiate a divorce action against H. ELA has known W and H for many years, even attending church with their children. Because of gossip in the community, the children of H and W approach ELA, begging for information about what is going on with W, and the whereabouts of H. ELA despairs over the children’s anguish, knowing that the information that he knows could ease their troubles and bring them some degree of comfort.

Analysis

This case study approaches the limits of MRPC Rule 1.6 and its exceptions related to “harm or injury” and “crime or fraud.”165 ELA has no duty to H or the children, only to W, who is the client. No matter how much the information would help H and the children, W is certain that ELA must maintain W’s secrets, honoring his duty of loyalty to her, his current client. However, could ELA contend that W has divulged facts that break the threshold of the “substantial injury” exception? All W has said is that she provoked H in order to gain his admission to a residential facility. However, she also mentioned that she lied to APS about H beating her. Could that be enough to meet another Rule 1.6 exception, namely for crime or fraud committed by a client?166 This author believes not, but it is very close.

If W went through this with a physician, the physician’s decision to contact APS would be affirmative, and there would not be any real problem raised with the state board of medical ethics over violation of confidential medical disclosure.167 Consider a case study that approaches the bright line more closely and includes social, philosophical, and theological implications.

Lawyers: Case Study C — Death with Dignity or Murder?

Lawyer (L) has represented Husband (H) and Wife (W) as joint clients for many years. In the last four years, H has been mentally victimized by Alzheimer’s disease, losing his spirit and becoming so paranoid and combative that W is totally worn out and in complete despair. In lucid moments, H screams at W that she must help him end it all, that he is too lost and afraid to go on. Their children insist that W needs relief and that

165 See ANNOTATED MRPC, supra note 103, Rule 1.6(b)(1)(2) and (3), at 101, 102.
166 Id.
167 See Opinions on Social Policy Issues, E-2.24 Impaired Drivers and Their Physicians, supra note 48.
placement in a nursing home will be a comfort to both of them. H always said he’d rather be dead.

W meets with L to make asset transfers and prepare for H’s placement in a nursing home. L explains that they will have to pay privately because they have too many assets for Medicaid. Total private pay for H will cost them $7,800 per month. W becomes enraged, bitterly decrying H’s fate and complaining that the nursing home is just going to gouge them. W vows to take care of H herself.

Several months later, L sees W in an emergency situation. H has fallen, and broken his hip. W looks completely beaten and exhausted. She asks for legal options to stop APS from forcing H into a nursing home after the hip surgery. Hearing no real positive options, W tells L that she is going to ask for an increase in H’s morphine and help him with his pain (never stated, but could this be assisting in his death?) so that he may go as peacefully as possible while he is still at home. She also explains that she was told to contact Hospice and that she considers this palliative care.

L is a dedicated Catholic, believing in the sanctity of life and not the quality of life. He explains to W that he has the ethical duty to disclose this confidential information to the authorities because it is murder. He tries to persuade W to “do the right thing” and place H in a nursing home. W threatens L that if he violates her right of confidentiality, she will sue him and file a complaint with the state bar.

L does not exercise his discretion, telling no one, disclosing nothing. Three days later, L is informed that H has died under suspicious circumstances. L calls a police detective and tells her what W told him.

Analysis

The facts of this case study may be happening on a regular basis. There are literal battle lines drawn between those advocating the philosophical principle of sanctity of life and those advocating the philosophical principle of quality of life, making the “to tell or not to tell” exercise of the lawyer’s discretion that much more complicated and troubling.168

In the case study, L does not violate the exception to MRPC 1.6 by telling no one what W told him prior to H’s death.169 He may be morally sanctioned, but not ethically. Neither will L be sanctioned for having called the police detective.170 In many states, confidentiality of client information does not die with the client.171 This is probably true in those states that do not have mandatory reporting requirements.172 It could be argued that even after H’s death, L has the discretion to tell the authorities because what W told him

169 See Annotated MRPC, supra note 103.
170 Id., R. 1.6(b)(1)(2) and (3), at 101, 102.
172 See Annotated MRPC, supra note 103, R. 1.6 (b)(1)(2) and (3), at 101, 102.
does not come under W’s attorney-client privilege. L was not W’s attorney during an adversarial proceeding and therefore W’s attorney-client communication was not for the purpose of securing legal advice or assistance in the adversarial proceeding.

3. Confidentiality — HIV and Other Infectious Diseases

Much like communications related to death or injury, attorneys will rarely hear from elderly clients about HIV and other infectious diseases. If such communication were made, it would come under the same subsection of Rule 1.6 that deals with reasonably certain death or substantial bodily harm. Under the black letter of the MRPC, however, attorneys may be hard-pressed to conclude on their own that an infection such as HIV or any other disease would in and of itself render death reasonably certain. It could fall within the “substantial injury” phase; yet, it is unlikely in the framework of Elder Law and the legal profession that the attorney could come to that conclusion alone. Certainly the attorney could ask to contact the attending physician to gain an understanding of the potential for harm or injury. Consider the next case study.

Lawyers: Case Study D — Old, Sexy, and HIV-Infected

T was in his second childhood. Widowed for more than a decade, T lived in an independent condo of a Continuing Care Retirement Community (CCRC). Although experiencing minor health problems, T lived it up what with many single women after his recent discovery of Viagra. It was like he was back in his 40s with the maturity and experience of all the years that followed. Except for one ugly little secret; neither T nor his girl friends had ever been educated about socially transmitted diseases, nor did they practice protected sex. Regardless of the Fertile Octogenarian Rule, they were certain that “protection” meant not getting pregnant and none of them believed there was any risk of that.

During a routine annual physical, Dr. H informed T that he tested HIV-positive. However, T lied to the doctor, telling her it must have happened some years ago because he was not currently active sexually. T insisted that Dr. H tell no one. Assured that T was not a health risk, Dr. H complied.

T went on with his carousing, stringing several girlfriends along, including M. However, M was playing her own game with T. Several years younger that T, M was a gold digger, having fleeced several older men out of their assets, to the dismay of their families who ended up inheriting nothing. She did the same thing to T, gaining control of a fortune and leaving T with little to nothing.

T went to ELA, his Elder Law attorney, trying to find a way to get his fortune back from M. ELA gave the grim news that it would take litigation and thousands of dollars, and T would probably not get much of his fortune back. T muttered that M may have taken him but that in the end she was bested by T because he was HIV-positive and now “so is she.”

Several years earlier, M was ELA’s client for estate planning when she was mar-

173 See Flowers, supra note 123.
174 See ANNOTATED MRPC, supra note 103.
175 Id., R. 1.6, at 89.
176 See supra note 149.
ried to a since deceased millionaire. ELA had no idea it was M to whom T was referring because she had been through two other marriages and was known by a different name.

Discussion Questions

1. Does ELA have any obligation to insist that T get counseling and education for his disease? Should he be required to inquire if T is still using Viagra? Does he have an obligation to investigate further for others with whom T had sexual relations and possibly infected?

2. Does ELA have an ethical obligation or a legal duty to keep T’s information confidential?

3. Does ELA owe a duty to M? Are there any grounds upon which ELA may have an obligation to M that trumps his duty of confidentiality to T?

4. What if M finds out about T’s attorney-client relationship, and believes that ELA is still her attorney? Is there an attorney-client relationship between ELA and M? If there is, how does ELA handle his duty to T and to M? If there is no longer an attorney-client relationship between ELA and M, does ELA have any other obligation to M?

Analysis

HIV disease among the elderly has been characterized as another hidden epidemic. Research and analysis of the disease among the elderly has been chronicled for more than 15 years, and yet the elder population knows little about the disease or that they are the ones needing education and protection. The facts and discussion questions in this case study have been revised from those in Doctors: Case Study A to target the role of the attorney. As the questions are examined, the slant of Vukadinovich and Krinsky are focused on the attorney. The result is that the confidentiality duty changes because of the differences between the CME and MRPC Rule 1.6.

The answer to all the discussion questions is that ELA has the discretion to report T, unless there is a statute that requires mandatory reporting of HIV. ELA could easily believe that there is no likelihood of substantial harm or injury. ELA may find it appropriate to advise T to seek counseling and education. However, unlike the physician’s obligation to find out about others with whom T may be having sexual contact, the MRPC does not mandate or in any way guide ELA in making the decision to pursue information about

177 Id., at 20.
179 See Marcia G. Ory and Karin A. Mack, Middle-Aged and Older People with Aids, 20 Research on Aging, 663–664 (1998) (People age 50 and older continue to be less knowledgeable about AIDS risks, perceive themselves to be at lower risk, and, for those with known AIDS-related risks, have made fewer behavioral accommodations to avoid such risks as compared to younger people. With recent data indicating a faster rise in new AIDS cases among the 50-plus population, middle-aged and older people can no longer be ignored in AIDS prevention or treatment efforts.) Id.
180 See supra note 41, and accompanying text.
181 See supra note 40, and accompanying text.
182 See supra note 110.
183 See supra note 37.
possible victims.\textsuperscript{184}

A more difficult question is raised in the case study when ELH realizes that M is a former client.\textsuperscript{185} ELA may have to sever his attorney-client relationship with T regardless of whether T agrees.\textsuperscript{186} Regardless of the answers, what is significant for ELA is the same as that for the physician — the discretion to disclose.\textsuperscript{187}

4. Confidentiality — Impaired Driving

Elder Law attorneys are confronted with clients and impaired driving as often as physicians.\textsuperscript{188} If the client is thereafter seen, and the attorney knows that the client is impaired and continues to drive, is that enough to trigger the exception under Rule 1.6(b)(1)? Since little in published legal articles and decisions are available, the following is a paraphrased case study from the ACP.\textsuperscript{189}

**Lawyers: Case Study E — Impaired Driver**

Mr. Craft (C) is an 85-year-old, active new client. He lives alone, and his two children live in distant states on the other coast. The only medication C takes is for prostate cancer; he has no other medical problems. During an estate planning conference with Attorney (A), memory problems surfaced. C mentioned that he got a little lost coming to the office, which was only a mile from his home. A did a Client Capacity Screen and C lost points for orientation, attention, calculation, recall, and visuo-spatial tasks. His total score was substantially deficient. C mentioned that he had recently seen his doctor, and admitted that the doctor strongly recommended a driver’s evaluation, but C refused.

C complained to A, “Why do that? If that test didn’t turn out so good, then I wouldn’t be able to get out of my apartment. I’ve got to be able to get to the grocery store and drug store!” A asked if she could call the doctor to discuss the situation. C agreed, and during the call, the doctor described his concerns about C’s ability to drive safely. C shot back that he only drove during the day and always in his own neighborhood. He said he had no moving traffic violations. Still, the doctor verbalized his worries about C being injured or getting lost, and about his driving responsiveness, especially in poor weather. “I don’t think I would want him to be out driving where my kids are walking home from school,” the doctor retorted to A. But he was also concerned about restricting C’s ability to get around and about patient identity issues.

A suggested that C go through the testing just to show everyone he could do it. C

\textsuperscript{184} See Annotated MRPC, supra note 103.
\textsuperscript{185} See supra note 148, R. 1.9.
\textsuperscript{186} Id.
\textsuperscript{187} See Annotated MRPC, supra note 103.
\textsuperscript{188} It depends on who the elder client sees first, the physician or the attorney. It has been stated to the author many times by geriatricians with whom he has worked for many years that if the impaired patient is seen and the problem of driving while impaired comes up, the physician makes the referral to an Elder Law attorney and alerts the attorney that he or she need to do something about the patient’ driving – that the attorney needs to stop it.
said, “Hell no!” The conversation became difficult and C left in a rage. As C tore out of
the parking lot in his car, he just missed a woman and her baby on the sidewalk. A decided
to call both children to alert them to the problem and ask for assistance in getting C to stop
driving. A also called the Division of Motor Vehicles (DMV) and filed a report requesting
suspension of C’s driver’s license. C’s license was suspended after he failed a driving test
the DMV required him to take.

C found out that A had called the children and the DMV and filed a grievance against
A. What is the outcome? Should A have done more or less?

Analysis

The analysis begins with a review of what was examined in the section on impaired
drivers and physicians. The assessment confirmed an ethical obligation on the part
of physicians to address patient impairments that might result in unsafe driving. The
analysis focused on identification of potentially unsafe older drivers in order to change
driving habits before accidents occurred. As mentioned above, the CME has actually
published guidelines for physicians to follow. This was confirmed in practice by Profes-
sor Evans, explaining that the simple answer is to report, but that there is more underre-
porting. He framed three issues for physicians: 1) legal obligation, 2) standard of care,
and 3) practical policy. The legal ramification was explored by Evans with a comment
about older drivers without dementia generally being able to compensate for physical im-
pairments by changing habits, like not driving at night. However, when considering older
drivers with dementia, Evans recognized that they would forget that they are not to drive
even when their licenses have been revoked. Evans stated that the practical view that a
medical practitioner would take when faced with these situations would be to notify the
DMV. He went further, stating that many physicians would go further by involving the
family in a discussion of diversionary tactics like getting rid of the car or putting it out
of sight. This is consistent with the legal ethical mandate for the attorney to implement
diversionary tactics before disclosing confidential client communications.

The assessment in the medical case study references other studies actually showing
that no adverse events can be predicted based simply on chronic illnesses, functional
status, or mental impairment of patients. The assessment notes the controversy over the
safety of drivers who have been diagnosed with Alzheimer’s disease. One side of the con-
troversy suggests that persons diagnosed with probable Alzheimer’s disease could drive
for as many as three years once diagnosed. The other side contends that, “even early in
the disease, there can be difficulty attending to multiple visual sources of input.

190 See supra note 48, and accompanying text.
191 Id.
192 Id.
193 Id.
194 See Evans, supra note 6.
195 Id.
196 See Annotated MRPC, supra note 103, Rule 1.6(b)(3), at 102.
197 See Case Study 25, supra note 189.
198 Id.
199 Id. (Such a deficit in attending to and inhibiting appropriate stimuli could place even a mildly demented
With such conflicting research in the medical profession, Elder Law attorneys may be hard-pressed to frame the “substantial injury” requirement to trigger authorized disclosure of confidential client information. In the case study, the facts show that C is already implementing tactics that reduce the risk of having an accident. C also understands that he has a problem. Taking direction from the research of the ACP and its organizations, A should attempt to convince C to take a Driver Assessment Course to evaluate his visual and motor coordination and his behind-the-wheel abilities.

IV. Conclusion

The two Parts in this series of articles focused on confidentiality in the medical and legal professions. The inquiry was prompted by the rising demographics of older adults in this society and by the increasing professional interplay between doctors and lawyers with the same elderly patients or clients. Part II examined articles, opinions, and decisions in each profession, assessing several specific areas of confidentiality to determine the clarity of boundaries and to show differences between the professions that may be impediments to serving the same patient or client.

What Part II shows is that both professions guard against disclosure of patient/client communications when in a professional relationship. Both professions, however, allow for disclosure and waiver of the right of confidentiality when patient/client communications forecast certain death, harm, or injury. The article highlighted the Biddle case, which brought together medical and legal ethics within a multidisciplinary context. The Biddle Court declared the tort of breach of confidences when the hospital disclosed patient confidential information to the law firm, concluding that the law firm was actually a third party.

The article also showed that in addition to its declaration of principles, its introduction, and its terminology, the CME presents broad-based ethics sections that over-arch all other principles, including Opinions on Social Policy Issues, and Opinions on Professional Rights and Responsibilities. In these sections, the CME singles out Abuse of Spouses, Children, Elderly Persons, and Others at Risk; HIV Testing; and Impaired Drivers. The article showed how the CME goes further than the MRPC by examining several topics under its “Harm or Injury” exception, including areas of abuse, murder threats, HIV infection, and impaired driving.

The article then analyzed the MRPC by reviewing the attorney-client privilege and concluding that the legal profession imposes a tighter reign on disclosure but limiting the attorney’s disclosure to only that which is in a court order or only enough to protect against threatened certain death or substantial injury. Further, the article notes the adjectives of “certain” and “substantial” to be meaningful and posing a greater limitation on individual at risk as a driver. Id. 200 Id. 201 Id. (The most sophisticated courses are run by occupational therapists (OTs) who are certified in driver assessment and rehabilitation. These assessments are not designed to predict crash risk. Rather, they are designed to directly measure the effect of specific cognitive or physical deficits on driving skills. Many metropolitan areas have such programs.) Id.
just what the revised MRPC with the new exception actually allows.

While both professions allow professional discretion to report or not, the CME rules and guidelines provide physicians with clearer boundaries. In the end, physicians report more; attorneys report less. This may be due to the newness of the exception for attorneys.
BOOK REVIEW
THEORIES ON LAW AND AGEING: THE JURISPRUDENCE OF ELDER LAW

(Springer, 2009)
Edited by Professor Israel Doron

Reviewed by Kate Mewhinney, CELA

Where did Elder Law come from and where is it going? Is Elder Law really helping the elderly and how could it improve? These are just some of the questions addressed in Theories on Law and Ageing: The Jurisprudence of Elder Law, (Springer publishing company) edited by Professor Israel Doron of the University of Haifa. This collection includes ten essays that offer a rich diversity of well-researched analyses and thought provoking perspectives. Doron’s overview is a worthy addition to the library of anyone who works or teaches in the aging services field. The authors of the essays are among the most respected writers and thinkers in the field of Elder Law and policy. Several essays introduce theories of law that may be unfamiliar, such as law and economics, feminist jurisprudence, and the mental health theory approach. Other essays expand or deconstruct familiar theories of law on guardianship and elder planning.

It is fitting that Doron turned first to Allan Bogutz, an attorney in Arizona whose firm played a large role in the birth of the National Academy of Elder Law Attorneys. Anecdotes about real clients’ cases are woven into a review of the early years of Elder Law. Bogutz’s current criticism is that Elder Law practices became too focused on helping clients qualify for Medicaid to pay for nursing home care. Instead, he recommends that Elder Law attorneys attend to such broader elder issues as financial management and fighting age discrimination. Because the problems of older clients often involve medical or custodial care needs, Bogutz is encouraged that some Elder Law firms employ geriatric care managers or social workers, who help create the multidisciplinary expertise that frequently is required to fully assist the elderly. Readers unfamiliar with Elder Law will appreciate Bogutz’s very readable peek into the evolution of one of the leading Elder Law practices in the U.S.

Professor Lawrence Frolik focuses on the “old old,” or those over age 80. Because this age group is the fastest growing one in the United States, his remarks are an essential part of any collection of essays on the elderly. Frolik, a preeminent scholar in the field of law and aging, very effectively describes the real world conditions that older clients are facing and how an Elder Law attorney can enhance a client’s quality of life. The scope of his article is wide-ranging but very practical and deftly weaves in some sage advice for

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the family members of older clients. From tips on interviewing impaired clients, to basic counseling on long-term care insurance, this essay could easily be used as a stand-alone primer on Elder Law for aging services professionals, as well as lawyers.

On a more theoretical level, Professor Marshall B. Kapp assesses Elder Law from the perspective of therapeutic jurisprudence. Essentially, he asks whether laws and policies affecting the elderly are actually helping them in a real way. Put another way, do laws make older people feel better? For example, Kapp asks whether guardianship systems effectively protect vulnerable people or are being misused by the state to take control of older people. Perhaps the essay format is too constrained to fully explore some of the questions raised by Professor Kapp. To this reader it seemed that the questions raised were good ones but the discussion was at times unsatisfying. The focus throughout is on “command and control regulatory approaches” — such as federal laws on nursing home quality or Medicaid and Medicare home health care. These federal policies are described as paternalistic and are criticized as depriving older people of “personal autonomy.” Professor Kapp has written and edited an impressive range of important articles and books, and might have elaborated on his theory more effectively elsewhere. In this particular essay, however, the “therapeutic jurisprudence” theory often comes across as simply an attack on public regulation of health care, the Social Security program, and other programs that affect older people. Readers may question whether older people put as much value on what the author describes as the “personal self-esteem” of handling the details of their own retirement income investing. Do older people really want the responsibility and autonomy to negotiate the details of each condition of their nursing home stay, or is it more “therapeutic” to have the government handling those decisions?

No volume on the jurisprudence of Elder Law would be complete without recognizing the impact of aging policies on women. The essay by Professor Kim Dayton should be required reading for all students in the fields of aging policy. After quickly bringing the reader up to speed on the key approaches of feminist theory, Professor Dayton dives right into two central components of Elder Law: long-term care policies and policies on pensions and Social Security income. The impact of omitting chronic care from universal health care programs such as Medicare is to place the burden of care-giving onto women. Equally important are Social Security rules that contribute to a poverty rate among older women that is double that of older men. While Dayton cautions that a feminist perspective does not provide all the answers, it is a valuable approach to include when assessing the state of Elder Law today.

Professor Doron’s own essay is tucked modestly midway through the book. He has a startling ability to step way, way back from the issues for a broad view. How does he get such perspective? Perhaps, it is his perspective as an Israeli, born of Jewish refugees from Europe and schooled in Canada. Doron could be dubbed the international ambassador of Elder Law, given his extensive involvement in various international law and aging projects. Doron’s virtual view from space effectively outlines the big swirls of patterns in Elder Law. He outlines the wide sweep of laws that promise equality, but finds them lacking with regard to the vulnerability of older people. Then again, pressing up against the “protective dimension” of the law, he observes, are real risks of paternalism and the disempowerment of elders. In each dimension, Doron carefully articulates the strengths
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Disability law advocates and Elder Law advocates have not collaborated as often as our communities need. Although many Elder Law attorneys now include special needs planning in their practices, this niche tends to focus on the needs of younger people with disabilities. In “What Can Elder Law Learn from Disability Law?” Doug Surtees looks for points of commonality in legal theories that could link these two groups of advocates. Surtees brings us up to date on the different views of disability in the law, from the medical approach to the functional approach. Then, in the 1960s, scholars began to see disability in part as a social construct. Society creates disability by how we build buildings or require in-person participation when that might not be essential. By the 1970s, international documents began to reflect this appreciation of the social model of disability. Then the law evolved by applying a civil rights model to persons with disabilities’ needs by casting them as a minority. Moving beyond civil rights, the theory of universal inclusion or universalism embraces the vast range of human ability in every society. Surtees expands on the inclusive approach of universalism in an elegant and even inspirational manner. He concludes that the approach of universalism is more effective for elders than the civil rights or minority/majority approach used by disability rights advocates. Part of this is due to greater community acceptance of older adults, compared to those with disabilities. Surtees’ recommendation is that Elder Law advocates rely more on the universalism approach than the divisive civil rights approach.

A collection of essays on Elder Law jurisprudence should include an examination of the sticky issue of vulnerability. Are we being patronizing and are we reinforcing ageist stereotypes when the law acts to protect vulnerable older adults? Margaret Hall examines this dilemma in “Equity Theory: Responding to the Material Exploitation of the Vulnerable but Capable.” This essay analyzes at great length various aspects of undue influence and unconscionability case law. Hall is at her best when unfolding an excellent example of the doting grandmother who takes in her slouch of a grandson. Of course, the picture that is painted gets worse and worse, as drug-addled friends take advantage of the frail
elderly woman. Equity theory serves a useful purpose by encouraging a detailed examination of the situation. Instead of using the “all-or-nothing” approach of assessing mental capacity, equitable theories would allow a legal fact-finder to gather more information before intervening or offering to intervene. Hall’s essay gets most provocative where she ends up: counter-posing a nostalgic view of a communitarian society with the values of individualism and social diversity. It is a question that we must continue to consider as our countries age, our economies slide, and these dilemmas occur more and more frequently.

Those readers conversant in the finer points of mental health theory may get more out of W.C. Schmidt’s essay than I did. Professor Schmidt has written extensively about guardianship law and other health policy issues. His essay’s highly-conceptualized approach to common legal issues of older clients will be a new one for many lawyers. For example, Social Security is described as having “authoritatively established the elderly as a new category of deviants.” Schmidt’s essay briefly reviews theories of therapeutic jurisprudence and the therapeutic state, and appears to conclude that many legal policies (such as Medicaid and Medicare) have been effective in helping elders — i.e., that they are “therapeutic.” He also sketches out the academic debates about therapeutic jurisprudence in mental health law. For example, he lists the five “conundrums” that have been identified as challenging therapeutic jurisprudence: “the identity dilemma;” “the definitional dilemma;” “the dilemma of empirical indeterminacy;” “the rule of law dilemma;” and “the balancing dilemma.” He seems to conclude that legislators should rely more often on the findings of the social sciences. In this way, policymakers can take into account the real effects of laws. From there, we learn about normative premises and the implications of free will and responsibility. Schmidt argues for the abolition of involuntary civil commitment, although no data is presented that these laws are frequently used against older people. Guardianship, on the other hand, is frequently targeted towards older people and his essay addresses some of the theoretical debates in that arena. Schmidt describes guardianship as “a sanist, ageist archetype.” He believes there is still a need for the adversarial, due process model in the guardianship context.

The final essay, “The Future of Elder Law,” is by a heavy-hitter in the field, Professor Rebecca Morgan of Stetson University School of Law. Morgan’s perspective is valuable, as she has bridged the various worlds of academia, practice, and policy and is well-respected by all three. Because of the breadth of Elder Law, she writes, practitioners need to specialize in specific aspects of it. She echoes the advice of other writers: to be effective, an Elder Law practice must be able to collaborate with related professions. Morgan goes even further, though, by encouraging a multi-disciplinary approach on the policy level. For example, she suggests that the Elder Law community should partner with urban planners and architects to address the common client goal of aging in place. The future of Elder Law, Morgan predicts, must include a recognition that the law can only go so far in mandating family responsibility for older relatives. The role of law is limited. She cites Professor Dayton’s admonition that the gender- and age-biases of policies to “support” family caregivers must be considered. Coming full circle to the advice given by Allan Bogutz in the book’s first essay, Morgan focuses her attention on the “second generation” of Elder Law clients — the Baby Boomers. This group will face cuts in government programs, while they personally juggle the needs of aging parents,
college-age children, and their own retirement and health concerns. More demanding and litigious than the current Elder Law clientele, the Boomers will keep a new generation of Elder Law advocates quite busy.

Anyone who works or teaches in the aging services field will find at least one useful essay, and probably several, in Doron’s collection. He has brought the field of Elder Law to a higher level with this ambitious book. The talented writers of the essays are pioneers in uncharted territory.