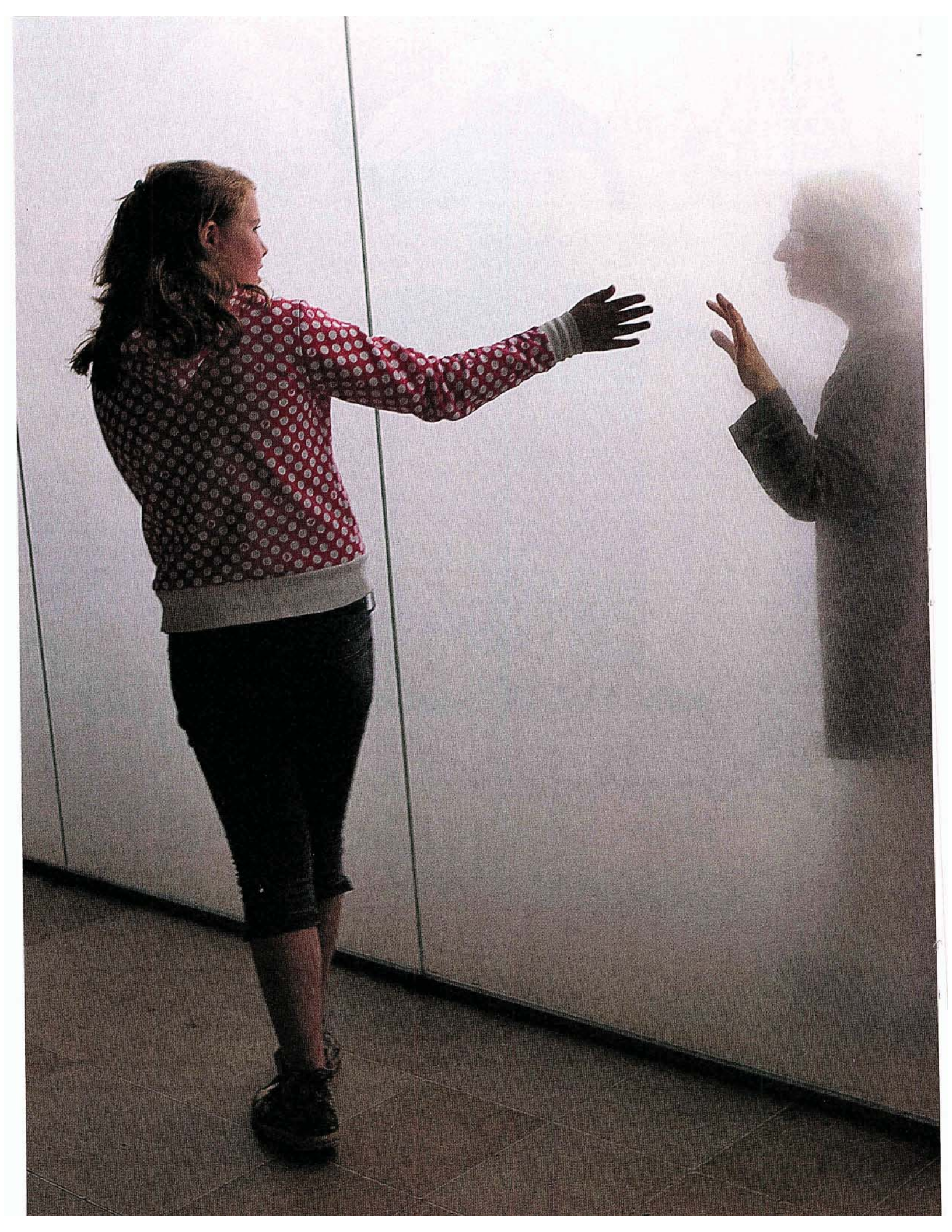
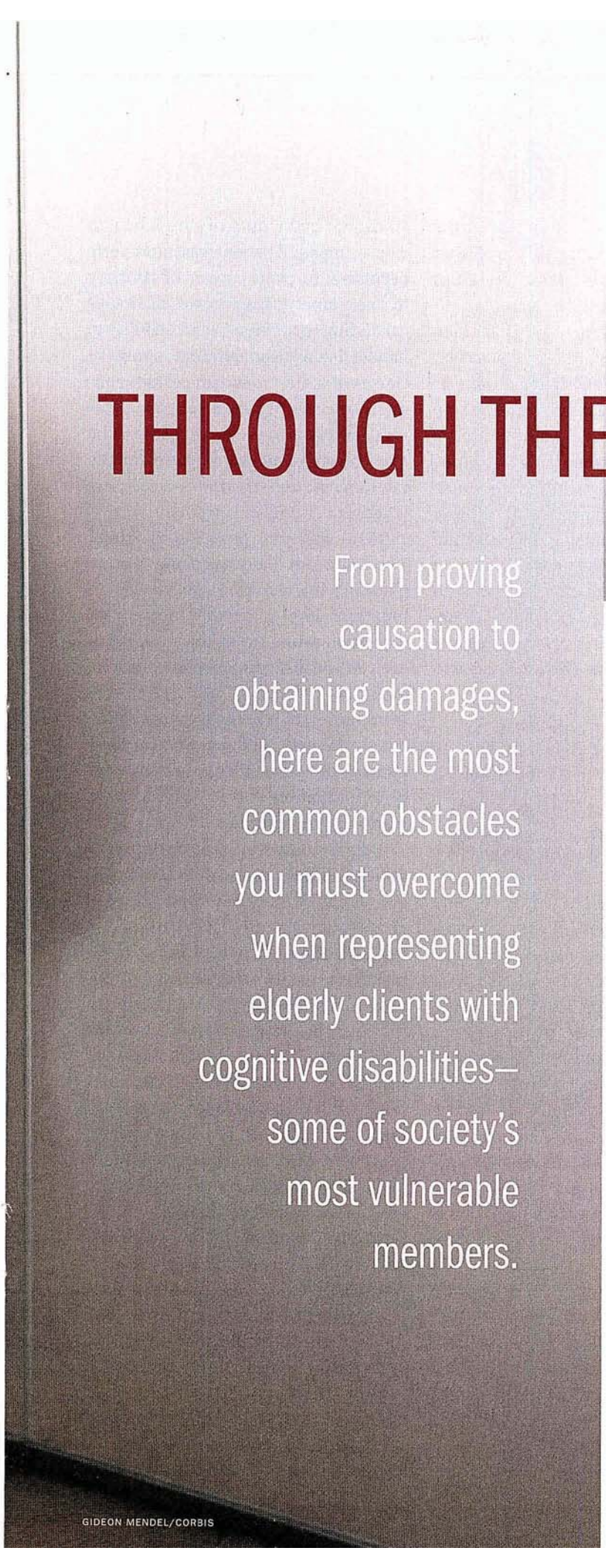


THROUGH THE HAZE

From proving causation to obtaining damages, here are the most common obstacles you must overcome when representing elderly clients with cognitive disabilities—some of society's most vulnerable members.



GIDEON MENDEL/CORBIS

By || **William S. Friedlander**

Your longtime client asks you to represent his elderly mother in her negligence claims against a nursing home. The case involves a perfect storm: fractures sustained in successive unobserved falls, untreated pressure sores over the sacrum and heels, unmonitored declines in nutrition and hydration, and a dislodged feeding tube unnoticed by staff that led to long-term hospitalization. The home has a history of inadequate staffing and inattention to resident safety, nutrition, and hygiene; the mother—a retired teacher—was in good physical health and mental acuity. But when you visit the potential client, you discover definitive signs of cognitive impairment: She is withdrawn, rambling, and unable to recognize her son or engage in a coherent conversation. Is this a case you're able to take?

As the population ages, representing clients with some degree of cognitive loss or impairment is increasingly common—not only in nursing home negligence cases but also in other areas of personal injury practice, from slip and falls to medical negligence. About 30 percent of people over 85 experience some form of dementia, defined as a pattern of impairment in memory, thinking, and social abilities severe enough to interfere with daily functions.[1] There are several forms of dementia caused by various diseases—most notably Alzheimer's.

Whatever the cause, cognitively impaired clients present numerous litigation challenges, from the client's mental competence for retaining counsel to proving causation and damages. Reviewing these obstacles early on can help you decide whether it's feasible to take

the case and how to proceed with claims or litigation in the client's interests.[2]

Practice tip: Do not limit your assessment to current cognition or functional capacity. Prior medical and mental health records, employment history, Internet postings, and communications with the defendant will impact the viability of the client's claims, competence, and persuasiveness—as well as the likely attitude of witnesses toward your client and the nature of possible defenses. For example, is your client easily agitated or a lifelong bully? Will her history allow you to argue persuasively for pain and suffering or hedonic damages? Will she need therapeutic support during discovery and trial? Answers to these types of questions will shape your decision to take the case and how to frame it.

SCHEDULE MEETINGS DURING THE TIME OF DAY WHEN YOUR client is most alert and communicative, and identify the least distracting or stressful locations for interviews and depositions.

Lawyers also should be aware of ethics guidelines. In particular, Rule 1.14 of the ABA Model Rules of Professional Conduct urges lawyers to maintain as "normal" an attorney-client relationship as possible and, at the same time, offers guidance for taking "reasonably necessary protective action" under the rubrics of client best interests and least restrictive alternatives.[3] Ethical issues also include when, and to whom, confidential information may be disclosed to protect the client's interests, being clear about the identity and unique interests of the client when family members step into the legal relationship, and addressing conflicts of interest that may arise when representing multiple clients.[4] For example, is your client the elderly mother or the competent son? Are the children at odds? Can or should they be privy to mom's medical records? Who will ultimately make decisions in litigation? When is a guardianship called for? Familiarity with the Model Rules and other ethics guidelines is a must—both to ask the right questions and to reach the correct answers.

Substantive Legal Issues

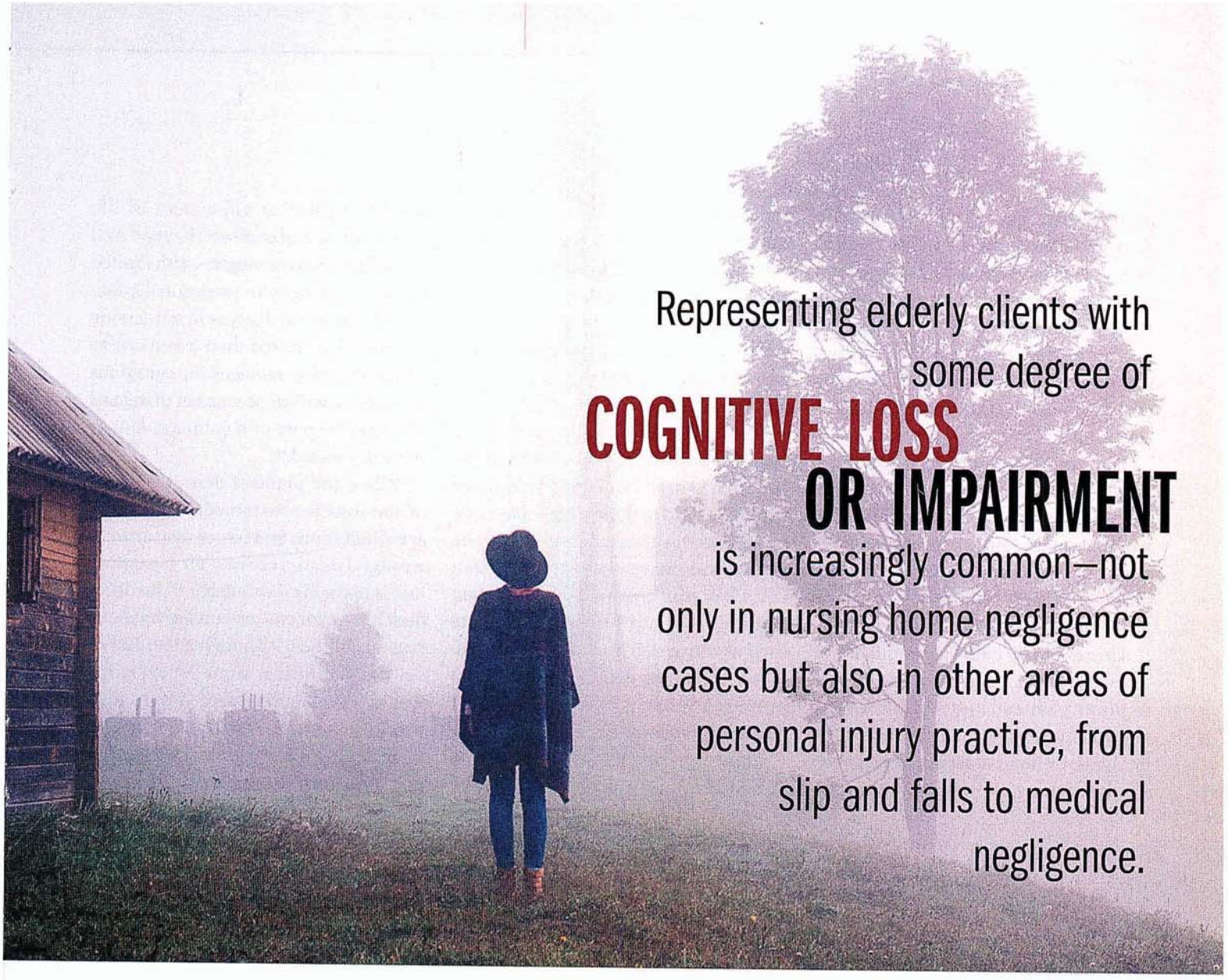
Once you have assessed the client's mental capacity, you then must examine how a client's impairments will affect your potential claims. Common sticking points in negligence cases include proving the elements of duty, causation, and injury—and rebutting defenses of contributory or comparative negligence. Consider the following when developing a case strategy.

When the client is impaired, do caregivers owe a special duty? Perhaps. In a nursing home case, for example, a court held that the facility had a duty to monitor exterior doors against night wandering because a resident's nighttime disorientation is foreseeable.[5] Likewise, another court ruled that a hospital had a duty of care when an elderly impaired patient was improperly permitted to grant powers of attorney to a non-family caregiver, despite medical findings of dementia and inability to handle financial affairs.[6] Some statutory causes of action mandate certain conduct, however, which means that lawyers may not always need to address the question of a particular duty of care.[7] Use relevant case and statutory law to assess whether a special duty exists.

How will you prove causation? The defendant likely will claim that the plaintiff's injuries were not caused by a breach of duty—but rather by preexisting impairments, prior illness, aging, or even willful disregard of medical advice or facility protocols. Your case assessment must factor in the requisite medical, psychiatric, and neurological testimony to establish that any impairments or exacerbation of prior impairments were negligence-induced.[8]

Retain an expert physician or practitioner—such as a gerontologist, neurologist, psychiatrist, or other specialist—to prove your client's injuries, particularly when the plaintiff's reflective or communicative capacity was previously compromised. For example, in a case when the client has severe dementia but was raped, courts have ruled differently about whether the client suffered.[9] Your expert might, in such a case, address issues of memory, trauma, or behavioral change, bearing on the etiology and experience of physical, mental, or emotional injury and pain in geriatric patients.

Will comparative or contributory negligence be an issue? Case law points to a lesser standard of personal responsibility or due care for a cognitively impaired plaintiff, who may not recognize the danger of failing to maintain a soft diet or elevate an ulcerated leg. There also is no legal ground for holding a patient's family liable for his or her confusion or disorientation.



However, defendants continue to raise comparative or contributory negligence as a defense.[10] Familiarity with case law, as well as expert testimony outlining the plaintiff's limitations, will help you put these claims to rest.

Overcoming Obstacles in Case Intake and Discovery

Cases involving cognitively impaired plaintiffs, particularly nursing home residents, will present challenges with investigation and discovery that will affect your underlying liability case. In addition to the plaintiff, other witnesses may have difficulties with observation, recall, communication, and mobility. It may be hard to locate and depose transient nursing home staff, and nursing home records may be difficult to retrieve or assess. Keeping this in mind, you must consider questions such as: Will the client have the capacity to sign releases, respond to interrogatories, or undergo depositions? Will elderly or impaired witnesses be mobile or competent to testify in court, and who will assess courtroom competency? Are there appropriate ways to preserve eyewitness testimony by deposition, interrogatories, or affidavits?[11]

Practice tip: Take time to gain your client's trust and allow the client ample time to comprehend the information you provide. Schedule meetings during the time of day when your client is most alert and communicative, and identify the least distracting or stressful locations for interviews and depositions. You also can invite family or caretakers to be in the room during those meetings to make the client more comfortable, but be sensitive to ethical constraints, such as confidentiality or conflict of interest. Communicate slowly and clearly, pause occasionally to check that the client understands you, and adopt a process of "gradual counseling"—based on a step-by-step identification of goals, values, options, consequences, and client reactions—to work through legal issues and litigation options.[12]

Damages

Substantiating your client's damages is perhaps the biggest challenge when representing cognitively impaired elderly

OLEH_SLOBODENIUK/GETTY IMAGES

people. Significant categories of economic damages—lost wages and future medical and caretaking expenses—likely will be minimal when the client is a retiree with a short remaining life expectancy. Depending on the degree of cognitive impairment, even pain and suffering damages may be limited by the plaintiff's lack of cognition.[13]

For example, in a case involving a nursing home resident with Alzheimer's who was raped, minimal proof of the woman's conscious awareness limited pain and suffering damages to distress during the rape only, but not for ongoing pain and suffering after the rape.[14]

However, the quantity or quality of a plaintiff's awareness may be minimal to prove pain and suffering or loss of enjoyment damages. A glimmer of alertness, eye or hand motions in response to stimuli, tears and smiles in response to pleasure or pain while in a vegetative state, or even efforts at self-extubation may suffice. Observations by family members or nursing staff and expert testimony regarding signs of consciousness, brain function, and capacity to suffer also can help support pain and suffering damages.[15]

Some states' laws allow hedonic or loss of enjoyment damages either separate from pain and suffering damages or without regard to the victim's conscious awareness.[16] Alternatively, you may be able to bring statutory causes of action that allow your client to recover certain damages without proving cognition, such as those that award a percentage of nursing home daily rates when you prove the nursing home has violated statutory standards.[17]

State law also might allow you to bring a claim for "moral damages" for loss of comfort or enjoyment of life under a breach of contract theory.[18] And some families have sought—with limited success—damages for intentional infliction of emotional distress in witnessing conduct that caused their loved one to suffer. Punitive damages for egregious conduct or willful or wanton disregard also may be part of a common law or statutory award.[19]

When the plaintiff dies as a result of the injuries sustained, other damages limitations and issues may arise. A wrongful death recovery for pecuniary loss is probably unavailable if the decedent has no income or familial financial responsibilities. Although some states, such as California, allow recovery for loss of companionship,[20] others may preclude punitive or statutory damages under nursing home or related legislation. And keep in mind that a Medicaid

Nursing Home Sexual Abuse Cases

Juwon Adebayo

Sexual assault is one of the most egregious examples of nursing home abuse—and many care facilities fail to investigate or report it. Take these preliminary steps to help you prepare your case.

When family members place loved ones in a nursing home or assisted living facility, they entrust that person's safety and well-being to the staff. Unfortunately, the elderly and people with disabilities often are victims of abuse and neglect, with sexual assault being one of the most egregious examples.

Attorneys investigating nursing home sexual abuse cases often focus on the facilities' negligent hiring and supervision of staff and residents. While failure to carefully screen staff is a pervasive issue and results in poorly trained or unqualified staff, there is another common issue: the facilities' consistent failure to investigate and report sexual abuse.

Sexual abuse in nursing homes is one of the most unrecognized and underreported aspects of elder mistreatment. Under state and federal law, nursing home facilities are required to document and report reasonable suspicions or incidents of sexual assault and must take steps to protect their residents.[1] When investigating a facility's failure to report, here are a few preliminary steps that can aid you in preparing your case:

- Research state and federal reporting requirements to determine the facility's specific reporting obligations.
- Review resident and staff records to determine whether the facility performed a proper background check or whether it was aware of any previous incidents of abuse committed by staff or fellow residents.
- Obtain a nursing home organizational expert who can provide a comprehensive evaluation and analysis of the total care and management of the facility, as well as the regulatory and reporting requirements of the care of specific residents.

AAJ members have had success handling nursing home sexual abuse claims and have shared their case materials and experiences in the AAJ Exchange's new Nursing Home Litigation: Sexual Abuse Litigation Packet. To learn more about this Litigation Packet and other AAJ Exchange resources that can benefit your practice, visit www.justice.org/litigationpackets or contact the AAJ Exchange at (800) 344-3023.

Juwon Adebayo *is a staff attorney at AAJ Exchange. She can be reached at juwon.adebayo@justice.org. To contact AAJ Exchange, email exchange@justice.org.*

Note

1. U.S. Dep't of Health & Human Servs., Office of Inspector Gen., *Nursing Facilities' Compliance With Federal Regulations for Reporting Allegations of Abuse or Neglect* (Aug. 2014), www.oig.hhs.gov/oei/reports/oei-07-13-00010.pdf.

or Medicare lien may negate a substantial portion of any recovery, even if the bulk of the damages award is for pain and suffering rather than for medical expenses.[21]

Practice tip: Focus on the equities of your client's claims and life trajectory: years of hard work or service to country or community, the value of freedom from pain or limitations in waning years, the slow healing process in the elderly, and the emotional and financial burden on the plaintiff's family and caregivers. These invite the jurors to look past the victim's impairments to the full value of your client's life, making the case for pain and suffering, loss of enjoyment, and—if the defendant's behavior was egregious—punitive damages.

Representing a client with cognitive impairments requires sensitivity to the client's limitations, family interests and expectations, ethical guidelines for representation, substantive law constraints, the challenges of persuading jurors of liability, and the difficulty of proving damages. But as the population ages and clients with cognitive impairments become more common, we must adjust case assessment practices to best represent these clients. T

William S. Friedlander *is a partner at Friedlander & Friedlander in Ithaca, N.Y. He can be reached at wsf@friedlanderlaw.com.*

Notes

1. For an overview and statistics *see, e.g.,* Normal Abeles & APA Working Group on the Older Adult Brochure, *What Practitioners Should Know About Working With Older Adults* (1998), www.nova.edu/gec/forms/practitioners_older_adults.pdf; Janice Fuhrman, *Elder Financial Abuse Creates Growing Challenges for Lawyers as Baby Boomers Get Older*, Cal. Law. (June 2015), www.callawyer.com/2015/06/elder-financial-abuse-creates-growing-challenges-for-lawyers-as-baby-boomers-get-older/; Daniel Marson, 2015 Annual Meeting of the Alabama State Bar, *Cognitive Decline and Dementia in an Aging Society: Impact on the Legal Profession* (July 15, 2015), www.alabar.org/assets/uploads/2015/07/1-Cognitive-Decline-Dimentia-in-an-Aging-Society.pdf.
2. *See, e.g.,* N.Y. St. Bar Ass'n, Power of Attorney New York Statutory Short Form, www.nysba.org/WorkArea/DownloadAsset.aspx?id=22346. Also note that the same impairment that prevents a client from personally retaining counsel—or, at the least, requiring a disability assessment before doing so—may allow you to fight a nursing home arbitration agreement signed in a hurry or under stress at the time of admission. *See, e.g., Benjamin v. Jewish Home Lifecare*, 2015 WL 2090373 (N.Y. Sup. Ct. May 4, 2015).
3. *See* Model Rules of Prof'l Conduct R. 1.14(a) & (b) (2016).
4. *Id.; see also* Charles P. Sabatino, *Representing a Client With Diminished Capacity: How Do You Know It and What Do You Do About It?*, 16 J. Am. Acad. Matrimonial Law. 481 (2000); Kerry R. Peck, *Ethical Issues in Representing Elderly Clients With Diminished Capacity*, 99 Ill. B.J. 572 (Nov. 2011).
5. *See Washnock v. Brookdale Senior Living, Inc.*, 2014 WL 495414 (E.D. Mich. Feb. 6, 2014); *see also Stearns v. Ridge Ambulance Serv., Inc.*, 32 N.E.3d 765 (Ill. App. Ct. 2015).
6. *See DeBoer v. Senior Bridges of Sparks Fam. Hosp. Inc.*, 282 P.3d 727 (Nev. 2012).
7. *See, e.g.,* N.Y. Pub. Health Law §2801-d (2009) (establishing a statutory cause of action and an alternative measure of damages for violation of state nursing home regulatory standards).
8. *See, e.g., Domoroski v. Smithtown Ctr. for Rehab. & Nursing Care*, 945 N.Y.S.2d 345 (N.Y. App. Div. 2012); *cf. Bickler v. Senior Lifestyle Corp.*, 266 F.R.D. 379 (D. Ariz. 2010); *Milliun v. New Milford Hosp.*, 20 A.3d 36 (Conn. App. Ct. 2011); *see also* Michael L. Rustad, *Heart of Stone: What Is Revealed About the Attitude of Compassionate Conservatives Toward Nursing Home Practices, Tort Reform, and Noneconomic Damages*, 35 N.M. L. Rev. 337 (2005) (discussing difficulty of proving causation in nursing home litigation with impaired clients).
9. *Guernsey ex rel. Itterly v. Country Living Pers. Care Homes, Inc.*, 2006 WL 1412765 at *10 (M.D. Pa. May 19, 2006) (finding no evidence of long-term emotional distress following rape of nursing home resident with dementia); *cf. Carlton v. Vancouver Care LLC*, 231 P.3d 1241 (Wash. Ct. App. 2008) (ruling that evidence of rape trauma syndrome and implicit memory should go to the jury on the issue of injury in the rape of a nursing home patient who had dementia).
10. *See Stogsdill v. Manor Convalescent Home, Inc.*, 343 N.E.2d 589, 605 (Ill. App. Ct. 1976), *superseded by statute as stated in Graves v. Rosewood Care Ctr., Inc.*, 968 N.E.2d 103 (Ill. App. Ct. 2012). *But see Kushner v. Schervier Nursing Care Ctr.*, 2011 WL 1201936 (S.D.N.Y. Mar. 23, 2011).
11. *See, e.g., Greene v Mullen*, 2010 WL 11230462 (N.Y. Sup. Ct. Jan. 26, 2010).
12. *See* ABA Comm'n on Law & Aging & Am. Psychological Ass'n, *Assessment of Older Adults With Diminished Capacity: A Handbook for Lawyers* 27–30 (2005), www.apa.org/pi/aging/resources/guides/diminished-capacity.pdf.
13. *See, e.g., Williams v. City of N.Y.*, 71 A.D.3d 1135, 1137–38 (N.Y. App. Div. 2010) (stating that some cognition is required to support a pain and suffering award); *Cresthaven Nursing Residence v. Freeman*, 134 S.W.3d 214, 230 (Tex. App. 2003) (reducing pain and suffering damages for broken leg where elderly decedent suffered from Alzheimer's and organic brain syndrome).
14. *See Guernsey*, 2006 WL 1412765 at **10–11.
15. *See, e.g., Bower v. Jo Ellen Smith Convalescent Ctr.*, 688 So. 2d 177, 179 (La. Ct. App. 1997) (referencing patient's medical record, noting "eyes open to verbal and tactile stimuli"); *Williams*, 71 A.D.3d 1135, 1138 (noting expert testimony regarding eye and hand responses to stimuli and efforts at self-extubation by patient with epilepsy, establishing sufficient brain function and control of motor functions to warrant pain and suffering damages).
16. *See Eyoma v. Falco*, 589 A.2d 653, 658 (N.J. Super. Ct. App. Div. 1991) (finding that loss of enjoyment damages do not require consciousness).
17. *See, e.g.,* N.Y. Pub. Health Law §2801-d.
18. *See Free v. Franklin Guest Home, Inc.*, 463 So. 2d 865, 873 (La. Ct. App. 1985).
19. *See Guernsey*, 2006 WL 1412765 at **18–19 (awarding $800,000 in punitive damages for nursing home rape of impaired resident in conjunction with limited compensatory damages); *Vincent v. Alden-Park Strathmoor, Inc.*, 928 N.E.2d 115 (Ill. App. Ct. 2010) (finding state law allows recovery of common law punitive damages for willful and wanton conduct, although punitive damages claims do not survive death of nursing home resident), *aff'd*, 948 N.E.2d 610 (Ill. 2011).
20. *See, e.g., Krouse v. Graham*, 562 P.2d 1022 (Cal. 1977).
21. *See, e.g., In re Homan v. Cnty. of Cattaraugus Dep't of Soc. Servs.*, 905 N.Y.S.2d 387 (N.Y. App. Div. 2010) (finding Medicaid lien recoverable in part against pain and suffering award).