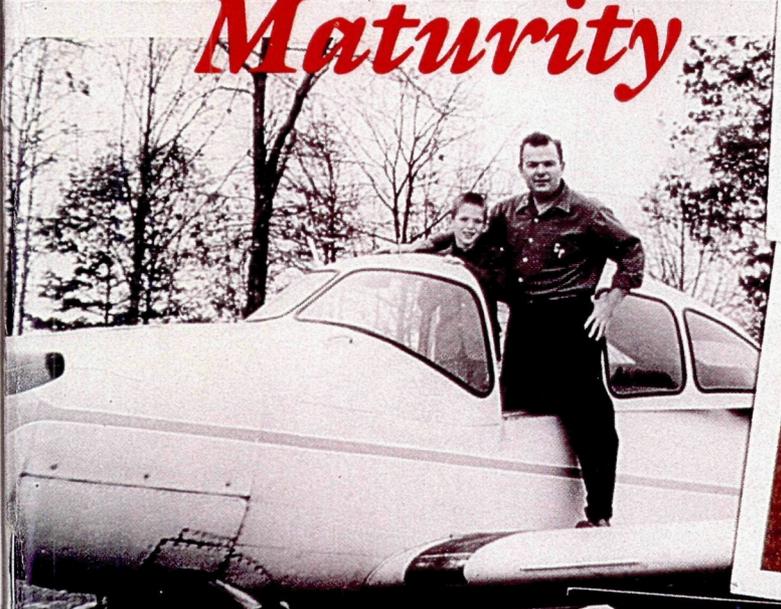
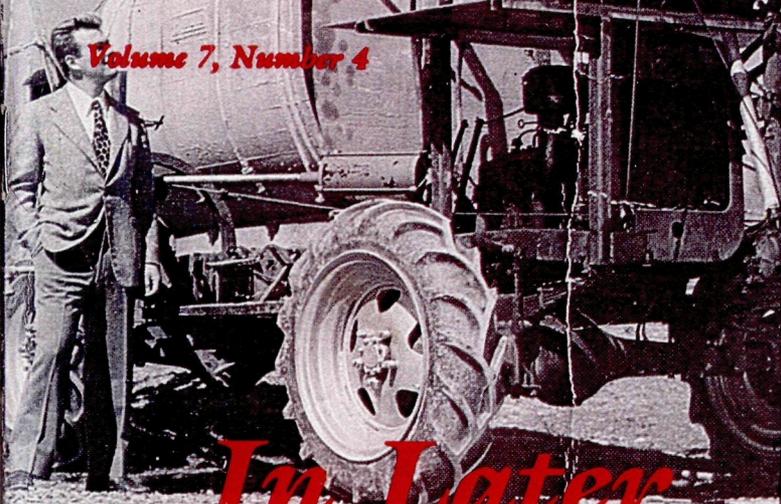


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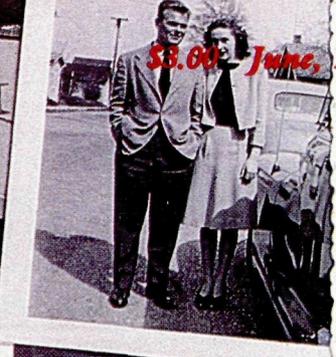
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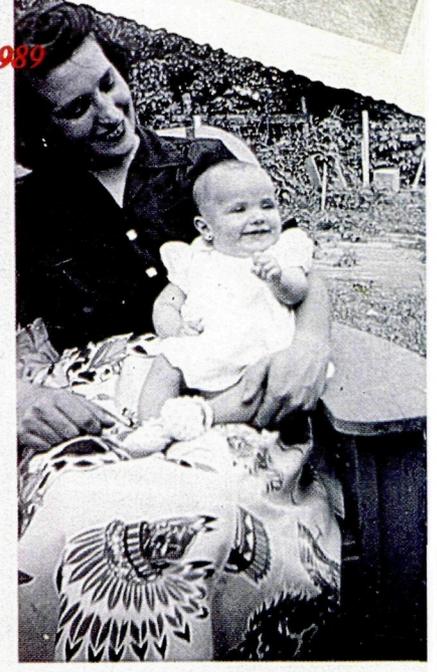


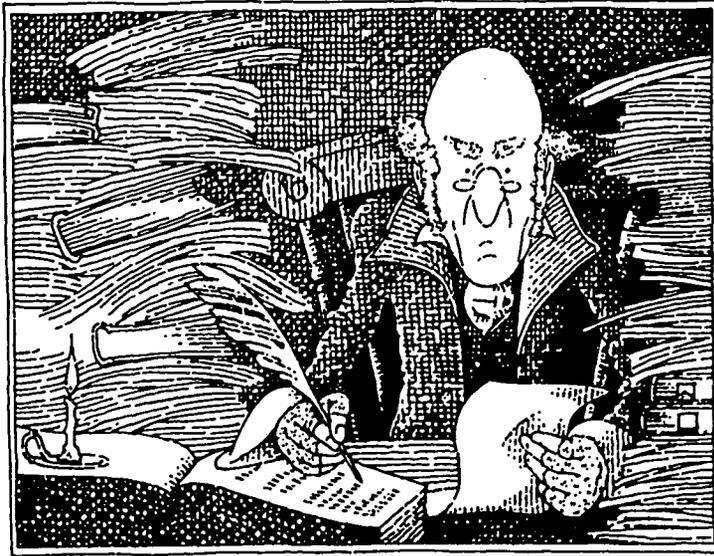
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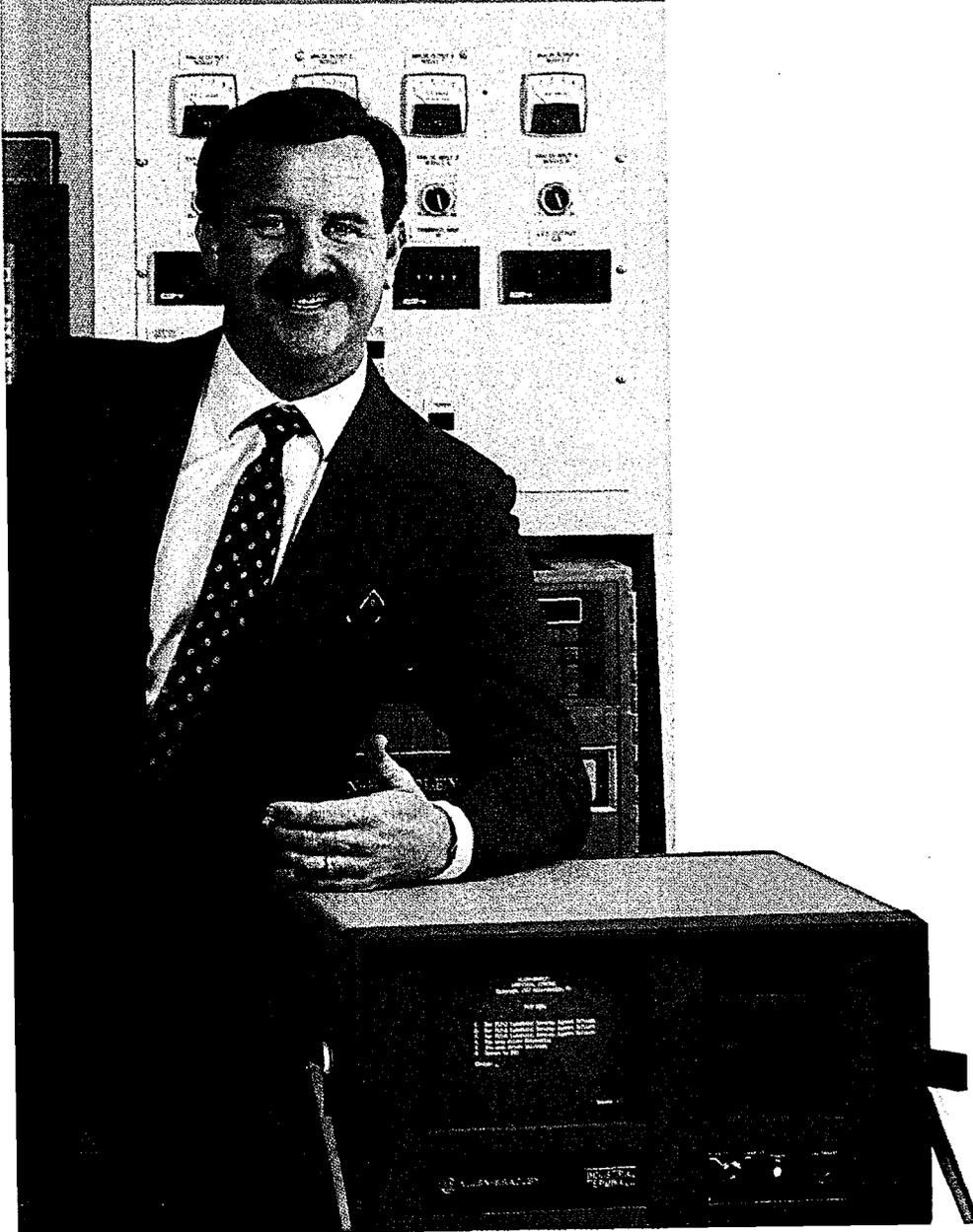
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JUNE 1989

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The Cover: Wilmington artist Gibby Perry drew from family experiences in designing the cover for this issue. In his own words: "Gibby Perry, cover artist and family anthropologist, envisioned a visual accumulation from a Delaware "Father Knows Best" that bespeaks continuity and illustrates aging as essential and binding as creation. The artist who ventures from landscape to collage with regularity, chose the specific and accessible format of "collage verite". The story, begins with (1) the artist's father and grandmother, protecting country and son. Newlyweds (2) Gil and Gail soon wander into the wilderness (3) of the Eastern Shore, with hope, strength, and ideas. (4) It is the baby boom, and Sis sits enthroned on an always fashionable Mom. Dad and first-born Geoffrey disdain limits (5); things change, though, with middle-management (6). Cheering a phenomenon, (7) Sally is still Mom's best friend; fickle modern girl, she leaves all for college, and puppy, Poppa and pony commiserate. You wouldn't have generations without babies, and the kids oblige (9). Pop and his grown-up nephew enjoy what winter brings (10)...this chapter closes as the honeymooners cut the cake (11), awash in trials and satisfactions."

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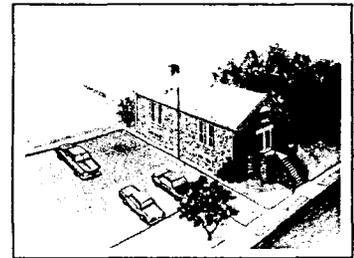
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EDITOR'S PAGE

This issue of DELAWARE LAWYER is the second to be devoted to elder law. Concentration in elder law is relatively new to private practitioners. Legal Services programs such as Community Legal Aid Society, Inc. have practiced it for as long as 13 years because of funding provided for legal services to the elderly pursuant to the Older Americans Act. In recent years as a result of the "greying of America" a number of individual attorneys and law firms have developed elder law practices. They have also organized the National Academy of Elder Law Attorneys.

"The mission of the Academy is to provide information, education, networking and assistance to attorneys, Bar organizations, and other individuals or groups advising elderly clients and their families; to promote high standards of technical expertise and ethical awareness among attorneys, Bar organizations and other individuals or groups engaged in the practice of advising elderly clients and their families; and to develop awareness of the issues surrounding legal services to the elderly."

Wills, traditional estate planning, powers of attorney, living wills, and guardianships are part of many elder law practices. Some firms and individual attorneys, however, concentrate their practices on issues that are presented in this magazine. They address planning for disability by assisting clients and their families to prepare for surrogate decision making for health care and financial management and to preserve income and assets to the legal maximum while providing for long term care, if and when it is needed.

Some law firms with elder law practices have social workers or nurses on their staffs to assist clients and their families in obtaining necessary services such as home health care or nursing home care.

Attorneys working with elderly clients must be familiar with government benefit programs such as Medicaid, Medicare, Social Security, and SSI in order to advise and assist clients in planning. Attorneys serving older clients also should know about patient rights, long term care insurance, reverse annuity mortgages, the status of the law with regard to right to die issues, as well as wills, trusts, and estate planning, because clients seek advice about these subjects.

In addition to developing expertise in substantive areas, lawyers must be able to recognize potential ethical problems in representing elderly clients. Competency may be an issue, and the client must be identified at the outset of the representation. For example, is the client the older person or that person's son, who has been the firm's client for several years and has brought the parent to the office?

All of these issues are discussed in this magazine. Although the topics may be depressing, I believe they contain much valuable information and I hope this issue of DELAWARE LAWYER will be an important resource for lawyers, the "elders" of our state, their families, and the service providers in the aging network. I thank everyone who contributed to this effort.

Judith A. Schuenemeyer

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PLANNING FOR DISABILITY AND THE NUTRITION ISSUE

Thomas Herlihy, III

Dying with dignity is difficult. For some death is made more arduous by laws and policies requiring the artificial prolongation of life. A vocal segment of citizens urge that terminally ill or irreversibly comatose persons may have all artificial life support systems withheld or withdrawn, except they must be artificially supplied with food and water. Under this view, it is permissible to remove a respirator, but the dying person must suffer the insertion of a feeding tube, which may be through the nose (nasogastric tube) or directly into the stomach (gastrostomy), and the continuation of feeding.

Some state legislatures have made this view law, and a bill to do the same was introduced by several representatives and senators in the last session of the Delaware General Assembly. Because forcing food and fluids on terminally ill patients is a hot issue, the bill will rise again.

Under the present law, a competent person can make a living will,¹ which will be effective if the declarant becomes incompetent and terminally ill, directing the withholding or withdrawal of maintenance medical treatment. The definition in the Delaware Death with Dignity Act of "maintenance medical treatment" refers to "any medical or surgical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore or supplant a vital function; and which would serve only to artificially prolong the dying process." The definition is qualified by the provision that it "shall not include the administration of medication, nor the performance of any medical procedure necessary to provide comfort care or to alleviate pain." Many consider nutrition and hydration by feeding tubes to be an "intervention which utilizes...artificial means to sustain...a vital function." A Delawarean's living will should preclude unwanted food and fluids when it states in general language that, if terminally ill, he does not want maintenance medical treatment as

defined by Delaware law. However, the bill before the Delaware legislature attempts to further qualify or limit the definition of "maintenance medical treatment". House Bill No. 544 as introduced in the 134th General Assembly provides:

(a.) The State of Delaware does not approve of or authorize starvation of patients through denial of nourishment, or dehydration of patients through denial of hydration.

Since food, water, nourishment and hydration are essential human needs, these are not to be included in the definition of medical treatment under Delaware law.

(b.) Food, water, nourishment and hydration administered either orally or artificially shall be provided to all patients and shall not be withheld or withdrawn if the withholding or withdrawal would cause death by starvation or dehydration.

If this bill becomes law, food and water would be administered whether the patient wants them or not.

The basis of the bill appears to be that since food and water are basic needs, they are not medical treatment. Laurence O'Connell, Vice President for Theology, Mission and Ethics of the Catholic Health Association, states in reply: "Food and water are no more basic than air, and people find it acceptable to remove a respirator."² Note that House Bill No. 544 says nothing about air as an essential human need.

On March 15, 1986 the Council on Ethical and Judicial Affairs of the American Medical Association issued a statement declaring that life prolonging medical treatment, including nutrition and hydration, may be withheld from a patient in an irreversible coma, even if death is not imminent.³ The principle of the AMA statement is that withholding food and water from an irreversible comatose patient allows the pathology of the

coma to take its natural course.⁴ House Bill No. 544 would compel a health care provider to interfere with the natural course of death by forcing an artificial invasion of the patient's body by means of the insertion of intravenous or tube feeding.

The bill is unconstitutional. The United States Supreme Court has recognized that a right of privacy does exist under the Constitution.⁵ Justice Brandeis referred to this right as "the right to be left alone - the most comprehensive of rights and the right most valued by civilized men."⁶ The right to refuse medical treatment is a right rooted in this nation's fundamental legal tradition of self-determination.⁷ The courts find that artificial feedings such as nasogastric tubes, gastrostomies, and intravenous infusions are significantly different from bottle-feeding or spoon-feeding; they are medical procedures with inherent risks and possible side effects, instituted by skilled health care providers to compensate for impaired physical functioning.⁸ Since mandatory artificial feeding may be an unwanted medical treatment, in violation of the patient's right to privacy, the patient has a constitutional right to refuse it. The Delaware General Assembly should not be permitted to take it away.

Patients who are dying are not interested in food. They cannot equate food with what we equate it to. It is simply what we project onto them, rather than what they are feeling.

Dr. Edward Viner is a Camden, New Jersey, internal medicine specialist and former oncologist who spent 120 days himself in an intensive care unit. He states that legislation requiring nutrition and hydration "is a very dangerous thing."⁹ When you keep some patients on the IV, he says "you just make them suffer longer."¹⁰ Dr. Viner says it is a "misconception" that "drifting into dehydration and coma is unpleasant. The patient who is dying is not interested in

food. He cannot equate food with what we equate it to. It is simply what we project onto them, rather than what they are feeling."¹¹ House Bill No. 544 not only would cause the invasion of a patient's right of privacy, it would be the living telling the dying how they should feel.

Delawareans were hoping the Court of chancery would clarify the law on the issue of artificial feeding. *In the Matter of Arnold Shumosis*, C.M. No. 5515, Del. Ch., Allen, C. (September 27, 1988). Arnold Shumosis's parents sought to remove his gastric feeding tube. Shumosis was profoundly affected by massive brain injuries as a result of an automobile accident. He was not in a coma or persistent vegetative state. His consciousness was intermittent and at a very low level. Shumosis died before the Court was able to decide the case, but his parents continued to seek a ruling that might aid others. Chancellor Allen declined to make a judicial determination, because he wanted the General Assembly to first address the issue in which new law would be made.

In the meantime if some other unfortunate Delawarean were to be the victim of unwanted artificial feeding, he or she would probably have to suffer while his family went through the agony and great expense of a court case to decide the issue. Actually, Delawareans should not have to wait for action in the General Assembly. The Attorney General of Delaware is responsible for the criminal side of this issue. Health care providers would not fear criminal prosecution if they had guidelines from the Attorney General. The Attorney General should know that the appellate

courts of at least five states have ruled that artificial feeding is a form of medical treatment that can be discontinued in cases where other life sustaining procedures can be terminated. The Attorney General could issue guidelines permitting the withholding or withdrawal of hydration and nutrition in situations falling under the Delaware Death With Dignity Act, which would cover the living will or health care agent provisions.

Health care providers would not fear criminal prosecution if they had guidelines from the Attorney General.

The immediate relief of health care providers from criminal prosecution should also reduce the risk of civil liability, assuming the providers made a good faith effort to follow the guidelines. The Attorney General should have issued guidelines within 30 days after Chancellor Allen refused to rule in *Shumosis*. If the Attorney General prefers the General Assembly to first address the issue, then he could, as has been done on other issues, announce the proposed guidelines, give the General Assembly 60 days to take up the issue, and if they do not resolve it, put the guidelines into effect. No Delaware family should have to suffer the pain and expense of this unresolved issue while the courts, the legislature, and the executive branch fail to establish the State's policy.

Delaware citizens have their own remedies. If they are competent and can communicate before or at the time the issue of artificial feeding arises, they can tell their health care provider to withhold or withdraw artificial feeding. When they are competent they can ex-

ecute a living will, an appointment of a health care agent under the Death with Dignity Act, or an appointment of an attorney-in-fact under a durable power of attorney. These instruments do not serve the same purposes, so that good disability planning may require a combination thereof. All of the instruments are designed to allow the health care wishes, made when competent, to be put into effect when the declarant becomes incompetent. However, the living will applies only to terminally ill persons and to life sustaining measures. The health care agent may make decisions for the appointor whether the appointor is terminally ill and whether the care involves life sustaining measures. The document making the appointment can include provisions found in the usual living will plus any other directives desired by the appointor. A durable power of attorney can include the directives of the living will and all of the decision making authority of a health care agent.¹² However, the durable power of attorney has the major advantage of combining surrogate power over health care with surrogate power over all financial matters. See Herlihy, "Before It's Too Late, Incompetency, Guardianships, Durable Powers of Attorney, and the Next Step," *DELAWARE LAWYER*, Summer 1985, page 30.

All three of the instruments may rely on general directions by the signatory not to prolong his life by artificial or mechanical support systems. Even though it did not involve written directions, a recent case involving use of a nasogastric feeding tube, causes concern about general health care directives. *In the matter of West Chester*

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Seeing is believing!

County Medical Center on behalf of Mary O'Connor, 534 NYS2d 886 (Ct.App. N.Y. 1988).

Mary O'Connor was seventy-four when she suffered an attack of congestive heart failure. During the next three years she suffered a series of strokes causing serious physical and mental disabilities. She could not stand or feed herself. When she lost her gag reflex, she could not swallow food or liquids without medical assistance. The hospital fed her intravenously, but it petitioned the court for authority to use the nasogastric tube. Mary O'Connor could not state whether she wanted this forced feeding because the strokes had left her permanently incompetent and unable to comprehend anything about her medical treatment. She was not in a coma or vegetative state, but could respond to simple questions or the physicians' probe with a needle. Her daughters, both practical nurses, opposed the use of a nasogastric tube because Mrs. O'Connor had told them on numerous occasions that she did not want her life prolonged by artificial means if she was unable to care for herself. But she did not have a living will, which might have given a direction to the hospital in language similar to Mrs. O'Connor's oral statements. The New York Court of Appeals authorized the hospital to insert the nasogastric tube because the evidence was not clear and convincing that Mrs. O'Connor would reject a nasogastric tube. The majority of the court found that her statements about not wanting her life artificially prolonged were statements "many of us might make after witnessing an agonizing death". 534 NYS2d 893. The statements did not have seriousness of purpose or have the solemnity of a living will.

A well-reasoned dissent found that the daughters established that Mary O'Connor did not wish any "artificial or mechanical support systems" to sustain her life, and she wanted "nature to take its course". It was erroneous for the majority to find these statements to be inadequate, because the statements were not casual remarks, but were made after several deaths in her family and her own hospitalization. Mrs. O'Connor's statements did not mention the issue of nutrition and hydration, but the majority's requirement of specificity mandates a patient to anticipate the artificial life support system he or she does not want. The dissenting judge stated it is unrealistic to expect or require a lay person to be familiar with the support systems available for treat-

ment, a determination of which is preferable, or the consequences that may result from using or foregoing them.

Thousands of living wills have been signed with the general language directing the withdrawal or withholding of artificial or mechanical life support systems. Rarely does the declarant specify what kind of life support system he or she does not desire. For example, the usual living will does not specifically direct that respirators, antibiotics, or feeding tubes be withheld or withdrawn.

The ruling in Mary O'Connor's case gave no effect to her general directives about not wanting artificial or mechanical life support systems because they were not specific. In order to prohibit the insertion of a nasogastric feeding tube, Mrs. O'Connor would have to state when competent that she did not want that specific device used when she was unable to feed herself. Is the requirement of specificity limited to oral statements? Could the O'Connor ruling be applied to the general language used in most living wills?

No Delaware family should have to suffer the pain and expense of this unresolved issue while the courts, the legislature, and the executive branch fail to establish the State's policy.

The O'Connor decision causes concern for everybody involved with living wills. The declarant also signs a living will with general prohibitions against artificial or mechanical life support systems has to worry that a doctor, hospital, or court may ignore the living will because it did not state the particular system to be avoided. The lawyer or organization preparing the general living will needs to be concerned that the document will not satisfy the declarant's intent to limit the artificial prolongation of life. If statements of specific intent, such as: "I do not want a respirator used," are to be put in the living will, will all possible mechanical or electrical support systems be covered? Will the document have to be changed each time medical science creates a new system or the General Assembly dreams up a new life necessity.

The health care provider has to decide whether the general directive includes the intent to withhold or withdraw a particular life support system to be used on the now incompetent declarant. The doctor may possess a living will prohibiting the use of artificial life support systems, but does this mean the doctor

can not insert a feeding tube? If there is nothing in a living will about nutrition or hydration, will the doctor be charged with violating the declarant's intent that artificial means not be used if he inserts a feeding tube? On the other hand, will the doctor be charged with negligence for failure to insert the feeding tube when the doctor relies on a living will with a general prohibition against artificial life support measures but no specific statement that a feeding tube was not wanted?

A living will with the general language that the declarant does not want the artificial prolongation of his or her life should not raise these issues or concerns. The dissenting opinion in Mrs. O'Connor's case provided sound reasons why general language, even if oral, would be sufficient. If specificity is required, the dissent reasoned that given the disparity of knowledge between lay persons and doctors, medical personnel will be reluctant to honor a patient's instructions if they are not clear or medically meaningful. This will require courts to intervene because doctors and family will be uncertain of the patient's wishes and concerned about the consequences of an erroneous decision. The value of a living will is that it allows doctors to safely rely on a statement of the patient's wishes without forcing the family to undertake an expensive and time consuming court action. If specific language is required, the living will's value will be lost in litigation construing the patient's statements as if they were statutes or contract terms.

The answer to the problem of specific or general language does not require legislation. The definition of "maintenance medical treatment" refers to "medical or surgical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore or supplant a vital function; and which would serve only to artificially prolong the dying process." The general language of the definition provides the flexibility to cover the many existing life support systems and the expansiveness to include future medical developments. If one declares that he or she does not want a treatment that artificially prolongs life, that general language should cover any mechanical or artificial sustenance of a vital function without need for a more specific description or reference to artificial procedures unknown at the time the living will was signed.

Thousands of Delawareans have written living wills with no more than

the general directives prohibiting the artificial prolonging of life. Other than the O'Connor case, all of the appellate court decisions would support general directives being sufficient to cause the withdrawal or withholding of artificial nutrition and hydration in appropriate circumstances. Although the Death with Dignity Act should be clear support, a Delawarean's disability planning could include, out of an abundance of caution, a specific directive against artificial feeding to prolong life, in addition to the usual general directives.

Planning for disability not only requires flexibility in the language used, but flexibility in the applicability of the instruments used. For example, the durable power of attorney can also be used as an estate planning instrument for the disabled when it is used in combination with a standby trust.¹³ If people want complete control of their assets and health care decisions while they are competent, they can execute durable powers of attorney with a springing power. That is, the durable power of attorney is signed while a person is competent, but it does not become effective until he is incompetent. At the same time the durable power of attorney is executed, a standby trust is signed. This trust is an unfunded living trust agreement that provides for the administration and distribution of the settlor's assets if and when the trust is funded. If the settlor becomes incapacitated, the attorney-in-fact funds the standby trust.

There are numerous advantages to the combination of the durable power of attorney and the standby trust.

The funding of the standby trust may be deferred until it is actually needed. Compared to the usual funded living trust arrangement, this avoids the immediate transfer of the settlor's assets with the related red tape, expense, and tax changes. Of course, if the settlor's assets are not transferred to the trust before death, there may be an unwanted probate of the estate. The standby trust arrangement may also avoid the expense of an active trustee often used for a funded living trust.

The combination allows the trust to receive as many or as few of the settlor's assets as may be desirable, as opposed to being limited to those assets the settlor transferred before becoming disabled under a funded living trust.

A comparison of the combination of a durable power of attorney and standby trusts with use of the durable power of attorney alone, reveals several advantages.

The durable power of attorney alone is often cumbersome if frequent switching of investments is desirable.

Since third parties are far more used to dealing with trustees than attorneys-in-fact, the standby trust has a clear practical advantage for the active management of a portfolio.

"The standby trust also has the potential of protecting the grantor's assets from exhaustion when governmental assistance is available to the grantor, whereas a durable power of attorney offers no such protection. Although the present state of the law on this point is unsettled, there is everything to gain and nothing to lose by expressing the grantor's intent in the standby trust agreement that the trust assets are to supplement, but not substitute for, any governmental programs that may be available for the grantor's health and support. See Lombard, *Planning for Disability*, (1986 Institute on Estate Planning) 1710-1712, for a discussion of governmental programs and applicable case law relating to the availability of assets from a discretionary trust to support a grantor otherwise entitled to governmental assistance.

"A final advantage of the standby trust over a durable power alone is that the trust can be utilized as a device to avoid the expense, delay, and publicity of probate administration. Rather than simply have the trust balance payable on death to the grantor's personal representative, the trust can spell out the ultimate disposition of the trust assets. Thus all the probate-avoiding advantages of a funded living trust can be realized without the necessity of transferring assets to a trust in anticipation of a disability that may never occur." (Gilmar)

Another disability planning instrument being considered in Delaware is the health care proxy. Under this proposed law, a competent person can execute a proxy delegating to an agent the authority to make health care decisions for the person when that person becomes incompetent. Why is this law needed when Delaware currently has a health care agent provision in the Death with Dignity Act? The Death with Dignity Act provisions, 16 Del. C. 2502(b) and (c), laconically authorize an agent to be appointed and authorize the agent to act for the appointor if, in the judgment of the attending physician, the appointor becomes incapable of making a decision in the exercise of the right to accept or refuse medical treatment.

Compared to the Death with Dignity

Act, the proposed health care proxy law would provide more specifics:

1. Persons residing in mental health facilities may appoint agents if they have sufficient competency.
 2. Certain persons may not serve as agents: the operator, administrator or employee of the patient's hospital, or the attending physician.
 3. An alternate agent may be named.
 4. The rights and duties of the agent are set forth. The agent's scope of authority and decision making standards are described.
 5. The agent is expressly provided the right to receive medical information.
 6. The procedure for making the decision that the principal (the appointor) lacks capacity to make health care decisions is defined and described.
 7. Health care providers would be required to ask patients at the time of admission if they have a health care proxy. If the provider is provided a copy of the proxy, it must be inserted in the patient's medical records.
 8. Immunity is expressly provided for the health care provider and the agent for the good faith carrying out or making of health care decisions.
 9. Hospitals with adult residents are required to educate and provide information to adult residents about the health care proxy.
 10. The Department of Health and Social Services is required to publicize the health care proxy law by issuing a summary statement and the Department shall require distribution of the statement to hospital patients and staff.
- Many Delawareans do not know their rights and options which can be exercised to plan for disability and death. Governments and health care providers are just beginning to formulate policies about the issues of artificial nutrition, hydration and other artificial life sustaining measures. It is the tragedies of people like Arnold Shumotic that make citizens, private institutions, and government aware of the limitation on or lack of remedies. Everyone engaged in health care must act now to minimize the sorrow of an individual artificially entangled between life and death.

Summary of Delaware Death with Dignity Act 16 Del. C. S2501 et seq.

Features of the Act of particular interest to health care providers. Hayman, "Evolving Delaware Law on the Termination of Life-Sustaining Treatment," Del. Med. Jrl., March 1987.

1. Any competent adult has the right to refuse medical or surgical treatment, unless the refusal is contrary to existing public health laws, and may make a written declaration instructing any physician to cease or refrain from treatment if the declarant is in a terminal condition. "Terminal condition" is defined as any illness from which it is unlikely that the person can recover and which will probably lead to death, with or without life-sustaining treatment. The definition does not state how long the process of dying may take. The fact that a declarant is in a terminal condition must be confirmed in writing by two physicians.

2. Any adult may appoint a surrogate decision-maker who may accept or refuse treatment, including life-sustaining treatment, if the appointor is incapable of making the decision.

3. The attending physician, the person with primary treatment responsibility, decides that the patient is incompetent to make treatment choices.

4. Any adult person may execute a declaration directing the withholding or withdrawal of maintenance medical treatment, where the person is in a terminal condition and under such circumstances as may be set forth in the declaration. "Maintenance medical treatment" does not include medication or palliative treatment, but does include any artificial method of sustaining a vital function which merely prolongs the course of dying. "Artificial means" are "manufactured or technical contrivances" which may be attached to the body.

5. The procedure for execution of a living will is similar to that for a testamentary will; however, neither of the two witnesses of the living will should be financially responsible for the patient's medical care nor be an employee of the health care facility where the declarant is a patient. Moreover, if the declarant is a

resident of a long-term care facility, the Department of Aging and the Public Guardian have oversight, and at least one witness must be a patient advocate or ombudsman.

6. A living will is ineffective during a patient's pregnancy.

7. A living will is freely revocable.

8. A physician may presume, lacking actual notice otherwise, that the living will was executed by a competent person. Similarly, execution of a living will does not suggest incompetence.

9. Health care personnel are immunized from liability for withholding medical treatment in reliance on a living will.

10. Anyone with good reason to believe that termination of treatment is contrary to the current wishes of the patient may petition the Court of Chancery for appointment of a guardian for the patient.

11. A living will shall be part of a declarant's medical records.

12. Neither the execution of a living will nor the termination of treatment in accordance with a living will is considered suicide.

13. A living will may neither be required for insurance or treatment nor may it bar insurance or treatment.

14. Criminal penalties attach both for coercing the execution of a living will and for intentionally creating a false impression that a patient has authorized life-prolonging treatment.

1 For a summary of the living will law, more accurately referred to as the Delaware "Death with Dignity Act", stating features of the Act of particular interest to health care providers, see Haytman, "Evolving Delaware Law on the Termination of Life-Sustaining Treatment," Del.Med.Jrnl., March 1987, page 206. (Attached)

2 Burleigh, "The Right To Die", ABA Journal, July 1, 1988, p.p. 72, 74.

3 *Ibid*, page 75.

4 *Ibid*.

5 *Griswold v. Connecticut*, 381 U.S. 479, 85 S.Ct. 1678 (1965); *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705 (1973)

6 *Olmstead v. United States*, 277 U.S. 438, 478, 48 S.Ct. 564 (1928)

7 *McConnell v. Beverly Enterprises-Connecticut, Inc.*, 208 Conn. 692, --- A2d---, (Conn. Sup. Ct., Jan. 31, 1989)

8 *In re Conroy*, 98 N.J. 321, 321, 486 A.2d 1209, 1236 (N.J. Sup. Ct. 1985); *McConnell v. Beverly Enterprises-Connecticut, Inc.*, supra.

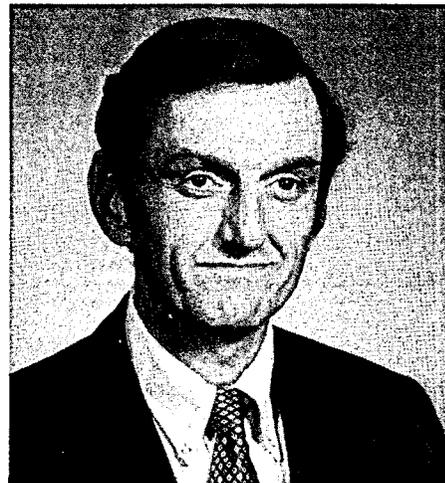
9 Burleigh, "The Right To Die", ABA Journal, July 7, 1988, page 75

10 *Ibid*.

11 *Ibid*.

12 *In the matter of Hilda M. Peter*, 529 A.2d 419 (N.J. Sup. Ct. 1987)

13 The following discussion of this combination is based on and quoted from Gilmar, "Planning for Disability," *The Practical Lawyer*, March 1989



Thomas Herlihy, III is a graduate of Dartmouth College and of the University of Virginia Law School. He has served a Deputy Attorney General, Chief Deputy Attorney General, Master, Family Court, Chairman of the Delaware Alcoholic Beverage Control Commission, a member of Court of Chancery Fiduciary Rules Committee, a member of the Delaware Division of Aging Committee on Death with Dignity/Living Wills, and as a member of the Delaware Bar Association Committee on Law and the Elderly. His previous article, "The Impetus of a Tragedy", 1983 and "Before It's Too Late, Incompetency, Guardianships, Durable Powers of Attorney, and the Next Step", 1985 appeared in this magazine.

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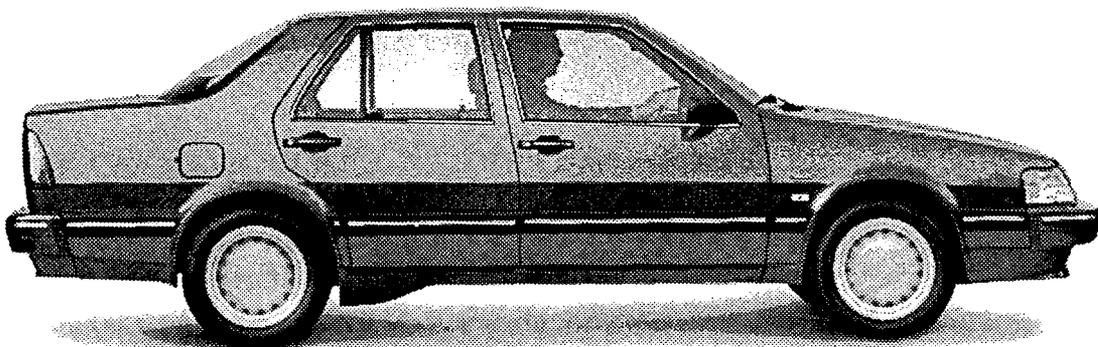
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CIVIL ASPECTS OF PATIENT ABUSE

Ann Woolfolk

I. Abuse as it occurs in long term care facilities. Imagine the following scenario¹:

Francis, age 78, has lived his whole life in Magnolia, Delaware. He has lived in the same house for 15 years. He is not much of a housekeeper, and since his wife died 12 years ago, his house has not exactly been a candidate for a spread in *Good Housekeeping* magazine. Nonetheless, he is happy and stays busy. An avid bicyclist, he spends as many as four hours a day cycling around Magnolia and vicinity. At least he did.

While bicycling early this spring, Francis was hit by a car. Although he was not severely injured, he had to be hospitalized for two weeks. He was then sent home with his leg in a cast. Since his family were concerned about his welfare, his daughter convened a family conference (without Francis) to decide how to handle the situation.

It was decided that Francis could no longer take care of himself. Furthermore the family decided that he had been unable to take care of himself before the accident, as evidenced by the reprehensible condition of his house. Since he would now be completely helpless, the answer was to put him into a nursing home.

On April 21, Francis was admitted by his daughter to "Haven", a nursing home with an excellent reputation. As Francis had reasonably large retirement benefits and owned a home worth around \$100,000, he was admitted as a private pay patient. He was opposed to his admission to Haven, but he realized that he would have difficulties taking care of himself at home, while wheelchair bound. Besides, he believed that he would be leaving the nursing home as soon as the cast was off. Soon after entering Haven, he decided that he could not wait that long.

He was not happy in a nursing home. For starters, he was accustomed to being outdoors a great deal. At Haven he was permitted to be out on the terrace for 10 minutes in the morning and 10 minutes

in the afternoon, always under the supervision of a nurse's aide. He was not permitted to go off the terrace, as the aide had to watch several other patients as well. It also upset Francis that he was not permitted to bring many of his belongings into the home. He was unaccustomed to walls stripped of pictures and dressers devoid of clutter. After spending two weeks in Haven, he'd had enough. He demanded to be discharged. No dice: his daughter had signed him in and only his daughter could sign him out. Haven notified the daughter, who refused to agree to the discharge.

Within two months, an independent and vibrant elder became a doddering, confused old man. What went wrong?

Francis decided to take matters into his own hands. He sneaked out of Haven and headed for home. He had often bicycled such a distance and knew the route well. He had wheeled himself about halfway home when the nursing home caught him. Upon his forced return to Haven, he was placed in a locked ward to prevent his "wandering off" again. The only locked ward at Haven was for those afflicted with Alzheimer's disease, but Francis was placed there anyway. He first grew desperate and then belligerent.

After labeling Francis "combative", a Haven physician administered sedatives to protect both him and the other patients. His arms were restrained to the wheelchair. Within days he became "compliant". In his drug-induced state he no longer objected to remaining at Haven, or, for that matter, to anything else. Although within two weeks of his placement on the locked ward his cast was removed, Francis did not get out of his wheelchair. Haven's physical therapist determined that therapy would not help. His muscles had atrophied beyond repair. Therapy was discontinued.

Francis's retirement benefits were insufficient to pay for the full cost of his care at Haven, and in order for him to remain at Haven, his house had to be

sold. His daughter petitioned the Court of Chancery for her appointment as the guardian of her father's property. The Haven physician executed an affidavit stating that Francis was unable to manage his property. A court appointed guardian ad litem investigated his condition for 15 minutes and concluded that he did indeed need a guardian of his property. Francis's daughter was appointed guardian and authorized to sell his home.

Within two months, an independent and vibrant elder became a doddering, confused old man. What went wrong?

As lawyers we ask: were any laws violated, and, if so, could those violations have been prevented? The answer to both questions is *yes*.

The Long Term Care Ombudsman (LTCO) program is empowered under both state and federal law to investigate the abuse of residents in long term care facilities. 16 *Del. C.* Section 1134, 42 U.S.C. Section 1396(q). The LTCO program is also charged with correcting violations of the rights of patients in long term care facilities. 16 *Del. C.* Section 1125, 42 U.S.C. Section 3027.

Recent changes in federal law reflect the growing importance that we as a nation attach to the rights of residents in long term care facilities. In 1987, the Congress amended the Older Americans Act, 42 U.S.C. ch. 35, to increase the provisions for investigating complaints by or on the behalf of long term care facility residents. 42 U.S.C. Section 3027(a)(12). In 1987, the Congress enacted the Omnibus Budget Reconciliation Act (OBRA), which recognizes a comprehensive list of patients' rights. 42 U.S.C. Section 1395i-3 (recipients of Medicare funds, eff. date 10-1-90), 42 U.S.C. Section 1396r (recipients of Medicaid funds, eff. date 10/1/90). The view that patients in long term care facilities are entitled to more than the right not be abused in their own homes has been given legislative underpinnings.

OBRA confirms the long term care facility resident's right to choose his own

physician, to freedom from restraints except where necessary for his safety or that of others and medically prescribed, to privacy, to confidentiality, to the reasonable accommodations of his needs, to voicing grievances, to participating in groups and activities, to reviewing inspection results, and to remaining in the facility absent certain narrow circumstances. Moreover, the resident is to receive notice of his rights and the facility is charged not only with respecting and protecting his rights, but promoting them. Claims can arise when the facility intentionally violates the rights of residents and when it inappropriately restricts them as a matter of administrative convenience. For example, OBRA would prohibit intubating a resident simply because feeding by mouth is too time-consuming. Moreover, OBRA prohibits actions that staff or the resident's family believe, often correctly, to be in his best interests, where such action would violate his rights under OBRA. For example, OBRA would prohibit a long term care facility from permitting a resident's spouse from selecting the resident's physician, so long as the resident is competent to make that decision for himself. The Congress appears to have recognized that a long term care facility resident's sense of autonomy may contribute to his well-being no less than his physical health and integrity. The Congress has also foreseen that, to enforce this panoply of rights, the LTCO, as the investigatory body, must have the authority to give the rights meaning.

Amendments to the Older Americans Act mandate state legislation requiring that LTCOs have access to the residents of long term care facilities and their records, and making interference with that access unlawful. State law must further declare that the LTCOs are immune from suit for the good faith performance of their duties, and that retaliation or reprisals by a long term care facility against those who give information to an LTCO are prohibited. Effective enforcement of OBRA requires LTCO power to investigate the violation of a resident's rights, to punish past violations, and to prevent future ones.

The State Board of Health is the licensing authority for long term care facilities, and it has the power to suspend or revoke a license. In lieu of exercising these powers, the Board of Health may permit a facility to voluntarily cease conduct jeopardizing a license. The Board of Health may require a facility to respect

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the rights of its residents as a condition to retaining its license.

Armed now with a woefully small arsenal of legal weaponry, let us return to the scenario created at the outset to this article. What went wrong?

Was it proper for Haven to permit Francis's daughter to sign him into Haven? Probably not. Although it is the policy of nursing facilities to require a responsible party's signature for admission, it is not legal where the resident himself is competent. Moreover, it is not a sound practice from a balance of power standpoint. It removes the decision making ability from the resident and vests the ability where it does not belong, thereby sowing the seeds for future rights violations. For example here, Haven relied upon consent by his daughter to deny Francis the right to leave when he wanted and freedom of choice in matters of care and treatment. Haven personnel could have discussed with Francis such legal devices as a durable power of attorney or a "living will". Both are statutory methods of addressing the problem of subsequent incompetency. 12 Del. C. Ch. 49, 16 Del. C. Ch. 25. As for those patients who are incompetent before they are admitted, Haven could discuss a guardianship proceeding with family members.

Was it a reasonable accommodation of needs to refuse to permit Francis to sit outside on the terrace at Haven? Clearly not. Haven has a legitimate interest in protecting its residents from injuring themselves, but if a resident like Francis can understand the dangers inherent in sitting on a terrace, Haven goes beyond its need to protect itself and violates his rights in denying him the use of the terrace. It is not enough to say that Haven has insufficient staffing for a nurse's aide to sit with Francis. He was fully able to sit on the terrace unsupervised.

Was it violative of Francis's rights for Haven to refuse to let him decorate his room as he wanted? The standard here is reasonableness under the patient's rights law of Delaware. If Francis was seeking to recreate the clutter of his own home, Haven was entitled to prevent it. If Francis wanted to surround himself with a few beloved possessions reminiscent of home, Haven was acting illegally when it thwarted this desire.

Did Haven have the authority to keep Francis in Haven against his will? Of course not. Haven should not have accepted the consent from his daughter. That acceptance simply muddied the waters by suggesting that someone other

than Francis was qualified to decide where he must live.

Upon returning Francis to Haven, was Haven acting within its rights in placing Francis in the locked ward for Alzheimer's patients? No. Such physical restraint had no bearing on his medical needs. The same is true of Haven's administration of sedatives and arm restraints.

Was Haven's cessation of physical therapy services to Francis legal? No. Haven was required under OBRA to provide physical therapy services "to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;" 42 U.S.C. Secs. 1395i-3(b)(2), 1396r(b)(4)(A)(i).

So much for Haven. But what about older folks who do not reside in long term care facilities? Do they have rights? Imagine now this scenario².

Virginia and her husband had done pretty well for themselves. Through good management and careful spending, they had managed to put two children through college and saved a nice nest egg for their retirement. Unfortunately, Virginia's husband had not lived long enough to enjoy his golden years. He died in 1965 at age 63. For the 20 years after his death, Virginia lived at the family home with the younger of her children, a son. The son, a licensed stockbroker has lost several jobs. Nonetheless, Virginia loved him and wanted to do all she could for him. She named him the major beneficiary under her will and maintained all of her funds in a jointly held bank account.

We must begin our treatment of the elderly with the premise that each is entitled to the respect accorded to anyone who has attained the age of majority.

After 20 good years of living with her son, Virginia developed Alzheimer's disease, which gradually eroded her ability to think and act for herself. Over the next several years, her condition deteriorated to the point where she was unable to bathe herself and cook for herself. Virginia's son did what he could but he was unable to care for her. Virginia began to wander along Route 13 in Dover, and was almost hit by a car several times before neighbors convinced the son that he had to do something.

A private nursing home was out of the question. It seems that Virginia's son had lost jobs because of a gambling problem. Worse yet, he had gambled away the jointly held assets on a risky real estate

venture, which had failed. Virginia received a monthly pension check, but the pension checks, coupled with her social security payments, were too small to pay for care in a nursing facility, but too large to enable her to qualify for Medicaid. Virginia's son could make arrangements to sell her house and apply the proceeds for her care, but he had himself to worry about. Now 60 years old, he was concerned about his ability to support himself without the benefit of Virginia's income. A public nursing home was also unsatisfactory. He did not want his mother to become a public charge.

The solution: Virginia's son locked Virginia in her bedroom to prevent her from wandering. When she began smearing fecal matter all over the bedroom furniture, the son restrained her. She lost interest in eating and began to lose weight. Her mental and physical health continued to deteriorate until at last her son became so concerned that he called an ambulance to have her taken to the hospital.

Again, were any laws broken? Could anything have been done to prevent the violations? The answer to both questions is yes.

II. Abuse as it occurs in other placements

The State provides a comprehensive scheme for the detection and elimination of abusive conduct when it occurs in a long term care facility. Both state and federal authorities conduct regular inspections to ensure compliance with all state and federal statutes and regulations. But abuse that occurs outside of a long term care facility is more difficult both to uncover and to prevent. Because there is no licensure of the living situations of elderly people residing outside of long term care facilities, there is no reliable mechanism for monitoring their care. Moreover, that an elderly person lives outside a nursing home is no guarantee that he is better able to protect against abuse than a long term care facility resident. Often elderly people who live with their families or alone are no better equipped physically or psychologically than long term care facility residents to fend off those who seek to abuse them. Nonetheless, such placements are not entirely uncontrolled.

Adult Protective Services (APS) is charged with providing protective services for adults who are impaired, abused, or unable to adequately care for themselves. The rights of adults in need

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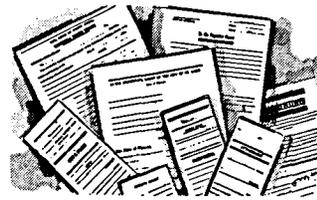
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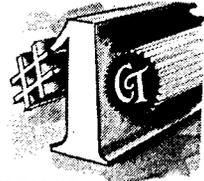


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of protective services due to abuse do not arise under 16 *Del. C. Sec. 1121* and OBRA. In these cases the abusers are not licensed facilities or their employees, but usually the elderly person's family or friends. Nor does the terminology commonly include the words "abuse" or "neglect"; the inquiry is whether an elderly person is being "exploited".

APS deals exclusively with impaired adults. It is a statutory requirement that an adult be "substantially impaired" before APS can provide protective services. 31 *Del. C. Sec. 3904*. An adult is impaired when unable to adequately care for himself and is entitled to services when faced with problems he cannot resolve. Quite clearly, the abuse of an elderly person would entitle him to protective services.

Abuse of an elderly person is by no means exclusively physical. As often as APS investigates complaints of physical abuse, it investigates complaints of financial and psychological abuse. Physical abuse ranges from actual beatings to the inappropriate use of restraints to prevent an impaired adult from removing a diaper.

Financial abuse appears to occur most often where the impaired adult gives family members joint or full legal title to his assets. For example, a family member may divert the pension and public assistance benefits of an impaired adult for his own use, leaving the impaired adult with no means of support. There is likely to be a durable power of attorney in this scenario. This perfectly legal and often advisable method of conducting financial affairs can be twisted into a means of abuse, which generally cannot be prevented by the impaired adult or a party acting on the impaired adult's behalf.

Psychological abuse occurs where the impaired adult is subjected to threats ("If you don't behave, I'll put you in a nursing home") or to ridicule ("Can't you eat without covering yourself with food?").

When confronted with situations like these, APS has several options. A case of serious abuse can be referred to the Department of Justice for prosecution. If APS believes that the impaired adult is likely to suffer immediate and irreparable injury or death if not removed from the abusive environment, it has the statutory authority to enter the environment, remove the impaired adult, and seek a judicial approval afterwards. Where possible, APS prefers not to use this authority, an extremely in-

trusive form of intervention.

Where the abuse is more serious but not life-threatening, and mediation is not successful, APS may nonetheless act to remove the impaired adult, but not through an extra judicial proceeding. APS may petition the Court of Chancery for an order for protective services, including removal of the impaired adult, or petition the Court to appoint the Public Guardian or another as the impaired adult's guardian. In either of these cases, APS strives to give the parties affected, including the impaired adult and his family, notice of the proceeding. APS may seek a guardianship of the person in the case of physical or psychological abuse, a guardian of the property in the case of financial abuse, or both.

Generally, such severe cases of abuse are not the types of abuse for which APS receives complaints. It is far more likely that APS will uncover abuse akin to violations of a long term care facility resident's statutory rights and better handled through means other than criminal sanctions.

APS views its role in cases analogous to the violation of a long term care facility resident's rights as very similar to the role of a long term care ombudsman. The APS worker attempts to educate and mediate the conflict between the impaired adult and the friend or family member who is perpetrating the abuse. This is most often successful when the perpetrator is not intentionally inflicting harm but believes that he is acting in the best interests of the impaired adult. For example, a family may be taught that an impaired person can be prevented from removing his diaper by placing mittens on the impaired adult's hands rather than tying his hands to the side of the bed. Often APS can enable the impaired adult to retain aspects of his autonomy that would otherwise be lost, where the perpetrator, though sometimes well-meaning, has stripped the impaired adult of his sense of control over his life. APS believes that the retention of control arrests, and can even reverse, the deterioration of impaired adults.

Having learned the rudiments of the law of Adult Protective Services, maybe we can determine how Virginia's life could have gone so awry.

There is no doubt that Virginia is impaired and entitled to protective services.

APS investigates upon the receipt of a complaint and may not enter a home unless there is probable cause of death or immediate and irreparable physical in-

jury. 31 *Del. C. Sec. 3906*. However, Virginia's predicament would only have come to APS's attention after the damage was done, after Virginia was in serious shape both physically and financially. Notification by the health facility after Virginia's son had called the police limits APS to rendering remedial rather than preventative services. The neighbors who complained to Virginia's son should have notified APS of Virginia's situation pursuant to 31 *Del. C. Sec. 3910*. This would have enabled APS to try to close the barn door before the proverbial horse escaped.

Upon early notice of Virginia's need, APS could have entered the home and removed Virginia to alleviate the physical abuse. APS could have moved to prevent Virginia's son from spending Virginia's money by removing all funds from the jointly held bank accounts. Under the scenario as written, APS is limited to trying to recover the funds, an impossible task. Once Virginia's health is restored to the extent possible, APS can assist in helping to find her a suitable placement.

The accounts presented here are frightening, but wholly realistic. Everyone will agree that they are morally and socially wrong. But they are not aberrations and the laws to prevent them are in place. Why do they occur?

Before any law can be effective, it must comport with the attitudes of those subject to it. Accordingly we must reassess our attitudes about the elderly. We must abandon the paternalistic notion that the elderly, simply because of advanced age, can no longer make decisions in their own interest. We must begin our treatment of the elderly with the premise that each is entitled to the respect accorded to anyone who has attained the age of majority, and revise that premise only upon reliable evidence that an elderly adult needs special care.

Second, we must rearrange the hierarchy of our values accordingly. Having adopted the premise that every adult has the right to be treated as an adult, not a child, we must determine that right is more important than administrative convenience. We must demand that facilities adjust their organizational schemes to their residents' needs, not vice versa. And we must treat the abuse of an elderly person by his family as just that, not as a mere family affair.

Once we adjust our attitudes and priorities to comport with OBRA and state law, we can begin to recognize the worth of our elderly and to accord them

the respect they deserve. The grim and cautionary accounts above must become aberrations, not routine occurrences. Let us expedite change.

¹Based on fact, this scenario is a composite of incidents reported to have happened to residents of nursing facilities.

²This scenario, like the first, is a collection of facts from Adult Protective Services cases.

Ann Woolfolk, who serves in the Department of Justice, Civil Division, is Counsel to the Department of Health and Social Services. She is a graduate of the University of Delaware and the Villanova University School of Law. She is an active member of the Delaware State Bar Association Committee on Law and the Elderly.

(Continued from page 40)

tributed from the trust would be subject to the throwback rules. Also, a trust must make estimated tax payments.

Whether these tax characteristics of a trust would be detrimental would depend on an analysis of the particular estate plan and other factors. During lifetime, however, there should be no disadvantages.

In summary, a living trust (with supporting durable power of attorney) can provide significant benefits and flexibility in planning for disability. It can meet a person's needs - during good health and disability - and those of his family, provided, of course, that we - unlike the ostrich - inform ourselves and act.



Wilmington attorney John A. Herdeg is engaged in private practice, with a primary emphasis on estate planning. A graduate of Princeton University with a law degree from the University of Pennsylvania, he was with Wilmington Trust Company for a number of years, serving as head of the Trust Department and chairman of the Trust Committee of the Board of Directors.



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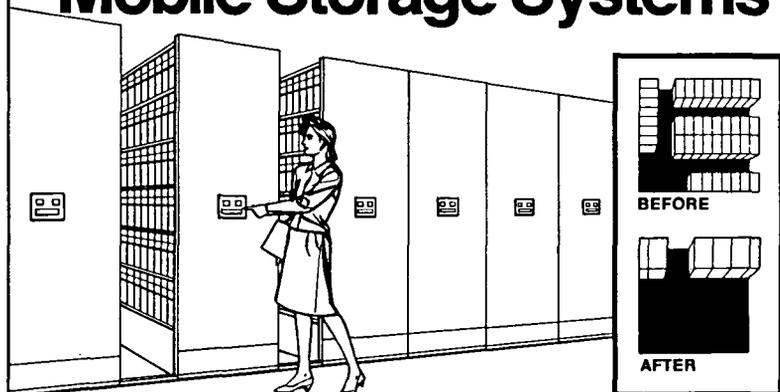
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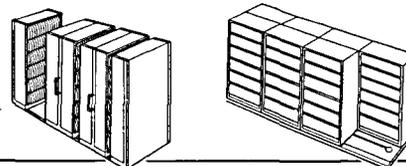
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Gail Riblett Robm

The choice is not just black and white anymore. It's not just home or nursing home. As the needs of the aging population in Delaware diversify, so do the attempts to meet those needs. And that means more choices, more decisions to make, and more people making those decisions.

Families, neighbors, and social agencies must often address an older person's declining capabilities for self-care. Perhaps a spouse has died, perhaps a care-giver can no longer provide, or perhaps the elder person is no longer able to do the things he once could do for himself. When that decline affects "ADLs" (the activities of daily living) such as diet, mobility, bathing, dressing, attention will be drawn to the older person. When his capacity for adequate self-care cannot be quickly restored, it is time to provide services.

One approach is to take the elder person to a service site. The other brings the services to him. We shall explore the second option first, since this often will allow the client to remain in his own home, while receiving needed services.

Home health aides and homemakers may be hired privately or through any of the several nursing service agencies. Both home health aides and homemakers help clients with their ADLs. Typically a homemaker will engage in limited "home-related" activities, such as marketing and light housework, while home health aides often concentrate more on the medically-related concerns. The cost of private home health care is, however, often prohibitive for many fixed-income elderly. The hourly agency rates are around \$10.00. Generally Medicare will pay for home health care with intermittent skilled care (visits by a licensed nurse, physical therapy, or speech therapy) at home under certain limitations: the patient must be confined to

home and his physician must design a care plan to be followed by a Medicare-approved provider. This does not allow for full-time care, meals, or homemaker services. As of January 1990, Medicare is scheduled to allow doctor-ordered home health care up to six days weekly.

The State of Delaware (Department of Health and Social Services) contracts each year with nursing agencies for homemaker services to allow the elderly to remain in their own homes while they recuperate from illness or injury. There are contracts with Geriatric Services (all counties), Quality Care (Kent, Sussex), Sussex County Senior Services, Upjohn (New Castle), VNA (all counties), and Medical Personnel Pool (New Castle, Kent). These services concentrate on non-nursing care, including ADL assistance, meal preparation, light housekeeping, laundry, and shopping. Homemaker services complement Medicare home health aide services.

Two other programs offer in-home services to the elderly in Delaware, but only under the special circumstances of respite care and hospice care.

Respite services are available for temporary relief to a care-giver. The Medicare hospice program allows short-term in-patient stays (maximum 5 days) to give a care-giver a breather before resuming care of a terminally ill patient at home. Medicare is planning a new home respite care benefit to begin in January, 1990. It will pay for the temporary services of a home health aide to relieve the care-giver of a Medicare beneficiary who requires assistance with ADLs. The plan will provide for up to eighty hours a year of home health care, nursing care by an LPN, and personal care services.

The State of Delaware has also recognized the need for respite services. In 1986 it made state funds available to

Quality Care to permit "time-out" for primary caretakers of impaired elders. In 1989, the state contracted with United Cerebral Palsy to furnish in-home visits of 3-5 hours for counseling, case management, and carrying out planned activities.

In-home care through hospice programs. Medicare hospital insurance (Part A) will cover hospice care if the patient's doctor certifies that the patient is terminally ill, if the patient chooses the special hospice benefits instead of the standard Medicare benefits, and if the care is provided by a Medicare-approved provider. Services include nursing, doctor care, medicines, physical therapy, home health aides, supplies, and counseling. The goal of the program is to relieve pain and to manage the symptoms of terminal illness, as to be distinguished from rehabilitative care. Services are available only for brief periods, usually 90 days or less.

These types of "special circumstances" home care are of very limited duration and for special situations. Hospice care is only for terminally ill patients at home, and respite care is only a temporary "time-out" for care givers. Despite their limited application, however, these services allow many of Delaware's elderly to stay at home, where they might be otherwise institutionalized. Where the special circumstances apply, hospice and respite services are invaluable in maintaining home-oriented care.

In addition to health care related services designed to permit an elderly Delawarean to remain at home, there are other means of achieving the same goal.

Senior centers offer both social and nutritional benefits. Participants can catch the "center bus" and enjoy three to four hours a day of reality orientation, socialization, health screening, and

planned activities that will sometimes delay the onset of dementia or social withdrawal. Delaware's first senior center designed to meet the needs of elderly mentally retarded clients opened recently in Milford, perhaps signaling a trend for senior centers to specialize.

The nutrition programs reach out from the centers, too. The State of Delaware allows senior centers to provide hot meals to SSI recipients or low-income homebound clients who are unable to prepare meals for themselves or who have no one available to help them with meals. These services are provided by St. Anthony's Senior Center (City of Wilmington), Geriatric Services (New Castle County), Modern Maturity Center (Kent County), and Sussex County Senior Services. These nutrition programs, often referred to by the community as "Meals on Wheels", depend upon a large network of volunteers to get meals for the elderly to the far reaches of the state.

Adult day care offers another type of program that the elderly may attend while maintaining their own homes. Adult day care centers offer more intensive care than is available at senior centers. There are more staff and more

(Continued on page 37)

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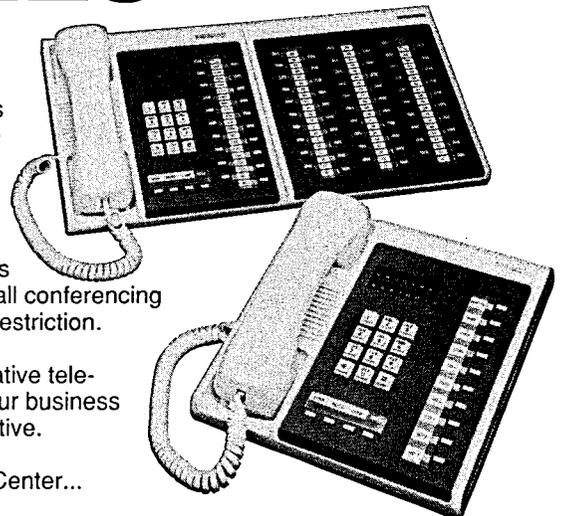
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MEDICARE - AFTER THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

Susan R. Weimer

Medicare, which is a federal health insurance program, primarily covers those 65 years old and older, who have paid into the Social Security retirement system during their lifetimes. Recently Medicare was studied by Congress with an eye toward expanding coverage for catastrophic care. The Reagan Administration and the 100th Congress put together legislation in 1988 to increase benefits, with senior citizens footing the bill through increased premium and tax liability. The law signed by President Reagan in July of 1988 is referred to as the MCCA, the Medicare Catastrophic Coverage Act of 1988. (P.L. 100-360, found at 42 USC Section 1395 through 1395xx and in 42 C.F.R., Parts 405 through 409.)

The MCCA does not change the basic eligibility criteria for participation in the Medicare program. Essentially, anyone 65 years old or older is eligible for Medicare coverage if he is entitled to either Social Security or Railroad Retirement benefits. The insurance program is divided into Part A, often referred to as hospital insurance, and Part B, basic medical insurance. Within coverage rules, Medicare Part A pays for inpatient hospital care, skilled nursing home care, some home health care, and hospice services. No monthly premium is paid by the beneficiary for Medicare Part A. Medicare Part B covers approved physician care, diagnostic tests and x-rays, medical equipment, prosthetic devices, and ambulance service. Part B does *not* cover routine physical exams, dental care, eyeglasses, or hearing aids.

Under the MCCA, effective January, 1989, a Medicare beneficiary will pay one deductible of \$564 each year for covered inpatient hospital services in that year. The "spell of illness" rule previously used to determine benefit periods, and daily co-payments for extended hospital care were eliminated by the new law. Therefore, the number of days per year of hospital care that can potentially be covered is now unlimited. While

this purported expansion in coverage sounds great, it is estimated that only 3.7 percent of all Medicare participants will enjoy its benefits each year. The average hospital stay for Medicare patients is only eight days.

Many older persons fear that they will require expensive nursing home care, impoverishing them and their families. The MCCA will not provide relief to those who desperately need financial assistance for chronic catastrophic illness such as Alzheimer's disease. Only skilled nursing home care has ever been covered by Medicare. The new law does not change this criterion for coverage.

The MCCA eliminated a covered period of hospitalization immediately prior to placement in a nursing home as a necessary precondition to nursing home coverage. The law also provides for a maximum of 150 days coverage per year for nursing home care. Beneficiaries must copay \$25.50 per day from day 1 to day 8 of the stay. However, it appears that few nursing home patients will benefit from these changes to expand nursing home coverage. Because of the restrictive rules applied in determining whether a nursing home patient will receive Medicare coverage, most beneficiaries actually receive less than 20 days of coverage.

The MCCA expands Medicare Part A coverage for home health care and hospice care. The preconditions to coverage are not significantly altered, but the number of days of potential coverage is increased. Effective January 1, 1990, up to 6 days per week of intermittent home health care and up to 38 consecutive days of daily home health care will be covered without any copayment by the beneficiary. A qualified beneficiary can receive coverage for an unlimited number of days of hospice care.

Medicare Part B coverage will expand in 1990. The basic premise that Medicare pays only reasonable and necessary charges remains, meaning that

Medicare will continue to pay less than is expected by most Medicare beneficiaries. Under Medicare Part B, the insurance pays 80% of *approved* service charges and the beneficiary pays the remaining 20% of charges. Part B is a voluntary component of the Medicare program whereby the beneficiary pays monthly premiums for coverage. These premiums will increase each year to pay for the new catastrophic coverage.

The supplemental premium is in reality a surtax paid by those eligible for Medicare who have taxable income. As a result, working taxpayers 65 and older will be subject to the supplemental premium even if they have not applied for nor received Medicare Part A benefits.

One new facet to Medicare coverage under Part B is a cap on out-of-pocket costs, to be \$1,370 per year in 1990, but costs to the beneficiary for noncovered services and charges will not count toward the cap. Accordingly, during 1990 a beneficiary will have to accrue \$6,850 in allowed medical expense before the cap would be reached. When Congress set up the financing mechanisms for the cap on Part B expenses it was estimated that about 7% of Medicare beneficiaries would benefit from the cap each year.

Other changes to Part B coverage under the MCCA include home IV drug therapy and prescription drugs. By 1991 prescription drugs will be covered after the beneficiary pays a \$600 deductible. The copayment will then be 50 percent. In the ensuing years the yearly deductible will increase, while the required copayment per prescription will decrease. Projections are that only about 16.8 percent of Medicare beneficiaries will reap any benefit from these changes in the program.

In designing the MCCA, Congress projected how many participants in the Medicare program would benefit from

expansions in coverage so that adequate financing provisions could be included in the law. Proponents of the legislation realized that, if the costs of expanded coverage were financed by an increase in taxes for all taxpayers, the bill would never become law. Consequently in the law as it was enacted, older taxpayers and Medicare beneficiaries bear the full cost of financing catastrophic coverage under the MCCA.

The first financing mechanism that applies to all older persons who choose Medicare Part B coverage is the addition of a flat amount to the monthly Part B premium, which will increase yearly. In 1989, for example, a flat premium of \$4 is added to the monthly premium of \$27.90. Those participating in Medicare Part B pay \$31.90 per month this year for coverage, which is deducted from their Social Security checks. By 1993 the flat premium amount will have increased to \$10.20. Even if the monthly premium rate remains at \$27.90, the increasing flat premium will devour ever more of the monthly Social Security check.

The most controversial aspect of the MCCA is the financing mechanism created to pick up the costs of catastrophic care under Medicare Part A. The supplemental premium, as it is called, is in reality a surtax paid by those eligible for Medicare who have taxable income. Anyone eligible to receive Medicare Part A for more than six full months during the tax year is subject to this premium. As a result, working taxpayers 65 and older will be subject to the supplemental premium even if they have not applied for nor received Medicare Part A benefits.

Medicare Part A eligible taxpayers who have an adjusted income tax liability of \$150 or more will be liable for the new supplemental premium in 1990. The tax rate per \$150 of tax liability of \$22.50 in 1989. The maximum premium per person this year is \$800, increasing to \$1050 by 1993.

The new supplemental premium is collected by the IRS together with federal income tax. Tables for computation of the premium are found in IRS Publication 934, "Supplemental Medicare Premium". The premium is treated as if it were income tax for purposes of estimated tax payments and collection. The tax is not deductible as an itemized deduction, medical expense, or tax paid.

Certain inequities become apparent in analyzing application of this tax to older Medicare eligible persons. First,

some who work will pay hefty supplemental premiums for Medicare benefits they will not receive, because their employers provide private health

Irate groups of the elderly are already lobbying for change.

coverage. Those with tax exempt investment income will pay smaller premiums than those who have equal amounts of taxable income. Single individuals, such as older widows, with taxable income will shoulder a greater burden under the law than married couples. It is too early to know whether changes will be made in the MCCA's financing of new expansions in Medicare coverage, but it is already apparent that some irate groups of the elderly are lobbying for change.

The government was required to send a notice by January 31, 1989 to all Medicare participants explaining benefits, copayments, and deductibles under the new law. Private insurance companies must also send notices to their Medigap policy holders explaining the impact of the MCCA on their insurance. The MCCA mandated review and implementation of state regulations concerning Medigap policies, in an effort to establish minimum benefit

standards, and rid these policies of duplicative coverage.

Other aspects of the Medicare program were altered by the MCCA. Only the highlights substantially affecting older persons have been discussed here. Statistics, projections, and other information used in this article were obtained from materials published by Legal Counsel for the Elderly and the National Senior Citizens Law Center. A recent article that was particularly useful, and should be of interest to Medicare advocates, is "Financing Expanded Medicare Benefits Under the Medicare Catastrophic Coverage Act of 1988", by Sally Hart Wilson, of the National Senior Citizens Law Center, Clearinghouse Review, Volume 22, No. 11, April, 1989, pp 1393-1400.

Sue Weimer, a graduate of Dickinson College and the Antioch School of Law is admitted to practice in Delaware and Pennsylvania. She is the Project Director/Attorney of the Senior Citizens Legal Assistance Program of Community Legal Aid Society, Inc. She is also an active member of the Delaware State Bar Association Standing Committee on Law and the Elderly.

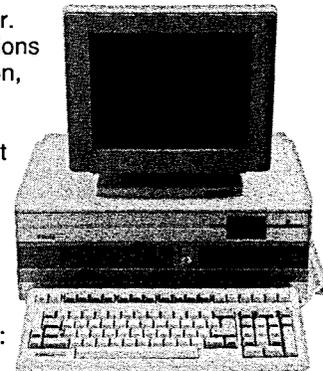
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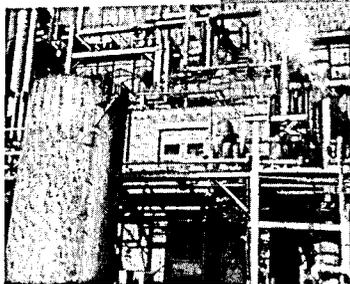
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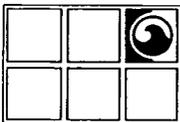
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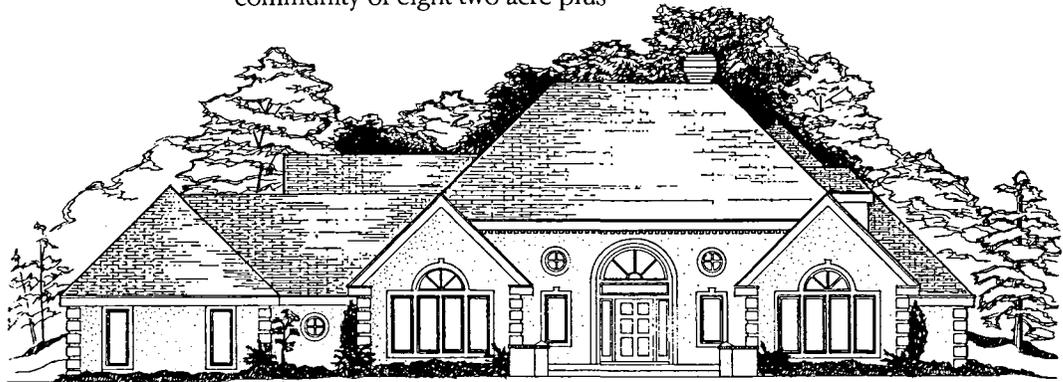
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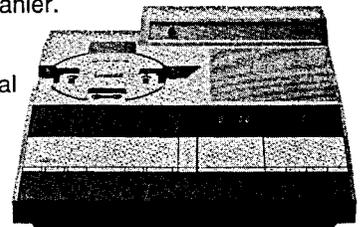
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RESTRICTIONS V. RIGHTS DISABILITY V. DIGNITY

The Long-Term Care Ombudsman Program

Marietta Z. Wooleyhan

A nursing home or other type of long-term care (LTC) facility is an artificial community inhabited by those who have no other options for a home. They experience the loss of autonomy and control of life, both psychologically and physically, as such basic decisions about what and when to eat, when to get up and go to bed, whom to associate with, and in some cases, what to wear, are made by the facility. A major issue facing the long-term care system is the need to protect the rights and dignity of those who live in these closed communities within the context of communal structure and rules. It is not a new issue. Laws and regulations for improving and strengthening residents' rights can be traced back to the recommendations of the 1961 White House Conference on Aging. Subsequently the Older American's Act (OAA) established the Long-Term Care Ombudsman Program headed by the State Long-Term Care Ombudsman, who is an independent, impartial mediator responsible for investigating abuses of residents' rights.

For more than a decade, the Ombudsman Program in Delaware has been working to ensure quality of care and life for nursing home residents, responding to their complaints and problems, and protecting their rights. The Ombudsman is a voice for those who have difficulty advocating their own cause.

In 1976 the Administration on Aging (AOA) observed, "The individual in the nursing home is powerless. If the laws and regulations are not being applied to her or to him, they might just as well not have been passed." This is the rationale for the Long-Term Care Ombudsman program.

The program has expanded over the years as stronger laws, regulations, and recommendations addressing patient rights have been promulgated. It is worth noting that industry response has been supportive.

Current Delaware law and regulations are based on Federal Resident Rights laws and regulations. The Omnibus Budget Reconciliation Act of 1987 (OBRA), P.L. 100-203, clearly spells out nursing home resident rights.

We must examine our attitudes about the intrinsic worth of long-term care residents and work to preserve individual autonomy at any age. We must work for home-like long-term care facilities where residents are respected and treated with full recognition of their dignity and individuality. We must better educate the community and enact laws with more stringent penalties for violation of residents' rights. We must secure those improvements for present long-term care residents, as well as for those of ourselves who will eventually come into the long-term care system.

The laws are clear about those rights: to be treated with dignity and individuality, to participate in the planning of medical treatment, to refuse treatment, to be free from abuse and restraint, to associate and communicate, to be assured of privacy, respect, and confidentiality of medical records, to be protected from inappropriate transfer and/or discharge, to manage one's own financial affairs, and to voice grievances. (Delaware Code Chapter 11, Subchapter 11.) LTC residents are becoming more aware of their right to assert grievances.

Complaints received and investigated by the Long-Term Care Ombudsman Program

1982 - 172
1983 - 285
1984 - 315
1985 - 328
1986 - 427
1987 - 700
1988 - 977

What type of problems are presented by the Long-Term Care Ombudsman Program? Here are some examples of those most frequently heard:

"Where are my things? I just came back from lunch and my room has been stripped." — "We need your room for a new resident so we moved your belongings to a new room."

"The TV goes off at 11:00 p.m. You need your rest."

"Your bath time is scheduled for 5:00 a.m. Monday, Wednesday, and Friday." (Long-Term Care Ombudsman Program received a complaint about a patient refusing to be bathed.)

"Do it in your diaper. I'm on break." (In response to a request for toileting.)

Responsible party forbids parent to be visited by other siblings against resident's wishes. The nursing home complies with responsible party's request.

"Why don't they tell these people we don't have room for all this junk." (Welcome for a new resident with all his belongings in two large plastic bags.)

"If she doesn't eat, we will have to tube feed her." (Resident unable to sign a living will, but family wants to

respect her life long wish not to be "kept alive".)

The food is not cooked properly. Meat too tough to chew, juice and milk watered down, no substitute meal offered, food cold.

"You can't expect to keep a radio safely in your room." (Many complaints of theft.)

"The individual in the nursing home is powerless. If the laws and regulations are not being applied to her or to him, they might just as well not have been passed." This is the rationale for the Long-Term Care Ombudsman program.

Complaints are varied. The Ombudsman must investigate, verify, and attempt to resolve the problems. Although use of the facility "in house" complaint resolution mechanism is the optimal route, many complainants are reluctant to make their problems known to the facility because of fear of retribution. In most cases this fear is unfounded, but unfortunately at times it is not. The Ombudsman is mandated to protect confidentiality.

Analysis of data relating to complaints and conditions in long-term care facilities enables the Ombudsman to identify problems for residents, and recommend to the proper agencies, committees, and Boards, changes in the system to benefit the institutionalized.

The Long-Term Care Ombudsman Program also provides information to the community about the long-term care system through speaking engagements, telephone inquiries, and referrals. The goal is an increased community role in the long-term care system.

The Ombudsman works with the facilities as an advocate, not an adversary. Ombudsmen are available to mediate resident/family/staff problems and to work with facility administration on policies that affect the quality of life for residents. A most rewarding aspect of the Ombudsman's function is providing educational programs for nursing home staff. Programs for residents

and families on patient rights and patient responsibilities are also available.

At present, the program has approximately 40 trained and supervised Volunteer Ombudsmen who give their time and caring interest to residents of nursing homes throughout the state. They are an extension of the Long-Term Care Ombudsman Program, visiting LTCs frequently as friendly visitors and enablers, helping residents to speak for themselves.

The typical resident has suffered many losses before entering a nursing home: spouse, family members,

friends, pets, income producing ability, health, etc. These losses are compounded when the right to make daily personal choices is restricted. The resident's right to exercise control of his daily life is not honored by staff in some facilities.

Marietta Wooleyhan has been Long-Term Care Ombudsman for the State of Delaware since 1981. She is a graduate of Ursuline Academy and the University of Delaware. Her previous experience includes work in a long-term care facility and in the Delaware Mental Health system.

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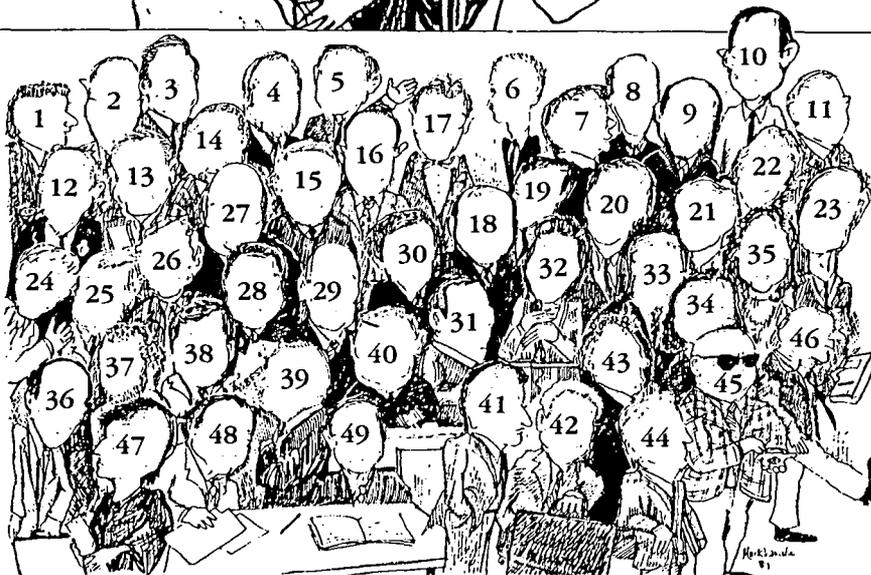
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encounter in court as they look
to caricaturist
Mark Vavala.*



*Mark Vavala
84*

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(me)

WHAT'S AVAILABLE?

THE DIVISION OF SOCIAL SERVICES LONG-TERM CARE PROGRAM

Catherine C. McMillan

Under the auspices of the Department of Health and Social Services, the Division of Social Services/Medicaid offers six long-term care services.

I. *Vendor payment coverage* in nursing facilities is currently provided for about 2100 eligibles statewide in 29 private facilities, 5 State facilities, and 10 group homes for the mentally retarded. It provides intermediate level, skilled level, and intermediate level care for the mentally retarded and intermediate level care for the mentally ill (limited to those sixty-five years of age or older).

II. *Medicaid Home and Community Based Waiver for the Elderly and Disabled* offers an alternative to institutionalization. All clients in this program receive case management services and, as needed, respite services (both in-home and institutional), medical or social adult day care, homemaker, emergency response system, and durable medical equipment, supplies, and appliances. Medicaid has served 159 clients in this program and plans to expand this program by 1994 to include up to 500 clients.

III. *"Super Skilled" vendor payment coverage in Medicaid enrolled Delaware long-term care skilled level facilities.* "Super Skilled" is a payment mechanism that allows Delaware Medicaid to pay a long-term care facility the actual cost of care for a patient who transfers to the facility from home or an acute care hospital. A patient who qualifies for this service is one whose care needs and medical condition fit the Delaware Medicaid "Super Skilled" criteria. Among other things, a patient in this payment classification would require continuous monitor-

ing and interventions by professional nursing personnel but would not require continuous physician monitoring (i.e. sub-acute in an inpatient hospital). This is an innovative service, which has allowed Delaware Medicaid to find placements for "hard to place" long-term care applicants.

IV. *Adult Foster Care* is provided to about 100 clients statewide, either in private homes or in residential sections of long-term care facilities. The Division of Social Services also processes 335 Division of Mental Retardation and Division of Alcoholism, Drug Abuse and Mental Health applicants for Supplemental Security Income supplementation. Receipt of the Supplemental Security Income benefits enables clients to purchase sheltered housing in Adult Foster Care homes. Adult Foster Care falls between independent living and an intermediate level of care in a long-term care facility.

V. *Homemaker services*, assists about 260 eligible clients each year. Services include non-nursing personal care, such as help with the activities of daily living (e.g., dressing, bathing, eating, ambulation, personal hygiene, etc.) and assistance with household duties, such as meal preparation, light housekeeping, shopping, laundry, etc. This service is intended to postpone premature institutionalization by maintaining normal household routines when a person is ill or recovering from an illness or injury.

VI. *Meals for Homebound Adults* assist clients confined to home, unable to prepare meals because of disability, and who have no others to prepare meals for them. At noon a

hot, nutritionally balanced meal is provided and a cold bag meal is provided for dinner. Special diet meals usually can be provided.

It should be noted that all services are regularly monitored for quality, effectiveness, and appropriateness. This is accomplished through the efforts of Division of Social Services/Medicaid Registered Nurses, Senior Social Worker/Case Managers and Medicaid Facility Compliance Reviewers.

Applications for these programs may be made as follows:

Vendor Payment Coverage, Home and Community Based Waiver, "Super Skilled" Vendor Payment Coverage

New Castle County - 368-6610
Kent/Sussex Counties
422-1393 (local)
1-800-435-5400 (toll free)

Adult Foster Care, Homemaker, Meals for Homebound Adults

New Castle County - 368-6610
Kent/Sussex Counties
422-1416 (local)
1-800-642-4772 (toll free)

Katie McMillan is a Chief Administrator, Medicaid Long-Term Care Services. She is also the Chair of the Division of Aging Adult Protective Services Advisory Council and a member of the Association of Delaware Hospitals, Ad Hoc Discharge Planning Advisory Committee. She serves on the Executive Council of the Delaware Developmental Disability Planning Council and as the DSS Staff Representative to the Department of Health and Social Services Five Year Long-Term Care Plan Task Force.

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THE OFFICE OF PUBLIC GUARDIAN: A HISTORY AND A PROPHECY

Barbara Blevins

The Office of Public Guardian was established by the Delaware Legislature in 1973 in response to the concerns of several social service agencies observing the needs of the elderly (12 Del. C. Section 3997). Health care and economic assistance agencies were encountering increasing numbers of elderly who were so impaired physically or mentally (or both) that they could not pay their bills or perform tasks of independent living, such as grocery shopping and house cleaning. Utilities might have been turned off for non-payment, creating health hazards. These elderly were also quite likely to have serious chronic medical problems, which required monitoring and care they were unable to secure for themselves. Taking prescribed medication might also have been beyond the scope of their capabilities because of confusion or poor memory. Furthermore, giving informed consent for medical procedures was beyond them. At times these situations were severe enough to place them at high risk because of benign self-neglect or because of their vulnerability to victimization by others. The decline in the ability to manage their own affairs usually was the result of the natural aging process or an acute illness such as stroke.

The concerned agencies formed a committee to study the problems of this frail population and to recommend solutions. Legislation to establish an Adult Protective Services program and the Office of Public Guardian was introduced. The legislature felt the complete package was too expensive and therefore enacted only the Office of Public Guardian ("OPG"), which became operational in 1974. Delaware's OPG has become nationally recognized and many states have modeled programs on it.

People who encounter the agency name for the first time most often ask, "What kind of agency is that?" I have coined the term "socio-legal" as a way of explaining it. A legal mandate in the form of a guardianship order is necessary to authorize the Public Guardian or any guardian to function in the ward's stead. The "socio" (social) is significant because, as social workers, the Public Guardian and OPG caseworkers are trained to assess a ward's needs comprehensively and to develop care plans that address all needs. We intrude as little as possible into the ward's life style, while offering the needed protection.

The statute that enacted the Office of Public Guardian is worded so as to make the Public Guardian the guardian of last resort. There are two reasons for this. First, the Public Guardian must make decisions on behalf of a ward using substituted or best judgment. Such decisions can have a tremendous impact on the ward's life. While such a decision may not be a poor one, it may not reflect the ward's wishes, life style, or values. Relatives of friends of people in need of guardians presumably have better knowledge of the proposed wards, enabling them to make decisions more attuned to what the wards would have wanted.

The second reason is the availability of only one Public Guardian with a very small staff for the whole State of Delaware. There is one full-time caseworker in New Castle County, one part-time in Kent and one part-time in Sussex. An administrative officer and an account clerk complete the staff. The small staff size limits response to the legal mandate to serve those who may need a public guardian. Massive amounts of paperwork and accounting/bookkeeping are required for proper record keep-

ing and accountability. Without computerization, all work is done manually and is very time consuming. Efforts to recruit volunteer clerical help have thus far been unsuccessful, but even a few hours a month of volunteer effort could be very helpful.

The coordinator of the Educational Surrogate Parent program is housed in the OPG under legislation enacted in 1987, but her duties deal with the educationally handicapped.

Before referring a case to the OPG, relatives (unless plainly unsuitable) should be approached about petitioning for guardianship of their family member. Family members frequently cite fear of becoming financially responsible for a ward's cost of care as the reason for declining to serve. Another reason given for not taking guardianship is the deterioration of family ties or connections and a consequent lessened feeling of responsibility for the family member. Before referring a case to the OPG, consideration should be given to whether the proposed ward could afford to purchase guardianship from a private agency or financial institution. If the resources are adequate, private guardianship services should be used.

Referrals to the Office of Public Guardian are made to the caseworker in the county where the prospective ward lives. Because of funding limitations, Kent and Sussex caseworkers are available only three days a week, which decreases the agency's ability to respond as quickly to referrals as would be desirable. While a caseworker listens to a referral, careful scrutiny must be given to whether the proposed ward is in imminent danger. If so, that must be dealt with by recourse to emergency service, such as a medical or adult protective service. Second-

ly, the caseworker must gather a great deal of information about the behavior of the proposed ward to establish that no other (and less restrictive) intervention than guardianship will suffice to protect person or property. Caseworkers then assess the degree of impairment, the environment, and the available support system. Because of the severe intrusiveness of guardianship and the limitations of personal freedoms that wards inevitably experience, public guardianship must be the last resort. If something less intrusive is available, such as a modification in the environment or the hiring of home health aides, it must be tried and found unworkable before petitioning for guardianship.

The Public Guardian must function under the same court rules as any other guardian in terms of filing procedures, accounting to the Court, and seeking Court authorization to sell assets. In addition to accountings to the Court of Chancery, the individual accounts of wards are audited by the state auditor as are state funds used by the agency. This is a second safeguard of ward's funds. The Public guardian is also bonded by the State of Delaware.

Care plans are developed for each ward as soon as possible after guardianship is granted. If the ward is to be left in his environment, the caseworker determines what support services will be needed and whether the ward can pay for them. If the home environment is not protective enough, the caseworker must decide what environment is in keeping with the needs and personality of the ward. It is an unpleasant task to tell someone that he must leave his home permanently, even if it is for his own safety, to live in an environment not of his choosing and restrictive of his freedom.

The Office of Public Guardian, when convinced that it is necessary to place a ward in a nursing home, attempts to match the personality of the ward with the home. Caseworkers visit wards in nursing homes as often as possible to stay informed of their welfare and to address problems that may develop. Guardianship of person reports are

submitted by caseworkers every six months to inform the court of major changes in the ward's situation/welfare and to request a continuation of guardianship.

Neighbors, relatives, and other agency personnel often have difficulty in realizing that some people choose not to live longer if they conclude that the quality of their lives does not warrant it. It is worth bearing in mind that the General Assembly has recognized a right of the individual to choose death over indignity when certain carefully specified conditions are met.

Once guardianship has been established, it usually continues until death. In my tenure as Public guardian only three guardianships have ended during the lifetime of the wards. Two were guardianships of wards who had shown significant improvement in their mental functioning. Regrettably, one was reestablished about a year later to give informed medical consent when further surgery was needed. The third termination occurred after the ward's assets had been used for the cost of her care. She had secured a job and was functioning much more independently and capably. She calls the caseworker to chat occasionally and seems to view the agency personnel as an important support system.

The Office of Public Guardian must advocate and protect the referee's right to be eccentric or to make choices with which others might not agree. That a person rejects amputation or chemotherapy, or lives in an unkempt, unsanitary house does not in and of itself justify guardianship. Neighbors, relatives, and other agency personnel often have difficulty in realizing that some people choose to live this way or choose not to live longer if they conclude that the quality of their lives does not warrant it. It is worth bearing in mind that the General Assembly has recognized a right of the individual to choose death over indignity when certain carefully specified conditions are met. See the Living Will Act, 16 Del. C. Section 25.

Presently, wards from Sussex County represent a disproportionately high percentage (42%) of OPG wards. Those wards living in their own homes or apartments require large amounts of direct service time from both the Public Guardian and the caseworker. The size of the county and time required to transport a ward (there is no public transportation) decrease the time available to caseworkers for accomplishing other job responsibilities. Since Sussex County is becoming a retirement haven, I feel it is inevitable that there will be an excessive increase in the demand for public guardianship services there.

Residents of Stockley Center for the Mentally Retarded in Georgetown also need guardianship services for giving informed consent to plans for medical care or behavioral treatment. Attorneys in Sussex County have been very gracious about serving "pro bono" or at reduced fees for Stockley residents. Other Delaware institutions that provide nursing home care are beginning to grapple with the need of their residents for guardianship services. Stockley and other state institutions have identified 499 residents who need guardians.

Obviously, the OPG with its present staff cannot meet this total need. The proposed budget of the agency for 1990 recommended dividing the Office geographically, creating a public guardian for Kent/Sussex Counties with clerical support and increased casework services. Unfortunately, the prospects are not too promising. This means a continued, severe limitation of guardianship services.

What is in the future of guardianship? I foresee an increase in request for guardianship, as issues relating to medical care and informed consent continue to arise. I predict that society will become increasingly complex and families more dysfunctional, creating greater demands for public guardianship. The issues, such as who will authorize tube feeding and hydration, will have to be addressed in Delaware as well as na-

tionally. Should life be maintained at all costs or only when there is "quality of life"? Should all Delawareans, unless they have clearly evidenced contrary notice, be sustained on food and water through tube feeding? (See Herlihy article elsewhere in this issue.)

Although we may debate such questions philosophically, they become very real when they affect us and the people about whom we care.

Barbara Blevins has been the Public Guardian of Delaware since former Chancellor William Marvel appointed her to that position in 1981. Her previous social work experience includes adoption studies for the Alabama Public Welfare Department and, since her arrival in Delaware in 1973 employment as a medical social work consultant. She holds degrees in Sociology and Social Work from the Universities of Mississippi and Alabama.

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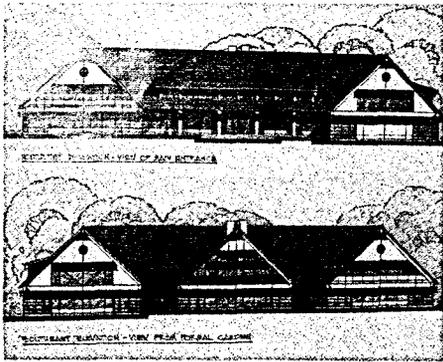
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(Continued from page 44)



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Larry Drexler, a member of the Board of Editors, practices law with the Wilmington firm of Elzufon and Associates. An increasingly regular contributor, Larry designed, commissioned, and edited the January 1989 issue on Tort Reform.

And The Verdict Is... The Radisson Hotel



The Tenth National Bank versus the people is going to be one heckuva tough case.



Indeed, *trial by fire*. Tenth National's people are flying down to work with us through the weekend.

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some place to eat, nap and work work work. *I've got a better idea, counselor. What about going the whole nine*

yards. We'll book a couple of Executive Level hotel rooms, hold our meeting in an Executive boardroom and we'll

eat off of a silver platter while we work work work. We'll do it in style. Sounds delightful, I can sure use a

change of atmosphere. But we can't justify going out of town to add comfort and luxury to work. I'm talking right here in

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attendant. You present a convincing argument counselor, but where's your supporting evidence? Haven't

you ever heard of the Radisson Hotel? The Radisson? Sure, but I thought they only... no objections counselor.

I've presented my case. And it's open and shut. So what's the verdict? The verdict is — by unanimous consent

— we're going to meet at the Radisson Hotel. Case closed.



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ENDING SPOUSAL IMPOVERISHMENT

A Nursing Home For One No Longer Means the Poor House For the Other

Judith A. Schuenemeyer

Admission to a long term care facility often is the first step on the road to poverty for the spouse who remains in the community. Income and assets quickly dwindle when applied to monthly nursing home bills, which can exceed \$2500.

In the Medicaid provisions of the Medicare Catastrophic Coverage Act of 1988 (MCCA) (Pub. L. No. 100-360 Section 303 as amended by the Family Support Act of 1988 (Pub. L. 100-485 (d)(16))) Congress has recognized the needs of spouses who remain in the community. It is not uncommon for such a spouse to be frail and exhausted from trying to provide care to the other spouse for as long as possible at home. When home care is no longer feasible, the couple confront not only the emotional trauma of institutionalization: they must deal with enormous financial burdens of institutionalization.

For a number of years the Medicaid program has been available to pay for long term care for those meeting the eligibility criteria. These addressed the institutionalized spouse but failed to recognize the sometimes harsh consequences for the community spouse. For example, a couple might have a total income of \$1000 per month, \$620, the husband's and \$380, the wife's. When the husband enters a nursing home, his \$620 income is no longer available to his wife. She is left with \$380 to meet all of her household and other expenses.

Beginning September 30, 1989 significant changes in the Medicaid law will help the community spouse avoid impoverishment.

As of that date the minimum monthly allowance for the community spouse must be no less than 122% of the monthly federal income poverty guidelines for a two-person household, (in 1988 that amount was \$786) plus an extra amount for shelter allowance, if shelter costs exceed 30% of the monthly amounts. The law provides for increases in the monthly allowance to 133% of poverty guidelines

in 1991 and 150% of poverty guidelines in 1992.

Using the example above, we can see that the wife would be entitled to an additional \$406 per month to bring her to the \$786 level. (Since new poverty guidelines are likely to be issued before September 30, 1989, she probably will be entitled to more than \$406). The husband will be left with \$214, and Medicaid will pay a larger share of the costs for his care.

If the circumstances were reversed and the husband were the community spouse with considerably more income, no part of his income could be deemed to be available to his wife.

The income of each spouse is determined according to the "name on the instrument" rule. Checks made to the order of an individual spouse will be considered that spouse's income. Spouses will be considered to have one-half interest in any check payable to both. Trust income will be attributed according to the trust provisions. If there are no specific provisions, trust income will be attributed to the spouse to whom payments are made. Joint payments will be attributed in equal shares to each spouse.

Since income is a threshold question in determining eligibility for Medicaid, reducing the income of the institutionalized spouse can make that spouse eligible for coverage. Except for income from trusts, the institutionalized spouse is permitted to rebut an ownership interest in income by a preponderance of the evidence. This might be done, for example, where a payment due one spouse is made payable to both for convenience.

Under the new law all *resources* of a couple (as to be distinguished from *income*) will be deemed to be available to the institutionalized spouse. The total value of resources owned individually or jointly will be assessed as of the *beginning* of a continuous period of institutionalization. Each spouse's share

will then be viewed as one-half of the total. Certain resources are exempted from the computation of total value. They include the home, household goods, an automobile, and burial funds.

The "snap-shot" at the time of institutionalization is important, not only for those applying for Medicaid at that time, but also for those who may apply in the future. States are required to assess and document the total value of a couple's resources at the beginning of institutionalization at the request of either spouse. The State may charge a fee for the assessment, if the spouse is not applying for Medicaid at that time. It seems wise to request such an assessment to avoid problems and delay at a later date when Medicaid may become necessary.

Although the total value of non-exempt assets at the time of institutionalization is deemed to be available to the institutionalized spouse, the community spouse is permitted to retain a minimum of \$12,000 in resources. States have the option to increase the minimum to \$60,000. The resource allowance may exceed \$60,000 if a court orders a transfer of resources to generate adequate income to support the community spouse. A couple can also request a fair hearing to present evidence that resources in excess of \$60,000 are necessary to generate sufficient income for the community spouse.

In addition to the changes regarding income and resources, the MCCA has made significant changes regarding the transfer of assets. Some individuals and families arrange to transfer property in order to preserve assets, and create eligibility for government-funded long term care. Usually the transfer is an outright gift to another family member. Since 1980, transfers for less than fair market value within 24 months of applying for Medicaid were deemed to be made for the purpose of becoming eligible for Medicaid. Unless the presumption could be overcome, the applicant would be ineligible for 24 months or for the period

of time the uncompensated value of the property would have paid for nursing home care, if less than 24 months.

Provisions of MCCA extend the period of ineligibility to 30 months or the period of time the uncompensated value of the property would have paid for nursing home care, if less than 30 months. For example, father, realizing he requires long term care, transfers his \$12,000 truck to his son. If the average cost for a private pay patient in a nursing home is \$2000 per month, he would be ineligible for Medicaid for six months.

The new transfer of asset rules apply to resources disposed of for less than fair market value after July 1, 1988 for all transfers except those between spouses. The rule on interspousal transfers becomes effective October 1, 1989.

The new rules provide that an individual will not be ineligible for Medicaid if the home is transferred to a community spouse or to a blind or permanently disabled child. Transfers of a home are also permitted to a sibling who was 1) residing in the home for at least one year before the transferor's admission to a medical institution or nursing facility, and 2) who has an equity interest in the home.

In recognition of the care provided by children, the parent may transfer the home to a son or daughter who resided in the home for at least two years before the institutionalization, if the child provided care that enabled the parent to reside at home.

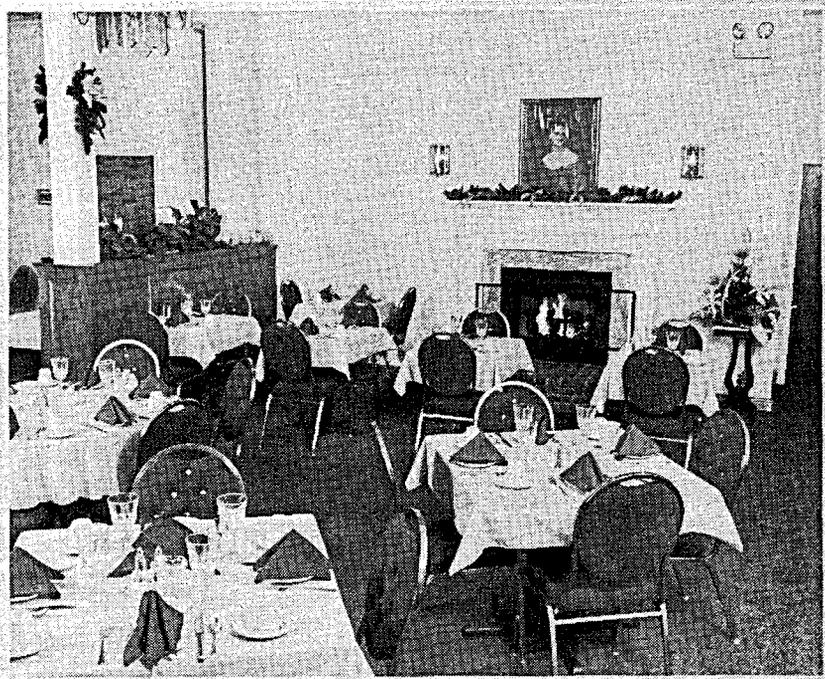
Transfer of resources other than a home are permitted, if made to or for the sole benefit of a community spouse or to a blind or permanently disabled child.

There will be no penalty for transfers if one can show an intention to dispose of the property for fair market value or other valuable consideration, or that the transfer was made for a purpose other than becoming eligible for medical assistance. There also will not be a penalty if the State determines that denial of eligibility would create an undue hardship.

It is premature to speculate on the consequences of the long term care Medicaid provisions of the Medicare Catastrophic Coverage Act. The new law does offer opportunities for planning to protect from impoverishment of the spouse who remains in the community.



Judith Schuenemeyer, who designed this issue and commissioned most of the articles, is the Chairman of the Delaware State Bar Standing Committee on Law and the Elderly. An authority on the legal problems of the aged, Mrs. Schuenemeyer serves as Deputy Director, Managing Attorney of the Wilmington office of Community Legal Aid Society, Inc. As of this writing she is the Acting Executive Director. A registered nurse as well as a lawyer, she brings two essential disciplines to confronting the problems of the destitute elderly.



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HOUSE RICH - CASH POOR NO MORE?

Reverse Mortgages Now Available for Elderly Delawareans

C. Andrew Vincent

By now you have probably heard about home equity conversion as an attractive method to help elderly individuals "unlock the equity" in their homes and convert it to retirement income while they continue to live in their homes. Much has been said and written about home equity conversion by a broad spectrum of professionals (attorneys, bankers, gerontologists, realtors, etc....) over the last 20 years. However, the actual volume of reverse mortgage loan closings nationally has been relatively low - only about 2,500 to date. A number of factors, which are beginning to come together nationally and locally, should lead to an increase in reverse mortgage home equity conversion activity in the 90's and beyond.

At first glance, home equity conversion through a reverse mortgage seems almost too good to be true. Spending some home equity while living in your home is a new idea for most elderly people and may seem like having your cake and eating it too. Until recently, the only way for the elderly to cash in on home equity to meet current cash needs was to sell their homes and move. Tax policy in fact encourages this seemingly simple option through the one-time capital gains exclusion for those over 55 who sell their primary residences. Second mortgage home equity loans, requiring immediate repayment are not feasible for elderly home owners on moderate fixed incomes.

Reverse mortgage home equity conversion may be as unfamiliar to today's elderly as the 30 year monthly payment forward mortgage was for them when they were young and purchasing homes earlier in this century. At one time in America you could only buy a home if you could afford to pay the full purchase price in cash. Demand and innovation led to changes in home purchase finance, at first you could pay half at closing and the other half in 5 years. Eventually the then radical notion of a 30 year, monthly payment forward mortgage was introduced and accepted. Today, a broad

and growing mix of home purchase financing options exists to assist people in realizing the American Dream of home ownership. In the foreseeable future reverse mortgages will enable many of them to that dream through retirement and old age.

Reverse mortgages would seem to be the answer for the elderly who want to stay in their homes, but who are caught in the bind of increasing costs squeezing limited fixed incomes. Elderly home owners, 80% of whom own their homes debt-free, own an estimated 700 billion dollars in equity nationwide. Home equity on average constitutes the majority of wealth held by elderly home owners. They have an average equity of \$60,000 in their homes. Although "house rich", the elderly as a group face the hardship of fixed cash incomes and increasing costs of living, particularly in housing (rising property taxes, utilities, and maintenance costs) and medical care. While they could sell their homes and move to apartments, most elderly people want to remain where they are. A house represents independence, security and stability, and an important link to friends, neighbors, and family. Living in an apartment off the proceeds of the sale of the home is an uncertain solution: the senior must speculate about how long she can live on a finite amount of money when faced with inflation and rent increases. Furthermore, she may not want to sell her home because she wants to preserve an estate for her heirs.

If reverse mortgage can solve a number of problems so easily, why haven't they taken off until now? There are several reasons. Lenders have been daunted by such obstacles as high start-up and marketing costs for an unproven market and significant risks related to unpredictable senior lifespans and future housing values. Borrowers may have been put off by encumbering their homes with liens, reducing the value of the estates, and by the novelty of reverse mortgages.

Recent local and national developments have begun to break the log jam. The Delaware Division of Aging (DOA) and its Task Force on Housing for Senior Citizens studied various state-operated reverse mortgage plans and the private Individual Reverse Mortgage Account (IRMA) offered by American Homestead Mortgage Corporation (AHMC) of Mount Laurel, New Jersey. The Task Force ultimately invited AHMC into Delaware and, to reduce entrance costs into a relatively small market, procured pro bono legal assistance from David B. Brown, Esquire, President of Delaware Volunteer Legal Services and Donald N. Isken of the law firm Morris, Nichols, Arsht & Tunnell. Wilmington Savings Fund Society (WSFS) agreed to advance credit and market the IRMA plan in Delaware. It has been available since April, 1988. DOA's Elder Housing Counseling Program provides counseling to potential IRMA applicants on reverse mortgages and other housing options.

A national Housing and urban Development (HUD) demonstrations program will provide FHA insurance for up to 2,500 reverse mortgages to be originated nationwide beginning this Spring. Many observers believe HUD's participation will bring legitimacy to the reverse mortgage.

American Homestead's IRMA is a shared-appreciation reverse mortgage loan available to borrowers aged 62 and older who own their homes debt free. Home owners agree to share a percentage of the home's future value in return for fixed monthly cash payments for as long as they continue to live in their homes, even if the total value of these payments and interest exceeds the value of the home. The tax free monthly payment amount depends on several factors, including the age - and thus life expectancy - of the borrower, the current value of the house, and the proportion of the home's future appreciation to be paid to the lender when the payments end. For example, a single

person age 75 with a home worth \$100,000 who promises American Homestead 70% of the house's future appreciation would receive around \$365 per month. If the borrower were 80 at application, the payments would be \$523 monthly. An 85 year old applicant would receive \$682. A 75 year old promising all future appreciation to the lender would receive \$496; and 80 year old, \$710; an 85 year old, \$924.00.

Today, a broad and growing mix of home purchase financing options exists to assist people in realizing the American Dream of home ownership. In the foreseeable future reverse mortgages will enable many of them to that dream through retirement and old age.

Through the end of September, 1988, four reverse mortgages had been closed, and two more settlements were scheduled for October, 1988. An additional 48 inquiries under discussion may lead to at least six to twelve additional loans. Given Delaware's population, AHMC is enthusiastic about these early results. In the small sample of six Delaware loans, WSFS reports that the average borrower was 75.8 years old, that he had lived in the home 27.3 years, and that the home was valued at \$138,333. Nationally, the typical reverse mortgage borrower is a 75 year old female with a life expectancy of 14 years who has become widowed and has suffered a reduction in Social Security and pension benefits as a result.

Reverse mortgages, including the IRMA, are not for everyone. There should be careful scrutiny of each potential applicant's needs. Sound legal advice is essential. Additional information on reverse mortgages is available:

Attorney's Guide to
Home Equity Conversion
Commission on Legal problems
of the Elderly
American Bar Association
1800 M Street, N.W.
Washington, DC 20036
(202)331-2297

Advising Older Homeowners
on Home Equity Conversion:
A Guide for Attorneys
Consumer Affairs Section
American Association of Retired Persons
1909 K Street, N.W.
Washington, DC 20049

National Center for Home Equity conversion
110 East Main Street
Room 1010
Madison, Wisconsin 53703
(608)256-2111

American Homestead Mortgage Corporation
Executive Offices - Suite III
305 Fellowship Road
Mount Laurel, NJ 08054
1-800-233-4762

EXAMPLE

ASSUMPTIONS:

- Borrower is single and 75 years old.
- Initial home value is \$70,000.
- Annual percentage rate (APR) of interest on loan advances is 12.1%
- Borrower pays all future home value appreciation to lender.
- Monthly advance to borrower is \$338.
- Borrower dies 12 years after loan initiation.

Loan Term	12 years
Annual average appreciation rate (of home value)	4%
Home value at end of loan	\$112,072
Total of monthly advances received	\$48,672
Interest on monthly loan advances	56,330
Appreciation share at 100%	42,072
	\$147,074
94% of home value* at end of loan	\$105,348
Total amount owed	105,348
Effective annual interest rate	12.2%

*By agreement with American Homestead, 6% of sale value is excluded for realtor's sales commission. In this example it isn't all peaches and cream for the lender, who waits 12 years for its money and winds up with a grand equity windfall of \$346. Of course the borrower's heirs get nothing, but it was her home, and the arrangement enabled her to remain there.

C. Andrew Vincent, Housing Planner at the State Division of Aging (DOA), has been active for over a decade in developing housing options for special populations, including the mentally, physically, and emotionally disabled of all ages. Mr. Vincent staffs the State Task Force on Housing for Senior Citizens and manages the DOA's Elder Housing Counseling Program, which counsels Delaware seniors about housing options.

(Continued from page 19)

structured activities, and day care centers emphasize the medical, recreational, and rehabilitative needs of their clients.

These centers can be found all the way from 11th Street in Wilmington (Program Activity and Care for the Elderly, or PACE), to GULL (Geriatric Unit for Living and Learning) at the Beebe Medical Center in Lewes. A center often operates out of an existing senior or retirement center, such as the Mature Adult Center, the Modern Maturity Center in Dover, or the FM Club at Foulk Manor.

Some centers are specialized (e.g. the Evergreen Center, an Alzheimer's Day Treatment Program on the Bissell Hospital site). Don't be surprised to find that there is a waiting list to be interviewed for attendance at the center. These programs are in high demand, because they offer the supervision for clients who cannot or will not handle the self-directed emphasis of most senior centers. With the added degree of supervision and the emphasis on medical and rehabilitative care, a senior can enjoy a safe daytime activity allowing the primary care giver to work or to enjoy some free time during the day when the client is not at home.

Another example of a support program that can allow the elderly to remain at home is care management, which links the client to needed services and provides counseling and consultation. In the fall of 1987, the VNA program, Elderscope, began to serve Wilmington's elderly. Now these services are available throughout the state. New Castle County Senior Services, the Modern Maturity Center (Kent County), and Sussex County Senior Services provide case management for elderly clients.

The Division of Aging has recognized housing as a vital issue among the elderly in Delaware. The Elder Housing Counseling Program, begun in March 1986, furnishes housing information and assistance. The "Matched Housing" program, as well as the current "Home Share" program, matches home owners with home seekers. Home equity conversion may also be available to generate income. (See discussion by Vincent elsewhere in this issue.)

Another trend in housing has been the growth of retirement facilities. Many of these have similarities, such as initial fees and recreational, social, and limited supportive services (transportation to

appointments, barber/beauty shops), but there are two main differences.

Continuing Care Retirement Facilities have fee structures and services that change as the needs of the client change. Continuing Care Retirement Facilities include Churchman Village, Forwood, Stonegates, Foulk Manor North, Millcroft, and Shipley Manor. As you can see, an advantage that many of these facilities share is that they are adjacent to nursing homes, so that skilled medical care is never far away.

Life Care Communities, on the other hand, boast of no increased cost (except monthly program fees) for the care of a resident for life. They include Cokesbury, Gilpin Hall, Jeanne Jugan, Methodist Country Home, and the Methodist Manor House. Some of these facilities have entry fees, and some have initial health or age application requirements. Many have long, long waiting lists. Even though they offer very little in the way of care or supportive services, two other housing options should be mentioned. Group homes, which provide shared independent living, often have private bedrooms and community social rooms as well as community dining rooms. These include Brandywine House, St. Patrick's House, Broad Creek Meadows, and Coverdale Group Home.

Subsidized housing include Wilmington Housing Authority, Luther Towers, Quaker Hill Place, Windsor and Woodlea.

The range of services, homemaker, home health aides, respite, hospice, day care, personal care facilities, and adult foster care, are expanding to meet the diverse needs of an aging population. To the same end, the state subsidizes programs for preventive health care, reduction of dependency, and community-based care. With such a diversity nursing homes are no longer the only choice for those who need more help than they have alone at home.

...And When It *Must* Be a Nursing Home

Elizabeth drew her wasted frame into a regal, somehow still imperious, stance. This was it, she thought. The End. They're putting me into a home.

Elizabeth's daughter, Sarah, was welcomed by Mrs. Williams, the foster care sponsor, the lady with whom Elizabeth lived. They huddled on one side of the room and allowed Elizabeth plenty of space to be alone with her thoughts. Elizabeth needed more care than she was getting now, they agreed.

Life used to be so simple. Elizabeth remembered when things started to fall apart. Sarah would come over and find only chicken in Elizabeth's refrigerator: one week old chicken, two week old chicken, and month old chicken. Then there was Meals on Wheels: Elizabeth got hers from St. Anthony's. It was nice to have hot lunches brought right to her door.

But Elizabeth stopped opening the door. She wasn't really ready to eat at noon, and she wasn't so sure about strangers coming to her door anymore.

When Sarah no longer knew how to get Elizabeth to eat properly she arranged for a social worker to visit Elizabeth. The Visiting Nurse came and told Elizabeth about cooking simple meals. Elizabeth began attending the senior center on Market Street, where she could enjoy activities and meals with other seniors. She liked preparing for the bazaars, and doing crafts together with friends at the long tables.

That worked until Elizabeth wandered away from the center three times in one week. She was just trying to get home a little early, but Sarah worried about her getting lost or mugged.

Sarah next put Elizabeth on a waiting list for the day care center. They both met with the director one evening at Elizabeth's home. Elizabeth truly loved going to the adult day care center. The nurse gave her her medicines every day, and she seemed to be less confused and more active. She felt that she was "watched" more, but she tolerated that because she knew she'd return to her own home every night.

In a little over a year, the neighbors noticed that Elizabeth was coming out less. She wasn't always ready when the day care bus arrived. Sometimes she was still asleep. She missed doses of her medicine, she ate less, and one morning when she slipped and fell in her bathroom, she couldn't get help right away.

Personal Care Facilities are fairly recent additions to an array of housing options for seniors. They are licensed by Public Health following guidelines for rest residential facilities. They offer nurses and aides, although the staffing is much less concentrated than it is in nursing homes. Personal care facilities are ideal for seniors who need some assistance with ADLs, such as a little help in dressing or bathing. They are not for clients who need to be fed or to receive any other type of skilled nursing care, such as dressings, tube feedings, physical

therapy, or oxygen. A monthly charge of around \$1500.00 usually includes 24-hour nurses aides, meals, and linen service. Often barber/beauty shops are accessible, and planned activities (e.g. community meals and social areas) promote interaction and offset withdrawal. Examples of these facilities are Green Meadow in Dover and Kamin in Ardentown. The availability of nursing staff and supervision of medicines may make this an attractive alternative for those who need daily medical monitoring, but who do not require nursing home care.

For less than half of the cost of a personal care facility, adult foster care offers community placements for seniors who are not capable of living independently. The State of Delaware subsidizes the incomes of some eligible seniors, so that they can afford to pay foster care sponsors the state-determined amount of \$432.00 monthly. The state considers this an attractive alternative to funding nursing home care for the same population. Seniors are eligible for adult foster care if they are nearly independent in their ADLs. Adult foster care homes caring for more than one client are licensed by Public Health under the guidelines for "Adult Family Care Homes". The homeowner, called the foster care sponsor, who often has no formal training or qualification, must furnish room, board, linens, and a supportive environment for the foster care client. Two state agencies, Geriatric Services and Supportive Care Services, handle adult foster care placement and case management for state clients. The same services may be purchased privately by clients who do not meet the state's income and asset guidelines.

Since the foster care sponsors are not nurses, they cannot administer medicines, but they may remind clients of timing and help to remove medicine bottle lids. Good sponsors, who are often in demand and rarely have openings, will oversee the client's schedule of medical appointments, and supply transportation. Ideally, the foster care clients would be integrated into the family, eating with the family at the dining room table, and even joining on family vacations. Less conscientious sponsors see the arrangement as more of a "boarding home with meals" set-up, and interact little with their clients.

This arrangement is often very attractive for clients who do not require much medical supervision, but adult foster care placement is not for the incontinent or those who require nursing care.

Sarah explained to Elizabeth that she needed to live where she'd have company, someone around her, all of the time. Elizabeth was relieved when she went to the adult foster care home from Pelleport, because this did not look like a nursing home. It was not *her* home, but it was a home. She went to the senior center every day, and ate dinner with the foster care sponsor and her family every evening. The sponsor helped with Elizabeth's medicines.

Elizabeth was hospitalized last spring after she broke her hip in a bad fall. She was then in a nursing home for a month to learn to walk with the walker, before she returned to the foster care home. She was proud of her ability to get around on her own, though she complained that the walker was clumsy.

Since she was so fiercely independent, it was doubly hard to realize that she was losing control of her bladder. Through the ordeal of private shame, the embarrassment of others finding out, and the medical conclusion that this was to be expected, Elizabeth clung fiercely to her dignity. Even when her daughter Sarah and Mrs. Williams talked her into entering a nursing home, Elizabeth tried to keep her feelings to herself.

Elizabeth realized that the decision was not entirely up to her. She moved to the nursing home, but the move was not nearly as traumatic as she and Sarah had feared. Elizabeth had had time - time to help her accept her limits, time to be angry at leaving her home, time to get over it. She now knew and accepted that she needed help, and decided to make the most out of her move. And that is why her stay at the nursing home has been successful.



Mrs. Robm holds degrees from the University of Delaware and the Widener University School of Law. For ten years she has been active in geriatric health care. She now works at Supportive Care Services, Inc. in alternative health care planning, decision making, and consultation. She also performs guardianship and foster care work. Mrs. Robm is a member of the Pennsylvania Bar and the American Bar Association.

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LIVING TRUSTS - BIDDING THE OSTRICH GOODBYE

John A. Herdeg

Planning for disability is something most of our clients - and perhaps we - tend to avoid. (Not unlike the ostrich.) And yet with increasing longevity, the subject must command more of our attention.

Each of us has witnessed the operation of a guardianship for someone who needed assistance. It can become a traumatic experience for the person involved and even his family. The publicity and the proceedings can create tensions and even emotional scars for everyone. The proceedings themselves are time-consuming and costly.

There are alternative solutions, but they require advance planning. A durable power of attorney is one choice. Such a power can be comprehensive and can survive loss of competency. It can clothe the attorney-in-fact with sufficient powers to address practically any situation.

Unfortunately, however, such powers are not a panacea. Third parties often are reluctant to accept them. Delays can occur and in some situations the powers themselves are rejected. In the final analysis durable powers of attorney can be very helpful but they are not the whole answer.

A well-designed "living trust" - one that holds and manages a person's property and is fully revocable - can provide additional protection and flexibility in such situations.

Unfortunately trusts are viewed by some as straight-jackets and cumbersome. Indeed they can be if they are not designed well or if they are not administered with sensitivity. A trust is simply a vehicle. Its objectives and terms can be as comprehensive and flexible as needed.

The most significant feature of a living trust is that it can be used by a person to hold and manage his property and can provide for a smooth transition of management responsibility in the event of disability. The person need not lose any autonomy in creating the trust, while enjoying the protections it can afford - if it becomes necessary.

Let us first address property management. In creating a living trust a grantor would normally transfer his investments to the trustee - who could be himself acting alone or with another. The terms of the trust would specify the investment philosophy to be observed in managing the property. Undoubtedly that philosophy would reflect the grantor's philosophy in managing his property. In reality the trust becomes an extension of the person creating it.

If the person creating the trust reserved to himself the management responsibility, the trust agreement would name another to succeed him. In the event of disability, responsibility for managing the investments would shift automatically to that other person. There would be no court proceeding, no delay, no costs and no publicity.

Aside from continuity in management, a living trust can also address one's financial obligations for himself and even others. In the event of disability, the trust agreement would shift these responsibilities to another. The successor would be authorized to use his best judgment in seeing that those obligations are met and to use income of principal - or both - as needed. Any excess income would be retained and reinvested for future needs.

A well-conceived living trust also can be used to continue one's practice of making gifts to others - e.g. to pay tuition or medical bills of another or to make annual exclusion gifts. While there is a danger such gifts within three years of death would be includable in the donor's estate for federal estate tax purposes, that danger can be skirted by using a carefully structured durable power of attorney. In such a situation the attorney-in-fact would be authorized to withdraw funds from the trust and to make the gifts directly. Of course, care must be taken to make sure the attorney-in-fact does not have a power to make otherwise taxable transfers to himself.

The flexibility of a living trust can also be used to gain additional benefits at death. By continuing the trust, it can be used as a will-substitute thereby assuring

further continuity in management, reduced probate expenses, and immediate benefits for the beneficiaries of the estate.

The estate settlement process often interrupts the management and enjoyment of a person's property. The will must be found and probated. The executor must be appointed and must then marshal, inventory and appraise the deceased's assets. New financial accounts must be opened and assets transferred to them. This process consumes time and, more importantly, the executor's attention.

Having the trustee in possession of the assets and responsible for both managing the assets and conferring the benefits can assure greater continuity in management and in the flow of those benefits. The executor is free to pay more attention to other property and the probate process.

Moreover, since the executor's responsibilities, as well as those of the Register of Wills Office, are reduced, the probate costs should be reduced. Of course, this will depend on the compensation of the executor and the trustee.

A collateral benefit of extending the living trust is the status of a trust as a private agreement, which is not filed or recorded with any government agency at death, thereby insuring greater privacy in settling the grantor's affairs at his death.

Looking at the tax consequences of a living trust, since such a trust would be revocable, it would be ignored for federal income tax purposes during the person's lifetime. All information would be reportable on the grantor's personal income tax return. In fact, if he acts as the sole or co-trustee, no tax return for the trust itself is required.

After his death certain income tax provisions arise that can be disadvantageous in some situations - at least when compared to probate. A trust cannot elect a fiscal tax year. Moreover, accumulated income subsequently dis-

(Continued on page 17)

(Continued from page 48)

statute found at 16 Del. C. Sections 2501 et seq. In essence a living will instructs health care providers and close relatives that under certain conditions of incapacitation the signatory wishes to refuse or discontinue particular medical interventions (such as tube feedings and hydration*, artificial respiration or electrical or mechanical resuscitation of the heart). Unlike some other states, Delaware expressly recognizes a competent adult's right to refuse or terminate such treatment so that enforcement of a living will should not pose a problem in this state.

Organ Donation Documents

Here is still another useful document permitting the elderly to retain some degree of control even after they become incompetent or die. Such documents are expressly recognized under Delaware law. 16 Del. C. Section 2713.

The beauty of these documents is that each offers the client the possibility of extending decisional authority into a period of legal incapacity or, in the case of organ donation, even beyond life. In this respect making these devices available to clients is very much in the spirit of the highest ethical ideal of lawyer-client relationships.

In the context of testamentary capacity, if a lawyer is asked to prepare a will for an elderly client whose competency is in question, though the lawyer has satisfied himself (through the use of a diagnostician or otherwise) that the elderly person is exercising his free will in seeking the preparation of a new will, and where the lawyer is aware that this new will may well be challenged by third parties, he would do well to consult with one or more diagnosticians, adequately inform them in writing of the legal standard to be applied in cases of testamentary capacity, and make the diagnostician's evaluation of that capacity as close in time as possible to the execution of the will. In addition, the lawyer may want to consider video taping the will signing ceremony. He will also want to choose his witnesses to the will signing with great care. The testimony of witnesses in a subsequent will contest will be given weight because of their opportunity to observe and judge the testator's mental condition. *In Re Matter of Langmeier, supra*. If the lawyer has explained to witnesses also the legal standard for testamentary capacity they could prove valuable in sustaining a contested will.

* This is under legislative attack. See Herlihy article, elsewhere in this issue. Ed.

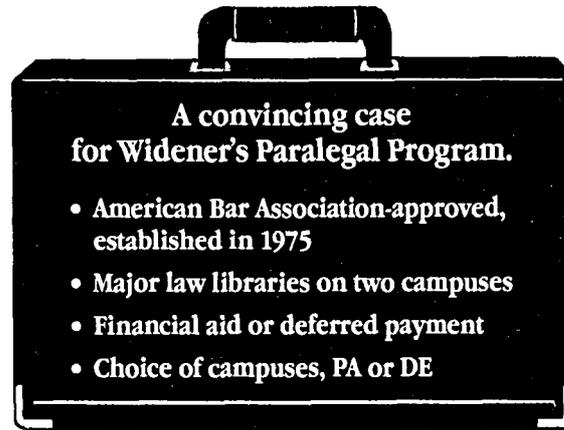
1 "Testamentary capacity in this jurisdiction has been defined to mean that one who makes a will must, at the time of execution, be capable of exercising thought, reflection and judgment and must know what he is doing and how he is disposing of his property. He must have sufficient memory and understanding to comprehend the nature and character of his act. *In Re Estate of Bandurski, Del. C., 281 A.2d 621 (1971)* ...was the person able to understand that he is disposing of his estate by will, and to whom he is disposing it?...was he capable of recollecting what property he was disposing of and to whom he was leaving it?...if so, the will is valid

regardless of whether or not the dispositive scheme might seem improvident to others and regardless of the mental condition of the Testator at times either prior to or subsequent to the execution of the will. *In Re Matter of Langmeier, Del. C., 466 A.2d 386, 402-403 (1983)*.

Daniel R. Losco, a graduate of Pennsylvania State University and Widener University School of Law, is an associate with the Wilmington, firm of Sawyer & Akin, P.A.. He is an active member of the Bar Association Committee on Law and the Elderly. He also belongs to the National Health Lawyers Association.

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DEFERRING THE ROCKING CHAIR

Lawrence S. Drexler

The class started promptly at 9:00 a.m. I arrived a few minutes early to survey the surroundings and check out my classmates. Professor David Morrison called "K-1 Art of Fiction: Great Short Stories" to order. The class discussion turned to Arna Bontemps' "A Summer Tragedy." Immediately, I felt the familiar dread that comes from lack of preparation. I looked around the classroom and realized that I was the only one not familiar with the story. I reviewed the school's handbook and was amazed to find that no tests would be given, no papers due, and no one would be graded. In fact, attendance was left entirely up to the student. Yet, the entire class, sans me, participated in a spirited discussion of a couple's suicide.

This was not a bizarre flashback to my freshman college English class. Instead, it was the beginning of a visit to the University of Delaware's Academy of Lifelong Learning. My classmates were not recent high school graduates completing their first credits. All of the class members were each at least 55 years old. In return for enrollment, the students have the opportunity to participate in a wide range of intellectually vigorous classes.

The Academy of Lifelong Learning was established by the University of Delaware in 1980. It provides "opportunities for intellectual and cultural exploration and development for men and women of retirement age." The premise of the Academy is to allow individuals of diverse backgrounds the opportunity to share interests and develop appreciation and knowledge of other areas in a structured environment.

The Academy is a cooperative that makes full use of its members' talent and experience in providing a college level educational experience. Members pay a per semester fee of \$95.00, which is, in essence, tuition. Where necessary, partial scholarships are available. Members of the Academy volunteer to be instructors, planners, and committee members in the Academy. Thus, the Academy is entirely self-driven. The instructor in one class is a student in the next.

It is useful to note what the Academy is

not. The Academy is not day care for the elderly. The Academy is not arts and crafts for the ancient. While the Academy does include art, it is on a sophisticated level, not to be confused with hooking rugs to kill time or art as therapy.

The course offerings include classes on the Supreme Court; the Solicitor General's relationship with the Supreme Court; Great Decisions of 1989; the Politics of Southern Africa; the History of the Celts, Roman, Saxons, and Vikings; Normans in Sicily; Ethics; Philosophy; French; German; Greek; Latin; Spanish; Literature; Science; Art; and Music. The Academy provides a forum for aggressive intellectual exercise for those who have retired and are not in what was euphemistically referred to as "the rocking chair stage." In other words, the Academy fills the otherwise empty period between retirement and the point where one is no longer physically or mentally capable of living outside of his home. The energy level of each class confirms that the people enrolled at the Academy are truly "Older People with Active Lifestyles" (OPALS).



Academy Chairman Dr. David Morrison conducts fiction class.

Samuel Arshnt, Esquire, a founding partner of Morris, Nichols, Arshnt & Tunnell, is typical of the participants in the Academy. Sam's decision to retire in 1980 at age 70 came as a surprise to his wife of now 49 years, The Honorable Roxana Arshnt, former Family Court judge: "Prior to 1980 I would have predicted that Sam would never have retired from the practice of law. He

retired at the peak of his career. He was willing to let younger people move into the prominent leading lawyer role. I did not believe he would ever do that. I thought he would stay and die with his boots on like many of his colleagues who didn't want to give it up."

Sam claims to have retired to "preserve the memories of those who knew me as I was when I was worth remembering rather than continuing to come to the office and practice law and deteriorate in the presence and eyesight of those whom I respected and liked. I was aware that while different people age at different rates, everyone does age. Aging includes diminished abilities and diminished physical and mental capabilities and I wasn't sure that I would recognize the day or era when I was really infirm and, to avoid that situation, I decided to retire."

Upon retirement, Sam had no plans for occupying his time. Judge Arshnt feared that Sam would not accept retirement and it would, in effect, drain the life out of him. Judge Arshnt's dire vision of her husband's withering away in retirement did not become reality. Instead, Sam Arshnt blossomed into new fields. In his first three years after retirement, his principal activities were gardening and consulting by telephone with his former partners. As Sam said, gardening "was not a pastime in which I soiled my hands during my practice of law." He also undertook to learn carpentry and plumbing as well as other trades in order to take care of minor problems around the house. He insists that his practice of these trades saved money, and did not increase his expenditures for professional correction of his work.

In 1983 Judge Arshnt retired from the Family Court. Sam reports that she was initially a nuisance, forcing him to "share the roost." While she will not admit to joining the Academy to get out of Sam's way, she did so shortly after her retirement. Her first class was in Shakespeare. Sam signed up, for a reduced rate, after hearing Roxana and her friends rave about the activities.

At present, Sam attends the Academy

four days a week while Roxana is on a reduced schedule of three days a week. In addition to attending class, the Arshts have thrown themselves into the management of the Academy. Sam's turn as a member of the Academy's governing board is up at the end of the 1989 spring semester.

The Academy is presently headquartered in the University of Delaware's Wilcastle Center (the old Wilmington Country Club) located off Pennsylvania Avenue opposite Tower Hill School. The Academy is in the process of a six million dollar fund raising drive for a new facility to house the Academy. The new building will be located on the grounds at Wilcastle in a building adjacent to the current facility.

The fund-raising effort got off to a flying start through the generosity of Sam and Roxana Arsht. The Arshts started the fund-raising effort with a one million dollar gift toward the cost of constructing the new building.

Sam described the donation as follows: "The gift reflects a feeling on our part that the Academy of Lifelong Learning is a very important asset to the community and to the University of Delaware. We wanted to be sure the community and the University appreciated the Academy. In our experience, we heard about the Academy by accident, came for a single course, and have stayed for five years. We found it to be an enjoyable, important experience and part of our active lifestyle."

The new building is sorely needed as the current enrollment of 1,000 stretches the physical plant to the limit. The new building will accommodate 1,600 students and will enable the Academy to expand to an evening program, which is presently not possible because of other use of the facility by the University.

Enthusiasm for the Academy is not confined to the Arshts; however, they are typical victims of the Academy's addictive power. The current chairman of the Academy, David Morrison, states that the Academy changed the entire vision of his early retirement from DuPont. "While I didn't have a specific goal upon retirement, I wanted to spend time working for the four different non-profit organizations with which I was involved. Due, in part, to my involvement with the Academy, my charitable interest is down to one organization and I have not traveled to the extent I would have liked."

The Academy has directly contributed

to the retirement from business of at least one of its members. Sig Ettinger, former purveyor of tickets at B & B Tickettown, went into semi-retirement and began attending classes at the Academy on his days off. On his days away from the Academy, working at Tickettown, Sig found the days growing longer and less fulfilling. He found himself concentrating on the clock rather than his job. As a result, Sig decided to end his part-time retirement and become a full-time member of the Academy. Sig now moderates one of the most popular courses at the Academy, a round table discussion on current events, which, due to demand, was offered in two sections in the most recent semester.

Similarly, Helen Bryant came to Delaware in 1987 to be closer to her daughter and grandson. She enrolled in the Academy and within two months she had a course added to the curriculum in which she would teach constitutional law. Subsequently, she developed a course on the Solicitor General's relationship with the Supreme Court, and this fall will teach a course on Franklin Delano Roosevelt. Mrs. Bryant's current schedule includes teaching two days and attending class two days.



Sig Ettinger - forced into retirement by a new career - leads the popular course on current events.

The Academy curriculum combines conventional lecture/seminar type courses with creative alternatives that take advantage of the additional time available to the retired. One class of note combines the stereotypical vision of travel in retirement with a conventional classroom experience. Classes that culminate in travel have been a regular feature of the curriculum. One such class centered on the Norman conquest of England. The current course, entitled "Normans in Sicily", is a follow up to that course. Both courses are taught by a former European vice-president for DuPont, and include classroom work at the Academy and historical tours in

Great Britain. The Great Britain portion included classes at Oxford University taught by that institute's faculty. David Morrison, the current chairman of the Academy's council, notes that "the students attend special classes at Oxford designed just for them in the historical background. They then go out to explore the subject areas that have been covered including a trip to Normandy."

The current class is a follow up where students initially spend class time at the Academy studying the Norman influence in Sicily. The class then travels to England for indoctrination at Oxford, including classroom work taught by Oxford faculty on the Norman influence throughout Europe with special attention to the occupation of Sicily. The group, including the Arshts, will then travel to Sicily for a first hand look at the subject of their studies.

Morrison says that Oxford is excited about expanding its role in assisting these types of courses. Morrison contemplates a course in Shakespeare that he would design in conjunction with Oxford to include travel and classes in Great Britain.

In 1986, the Academy offered a course in Russian history that included a trip to the Soviet Union. As it happened, the trip followed, by two weeks, the Chernoble disaster, which resulted in the cancellation of the Kiev leg of the tour.

Travel classes are not confined to international trips. Courses have included day trips such as a visit to a Philadelphia museum for a mythology class. In all cases the classroom portions of a travel course are available to non-travelers.

The Academy welcomes all comers, regardless of the extent of formal education, so long as they are interested in learning. The membership includes retired DuPonters, housewives, entrepreneurs, teachers, artists, journalists, as well as lawyers and judges. Interestingly, although not surprisingly, members of the Academy tend to take courses that offer new areas rather than spending time in our chosen fields. For instance, a retired DuPont scientist told me that he did not take a single science course at the Academy and had taken, exclusively, English and philosophy courses.

Teaching is a different matter. Members of the Academy rely on their own experience to teach classes. Several of the literature courses are taught by two former English teachers. Similarly, Helen Bryant, a recent transplant from

Louisville, Kentucky, teaches courses on the Supreme Court and the law which were adapted from classes she taught high school seniors for 30 years. Nevertheless, Academy teachers do not stay exclusively in their former profession. For instance, the course catalog lists Ernest Grabill, a retired duPont chemical engineer, as an instructor in mythology.

According to Morrison, experts rank the Academy as a leader in education for people over 55. The Academy is hailed as a role model in a field that includes similar schools sponsored by Harvard, the New School for Social Research in New York City, and Temple. The University has been consulted by other institutions to assist in establishing similar programs elsewhere.

The work of the Academy is not confined to the Wilcastle location. In 1985, the Academy added an outreach program in which Academy instructors and other members make presentations of various subjects, drawn from the Academy curriculum, at retirement homes and senior citizen centers in the community. During the past year the Academy has established a branch campus in Milford, Delaware.



Roxana and Sam Arsbht with model of a new home for the Academy.

The Academy program goes beyond classes. An important facet of Academy life is the interaction of participants during the lunch hour. During my visit, one of the lunch rooms was treated to an impromptu piano concert. Every Wednesday the Academy presents an "Enrichment Program" consisting of performances, lectures, or both of topical interest.

Consistent with the ideals of retirement living, the Academy presents the Eden of classroom life. No tests, no quizzes, no grades, no papers, and no required attendance. There is homework in the form of reading; however, no one has been chastised for



Roe V. Wade is the topic - rapt attention in Sig's classroom.

failing to do homework. The school provides an atmosphere for an orgy of in-

tellectual intercourse without creating
(Continued on page 33)

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REPRESENTING THE ELDERLY:

Ethical Challenges

Daniel R. Losco

Americans over sixty-five are now twelve percent of the nation's population, and by the year 2000, will be more than thirteen percent. If current projections are accurate, by the 2020 nearly twenty percent of the population will be over sixty-five. More importantly, the percent of the population over eighty-five, the "old old," will increase by the year 2000 from one percent to more than two percent. As our society's aging trend continues, lawyers must be attuned to the specialized requirements of elderly clients and the ethical obligations arising therefrom. Indeed, Ethical Consideration 7-11 of the ABA Code of Professional Responsibility makes age relevant to the degree of an attorney's responsibility to his client by providing: "the responsibilities of a lawyer may vary according to the intelligence, experience, mental condition or age of a client..." (emphasis added).

While the Ethical Considerations have always been "aspirational" (as to be distinguished from mandatory), a practitioner would be wise to familiarize himself with the special responsibilities and ethical implications that arise from the provision of even very ordinary legal services to the elderly.

I. ATTORNEY COMPETENCE *Laws Relating to the Elderly*

Rule 1.1 of the Model Rules of Professional Conduct adopted in Delaware requires that:

"a lawyer shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation."

In the case of the elderly, a lawyer needs more than a knowledge of law. He must be alert to the special legal concerns of the elderly. Attorneys who regularly represent elderly clients need a working knowledge of guardianship (12 Del. C. Section 3914), estate, tax and health care planning; and public benefit programs, such as Medicare, Medicaid, Social Security Old Age and Survivor benefits, Supplemental Security Income

and Social Security disability insurance. (Note that public benefits planning is becoming as well recognized as estate and tax planning). They should also be conversant with legal provisions relating to pensions and age discrimination, and the legal ramifications of housing needs for the elderly (e.g. reverse annuity mortgages, subsidized housing programs for older persons, and property tax discounts for the elderly).

Communication Skills

Aside from being familiar with the black letter of the law that applies to elderly clients, other specialized tools need to be polished when dealing with that clientele. For example, Model Rule 1.4 states:

"A. A lawyer shall keep a client reasonably informed about the status of a matter and promptly comply with reasonable requests for information.

B. A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation."

In the case of an elderly client who is completely unable to communicate, this duty may be diminished. For example, the comment to Rule 1.4 states that "...fully informing the client according to this standard may be impracticable, for example, where the client is a child or suffers from mental disability." On the other hand, many elderly clients are quite capable of making rational decisions about legal matters, provided the time is taken to communicate and explain the options available in a patient and supportive manner. In this sense the attorney's job goes far beyond that of a strict legal technician. An attorney serving the elderly must take seriously his expanded role as advisor, counselor, drafter, supporter, reinforcer, and friend. The elderly client may depend upon the attorney for aid with needs that exceed what would narrowly be categorized as "legal". Everyone needs to feel in control through participation in important life decisions including one's legal affairs. Valuable perceptions of self

determination may be fostered by healthy attorney-client communication and interaction. In working with the elderly, physical and mental limitations and the peculiarities of the psychodynamics of the attorney-client relationship may make communication especially challenging, but the attorney has a responsibility to strive to overcome these difficulties.

II. CONFLICTS OF INTEREST/ CONFIDENTIALITY

Who is the Client?

Probably every general practitioner has encountered a scenario in which an older person is escorted, voluntarily or not into his office by some family member for the purpose of signing a new will, granting a general power of attorney to the family member, or for a guardianship. These occasions give rise to a conflict between the attorney's duty to act in the client's "best interests" and his duty of zealous advocacy of the client's autonomy. Perhaps a more fundamental question is "Who is the client?" Where the elderly person is unable to articulate clearly his desires or his goals in taking legal representation, this becomes a real issue. Are you working for the elderly person or are you representing the family member who has brought him in? The attorney must determine whether a possible conflict of interest exists. The attorney must deal with the social fact that, although families ordinarily are supportive, loving advocates of their older members, this is not always the case. Families may indeed be motivated by economic, psychological, or other factors, aside from the best interests of the ostensible client. Present ethical codes for attorneys convey little definitive guidance for resolving such conflicts. As noted earlier, Ethical Consideration 7-11 recognizes that an attorney's responsibility may vary in accordance with a client's age or mental condition. Ethical consideration 7-12 provides that, when a client is incapacitated, the attorney's duties or standards of practice are "higher". There is no guidance, however, about the specifics of those additional duties or

that enhanced standard of care.

If the lawyer accedes to the family's request to represent the older family member, he should explain clearly and carefully to the other family members his ethical obligations of undivided loyalty to the client and the requirement of confidentiality of client-lawyer communications. If the family member is paying the lawyer to represent the older person, then other ethical problems must be resolved. Model Rule 1.8 requires the consent of the client after consultation, no interference with the independent professional judgment of the lawyer or with the client-lawyer relationship, and preservation of the confidentiality of the client-lawyer relationship. In addition, the lawyer must be alert to conflicts of interest if he undertakes to represent other members of the family. Model Rule 1.8(f) requires that the lawyer makes clear to the unrepresented person that the lawyer is not disinterested, and if the lawyer has reason to know that the person misunderstands the lawyer's role, then the lawyer must make reasonable efforts to correct the misunderstanding. Such misunderstandings are obviously a real concern when dealing with an elderly person with an incapacity of some severity.

Client Competency

This issue of understanding leads back to the more fundamental problem of client competence. Model Rule 1.14 states that:

(a) When a client's ability to make adequately considered decisions in connection with the representation is impaired, whether because of minority, mental disability of for some other reason, *the lawyer shall, as far as reasonably possible, maintain a normal client lawyer relationship with the client.* (emphasis added)

The comments to Rule 1.14 go on to state that the normal client-lawyer relationship is based upon the assumption that the client, when properly advised and assisted, is capable of making decisions about important matters. If the client's incapacity is severe, it may be impossible to form a normal attorney-client relationship. Under those circumstances, a lawyer appointed to represent the incapacitated person is clearly acting in the "best interest" role and can be guided accordingly. It should be noted that the comment to Model Rule 1.14 states that under such circumstances "the lawyer often must act as a de facto guardian." This is perhaps an un-

fortunate choice of words in that a guardianship relationship raises new issues of responsibility and liability that an attorney may not expect or desire.

The Model Rules also expressly recognize partial and intermittent incapacity. See, Comment to Rule 1.14. On the other hand, they give the attorney no guidance in evaluating capacity of any type.

The comment to Model Rule 1.1 states that if possible, the lawyer should consult an appropriate "diagnostician" for guidance on the issue of competency, but offers no guidance regarding the selection, compensation, or confidentiality responsibilities of that diagnostician. The Delaware case of *In Re Matter of Langmeier, Del. Ch.*, 466 A.2d 386 (1983) deals with this problem in the context of testamentary capacity: a non-family member hired an attorney to draft a will for an elderly widow. Realizing that capacity was an issue, the attorney hired a clinical psychologist to examine the testatrix for competency. The psychologist's examination consisted of giving the testatrix four (4) psychological tests dealing with word recognition, free association, and organic brain damage. He concluded that the elderly woman was competent to execute a will. The will was challenged by other family members, because it left the bulk of the old woman's estate to a housekeeper. It came out at trial that the psychologist did not question the testatrix with regard to the nature and extent of her property, her desire to make a will, or her testamentary plans. In addition, the psychologist admitted that he was not aware of the legal requirements for testamentary capacity under Delaware law. As a result, his conclusions about the woman's testamentary capacity were discredited and were not accepted by the court. *Id.* at 394, 402.

The moral of Langmeier: if you use a diagnostician to support a person's capacity to make a will or take some other action, you must tell the diagnostician what the legal test of capacity is under those circumstances in order for his conclusions to stand up in court. 1

Confidentiality

Problems of confidentiality arise when you engage a diagnostician or following the mandate of Model Rule 1.14(b), which permits the lawyer to seek the appointment of a guardian or take other protective action when the lawyer reasonably believes that the client cannot adequately act in his own

best interests. Disclosures of the client's disability can adversely affect the client's interests. The comment to Model Rule 1.14 notes that raising the question of disability could, in some circumstances, lead to proceedings for involuntary commitment. The comment goes on to state that the lawyer's position in such cases is "an unavoidably difficult one." In addition, the comment admonishes the lawyer that the appointment of a guardian can be expensive and traumatic. These unresolved issues present a state of continuing confusion regarding the question of whether the lawyer should take it upon himself to make decisions for the client in the client's best interest or whether the lawyer should defer to the Courts by bringing guardianship proceedings. The bottom line is that the lawyer is often caught between the mandates of conflicting disciplinary rules. While Rule 1.14(b) permits a lawyer to seek the appointment of a guardian or take other protective action if he reasonably believes the client cannot adequately act in his own best interests, the lawyer clearly has a paramount duty of loyalty to his client. If the lawyer doubts the competency of the client, this may influence advocacy by the lawyer of the client's interests, jeopardizing the lawyer's loyalty to the client. For example, if the client proposes some action that seems bizarre, the lawyer may be tempted to notify a family member. A disclosure to the family member may be a violation of Model Rule 1.8(b), which prohibits use of information to the disadvantage of the client. If the lawyer determines to seek a guardian, the client's liberty is at stake and the lawyer's position is adverse to that of the client. Furthermore, in seeking the appointment of a guardian, the lawyer may be required to use or disclose information obtained in the representation of the client and thus violate the confidentiality rules.

In representing the impaired elderly client the lawyer is often caught between the mandates of conflicting disciplinary rules.

III. AVOIDING PROBLEMS WITH NO CLEAR SOLUTION

From the foregoing, it is abundantly clear that there are no clean answers to the ethical problems posed by the representation of elderly clients with some degree of incapacity. Perhaps the best way to serve a client is to anticipate these issues. Most clients have the foresight to see their attorneys for the

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THE LAW THAT WASN'T A LAW

Frank Crotzer

This is about the law. It is also about the English language. Specifically, it is about how, when the two are brought together, they can both become devoid of meaning. As someone with a Master's Degree plus thirty hours and ten year's teaching experience in English, I thought that I understood the English language fairly well. I also thought that I had a fair understanding at least of the reasons why we have laws. I am beginning to have doubts on both counts and am wondering whether I have a case for suing my twelfth-grade Government teacher. No, I am not a co-defendant in the Iran-Contra Scandal or a Wall Street inside trader; I am simply an apartment renter in New Castle County, Delaware.

As a renter, and especially as one who, in the past, has experienced a landlord who stopped doing maintenance and a condo conversion, I have had numerous reasons to consult the Delaware Landlord-Tenant Code. Naively perhaps, I thought the purpose of this document was to clarify my responsibilities as a tenant, my landlord's responsibilities, our respective rights, and, in general at least, the conditions under which rental housing operates in this state. In some instances, the code fulfilled this purpose, but I am now discovering that it may not always mean what it says and that the legislature may have spent time and taxpayer money to produce a document that no one understands.

My specific concerns at the moment revolve around the rather simple matter of security deposits. My landlord, like many others, demands that, each time the rent is raised (which is yearly), tenants pay additional sums to make the already held security deposit equal the new rent. I, like every tenant I have thus far encountered, find this demand objectionable for rule-abiding tenants with good records, especially since the legislature has failed to require landlords to pay interest on these deposits, as is done in sixteen other states and by other entities in Delaware (which, ironically, hold far smaller deposits). Landlords have, by the way, fought bills that would require interest payment every time they have appeared.

The Landlord-Tenant Code does not

address this specific issue directly; hence, these deposit hikes occur under the principle, "if it ain't prohibited, it's permitted", a principle that leaves people open to all sorts of mischief. By default, the landlords have become mini-legislatures unto themselves, in essence, making laws wherever there are none. Since rental contracts rarely, if ever, involve real negotiation, tenants are given a "take it or leave it" (literally) situation and have no means of getting something in return for their additional security deposits, such as painted walls or shampooed carpets usually provided for new tenants for the same or a similar security deposit. Renewals are "new" leases for the landlord's purpose, but not for the renter's. Logically (if the term can apply here), I wanted to know what the Landlord-Tenant Code did say about this. Having minored in Philosophy and watched Judge Wapner, I thought I might be able to construct an argument against these continual hikes. Printed in Section 5511 of all the copies of the code I have seen are the following:

(a) If a rental agreement requires the tenant to provide any deposit to the landlord to be held for the term of the rental agreement, or any part thereof, said deposit shall be considered a security deposit. No landlord may require a deposit in excess of one month's rent on contracts for one year or more.

(b) A security deposit shall be placed in an escrow bank account by the landlord and shall not be used in the operation of any business by the landlord. The security deposit shall be held and administered for the benefit of the tenant, and the tenant's claim to such money shall be prior to that of any creditor of the landlord, including but not limited to trustee in bankruptcy, even if such money is commingled.

There are additional subsections, which do not bear in anyway on the issue of deposit increases. Subsection (a) is pretty clear, even for legalese: tenant money held by the landlord (for reasons given in subsection (c)) is called a security deposit, and the landlord can't ask for more than a month's rent, unless the tenant rents for less than a year. Un-

less they are unfamiliar with the terms "escrow" and "trustee", most people would probably feel that subsection (b) is pretty clear as well: the security deposit belongs to the tenant, cannot be used by the landlord for business purposes or to pay the landlord's debts if he or she goes belly up.

Apparently, however, our legislators have discovered a new way of using the English language. When I sought some clarification of the words "administered for the benefit of the tenant" I discovered that they apparently have no meaning or that no one knows what that meaning is. No one in the legislature, the Division of Consumer Affairs or the Attorney General's office seems to have a clue. This surprised me. The words are fairly simple: a common verb, modified by an adverbial prepositional phrase (telling how), followed by an adjectival prepositional phrase (telling whose). My freshman comp students could handle this! Even more surprising, everyone seemed to be stymied by one word: "benefit". I found four definitions of this word as a noun in my dictionary. Since it obviously does not refer to an insurance payment and bears no relation to Live Aid, I eliminated two immediately. Since landlords are not generally known for charitable acts, I was able to rule out a third possibility. This left me with "anything contributing to an improvement in condition; advantage." That must be what the writer meant. Since I could discern no improvement in my condition or personal advantage in this situation, especially considering the deposit hikes, I too became confused. Apparently, the General Assembly has entitled me to some benefit which is not beneficial to me.

The method by which my landlord enforces his security deposit law brought about another instance of confusion. I have ignored his requests for additional security money, and, instead of taking me to court for what he feels is owed him (perhaps out of fear that the judge will know what "benefit" means), my landlord makes payment of the past hikes a condition of offering a new lease. This time, the landlord has demanded that next year's hike be paid two months

before the new lease and new rent take effect. It occurred to me that this would, technically, violate the "in excess of one month's rent" provision of the code, and I called Consumer Affairs to check this. I was told that Consumer Affairs could tell me what the law says (which I can do for myself), but not what it means, that a judge must do the latter. Did someone put me in a Fellini movie while I wasn't looking? Though further appeals to Consumer Affairs resolved this matter as I had hoped, the non-interpretation policy is applied to all matters not specifically and unequivocally spelled out in the code.

I do understand some of the bases behind this bizarre situation: in our system, the legislature enacts laws, judges interpret them, and the Attorney General's office and Consumer Affairs do not give private legal advice. Sticking too strictly to these roles, however, seems to me to create a number of possible problems. First, we have laws that are not laws. The Attorney General and the Division of Consumer Affairs have enforcement functions, but how can they enforce a law when they are not allowed to determine its meaning? Also, if judges are given exclusive rights to interpret, why have written laws to begin with? Essentially there is no law until the judge speaks, so why not disband the legislature, let landlords do as they wish, and, if the tenant objects, have them go before the judge and let him or her decide what is permissible? Second, we have words that are not words since they fail to signify anything definite, like some views of literary criticism, where the literary work is held to mean whatever the reader feels it means and the writer is irrelevant. The law says I have to pay rent; does it really mean that I do? More practically, since renters are often less able to afford taking legal action, this situation adds to the argument of those who say that justice exists only for the wealthy in this country. Finally, depending too much on the courts contributes to the problem of our overburdened court system. Based on the number of apartments, there could be 31,500 tenant-litigants on this issue or a similar one in New Castle County alone.

Are there solutions to these problems? Many have told me that any solution rests with the General Assembly, but there are further problems with this approach. First, it is very difficult to get small issues on the crowded docket at Legislative Hall; meanwhile, tens of thousands of Delawareans continue to suffer financially. Second, if legislators do address

this issue, who will insure that they do not produce a code revision which is equally vague and unenforceable? Third, how do we guard against every possible means landlords may find to get around the law? As for the courts, there is a point at which interpretation borders on legislation and at which deciding if a law is being violated becomes redundant. There are many complex issues and conflicts where judicial input is necessary, but is a minor point of the Landlord-Tenant Code one of them? There is also a distinction between individual legal action and a citizen complaint, especially when an entire group of people is affected and there is a statute which purports to address the issue at hand. This situation suggests an executive role, not a judicial or legislative one. A District Attorney does not wait for a private citizen to get a judge to decide whether or not the law really prohibits murder before filing for an indictment, and this involves individuals.

There are a couple of additional points worth noting here. Many people with whom I have spoken, including attorneys, legislators, and other officials, feel that at least some landlords may themselves be drawing interest on tenant security deposits, which would be a compelling reason for them to want to add to the millions of dollars they already hold as such. No one seems to know whether or not this is legal either, but someone other than me should be interested in finding out. Also, I have been unable to find any individual attorney or action-oriented group interested in pursuing this matter. Given the un-

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preparation of wills as they begin to advance in years. It is at this time when they are still clearly competent that significant planning (aside from the normal estate planning and tax planning) can be done in order to defuse the inherent conflict of interest and confidentiality problems that invariably arise in dealing with incapacitated elderly people.

Durable Powers of Attorney

When discussing wills, an attorney should also point out the desirability of a durable power of attorney, which would survive the grantor's subsequent incompetence or become effective upon incompetence. The durable power allows an older client to choose a surrogate decision maker ahead of time, giving the client more control over his affairs during subsequent incapacity than he would otherwise have. The Durable Power of

certainties I have encountered, I can't say that I blame them.

So I am left with questions. Have I been misleading my students about the nature and purpose of language? Does having laws really serve a purpose? I don't even know whether to consult Ralph Nader or Edwin Newman.



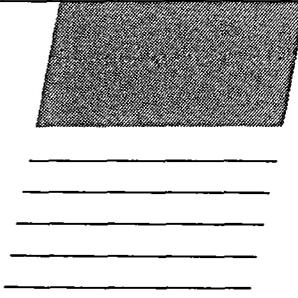
Frank Crotzer is a living reproach to certain aspects of our profession. As his accompanying article makes clear, there are highly intelligent, well educated people, fluent in the correct use of the language and at home with abstract ideas, who find many aspects of the law a cross between a mystery and a morass. Mr. Crotzer, who teaches English at the University of Delaware, has a strong interest in sports law and a predicament of the exploited athlete whose physical skills outdistance his readiness for higher education. He has suggested that if he writes something on this topic, this fortunate magazine may have first crack at publishing.

Attorney Statute, 12 Del. C. Sections 4901 et seq., does not explicitly provide a durable power to delegate the grantor's power over his own person (such as the power to make health care decisions). I see no reason why a power of attorney drafted with such an explicit provision included would not be enforced. Note, however, that generally the appointment of a guardian or other fiduciary charged with the management of the principal's property or the care of his person will terminate all previous powers of attorney. 12 Del. C. Section 4903(a).

Living Wills

This is another useful tool that I routinely counsel estate planning clients to consider whether they are young or old. A living will is expressly authorized under Delaware law by virtue of the Patient's Right to terminate Treatment

(Continued on page 41)



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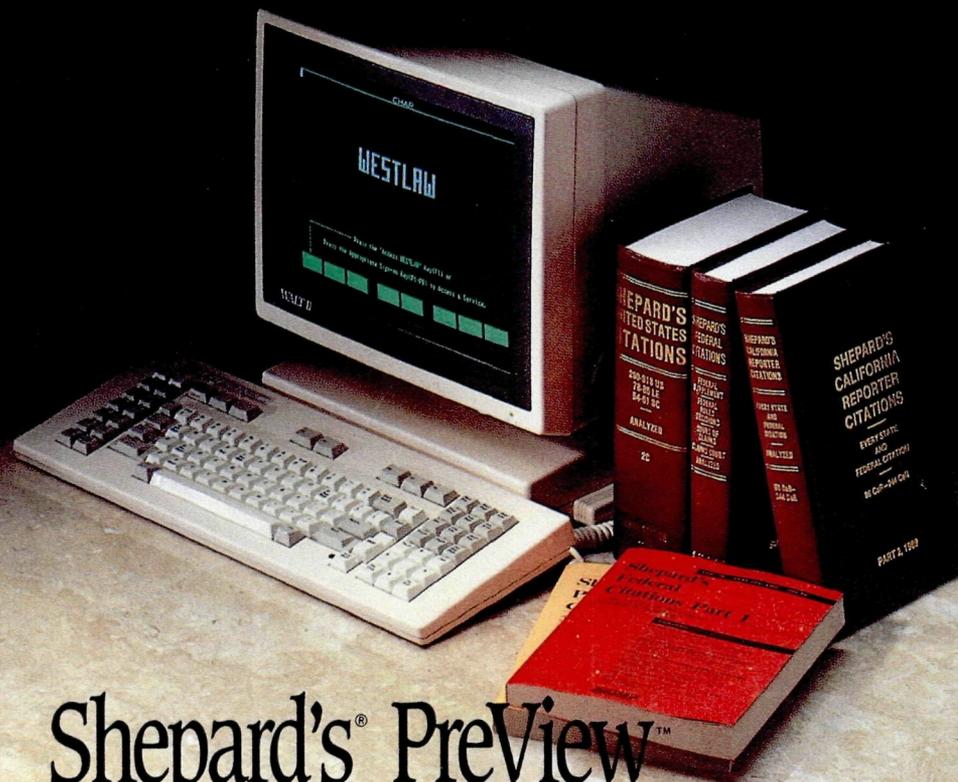
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