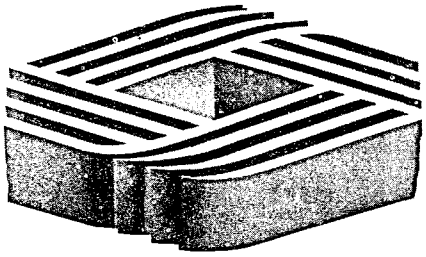
DELAWARE LAWYER

A PUBLICATION OF DELAWARE BAR FOUNDATION

$2.50 Volume 4, Number 1 SUMMER 1985

The Elderly in Delaware *Looking into the Future!*



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VOL. 4 NO. 1
SUMMER 1985

CARVEL STATE OFFICE BUILDING · 820 N. FRENCH STREET · WILMINGTON, DE 19801
(302) 658-5278

Contents

Cover: Gertrude Lowell in her 84th year is the *grande dame* of organized efforts on behalf of the elderly in Delaware. For ten years she has edited and published the *Delaware Senior Citizen,* a monthly newspaper. She was instrumental in reforming the activities of the Nemours Foundation and restoring it to obedience to its governing instrument, which calls for services to the elderly. She has served on many boards and commissions addressing the needs of seniors.

Gertrude looks to the future of our growing elderly populace. Her crystal ball reveals the Honorable Maurice A. Hartnett, III, who as Vice Chancellor of Delaware rendered an opinion of prime importance to the protection of the old and frail. See especially Tom Herlihy's article in this issue. Cover photography by Eric Crossan and Albert C. Johns; cover design and production by Rexis Art Studio.

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 ISSN 0735-6595.

Address Changes and Subscription Orders should be sent to: DELAWARE LAWYER, Delaware Bar Foundation, Carvel State Office Building, 820 N. French Street, Wilmington, DE 19801.

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EDITORS' PAGE

This issue, devoted to the interests of the elderly and law applicable to their circumstances, was conceived during our discussions with Elizabeth Henry, a former Magistrate. She is a remarkable lady, who served as a super resource person to the Division of Aging. She and Special Editor Judy Schuenemeyer entered into a brainstorming spree, designed the issue, and corralled our authors. On celebrating her seventieth birthday Elizabeth left the Division to pursue yet another career in the Peace Corps. In a very real sense this issue is Judy's and hers, and we thank them for it.

Thanks also to Larry Drexler, Editor Dave Drexler's son and a new member of the Delaware Bar, who volunteered research services and gave generously of them.

WEW

From one special issue editor:

This issue of *Delaware Lawyer* is dedicated to the nearly 100,000 people in Delaware who are estimated to be over 60. We use age 60, not because we think people in their 60s are elderly (we know they are not), but because 60 is the threshold age for most programs under the federal Administration on Aging and the Delaware Division of Aging. Those of us who have contributed to this issue do not view the older members of our population as a homogenous group, although they are often treated as though they were. They have a wide range of characteristics and needs. Many have little in common with their peers other than age and the need to deal with Medicare after age 65 and Social Security after retirement.

The articles in this issue address a number of concerns—some serious and troublesome, others in a lighter vein. We hope the material included is informative and useful.

Judith A. Schuenemeyer

ADVERTISER INDEX

Volume 4, Number 1 Summer 1985

fragile storage

only old women
touch the knicknacks every day
caressing their memories
with the gentle edges
of a feather duster.

the silver is closed away
in chests and vaults
stainless steel dries itself
in the drain basket.
the glow of dreams still reflects
in sunstream through the windowpane,
bounces in the sparkle
of a cut crystal bowl,
and rests in the eyes of quiet women.

each day is dreambound
weighted with the sandbags of yesterday.
shaking the dust from their dreams
resisting the pull, some surface
to bustle briefly through the
corridors of senior centers,
supermarkets and shopping malls.
carrying with them the memory
of hucksters calling
from street to street
tempting young women
from their household chores
to bright vegetable and fruits
interspersed with gossip.

only old women remember
which day the washing was done,
long afternoons ironing shirts
and careful hours preparing
sumptuous meals. now,
like an abandoned shell
the house sits empty all day
waiting for impersonal buttons
to be pushed to microwave
a frozen meal. technology
has found a way to speed the clock,
separate families, eliminate
whole patterns of life.

only old women
dust the knicknacks everyday,
remembering their other lives.
lingering repositories
of silent scenes.

e. jean lanyon

E. Jean Lanyon was appointed Poet Laureate for the State of Delaware in 1979. A member of First State Writers and Eschaton Writers, Jean actively encourages poetry and creative writing throughout the state. She participates in the annual spring Young Writers' Workshop, sponsored by the Reading Council of Northern Delaware, and has lectured at the Academy of Lifelong Learning. Her sensitive verse is an affecting addition to this issue.

THE GREYING OF DELAWARE

Delaware Division of Aging

You make me chuckle when you say that you are no longer young, that you have turned 24. A man is or may be young to after 60 and not old before 80.
—Oliver Wendell Holmes, Jr.

When Oliver Wendell Holmes, Jr. was appointed to the United States Supreme Court at the turn of the century, the average life expectancy at birth was 47.3 years. By 1950 life expectancy had increased to 68.2 years, largely because of reduced infant mortality rates and the near elimination of deaths from infectious disease. Today, average life expectancy at birth is nearly 74 years (69.8 years for males and 77.5 years for females).

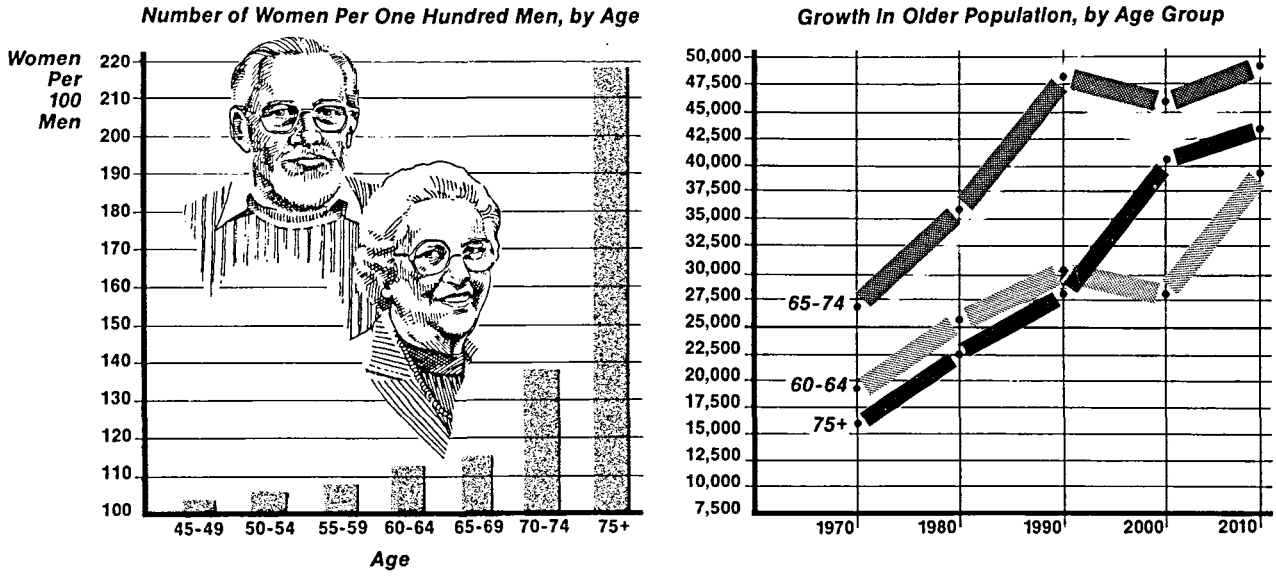
Advances in medical care are enabling more people to live longer, thus contributing to the overall aging of our population. There is no doubt that our society is aging, as are most industrialized western societies. Older persons are increasing in both actual numbers and as a part of the total population. The implications for every aspect of society are profound.

Those over the age of 65 numbered some 3.1 million persons in 1900, representing 4.1% of the population. By 1950, their numbers had swelled to over 12 million and their proportion doubled to 8.2%. The 1980 census counted 25 million older Americans, or 11.2% of all U.S. citizens.

The growth of Delaware's older population closely parallels that of the country overall. In 1900, Delaware's total population was slightly more than 180,000. Only 4.6% (or 8,468 persons) were over age 65. By 1950 the total population had increased to nearly 320,000 and the number of older persons to 26,320 (8.3%). During the next 30 years the population of Delaware increased rapidly (87%) to nearly 600,000. The older population more than kept pace: it doubled to 59,179, increasing the over 65 age group to ten percent of the whole. By the turn of the century, one in every eight will be over 65.

Increased longevity is not the only reason for this trend. Demographers agree that two other factors—birth rates and immigration/migration patterns—affect the age composition of a society.

DELAWARE



Immigration has been a major contributor to our large number of elders. From the late 1800s to 1903, the U.S. received 27.6 million immigrants, the vast majority of whom were 15-39 years old. While initially lowering the average age of a society, past immigration rates affect the number of older persons in subsequent years.

Following the establishment of immigration quotas, the impact of immigration on population structure began to decline and will continue to decrease over time. Migration patterns within the country continue to affect the aging of state populations, however. Although states such as Florida are generally associated with the influx of retirees, Delaware is also affected by migration patterns.

Delaware ranks 8th among the states in the in-migration of older persons. Between 1975 and 1980, Delaware's older population increased 14.8%, more than half (7.76%) of which is directly attributable to those who relocated or retired here. This influx was not balanced by a corresponding out-migration. During that period only 4,160 older persons left the state, placing Delaware 50th among states in out-migration. This suggests that rightly or wrongly Delaware is perceived as a pretty good place in which to be old.

Despite the roles played by life expectancy and immigration/migration, the fertility rate is the most important determinant of both the size of a population and the extent to which the elderly are a part of it. (Past fertility rates determine the number of persons who may survive to age 65; current birth rates determine their relative part in the total population.)

Persons born within a five or ten year period are referred to as "birth cohorts" or a cohort group. Cohorts share many characteristics and often differ in significant ways from the cohort group that precedes or follows them. Each cohort group places its unique stamp on society as it progresses through the life span. Each stage of life has its own particular needs and age-specific concerns about housing, employment, life style, law, political issues, and consumer needs. The magnitude of the impact of a cohort group is closely related to its size and proportion of the overall population.

The growing number of elderly has had a major impact on society over the last two decades and projections of their sky-rocketing numbers suggest this influence will continue to increase through the year 2020. This "greying" of the population will be the major social phenomenon of the next half century.

The rapid increase in the number of older persons since 1950 has had a profound influence on both the nation and the State of Delaware. It has had a particularly noticeable impact on public policy. As the trend continues, the private sector will increasingly be affected.

The rapid increased in the number of older persons since 1950 has had a profound influence on both the nation and the State of Delaware. It has had a particularly noticeable impact on public policy. As the trend continues, the private sector will increasingly be affected.

Aging first became a public concern during the Depression. In 1935, the Social Security Act was enacted to protect individuals against the vicissitudes of life and to guarantee a minimum income in retirement. Organized associations of older persons were instrumental in the establishment of the Social Security system (as well as the initiation of private pension plans). For the first time, the elderly had become a recognized political force.

Little of consequence in public policy for the elderly occurred during the 1940s as the nation was absorbed in the war effort. Concern for the elderly emerged again in 1950 when the Federal Security Agency (the forerunner of the Department of Health and Human Services) convened a National Conference on Aging attended by over 800 delegates. This conference set the precedent for the White House Conference on Aging.

The first and most influential White House Conference on Aging (WHCOA) was held in 1961. Like succeeding conferences in 1971 and 1981, its purpose was to identify issues posed by an aging population and develop national policy agenda. The 1961 WHCOA cast the greying population into the arena of public policy and established the elderly as a political force. The result: the passage of major legislation in the mid-1960's.

→

In 1965 Congress enacted Medicare and Medicaid, creating the country's first national health insurance programs for the elderly and poor. It also passed the Older Americans Act, the first and only piece of federal social service legislation directed solely at the elderly.

The Older Americans Act (OAA) was a response to the concerns of older persons identified in the 1961 WHCOA. These included difficulty in securing the services provided by existing systems and the lack of an adequate voice in public policy. The OAA provided funds for developing an accessible system of coordinated community and in-home services, deemed a matter of entitlement to those over 60. It also established the Federal Administration on Aging, responsible for representing the needs of older persons to other federal agencies and coordinating programs with them. It simultaneously created counterpart agencies with similar responsibilities in each state. State Units on Aging represent the needs of older persons on the state level and administer federal funds allocated to the states under the Act to fund a comprehensive network of services.

The decade of the 1970s saw the beginning of the rapid growth that foreshadows a trend expected to continue until 2020. The older population in Delaware increased by 35% (15,346 people) between 1970 and 1980, as contrasted with a 5% increase for all other age groups. An increase of another 25% is expected before the end of this decade (compared to 7% growth for the overall population).

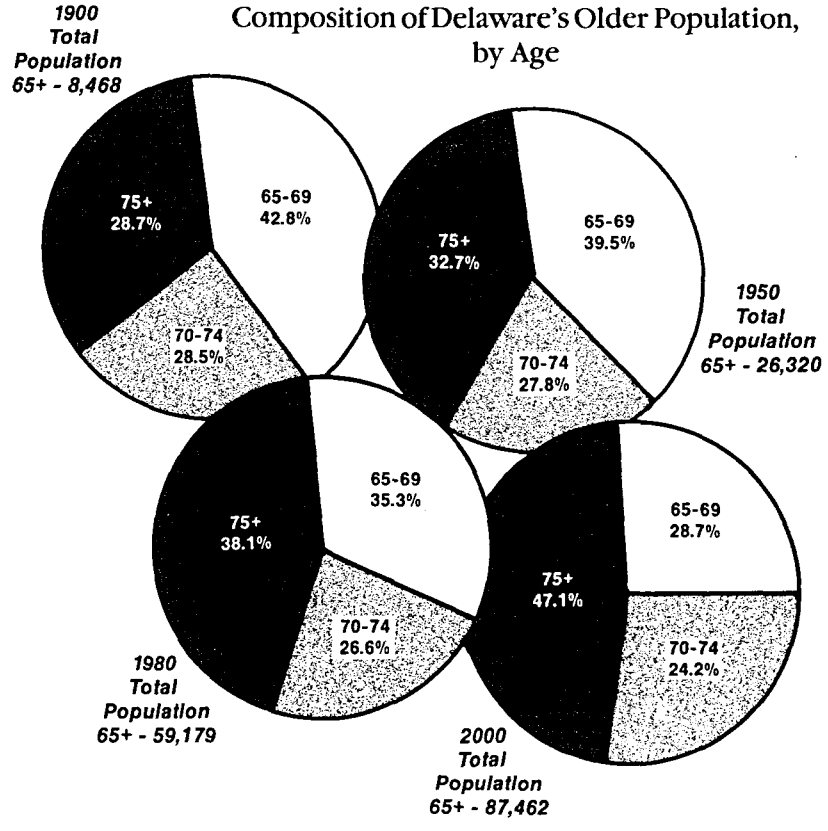
Most dramatic is the growth of the oldest portion of the population—those over 75. This is by far the fastest growing segment of the population, expected to increase by 42% (or 9,365) before the end of the decade. This is the age group most likely to develop the limiting chronic conditions that can accompany advancing age. This group has the greatest need for health and social services.

Only one person in eight between the ages of 65 and 69 has some functional impairment. Within the 75 to 79 age range, the number climbs to one in five. After age 85, more than a third have some functional impairment.

Many adapt quite well to some limitation and continue to be totally independent; others can live more or less independently with support from family, neighbors, or formal service agencies.

The vast majority of older persons

Composition of Delaware's Older Population, by Age



cope with age-related changes and live independently. Only 3.3% of Delaware's older population is institutionalized (lower than the national average of approximately 5%). The remainder live in homes, apartments, or with family. Fully 90% of those living in single family homes own them.

This latter figure demonstrates the desire of most to live independently in their own residences. The value placed on independence does not decrease with age, although one's ability to live independently may be jeopardized by declining health or limited financial resources. These are generally considered the two most pervasive problems associated with aging. They affect far more women, especially widows, than men.

Since women outlive men by almost 8 years and because cultural attitudes encourage men to marry women at least several years their juniors, a majority of women face at least a decade of widowhood. There are 118 women for every 100 men between ages 60-64; after age 75, there are more than twice as many women, 220 for every 100 men.

This difference in ratios attributable to differences in longevity render many older women far more vulnerable than males of the same age. Not only does it cause differences in living arrangements, social contacts, and isolation; it has a dramatic impact on economic status.

More than twice as many females as males live at or below the poverty level. This is partially due to their status as widows, but it is also due to differences in work histories. Even working women of that era often interrupted their working lives for child-rearing and homemaking. This has drastically reduced their income in retirement, since retirement income, be it social security or private pensions, reflects work history.

These differences between older males and females have prompted some gerontologists to state that the problems often associated with old age are the problems of women. While this is very often the case, it is unfair to stereotype, all older women or even all older people in general as having "problems."

The aging of our population, just like the aging of individuals, is not really a problem. Rather, it is a challenge. As the entire life span is a matter of adjusting to challenges characteristic of different stages of life for an individual, so the aging of a population is a matter of adaptation. It is a challenge faced by all the industrialized nations of the world. It is a challenge confronted in this issue.

Scylla and Charibdis: Restriction and Neglect

Delaware Division of Aging

On March 1, 1983 the Division of Aging inaugurated Adult Protective Services, a program intended to guard impaired adults from abuse, neglect, or exploitation, while preserving so far as possible their freedom and independence. The core of an adult protective services program is the client's right to self-determination. It aims at preserving his right to make his own decisions. Conflict between the APS client and the community can arise when he chooses to live perilously or even self destructively. Provided the client is competent, committing no crime, and not harming others, APS must insure that his rights are upheld. Consequently, APS makes every attempt to keep services *voluntary* in recognition of the client's right to refuse them.

In the first year of operations the Division received nine hundred reports of abuse, neglect or exploitation of impaired persons over eighteen. Reports are categorized and ordered by priority in the following manner:

1. Life threatening Bodily Injury. This includes physical abuse as evidenced by bruises, burns, broken bones, etc.
2. Neglect of an impaired person by one responsible for his care. It includes the withholding of food, medical care, clothing, or proper supervision.
3. Exploitation such as the illegal or improper use of the assets of an impaired adult. Although financial exploitation is more usual, the category also covers sexual abuse or exploitation.
4. Psychological Abuse such as verbal assaults or threats, provoking fear, or isolation.
5. Inadequate Self-Care, including hazardous living arrangements, poor money management, or refusal of medical treatment.
6. Disruptive Behavior, typically that which is unacceptable or offensive to community standards.

What happens to referrals? Preliminary screening attempts first to distinguish between the multiply impaired and those who can be served effectively, but less restrictingly, by other supportive services in the community. The latter group is referred to other organizations. During the first year of operations four hundred less impaired adults were referred to a variety of social, medical, or legal agencies. The remaining five hundred were assigned to Adult Protective Service workers for assessment and ongoing casework.

The largest reported category was inadequate self-care.

Category	Number	%
Life threatening Bodily Injury	77	12
Neglect	118	17
Exploitation	121	18
Psychological Abuse	63	10
Inadequate Self-Care	239	36
Disruptive Behavior	45	7

A final problematic issue is the availability of community resources. Adult Protective Services depends upon other agencies in providing help for its clientele. In formulating a service package for a client, an APS worker must frequently choose a more restrictive plan because back-up resources just aren't available. For some client populations (e.g. borderline mentally retarded individuals who are socially, emotionally maladapted) existing resources such as housing are so scarce that the prospect for stabilizing their cases is extremely poor.

Over sixty percent of the reports received by APS during the first year of operation were substantiated. In an additional ten percent the reports were unsubstantiated, but the adults were determined to be at risk.

Adult Protective Services does have limited funds available for emergencies when a client's needs cannot be met through his own resources or by other agencies. Emergency funds can pay for shelter, psychiatric evaluation, psychological evaluation, a language or sign language interpreter, a homemaker, home health aide services, medical examinations or treatment, or legal services. During the first year of operation APS emergency funds assisted thirty-five clients, principally with homemakers, home health aide services, and shelter.

Adult Protective Services is just one of the services that should be available to impaired adults on a continuum of care. The integrity and success of the program is dependent upon the skill of the workers and the availability of range of social, medical, and legal services designed to meet the varying needs of the population we serve.

At the outset an APS worker attempts a comprehensive assessment of the client and his environment, identifying strengths as well as needs. The worker can rely on other professionals in making his assessment. Social, medical, and psychological specialists contribute to an interdisciplinary assessment process that has proven invaluable in planning the right program for a client.

The typical Adult Protective Services client is a female (sixty-four percent) over sixty years of age (sixty-seven percent). Most APS clients are white (sixty-four percent) with incomes below poverty level (seventy-seven percent). About one third live alone. A slightly higher number live with spouses or relatives. Many clients have multiple impairments. The most common are: mental health, including organic brain syndrome and depression (twenty-three

percent), mental retardation (eight percent), urinary incontinence (seven percent), and diabetes (six percent).

Assessment completed, it becomes the social worker's job to create a package of medical, social, and even legal support services calculated to meet the client's needs in the least restrictive way.

During this phase of the casework process the Adult Protective Services worker may encounter several problems. Competency is a paramount issue. There are adults who are no longer able to make decisions regarding their health, their finances, or their daily living. But a more difficult problem is that posed by the adult whose decision making abilities have been impaired but who is neither totally competent nor totally incompetent. Providing casework services to members of this population is like walking a tight-rope, where the worker teeters between protecting the client and preserving his rights unimpaired. Adult Protective Services must also assume a frequent advocacy role in preserving the rights of the eccentric or highly independent competent person capable of informed decisions, who nevertheless place himself in conflict with community norms or notions about what is seemly for "old folks".

The vast majority of all Adult Protective Services are voluntary. In the first year of operations only two percent of the cases required involuntary services. All but one of these cases resulted in permanent guardianship. In an additional four percent of cases the family or another agency petitioned for permanent guardianship. This reflects the national experience: approximately ninety-five percent of protective services are voluntary.

DELAWARE LAWYER gratefully acknowledges the editorial contributions of the Delaware Division of Aging in setting the stage for this issue:

(The Greying of Delaware)
Eleanor Cain, Director of the State Division of Aging, has served on the boards of many national committees and is past-president of the National Association of State Units on Aging. In 1982, she was appointed by President Reagan to a 25-member U.S. delegation attending the World Assembly on Aging in Vienna.

Jeffrey Quinzer, a graduate of the All-University Gerontology Center at Syracuse University, has been head of planning and research for the Division of Aging for over five years. He attended the 1981 White House Conference on Aging.

Maureen Roser (not pictured), a planner with the Division of Aging, prepared data for the charts and some of the statistics included in the article.

(Scylla and Charibdis)
Karen Michel has an M.S. in Counseling and over ten years social services experience working mostly with older persons. She is currently Administrator of the Division of Aging's statewide Adult Protective Services Program.

D R G: An Experiment in Costly Thrift?

Judith A. Schuenemeyer

Four years ago the dire effect of escalating health care costs on the Medicare program led Congress to enact the Social Security Act Amendments of 1983 (*42 U.S.C. §1395ww*). This legislation established 467 Diagnosis Related Groups (DRGs) to determine the payment a hospital gets for serving a Medicare patient. The theory behind these categories is that people with similar health problems use similar hospital resources, and to more or less the same extent.

In devising DRGs the Health Care Financing Administration considered diagnosis, age, treatment procedure, discharge status, and gender. It was decided that each DRG called for a certain number of days of hospitalization, level of care, and particular treatment. Payments to hospitals reflect these factors for all patients within a DRG. Medicare pays the predetermined amount for a DRG that a hospital reports for each recipient upon discharge from care.

Patients who exceed by a fixed number of days the mean length of hospital stays specified for their DRG, or whose cases have unusually high costs (e.g. because of complications) are called "outliers", and hospitals may receive additional payment for their care and treatment.

This prospective payment system is a radical departure from that in effect for many years. Under the former system Medicare paid in accordance with the number of days and the types of services provided. The longer the stay, the more money the hospital received. There was no incentive to cut costs or improve efficiency.

Under the DRG system, if a patient stays less than the average stay for her diagnosis-related group the hospital makes money. If she stays longer, but not long enough to fall into the "outlier" category, the hospital loses money. The incentive is to contain costs by early discharges, since Medicare pays only a fixed amount for each DRG.

It should be noted that nursing homes and hospitals for children, rehabilitation, and psychiatric disorders are not subject to the DRG system of reimbursement and will continue to be reimbursed as before.

Under the former system Medicare paid in accordance with the number of days and the types of services provided. The longer the stay, the more money the hospital received. There was no incentive to cut costs or improve efficiency.

DRG is not yet in full force. It is being phased in over a three-year period, beginning with a hospital's first accounting period on or after October 1, 1983. In the first year 25% of a payment was computed by applying regional DRG rates, the remainder by the hospital's historic cost experience. During the second year 50% of a payment reflected a combination of national and regional DRG rates, the balance the hospital's cost experience. In the third year, payment based on the combined national and regional DRG rates will rise to 75%. By the fourth year payment will be totally geared to *national* DRG rates.

The rates differ between rural and urban hospitals and for very small hospitals (less than 50 beds). There are other factors in setting rates of payment, such as regional wage differences, special needs of sole community hospitals, new hospitals, risk-based health maintenance organizations, and hospitals that provide atypical services or essential community services, extraordinary circumstances beyond a hospital's control, medical and paramedical education costs, and a significantly fluctuating population served by a hospital.

DRG Impact on Hospitals

The prospective payment system is forcing hospitals to look carefully at what they do and what it costs them do to it. Cost control is paramount. Fewer people are being admitted to hospitals. More surgical procedures are being performed on outpatients. Since patients are now hospitalized for shorter periods, there are more empty beds, and the patients who remain are generally the very sick.

Hospitals are reducing staff partly in response to a declining population and for reasons of economy. At a minimum, vacancies are not being filled; in many instances professional nurses and other staff members are being let go.

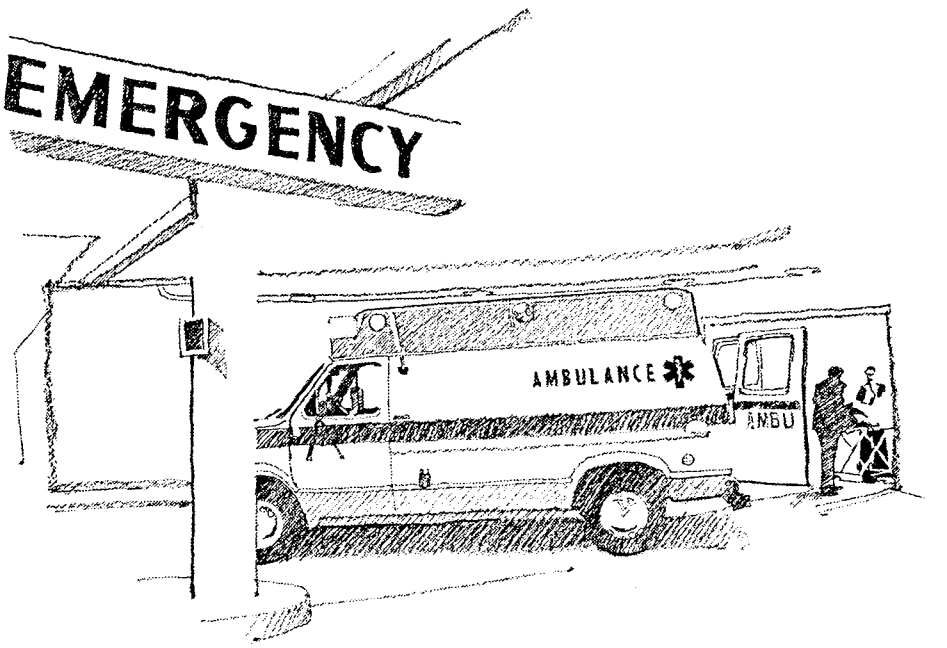
In order to function effectively within the DRG system, hospitals must make greater use of computers in tracking financial data, medical record data, and case management. This means more staff for data processing and retraining present staff to collect and properly record information required for DRG billings.

Review committees within hospitals must examine case data to find out why patients within the same DRG have shorter or longer stays, and therefore save or lose money for the hospital. Physicians who formerly made money for a hospital by keeping patients institutionalized for longer periods may now be costing the hospital money, and their patients' records are likely to be closely monitored. So too, nursing care and the conduct of individual nurses may be scrutinized to see if certain actions are leading to longer or shorter hospital stays. For example: are infections developing more frequently on some units than on others, prolonging stays by patients on those units?

Since patients are being discharged earlier, discharge planning becomes a more important hospital function, which may begin as soon as a patient is admitted. Plans must be made for the many Medicare recipients who require home

health care or a temporary stay in a nursing home because they or their families are unable to provide adequate care.

DRG experience in New Jersey furnished a model for the federal system. It has shown that financially unstable hospitals may be forced to close. Other hospitals may respond quite innovatively to the challenge of DRG by converting unused wings or units to long-term (nursing home) care or by creating new services such as home health care to generate revenues and use staff and other resources more effectively. Still other hospitals may merge in order to operate in a more cost efficient manner.*



Implications for Medicare Recipients and Others

Early discharges may lead to more readmissions, and hospitals may be found liable for negligence if harm results. Even if no complications, harm, or law suits follow, those who live alone and have no available help will experience considerable difficulty in meeting their daily needs while they recuperate.

Reduced nursing staffs and shifts in hospital populations to very ill patients may result in less and that of lower quality nursing care for *all* patients. This may give rise to more patient injuries and more malpractice claims.

Since Medicare recipients may cost a hospital money, there may be a reluctance to admit them to full hospital care. Consider for example, a recipient complaining of chest pain, who is taken to the emergency room. She may be retained there for many hours while tests are being performed to determine if there is a serious illness. Under the former payment system such a person, especially an elderly one, would probably have been admitted to the hospital almost immediately. Hospitals may now be genuinely concerned lest such a patient exceed the usual stay or the cost assigned to her DRG.

Unanswered Questions

Will the DRG system bring health care costs under control, or will those costs merely shift from Medicare to other sources, e.g. other hospitalized patients, insurance companies, nursing homes, home health care agencies, Medicaid, or other federal/state programs?

How will the quality of care provided in hospitals be affected?

How much money will DRGs save the Medicare program?

What are the costs of setting up the DRG system, and living with it. Who will pay those costs?

Are Medicare recipients, all disabled or elderly, victimized by the transformation of Medicare into a "stick or carrot" device to control health care costs?

How will the medical and nursing professions react to the "Big Brother" aspects of DRG? The last thing the elderly need is ministrations of resentful doctors and surly Florence Nightingales.

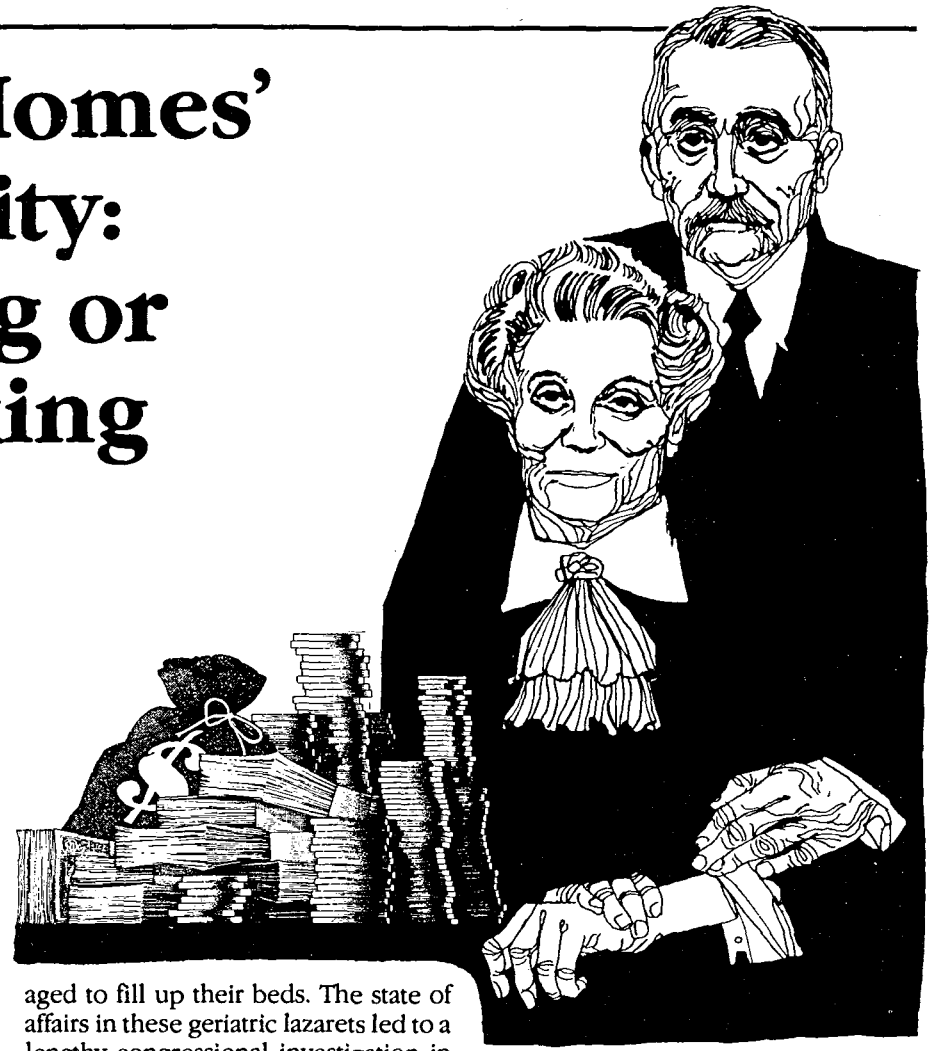
Medicare's Future With DRGs

It is too early to tell how much money the prospective payment system will save for Medicare and whether the system will affect total health care costs. The Secretary of Health and Human Services has been directed to study the feasibility of extending the DRG system to physicians' charges. It is conceivable that the system may eventually cover home health care. DRGs could also challenge the health care industry to develop more cost effective means of deliving high quality care for us all.

Judy Schuenemeyer holds a Bachelor of Science Degree in Nursing from Loretto Heights College in Denver, Colorado, where she worked as a registered nurse. She later graduated from the University of Georgia School of Law. A member of the bar in Georgia and Delaware, Judy is the managing attorney of the Wilmington office of Community Legal Aid Society and the chairman of the Senior Citizens Rights Committee of the Delaware State Bar Association. She is also a member of the Publications Committee of The American Association of Nurse Attorneys. Judy has conducted seminars on malpractice and other legal issues of concern to nurses.

**This may be all to the good. The late Aneurin Bevan, the Welsh Labour MP, said it all and said it short in the House of Commons: "I would rather be kept alive in the efficient if cold altruism of a large hospital than expire in a gush of warm sympathy in a small one." The Editors.*

Nursing Homes' Top Priority: Caregiving or Profitmaking



Nancy Davitt

In my twelve years as a medical social worker and a Director of a local hospital social service department, I was very active advocating and lobbying for improved nursing home care and more effective resources to help those patients who needed such services. Later I worked for about three years with the Division of Aging as the head of the Long-Term Care Ombudsman Program and the Advocacy Assistance Unit and continued my efforts to improve the long-term care delivery system with a special emphasis on the nursing home component. I have served as a speaker and panel member of a wide variety of national and local conferences, symposia and workshops dealing with problems involved in the delivery of quality nursing home care services. In spite of my career change, I have kept in touch with present advocates, especially the current Nursing Home Ombudsman Mrs. Marietta Wooleyhan. For these reasons, I feel competent to discuss these issues.

Over the last twenty years, nursing homes have turned into an industry and a profitable one. The term "nursing home" is applied to a wide variety of institutions that furnish medical care, primarily for the elderly. Before Medicare and Medicaid, most nursing homes were public institutions or non-profit homes, often called "homes for the aged." Once federal and state monies became available for nursing home care, the new industry evolved rapidly.

In the mid-1960s many so-called "nursing homes" were no more than boarding homes that gave little or no medical care. Unfortunately, many states accepted such establishments for Medicaid reimbursement and unwittingly encouraged them in such reprehensible practices as shanghaing the urban aged to fill up their beds. The state of affairs in these geriatric lazarets led to a lengthy congressional investigation in the 1970s. The Subcommittee on Long-Term Care issued a series of reports entitled "Nursing Home Care in the United States: Failure in Public Policy". The title sums up their findings. The conditions revealed sparked a nursing home reform movement and fueled exposes such as Mary Mendelson's *Tender Loving Greed: How the Incredibly Lucrative Nursing Home "Industry" is Exploiting America's Old People and Defrauding Us All,* and Frank Moss's *Too Old, Too Sick, Too Bad: Nursing Homes in America.*

At the same time in Delaware, Daniel Weiss, then a representative in the General Assembly, chaired an investigation of nursing homes and boarding homes. Hearings revealed many problem areas primarily related to the quality of care. The outcome was a number of recommendations to the State Department of Public Health to strengthen licensing requirements and to improve the enforcement of state and federal regulations.

The cause of many nursing home problems disclosed by these investigations turned out to be the reimbursement policies (especially those of Medicaid), which encouraged the undiscriminating placement of the elderly in nursing homes whether they needed it or not. In the commercial race to provide Medicaid beds, proprietors emphasized the physical and environmental requirements and shortchanged quality care and the adequate training of staff.

Medicare and Medicaid

Medicare (Title XVIII of the Social Security Act) provides coverage (hospital insurance) for "extended care" after a minimum of three days in a hospital. Upon admission to a "Skilled Nursing Facility" (SNF), more commonly called a nursing home, within fourteen days of discharge from a hospital, Medicare provides full coverage for the first twenty days and partial coverage for the next eighty. Initially this encouraged three day hospitalizations for the elderly, followed by transfers to skilled nursing facilities. Not surprisingly, many of those hospitalizations and transfers were not medically necessary. Within a short time, (a short time, that is, for bureaucratic reaction) the Federal government squelched the unexpected demand and

consequently unexpected costs by severely curtailing eligibility. Medicare coverage for nursing home care was effectively limited to those seriously ill or in need of rehabilitative care. In my opinion, the bureaucrats overreacted. Denial of coverage became the norm. Although administrative law judges and courts have regularly overturned such denials, the appeal process has placed an undue burden on wrongly deprived beneficiaries, and many of these have failed to appeal. As a result, eligible Medicare recipients have paid for services for which they were clearly entitled or have received no services at all.

At the same time that Medicare was restricting nursing home coverage, Medicaid (Title XIX of the Social Security Act) was expanding it. Medicaid,* a Federal program funded by federal and state funds, is administered by the states. Despite a requirement of minimum services in order for a state to participate in the program, coverage varies from state to state and even from year to year as the states cut back on their services.

Medicaid soon became the major funding source for nursing home care in the United States at an annual cost of billions. For almost a decade there were few curbs on Medicaid nursing home care reimbursements until it became clear in the 1970s that fraud and abuse were rife.

As costs continued to rise and the economy to fall, government restricted eligibility for services and decertified facilities that did not meet the program requirements. A number of terminated facilities brought suit, challenging the government's right to decertify. Leaders of the nursing home reform movement became concerned that decertification, even if warranted, made no provision for the residents of substandard facilities. To a resident, decertification ends coverage and forces him to move elsewhere, regardless of his wishes or the availability of a bed in a certified facility. Consequently, nursing home advocates preferred forced improvement or receivership for substandard facilities. However, they lost a major battle when the Supreme Court ruled that the residents of a terminated facility had no due process right to a hearing to protect their interests in continued occupancy. *O'Bannon v. Town Court Nursing Center,* 447 U.S. 773 (1980). The Court rejected the argument that involuntary transfers would cause transfer trauma and as a result the residents would suffer physical and mental deterioration.

In Delaware, Medicaid nursing home care coverage has had a checkered career. The state sets reimbursement rates for intermediate care and skilled care for *each* certified facility with reference to the costs peculiar to each. Result: reimbursement rates for each level of care, each requiring different standards of participation, vary from place to place, and in some cases markedly. The state determines the eligibility of each Medicaid applicant for skilled or intermediate care, which should enable it to control "inappropriate" placements, i.e., those not medically necessary. Since the costs of caring for a Medicaid resident vary depending on where he is placed, the state can wind up paying more for intermediate care in one case than for skilled care in another. The highest reimbursement rates are received by state institutions because they include ancillary services, e.g., physicians and drugs, in the basic rate. The current caps on Medicaid reimbursement rates are $48.26 a day for skilled or intermediate care in a private facility and $93.77 a day in a public facility. In comparison, the average rates charged to a non-Medicaid resident in a private facility are $68.00-$74.00 a day for skilled nursing care and $46.00-$50.00 a day for intermediate care.

Reimbursement rates under Medicaid have always been a source of contention between the state and the local nursing home industry. Nursing home administrators cite them as the major reason for the existence of Medicaid discrimination, e.g., refusal to accept Medicaid patients, discharge of residents who become eligible for Medicaid after exhausting their own resources or requiring applicants for admission to pay private rates for a minimum period, usually two years or more.

Although Delaware has never required that licensed facilities accept some Medicaid patients as a condition for licensing, our neighbor, New Jersey, has done just that and has successfully defended its position in court. See *New Jersey Ass'n of Health Care Facilities v.*

* *Medicaid provides two levels of care in nursing homes, skilled care and intermediate care. It should be noted that skilled nursing care under Medicaid does not necessarily mean the same thing as skilled nursing care under Medicare.*

Finley, 402 A.2d 246 (N.J. Super., 1979), *aff'd, Matter of Health Care Administration Board,* 415 A.2d 1147 (N.J., 1980), *appeal dismissed, cert. den., Wayne Haven Nursing Home v. Finley,* 101 S.Ct. 342 (1980).

There is one other significant wrinkle in the Medicaid nursing home program that does not apply to any other Medicaid service: applicants who meet a medical needs test can be covered even though their incomes exceed the Medicaid eligibility limit. In Delaware, a person with a monthly income of $585.00 and assets of $1,600.00 (not counting up to $1,500.00 in burial fund) may be eligible for nursing home care. The only problem with this exception is that it may force such people into nursing homes because they may be ineligible under Medicaid* or other State programs to receive home health services. It also limits a resident's discharge options. Once you leave a certified nursing home, you lose your coverage unless you transfer to another one.

* *Medicaid patients now occupy more than half the skilled and intermediate care beds in approved facilities in Delaware.*

Regulation in Delaware

A new or proposed nursing home must secure a "certificate of need" before it can apply for a state license. Standards for awarding certificates have changed in recent years. They stress more and more the kind of care the applicant intends to furnish and less the need for beds *per se.* This more realistic approach has resulted in a surge of approvals, primarily for something known as a "life care facility", where residential care is the principal business, and skilled and intermediate care wait in the wings until residents who become ill really need them.

Armed with a certificate of need, the applicant must next meet the licensing requirements of Title 16, Chapter 11 of the Delaware Code. If the applicant wants to be eligible for Medicare or Medicaid, it must also meet the federal regulations found in 42 C.F.R. Part 405 and administered by the Health Care Financing Administration (HCFA) of the Department of Health and Human Services (HHS). Responsibility for determining compliance with both state and federal regulations lies with the Office of Health Facilities Licensing and Inspection of the State Division of Public Health. This office is severely understaffed. At one time the federal government paid the State the full expense of reviewing the federal programs. A federal cost-cutting measure that coincided with a similar State cutback, forced a reduction in staff. Although the number of professional staff members has since returned to its previous level, the number of licenses and nursing home beds has increased significantly. In addition, this Office's review role is not limited to nursing homes, but includes hospitals, clinical laboratories, hospices, etc. As always, when one trys to do more with less, the quality of work has to suffer.

In Delaware, when it comes to regulation, there is built in conflict of interest. The Secretary of the Department of Health and Social Services and the Director of the Division of Public Health are responsible for the operation of five major health facilities as well as the Office of Health Facilities Licensing and Inspection. They also constitute the Board of Public Health, which hears nursing home cases. Thus the Secretary and the Director are put in the uncomfortable position of having to enforce regulations that they are also commanded by law to obey.

Enforced and improved regulation is a major goal of all nursing home advocates. In the early 1980s, HCFA issued proposed regulations for skilled and intermediate care facilities. For about two years, there were regional and national hearings that prompted extensive responses from nursing home advocacy groups, including nursing home residents, and the nursing home industry associations. After all that outpouring of concern, the federal government placed a moratorium on any regulation changes and Congress appointed a National Task Force on Long-Term Care Regulations, which held public hearings last fall to ventilate the same issues. However, as long as government, federal and state, continues to underfund enforcement, the imposition of new regulations will not have much effect on the actual care received by nursing home residents.

Medicaid and state laws also provide for Patient's Rights.* The Delaware statue 16 *Del. C.*, Section 1121 *et seq.* was borrowed *in toto* from Maryland. Unfortunately we used the original Maryland

* *Our statute, expressive of decent concerns, is a model of right thinking, as noble as a Boy Scout's oath, and just about as legally potent.*

law instead of the amended version, which corrected such oversights as lack of any enforcement provisions. Our statute professes to uphold all rights found in most model laws. The problem lies in enforcement, for violations carry no penalties.

Today, as never before, nursing homes are admitting older and sicker patients probably because of hospital response to the DRG Program.* Nursing home residents are less able to register their complaints and pursue their rights without third party assistance. Investigation of complaints of violation of the Patient's Rights law has been delegated to the Nursing Home Ombudsman Program, which is located outside the State system in a private agency. It is currently headed by Marietta Wooleyhan, the Nursing Home Ombudsman for Delaware. This federally-sponsored program currently mandated by the Older Americans Act evolved from a series of model programs set up in 1972 to assist nursing home residents by improving the quality of care. The Ombudsman receives complaints principally about the lack of care, poor quality of care, physical and emotional abuse or neglect by staff, loss of personal possessions, abuse or poor administration of drugs, unnecessary use of physical restraints, poor food, uncleanliness, lack of privacy, loss of freedom to do anything that would conflict with the sacrosanct rules of the facility, lack of physicians' services, misuse or mishandling of residents' funds, and involuntary transfer either within the facility or out of it.

Many residents and families don't complain. Are there no problems? Or is there is a more insidious reason for such a silence—a fear of retaliation? Those who do complain frequently request anonymity. My experience convinces me that this fear is a very real one. You have to respect a fear of retaliation expressly forbidden by our Patient's Rights law, because it is almost impossible to prevent.

In my estimation, the most important right guaranteed by our law is the resident's "right to be treated with consideration, respect and full recognition of his or her dignity and individuality." 16 Del. C., Section 1121(1). In many settings in our society, we treat the elderly as helpless, dependent, and incapable of making even the most minor decisions. This is especially true in institutions such as hospitals and nursing homes. Few nursing home residents have been declared legally incompetent, but many are treated as if they had been and are held in virtual protective custody. I do not say that nursing home residents can function at full mental capacity, but that their limitations should be accommodated and not seized upon as an excuse for indignities. Too often I have seen what amounts to a presumption by staff of a resident's lack of mental capacity. Attitudes reflecting such presumptions soon become self-fulfilling.

While I was at the Division of Aging, we funded a short-term therapy program for nursing home residents whom the staff had identified as almost non-responsive to verbal stimuli. By the end of the program, the therapist, herself a senior citizen, had all the residents talking and sharing memories. The key to this therapy was recognition of the self-worth of each individual in the group. The approach works, but it takes time and skill.

* *See Judith Schuenemeyer's article on the DRG Program in this issue.*

It is my belief that the attitudes of a nursing home staff determine the quality of care and the quality of life for the residents. Nursing homes reflect a medical model, but they are not part of the medical mainstream. (One of the most frequent complaints of nursing home administrators is their inability to get physicians to visit their patients and to complete the necessary documentation required by law.) Nursing homes generally pay their nurses less than hospitals and offer fewer benefits. The bulk of residents' care is provided by nurse's aides, who are frequently trained on the job and often receive only a minimum wage. We need to provide staff training in geriatric nursing care, a rather recent nursing specialty, in order to give the best possible care to this at-risk population. As long as we fail to do this, we can expect complaints of abuse and neglect to continue.

At this point, you probably believe that I don't think that there is such a thing as a good nursing home. That is not true. When an applicant takes part as much as he can in the decision to enter a nursing home and the staff members are enlightened and informed geriatric caregivers, there is every reason to believe that the applicant will adjust well and receive good care.

In many cases, especially those of really sick people, admission must be handled by family or friends, often assisted by medical social workers. The availability of the type of bed for the care needed and the applicant's resources often determine where he is placed. Such admissions are distressful to all concerned and the pressures eliminate any real choice. For example, when the hospital staff and the doctors say that a patient must be moved or lose Medicare hospital coverage, there is rarely the time to determine the best place to serve the patient's needs. Anyone who reasonably expects to face such a decision for an elderly relation or friend should take the time to visit as many nursing homes as possible. Also one should check the provisions in admissions contracts. In a recent review of a sampling I noted that the waiver of a resident's right to security in the storage and use of his personal possessions was common.

I've known residents who were relatively content in generally poor facilities and I've known residents who were very unhappy in excellent ones. When a resident is placed in facility without some effort to inform him of the reasons for admission, unless he is comatose or non-responsive to verbal stimuli, you can expect problems from the outset. How a staff deals with such problems depends on the quality of their training and the level of their skills in handling emotional distress. Good care depends on an understanding of the resident as an individual, which means much more than a mere grasp of his physical limitations. Such understanding cannot occur if the facility is understaffed or the staff is undertrained.

The health, dignity and security of our elderly citizens who reside in nursing homes will remain at risk, just as they were when they lived alone and unsupervised or uncared for in their private residences. They'll be at risk until we find a way to put teeth in our benevolent but edentate statutes and use those teeth to chomp down on violators. Regulatory enforcement is a necessity, not a luxury.

. . . AND NOW FOR A WHIFF OF BRIMSTONE (DTLA PLEASE NOTE)
The aged may be frail, but they can engage the services of robust plaintiffs' lawyers.

Hospital Falls —Negligence

Rhonda G. Beldner, R.N.

In a world of highly publicized malpractice trials, where spectacular sums are awarded by juries for severe damage or loss of life incurred by relatively young complaintants, we may tend to overlook the cases of elderly clients with terminal diseases, who sustain injury or loss of life directly attributable to negligence.

Every year, thousands of these potential cases against hospitals, physicians, and particularly against nursing personnel go unnoticed. One of the most common sources of inadequate nursing care contributing to complications and death of older patients is the failure to minimize the risk of patient falls during a hospital stay.

While it is the physician's responsibility to order proper restraints once alerted to a patient's predisposition to fall, the hospital has an obligation to prevent falls and to deal with the problem in its policy and procedure manual. The hospital or medical center's stated goal should be to alert the nursing staff of their responsibility in the minimization of falls through identification of "PTF" (prone to fall) patients, while undertaking immediate treatment if preventive action fails.

A publication of the American Nurses Association, *Gerontonlogical Nursing Practice*, states that it is the duty of nursing personnel to collect data on the health status of the older adult, including the patient's ability to perform the activities of everyday living, such as getting out of bed and walking unassisted. The health status data are collected from medical records, the patient, those close to the patient, and others responsible for the patient's care. The typical nursing problem list should enumerate a patient's strengths and weaknesses and evaluate them by comparison with the norm. Nursing goals should then be defined and specific approaches stated in order to reach these goals.

How do these standards of care fit into the real world of caring for the elderly patient? Nursing personnel are clearly responsible for insuring that a patient's risk of injury from hospital falls is minimal. Developing a nursing diagnosis that takes into account a patient's neurologic status, debilitating diseases, drug status, mental state, sensory deficits, and age is the key to minimizing that risk. Ideally documentation of nursing care history includes the patient's level of alertness, physical or mental disabilities, previous falls, sleep habits (e.g. the need to get up at night), and current medications. Standard procedure should include orientation of patients to the location of bathrooms, checking brakes on bedcoaster, answering patient calls promptly, leaving the frame of the bed in the low position whenever the nurse is not in attendance, raising at least two siderails on every patient at bedtime, and reporting wet floors or hazardous conditions immediately.

When a patient is "at risk", further precautions are recommended: escorting ambulatory patients to the bathroom or offering a bedpan at least every four hours, use of a geri chair or wheel chair with wheels in the locked position, and the use of a jacket or sheet restraint when necessary. For example, if an elderly patient is admitted to the hospital with a neurologic deficit or an unsteady gait, consider this patient at high risk of falling and evaluate him accordingly. If a patient also has a history of falls, or stronger case exists for more extreme measures in preventing falls during a hospital stay.

Everyone who enters a health care facility, including the terminally ill or quite elderly patient, is entitled to scrupulously attentive care. Nursing standards exist so that care is optimized for every patient. The professional nurse has a duty to uphold these standards for all patients, thus minimizing the risk to the elderly and terminally ill.

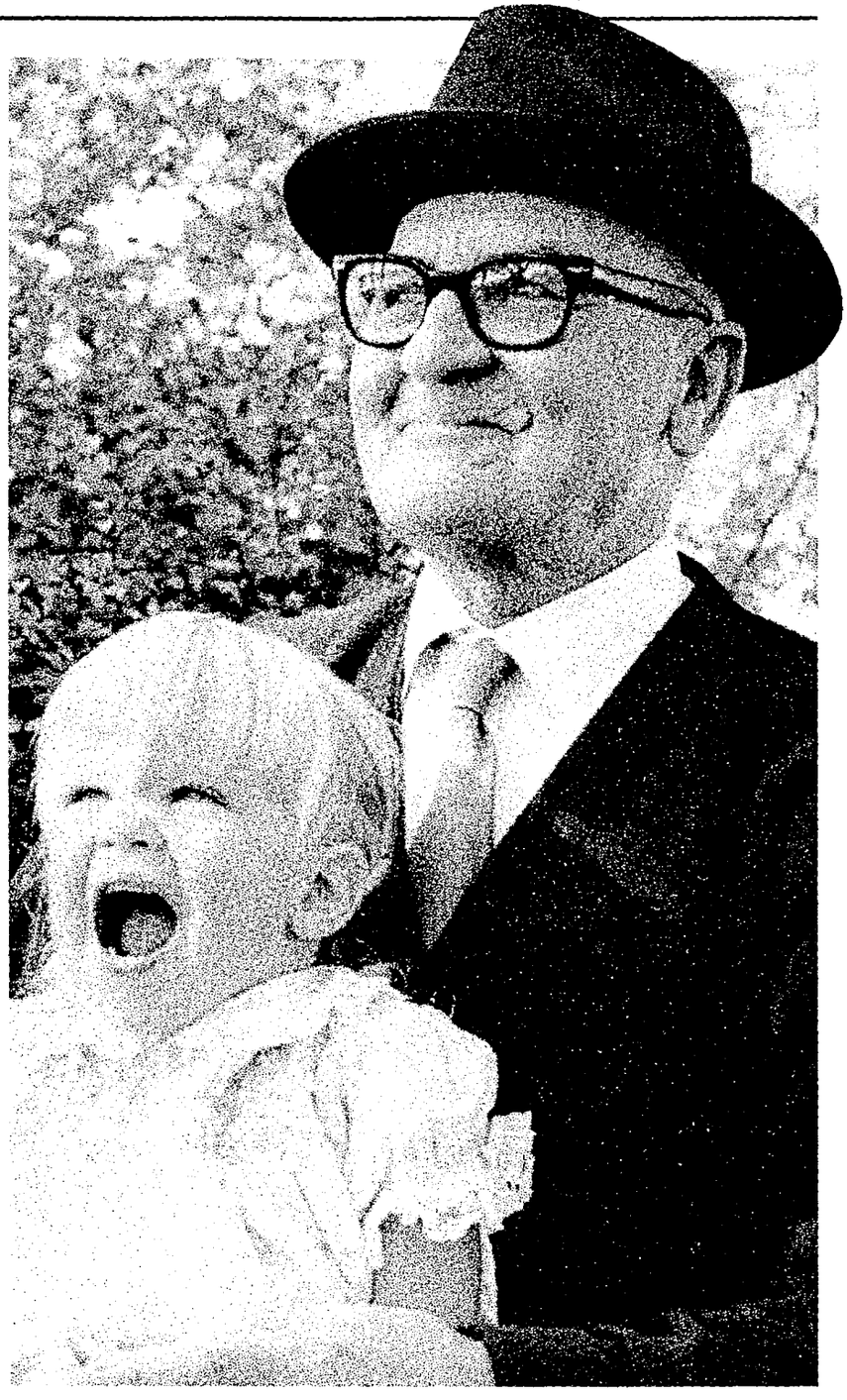
Rhonda Beldner, a graduate of Temple University, School of Nursing has wide experience in her profession, ranging from work as an Emergency Room nurse to the position of Assistant Director of Nursing at Doctors Hospital in Hollywood, Flordia. Today she is the Executive Director of Philadelphia Medical Advisors, Inc. In a letter to DELAWARE LAWYER *she enlarges on the theme of her trenchant observations above, the growing exposure to malpractice as a result of an increasing population of the elderly and failure to apply techniques adapted to their special needs:*

"In the past two years, I have been the Executive Director of Philadelphia Medical Advisors, a medical-consulting firm. Numerous cases have come to our attention from the state of Delaware. As in every other state in the United States, we have noticed that most medical malpractice claims are based upon poor communication between the medical staff and patients. In addition, a further complication arises when medical charts lack proper documentation. One hopes that, with an increased awareness on the part of not only the medical community but the general public as well, better communication skills will arise. People will ask for more precise information and medical personnel will be held responsible for giving optimum health care."

Parent to Child— Child to Parent

Obligation and Abuse in America

Suzanne K. Steinmetz



THE MYTHICAL PAST

As formal institutions replace the role of family in religion, education, occupation, and finance, the family is left with its principal responsibility, the fulfillment of the expressive needs of its members. The *way* in which care is provided, not the mere fact of provision, has become the measure of family health. In our attempt to glamorize the family of the past we have overlooked the failures and idealized the strengths. We have tended to blame contemporary family related problems on changes such as the two car family, the two career family, increased occupational and geographic mobility, a high divorce rate, and the "pill". But there is abounding evidence to refute the notion of idyllic intergenerational relationships in families of the past. Hareven, an authority who has examined the institution of the family over time, observes: "Families shared their household space with other kin only as a last resort during periods of housing shortages or severe economic constraint."[1]

The family idealized in literature was not the reality. Kent notes: "the three-generation family pictured as a farm idyl is common, yet all evidence indicates that at no time in any society was a three generation family ever the common mode, and even less evidence that it was idyllic." When three generational patterns did exist it was for a short span of time — while a young couple built their home, or amassed resources needed for settling new lands, or when the elder moved in to die. The shorter life expectancy decreased the overlap between generations. Only the fittest survived; the weak and infirm, young and old, without recourse to modern medicine, succumbed quickly. Contrary to the picture of the family gathered at the bedsides of elders devoting 24 hours a day to their care, elders continued working until severe illness or death, and were not dependent on their adult children for prolonged care.

Colonial America often turned to the Bible for family guidance. "He who spares the rod hates his son, but he who loves him disciplines him diligently." (Proverbs 1:24) Children were commanded to: "Honor thy father and thy mother that their days be long upon the earth." (Exodus 20:12). A 1646 law declared:

If any child[ren] above sixteen years old and of sufficient understanding shall curse or smite their

natural father or mother, they shall be put to death, unless it can be sufficiently testified that the parents have been very unchristianly negligent in the education of such children, or so provoked them by extreme and cruel correction that they have been forced thereunto to preserve themselves from death or maiming...

If a man have a stubborn or rebellious son of sufficient years of understanding, viz. sixteen, which will not obey the voice of his father or the voice of his mother, and that when they have chastened him will not harken unto them, then shall his father and mother, being his natural parents, lay hold on him and bring him to the magistrates assembled in Court, and testify to them by sufficient evidence that this their son is stubborn and rebellious, and will not obey their voice and chastisement, but live in sundry notorious crimes. Such a son shall be put to death.

Apparently Biblical precept did not improve parent-child relationships. Increase Mather in *Dignity and Duty* complained that "There were children who were apt to despise an aging mother;" and Landon Carter, in 1771 noted "It is a pity that old age which everybody who lives must come to should be so contemptible in the eyes of the world." The respect enjoined by the fourth commandment did not necessarily embrace affection. Although the elderly might have special pews in church and even enjoy a presumption of grace because of wisdom, many were viewed as wicked, possessed of the spirit of the devil, addicted to witchcraft, and worthy of penal consequences. The elderly who were poor, female, and widowed, three attributes often found together, were despised and treated badly. Colonial court records disclose frequent attempts to bar old people from a town lest they increase the pauper population.[2] A 1772 New Jersey law required the Justices of the Peace to search arriving ships for old persons as well as other undesirables and to send them away. Neighbors often "warned-out" poor widows and forced them to wander from town to town. The minutes of a meeting of the Boston City Selectman held in 1737 report:

Whereas One Nicholas Buddy an Idle and Poor Man has resided in this Town for Several Years past, and is in danger of becoming a Charge to the Town in a Short time, if not Transported. And There being now an Offer made by some of his friends of Sending him to Jersey (his Native Countrey) Provided they might be Allowed the Sume of Five Pounds towards defraying the Charges of his Passage thither.

The selectmen appointed Captain Armitage and Mr. Clarke to complete the arrangements and authorized payment, not to exceed five pounds, on condition that Buddy be sent home.

The questions that immediately come to mind are: "Where are the loving, caring children of yore?" "Why are they not caring for their elders?" It is probable that there were no such children, just as today more than half of the residents of nursing homes have outlived family and friends.

Parents in Colonial America often found it necessary to use property transfers, both by will and by deed of gift as hedges against maltreatment of themselves or their survivors in their old age.[3] These documents often included elaborate instructions for a surviving wife's care, requiring the child who inherited the property to furnish food, clothing, shelter, and services or risk forfeiture of his inheritance. In pre-revolutionary Andover, Massachusetts, a deed of gift of the family homestead to an unmarried son when he reached 30 required him to "take ye sole care of his father Henry Holt and of his natural mother Sarah Holt" for the rest of their days and to provide for all their needs, which were carefully detailed. Failure to do so would result in forfeiture of the property. One Joseph Winslow left all his movable properties to his wife for her to distribute after death in accordance with their off-spring's performance of filial duties. Such precautions would hardly have been necessary unless the grantors knew of elders mistreated by their children after property transfers. The threat of revocation was a widespread and doubtless prudent retention of economic power.

Parental economic control of adult children often made for conflict. One eighteenth century son, Robert Carter, remained for 20 years under his father's authority until his early 50's, by which time bitter conflicts bordering on violence had ensued. The father, who feared for his life to the point of arming himself with a pistol, wrote: "Surely it is happy our laws prevent patricide or the devil that moves to this treatment would move to put his father out of the way. Good God, that such a monster is descended from my loin."

The Victorian family was also not immune from severed intergenerational ties. In 1889 a bill was presented to the board of commissioners of Brown County, Minnesota for the boarding of a poor, sickly old man who had been driven off by a son who no longer wanted to support him. Unfortunately, this situation still exists. According to the January 23, 1985 issue of the Wilmington News Journal an elderly couple who deeded their home to a grandson with the understanding that they would be able to spend their remaining years in the home, discovered that the house had been sold out from under them and that the grandson had skipped town with the money.

CONTEMPORARY FAMILY RELATIONS

Although a variety of studies suggests that contemporary parent-child relationships throughout the life cycle are probably more humane and caring than at any time in history, comparisons with the past may be less than illuminating. The relatively long period of child dependency (post maturity), and increasingly longer periods of elders' dependency on adult children are among the many circumstances of family life today that simply did not exist in the past.

The Cycle of Caregiving

Because of the cyclical nature of caregiving, we can obtain insights into the treatment of the old, by examining the way in which adults deal with the very young. Although we are a society that prides itself on caring for and protecting the weak and vulnerable, it was not until the early 1970's that all states had enacted legislation to protect children from abuse and neglect.

In 1874, the need to define a young girl as a member of the animal kingdom in order to secure protection under the recently enacted Society for the Prevention of Cruelty to Animals drew public outrage and resulted in the formation of the Society for the Prevention of Cruelty to Children.

A nationwide study found that eight percent of the children had been kicked, bitten, or punched, (an average of nine times a year). Four percent were beaten (an average of six times a year). Three

percent were abused with guns or knives. Forty-one percent of the mothers in one study reported that they used physical punishment on their babies who were under six months of age, and 87 percent had done so by the time their children were two. Similar findings were reported in another study. Twenty-five percent used physical punishment before six months, and about 50 percent did so by one year of age. Physical abuse is not limited to the very young. It appears throughout childhood. One report showed a peak in the use of abuse for 15-17 year olds and one nationwide study of adolescent girls reports that 12 percent had been beaten and nine percent raped.[4]

We have learned a lot about families who abuse their children. They may be experiencing stress from unemployment, too many children, unsatisfactory living arrangements, marital problems, and insufficient education or knowledge about the development and care of children.

Children who have faced brutalizing childhoods are likely to be disproportionately represented among rapists, assaulters and batterers, murderers, wife and child abusers, suicides, and victims of personality disorders. Furthermore, while the probability of attacks on nonviolent parents is about one in 400, the likelihood of attacks on parents who use violence on their adolescent children increases to about *200* out of 400. *Unresolved parent-child conflicts and abusive family interaction continue throughout the life cycle.*

Concern about adult children's care of their elders surfaced in the early 1980s with the discovery of "granny bashing". Those at risk of abuse are frail, elderly (over 75) women in the care of family members, usually a daughter or daughter-in-law. Although much of the abuse occurs when the caregiver attempts to restrain or force the elder to take food or medication, about four percent of dependent elders in the care of their own families are threatened with physical force, and three percent are physically abused. Eighteen percent of these elders reciprocate by hitting or slapping the caregiver — a method of last resort when one has no other means with which to assert control such as power, prestige, authority, money, and independence.[5]

As a result of heightened public awareness, most states have passed some type of adult protection legislation. In Delaware, for example, 31 *Del. C.* Chapter 39, was enacted in 1982. We are shocked, nevertheless, to find a society that professes to view the family as an oasis of love and care yet still abuses and neglects elder relatives. What changes in the family have led to so much abuse and neglect of the elderly?

One of the first is directly related to increased longevity. The average life expectancy of 35 years in the 18th century has risen to the mid 70s. By the close of the century, nearly one in five of us will be 65 years of age or older. The greatest increase, 53 percent, will be among those 75 years or older. These frail elderly are most vulnerable to physical, mental, and financial crises requiring care by families and society. It is not only the increased number of frail elderly that has changed family relationships. We must recognize that those in their 8th, 9th, or 10th decades have children who are elderly themselves or nearing that stage of the life cycle. In fact, about one in 10 has a child over 64.

Role Reversal

Biomedical research has dwelt on extending life expectancy, while paying minimal attention to the quality of elderly life. The problems of increased longevity are not confined to the elderly, but encompass the whole family life cycle. Middle-aged children often are unable to cope with problems arising from within their own nuclear families. The additional burden of shouldering a parent's problems can become a tipping point with the potential for abuse and neglect. The change in the role of the child from being cared for to that of caretaker may build feelings of resentment and misapprehension in both generations. Love and respect can easily turn into guilt, hatred, and disappointment, as children attempt to function in their new roles. Unresolved conflict between parents and adolescent children often continues throughout the life cycle, with the result that contact may remain at the level of obligatory vaca-

tion or holiday visits during the child's adulthood. In families with these unresolved conflicts it is unlikely that a child will enthusiastically shoulder the care of an elderly parent. The motivation to care for the older kin may arise not only out of love and concern, but from a sense of responsibility, duty, or guilt. When the child generation is responsible for two or more older kin, the pressure and strains, which vary with the degree of dependency needs of the elderly, can be severe.

Stresses that Contribute to Elder Abuse

Generationally inversed families, where the parent has been forced into the role of the child (and vice versa) can be breeding beds of conflict and violence. For the elderly person economic dependency produces loss of control, self-esteem, and prestige. The caretaking generation faces an economic drain and conflict over competing goals for the use of limited resources. Moreover, an elder's severe or chronic illness and physical and mental deterioration that often accompany aging place additional burdens on the caretaking family. Medical costs frequently are not compensated by public or private health insurance, or at best are under-compensated. Those costs compete with other expenses such as children's education, weddings, or provision for the caretaker's own retirement.

Social, psychological, and emotional dependencies must also be negotiated. Studies have found that physical dependencies are easier for caretakers to deal with and are not as stressful as social/emotional dependencies. The continual decision making associated with emotional dependencies can be deeply disturbing for the caregiver. The time required to care for a dependent elder often precludes fulfilling the needs of the caregiver.

As the dependency of the vulnerable elderly increases, so does the potential for abuse, unless adequate resources are found. Although parents are legally responsible for the care of their children until 18 years of age, this is often extended while children attend college or find employment. Middle-aged parents often see themselves as living in a house with a revolving door; a mature child is launched into marriage or a career, just as another returns home (frequently with grandchildren in tow) after a divorce or career change. Then a great-grandparent moves in because he or she can no longer live independently. A middle-aged couple who had yearned to enjoy the privacy and freedom of the empty nest may quickly find themselves responsible for a four generation family under one roof, without the support services and resources that enable them to adequately fulfill these multiple roles.

We must recognize that those in their 8th, 9th, or 10th decades have children who are elderly themselves or nearing that stage of the life cycle. In fact, about one in 10 has a child over 64.

The Economic Impact of Caregiving

The monetary standards defining eligibility for government support make it difficult for middle class families to receive benefits until assets are spent. Institutionalized care is shockingly expensive and there are very few financial incentives or rewards for families who do provide care for their elders.

This economic impact of caregiving has profound effect on women. Women enjoy a long life expectancy, often outliving their spouses. With the spiraling cost of living they may be forced to continue working until mandatory retirement or their own health needs prevail. If they must seek employment to meet financial obligations then they are no longer available as full-time caregivers for their elderly parent, and their "family" income may exceed the limits for subsidized services.

A maximum Federal tax credit of $720.00, allowed for the care of a dependent child or elder hardly compensates for the actual cost of care, although the credit is predicated on the notion of "need to work". Many states changed their relative responsibility laws with the passage of Medicaid legislation, especially when this act was amended in 1977 to prohibit the requirement or even to permit relatives other than a spouse or dependent child to contribute to the cost of nursing home care. However, the 1983 budget proposed to "Allow States flexibility to recover long term care (LTC) cost from beneficiary

estates and relatives" by removing Federal laws and regulations that pose barriers to State collections for beneficiaries' estates and the incomes of beneficiaries' families.

Available data suggest that most elderly people do not want to be dependent on their children; most adult children do provide support at the level possible. Many of the adult children to which the reinterpretation of relative responsibility applies are themselves elderly (or nearly so) by census definition, and many of these adult children have some level or responsibility not only for several elderly kin but also for their own children and grandchildren. the effect of being caught in the middle is evident in a comment made by one 60 year old respondent regarding her 84 year old mother: "I don't want to consider my mother a burden. I would be glad to continue to care for her if she were not unpredictable and I could. This is the selfish part — I want to do some of the things I like to do because I am not very young either."

The attitude of the Federal Government toward the problems of aging ignores the length of time one may be responsible for the care of an elderly relative. Studies on aging have tended to overlook the rights and needs of adult children and to blame them if they have not provided a comfortable, happy arrangement for their aged parents during a filial caregiving that may last for 10 to 15 years. Studies conducted in Delaware, showed that the average length of time for caregiving was 9.5 years. Moreover, 30 percent of the families interviewed had cared for an elder for 10 years or more, 17 percent for 15 or more and 10 percent upwards of 20 years.

The Delaware code clearly defines the limit of responsibility for a parent's care of a child to age 18 unless the child is handicapped. But spouses, parents, and children are liable without limit for expenses incurred in the care and support of a relative not covered by Medicaid. 13 *Del. C.* §§501 and 503. Since the Delaware law fulfills the requirement of "general applicability" and is not limited to any one group (e.g. those receiving Medicaid benefits), it has not been successfully challenged. Although most state legislation proposed in a flurry of activity after the announcement of the 1983 Federal Budget has been withdrawn, defeated or overturned on technicalities, the degree of liability specified in those bills points to financial devastation for families if such legislation is widely adopted.[6] For example, Massachusetts would have required each adult child *residing* in the state and with taxable income over $20,000 to pay up to 25 percent of the cost of maintaining a parent. Elders whose children did not pay the amount assessed would lose entitlement to nursing home care. Drafted legislation in Mississippi proposed a sliding scale of $25 to $250 a month on income exceeding $8,000. A bill drafted in Colorado would have made children responsible for the *total* cost of care, thus freeing the state from all responsibility for caring for the elderly.

What about the responsibility of children who were once abused by the now needy parent or who were brought up by others? Are they expected to care for those who abused, neglected, or abandoned them? Indiana limited responsibility to children between 21 and 60 (thus eliminating the elderly child) and to those who were provided with necessities until age 16. Wisconsin's bill defeated in 1982, specifically excluded abused children and those who had little contact with parents after reaching adulthood.

If legislation like this becomes law, family members will be responsible for the care of an elder while trying to save for their own old age. We may be entering in an era where we must confront the problems not only of "pauperized widows" who have exhausted their assets to care for the final illness of a sick spouse, but "pauperized adult children" who will have to spend down their own resources in order to meet eligibility requirements for subsidized care of their recently pauperized mother.

We need incentives for families to care for their elders at home as well as making it financially attractive to contribute to their care when they must become institutionalized. The following incentives cited in the Nursing Home Law Letter suggest other, more positive, ways of helping families care for their elders:

1. Providing financial assistance for home health care;
2. Extending Medicaid coverage to home services for elderly living in group homes, halfway homes, or shelters;
3. Allowing tax deductions for children who contribute to the support of an elderly parent;
4. Providing Federal grants or tax credits to children who add or convert living space to allow parents to reside in their homes;
5. Ending existing eligibility disparities that allow higher Medicaid eligibility for the institutionalized.

To the above, the Task Force on Senior Citizen Health Care recommended the development of comprehensive package of community care legislation, as has been adopted in at least 22 states, that would develop a coherent system of community-based services and would address service, cost control and quality assurance, based long-term care needs and goals in Delaware.[7]

The Federal Administration has clearly abdicated its responsibility to help families care for their elders. If families are to be held responsible for this care, then support services that recognize the diversity of needs of both the caregivers and the elder must be available. To do otherwise condemns these families to stress, conflict and potential abuse.

Footnotes

1. See T. Hareven. "Family time and historical time," Daedaulus (Summer, 1977) 57-71. p. 65. D.P. Kent. "Aging-Fact and Fancy," *Gerontologist* (June, 1965): 51-56. p.55, and R.H. Bremner (ed.), (1970) *Children and Youth in America: A Documentary* History Vol. 1 Boston: Harvard University Press. p.37, for a discussion of the mythical view of family.
2. The *Records of the Boston Selectman.* "A Report of the Record, Commissioner of the City of Boston: Vol. 15, 1973-1742. Boston, Mass.: Rockwell and Churchhill City Printers, 1836. p.61. provide insights on attitude towards and care of the elderly.
3. D.B. Smith, *Inside the Great-House: Planter Family Life in the 18th Century Chesapeake Society.* Ithaca, N.Y.: Cornell University Press. 1980; D.H. Fischer (1977) *Growing Old in American,* New York: Oxford University Press; P. Greven, *Four Generations: Population, Land and Family in Colonial Andover, Massachusetts,* Ithaca, N.Y.: Cornell University Press; and J. Demos, *A Little Commonwealth,* New York: Oxford University Press, 1970, described family life in colonial America.
4. See M.A. Straus, R.J. Gelles, and S.K. Steinmetz, *Behind Closed Doors: Violence in American Families* New York: Doubleday, 1980, for a national study of family violence; C. Wittenberg (1971) "Studies of child abuse and infant accidents" in J. Segal (ed.) *The Mental Health of the Child: Program Reports of the National Institute of Mental Health.* Washington, D.C. The Police Foundation and B.M. Korsh, et al (1965) "Infant care and punishment: a pilot study." *American Journal of Public Health* 55:1880-1888, report physical discipline of infants and toddler; and G. Knopoka. *Young Girls: A portrait of Adolescence.* Englewood Cliffs: Prentice-Hall for a discussion of the violence perpetrated on adolescent girls.
5. The following articles by S.K. Steinmetz, "Elder Abuse". *Aging* 315-316 (Jan./Feb.):6-10; "The Aging Parent: Myths and Realities" *Torch* 56(1):15-21. 1983. "Dependency stress and violence between middle-aged caregivers and their elderly parents." in J.I. Kosberg (ed.) *Abuse and Maltreatment of the Elderly: Causes and Interventions.* Boston: John Wright/PSG Inc., 1983; "Family violence towards elders," in S. Sauders, A. Anderson, C. Hart and G. Rubenstein (eds.) *Violent Individuals and Families: A Handbook for Practitioners.* Springfield, Illinois: Charles C. Thomas Publishers (1974). and article by Steinmetz and D.J. Amsden "Dependent Elders, family stress and abuse," in T. Brubaker (ed.) *Family Relationships in Later Life* Beverly Hills: Sage Publications, 1983, discuss the Elder Abuse study conducted in Delaware and the stresses associated with caregiving.
6. See *The Nursing Home Law Letter:* No. 56 (Feb) 1982 No. 57 (March) 1982; No. 58 (April) 1982; No. 67 (Dec) 1982; No. 80 (Jan) 1984 and No. 81 (Feb) 1984 for a discussion of these laws.
7. State of Delaware. *Report of the Task Force on Senior Citizen Health Care House Resolution* 159, 132nd General Assembly, 1985.

Suzanne K. Steinmetz, Professor of Individual and Family Studies at the University of Delaware, received her Ph.D. in Sociology from Case Western Reserve University. Dr. Steinmetz's research and teaching interests include family, deviance, sex roles, violence, research methods, aging, and socialization. She is author of The Cycle of Violence: Assertive, Aggressive and Abusive Family Interaction; Violence in the Family *(with M. Straus);* Behind Closed Doors: Violence in American Families *(with M. Straus and R. Gelles);* Resource Booklet for Families in Crisis; *and Volumes 3-4; 8-10 of the Delaware Academy of Sciences* Transactions. *She has served on the editorial board of* Journal of Marriage and the Family; Torch *(an international/ interdisciplinary journal);* Aggressive Behavior *and* Family Violence; *and editor of a monograph series* Changing Issues in the Family. *She co-edited (with M. Sussman)* A Handbook on Marriage and Family *(in press); and is currently completing a marriage and family textbook (with S. Clayan).*

Dr. Steinmetz has been involved in several international conferences: the NATO-sponsored conference on aggression held in Monte Carlo, 1973; the International Society for the Study of Behavioral Development in England, 1975; the International Society for Research on Aggression in Paris, 1976 and in Washington, DC, 1978; the International Society on Family Law in Montreal, 1977; and the Groves Conference on Ethnicity and the Family, Grand Bahamas, 1983.

Dr. Steinmetz, a co-investigator under a grant from the National Institute of Mental Health, studied violence in American families, and received a Delaware Humanities Forum grant to present a series of programs on "The Battered Partner: The Law and Family Violence", and to develop a resource booklet for helping battered spouses. A member of numerous professional and honorary societies, Dr. Steinmetz was President (1976-77) of the University of Delaware Chapter of Sigma Xi, a national scientific research society, and the Delaware Academy of Sciences (1980-81). She was awarded the Key to the City in Kansas City, MO for her research and advocacy in family violence in 1984.

Dr. Steinmetz has testified before the U.S. House of Representatives, Science and Technology Sub-Committee and the Senate Sub-Committee on Child and Human Development, on Domestic Violence; a Senate briefing on elder abuse; a joint Senate and House Committee on Aging, hearing on Elder Abuse. She has been involved in numerous radio, TV, and newspaper interviews. She is a frequent guest on local TV shows and has appeared several times on the Today, Phil Donahue, Donahue on Today, *and* Sonia *shows. She is currently participating on a TBS special on Elder Abuse. Her research has been an integral part of* Time *magazine,* U.S. News and World Report, Parade, *and* Reader's Digest *articles. She was also selected by* Delaware Today *magazine as "Someone to Watch in 1979" and was featured in a 1980 article in that magazine.*

Dr. Steinmetz was funded by the Delaware Division on Aging to provide staff training, technical assistance, conduct research, and publish a series of booklets on the special needs of the elderly. She is currently completing a research monograph based on an in-depth study of the stress, conflicts, and abuse which occur in generationally inverse families.

REFLECTIONS

Growing Old, Unloved, in a Winter Fury of Sere Memory

Alan J. Fink

Last year, the day before Christmas, Sarita Polsky panicked when through the perspiring window panes overlooking the inner courtyard of the St. Francis Hospital she saw violent swirls of snow.

As she had for the last 20 years, Sarita finished the drudgery of her X-ray technician's job at 4:30 p.m. Possessed by the need to return quickly to her apartment, she failed to notice the festive mood around her. At 4:31 Sarita made a beeline for the coat closet located at the outlet of the laboratory. Quickly she opened the closet door; then with her right hand, ripped her camel's hair coat from a hanger, and with her left hand gathered her fur hat, leather gloves, and rubber boots from the closet shelf. Holding her boots with her teeth, she dressed herself as she moved through the laboratory doorway, scampering into the hallway toward the main exit of the hospital.

Briskly making her way to the Clayton Street exit she waded through schools of fellow workers on their way to their annual parties. Each time she passed a coterie of hospital workers she experienced a chill as she dutifully murmured an inaudible "Merry Christmas." Sarita felt relieved when the electric door of the hospital lobby crashed open. She trudged up the steps onto Clayton Street fighting the waist-high snow. Sarita leaned against the vicious wind that was piling snow above the cars and hurling every object not tied down toward Interstate 95.

Sarita forgot the intense heat of the hospital foyer as she started to balance herself against the freezing gales of snow. Sarita's apartment house was three blocks from the hospital, but on this day the distance would have felt like 50 miles even for a world-class runner. As she battled her way home, she became conscious of every sub-unit of movement. She pleaded with each part of her body not to fail her. Despite hearty encouragement to herself, she soon realized that she was immobilized by the counterforce of the icy wind.

As she continued to look into the snowstorm, a large black spot surrounded by bright concentric circles of blue and red occupied her entire visual field. Sarita became hypnotized by this hallucination. Suddenly she believed she saw her own image beyond this haze of red-blue and black, landing in the safe port of her apartment lobby. As she watched the image of herself walking through the lobby, she realized that this she-vapor was about to perform as she had every day for the last twenty years at 4:45 p.m. She cringed as she saw her vision say smilingly to the doorman, who was sitting at his usual out post at the apartment house switchboard, "Mr. Peters, I am so glad you were watching the store while us little hens were working."

He never looked at her, but he continued to read his newspaper. Then, as if on cue, he chuckled through his pipe, "Another day, another dollar, eh Sarita."

As soon as Sarita's vision pressed the elevator button, the automatic door flew open. Seconds later Sarita watched as the door opened once again depositing Sarita's vision on the 15th floor of the apartment house. The vision walked down the hall to Sarita's apartment, unlocked the door, and walked in.

By this time Sarita's movement ceased. Her sweat had turned to ice. Her ears were burning while the moisture in her nostrils and throat solidified. After one hour, her struggle with nature had taken her one block, and now she was losing ground in the battle. Yet, her vision in the large dark spot and colored circles did not fade. She started shouting to her vision, who was about to take off its coat and relax in a warm apartment.

"Go into my bedroom where you will find a mahogany dresser. Pull out the bottom drawer, and you'll find a red velvet covered picture album. Open the album to the third page, and hold the page open towards me so I can see the picture of Stan and me."

Sarita's vision walked mechanically into the bedroom of bronze, wood, and glass. As the vision was about to bend to pull the album out of the bottom drawer she noticed her face in the Victorian mirror above the dresser. When did her cropped hair become so thin and gray? When did she develop crow's feet around her eyes? When did the hair grow on the upper frowning lip? Wasn't her bright red lipstick put on too thickly?

Sarita called to her vision through the black spot and colored circles, "It won't help to wonder about what happened to our looks. Please, please open the album."

Sarita's vision obeyed. But Sarita could not gaze at the picture that she desperately wanted to be the last scene she saw on earth. She had touched and kissed the picture a hundred times in the loneliness of her apartment. She remembered the peace of falling asleep calling out his name with that picture pressed firmly to her breasts.

On the lower white border the picture's title read *Summer 1958 — Rehoboth Beach — Our last date together.* Above this caption lay a young couple on a green wool blanket surrounded by fellow sun worshipers. The young woman was resting her head in the young man's lap while her back rested on the blanket with her legs shooting out over the blanket ending in her feet covered by the white sand. He sat at the back of the blanket squatting with his arms akimbo, and his upper body rigid -at attention. If you looked carefully, you could see that she was staring into his eyes; yet if you studied his eyes, you saw he was not looking at her but was staring into space.

Sarita remembered this 100 degree day in different ways at different times. But now she remembered, as clearly as

Illustration by Richard Reed, a native Delaware artist.

the blue sky in the snapshot, how she felt with her head in Stan's lap. For many years she had fooled herself into thinking that this picture captured the moment of eternal love in her life. But now when she saw Stan's glazed eyes, she remembered how sickened she was by Stan. Sadly she remembered what they really said to each other on the beach, on the blanket twenty years ago.

"Stan, let's talk about us. You never want to talk about us."

"Sarita, you know I look fantastic in my dress blue uniform. The other day the major's wife stopped me as I was walking into the PX just to tell me how proud she was of the way I looked in . . ."

Sarita interrupted, "Stan, who cares about the major's wife? Come on, tell me that you love me. Tell me you like to hold me. Tell me that you want to kiss me."

Stan kept on, "Sarita, you know if the major's wife likes me I could get that artillery position in Germany that . . ."

Sarita pleaded, "Stan, can't we talk about someone else except you? Could we try us for a change? Could we talk about our future? Won't you tell me that you love me? You once did."

Stan never stopped talking about himself despite Sarita's begging.

"Sarita, wait until those troops see me. I'm just what they need, you know. I'll kick their butts until they are the finest combat unit in Germany."

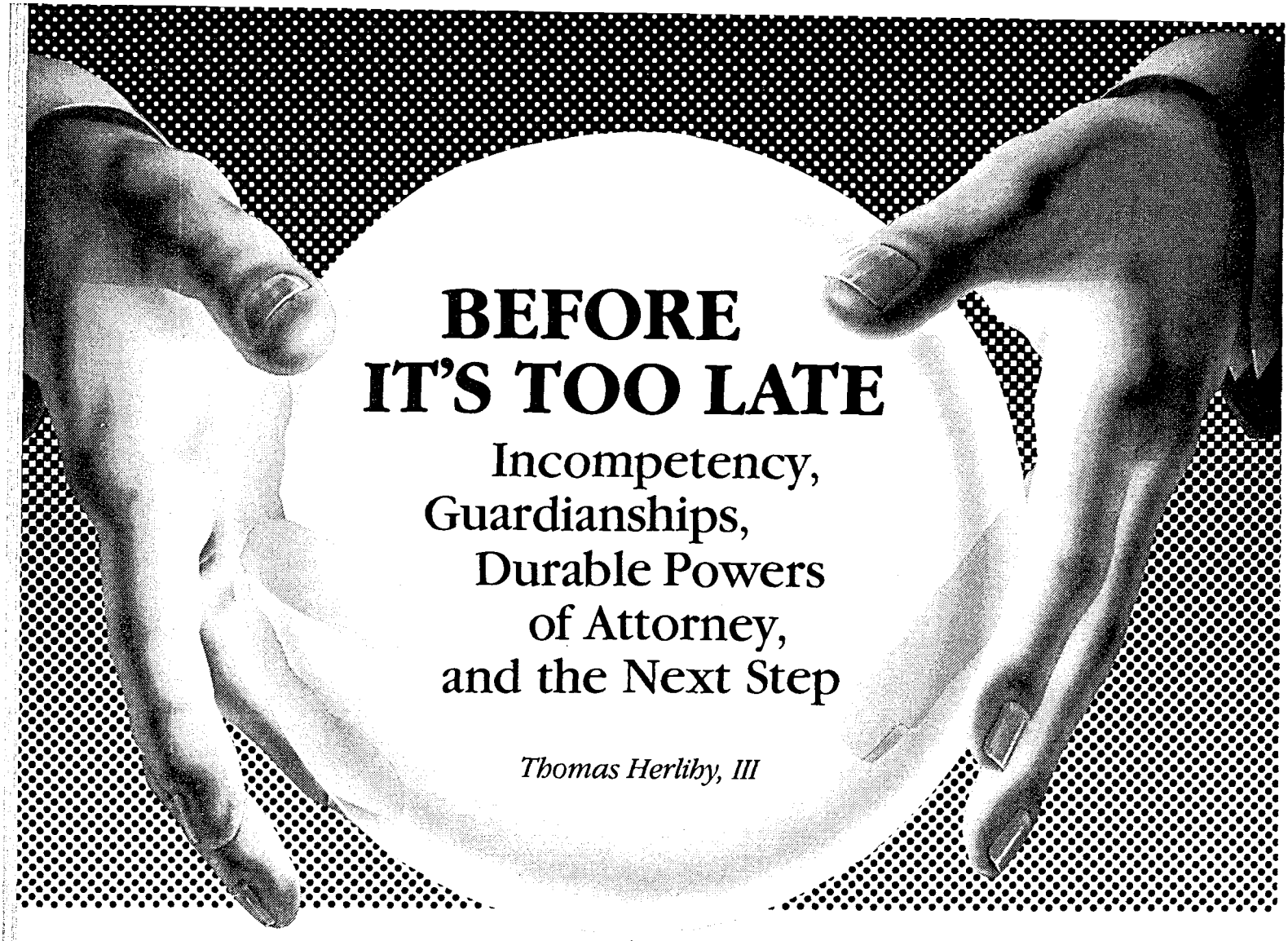
Sarita gave up. "Stan, you are a crazy son-of-a-bitch. You can't hear when people talk to you because you are so wrapped up in yourself."

Sarita then remembered that her recognition of Stan's extraordinary insensitivity made her physically sick. As she got up from the beach blanket, she felt dizzy and nauseated. She vomited and fell to the ground — unconscious.

It took one week before the snow melted so that anyone could even look for Sarita. She was found by her doorman, Mr. Peters.

For many months thereafter he delighted in telling the story of the extenant who was found in the snow bank in the the blizzard of 1986. He always ended the story suggesting that she drank heavily in her lonely apartment.

Alan Fink is a neurologist engaged in private practice in Wilmington. Dr. Fink has a wide range of interests beyond his demanding profession. They include tennis, running, the study of the history of medicine, and, needless to say, the composition of deft fiction.



BEFORE IT'S TOO LATE

Incompetency, Guardianships, Durable Powers of Attorney, and the Next Step

Thomas Herlihy, III

A Call Too Early — Too Late

Picking up the receiver of your ringing telephone at four in the morning is like picking up a hitchhiker on the interstate at the same hour. It is almost always trouble.

"Is this Mr. Edward Malley?"

"Yes." Ed's breathing went on standby. Whoever it was had the right number.

"My name is Karen Michel. I'm with the Delaware Division of Aging, and I'm calling about your father."

"My father?... Is he all right? What's wrong?"

"He's OK now, but a few hours ago the State Police found him wandering in Claymont." Ed's breathing returned.

"Claymont! What was he doing there? He lives in Newark."

"That's the problem. We can't figure what he was doing there, and he can't or won't tell us. A State Policeman found him walking in the middle of the road. He'd not been drinking but he didn't know where he was. What's more, he offered the policeman hundreds of dollars to help him get home."

"Oh no! I figured he was slipping, but I never realized it was this bad. Is he at home?"

"The policeman took him home and he found that your father lived alone. There was hardly any food in the house. The policeman called me because he was concerned about leaving your father alone. That's where I come in. Adult Protective Services helps elderly people who are incapacitated. We enter emergency situations where an impaired older person may suffer serious harm or abuse and where he can't seem able to manage his problems. Have you seen your father lately?"

"No, not lately, I... I've found it hard to get away from my job here in Seaford, but I've talked with Dad on the phone quite a bit since Mom died. He seemed OK to me. In fact, we talk about old times. He has a fantastic recall of things that happened years ago."

"That's not unusual, even with someone who is slipping in other respects. I'm not a doctor, but I've talked with your Dad, and he's not completely aware of where he is or what's going on in the world. He couldn't tell me who is President now." Ed's informant paused, as if gathering strength to say something unpleasant but inevitable. "Can you come to Newark right away? Your Dad should see a doctor. You may want to consider a court-appointed guardian to manage his property and his care. Your Dad's physician and attorney can help you."

"Do you mean I have to go to court to get something done here?"

"Maybe. A lot depends on whether your father is competent. If the doctor thinks he's incompetent then you'll have to go to court, but if he's competent to sign papers, you'll probably avoid that. You'll undoubtedly have to decide whether your father can stay where he is or whether he should enter a retirement home. Right now, I think your Dad will be all right at home with me keeping an eye on him—at least until you get here... by the way, when will you?"

"I'll come up-state first thing tomorrow. How do I reach you?"

"I'm with the Adult Protective Services Unit of the Delaware Division of Aging. Call me at 421-6791."

Ed groped for and then found the switch for the lamp. In the sudden light he first noticed that his wife, Ann, was also sitting up. Her wide eyes told him she had heard all he said. He asked Michel to repeat the number and wrote it down.

After thanking Michel, Ed hung up and lay back on his bed. He related to Ann what he learned from Michel. After they discussed getting in touch with his Dad's doctor, they agreed it was going to be a long day and they should try to get some more sleep. Though darkness returned to the room, Ed's mind was far from rest.

He could kick himself hundreds of times. He knew... he knew. He had known his Dad was on the downward slope, yes even pretty far down, but he couldn't bring himself to do anything about it. He knew more than he had let on to Michel, and more than he was willing to face himself. His Dad probably knew too. They had never discussed it. How does an elderly person swallow all that independence, and submit to the dominance of another? What's the right time for such a decision? When does a child confront a parent? When does a parent become a child, and the child the parent? Ed knew it was too late to avoid court. A physician, an attorney, a social worker, and even a judge would have to be involved. Had he or his Dad acted sooner, they might have avoided the expense and public domain of the Delaware court.

Foreseen mental incapacity poses a dilemma. It's distasteful to prepare for it and it's too late to do anything when it arrives. We abhor the thought we may suffer the loss of mental capacity. We stubbornly believe we will be in control of our minds to the moment of death, and refuse to plan against the tragedy of failed intellect.

Some people even refuse to make wills. They dislike considering or even talking about what will happen to their assets. But the inevitability of death forces many of us to make wills. On the other hand, we like to think mental incapacity is only a remote possibility. And so we don't prepare for it.

Death and mental incapacity have a common result. Once they happen, we have lost the opportunity to do something about them. If we become mentally incapacitated before we plan, we leave our finances and care to the law, the judiciary, and those the court appoints as our guardians.

Once we lack mental capacity, we may not make contracts, write checks, invest, sell property, make gifts, make wills, drive, or vote. A person must be appointed by a court to be guardian for the mentally incapacitated person, referred to as the "ward", to make the necessary decisions regarding his care and financial affairs. Court proceedings cost money, and may create emotional upheavals for the mentally incapacitated person and his family. For these reasons, a family may often delay seeking appointment of a guardian.

In the meantime the assets of the mentally incapacitated person may not be effectively invested or well maintained. Large sums of money sit in non-interest bearing checking accounts and real estate falls into disrepair. If family or relatives do not live nearby, the mentally incapacitated person may neglect his appearance, dress, living quarters, and diet. In many cases people suffering from senile dementia give up grooming themselves, wear the same soiled clothes, live in disordered residences, and fail to eat healthful meals. They become careless with their assets and their safety. There have been cases where the demented uncomprehendingly display large checks or sums of money. They become subject to designing persons and the undue influence of others. When they leave their residences, they become lost or move about without regard to the time of day or the hazards of travel.

The phone call Ed Malley received illustrates a number of the symptoms and problems of an incompetent. It also prompts a question: why doesn't Ed simply put his father's assets into joint title with himself and take the old gentleman back to Seaford? In fact this is exactly what some people do. They hope to avoid the problems of mental or physical incapacity by creating joint ownerships with those to whom they will look for care in the event of incapacity. The "solution" has serious disadvantages that can be vividly shown by assuming some additional facts. Ed Malley has a sister, Helen, who lives in San Diego. Their father has a will dividing his estate between them. After his father's physician assures him that Dad is competent, Ed convinces his father to transfer nearly all his assets into joint ownership. They think that if his father becomes incapacitated, Ed will be able to handle all his father's affairs, and upon his father's death will share the estate equally. They are wrong. The father may have to pay more taxes than he should, and establishing jointly owned assets with Ed will not permit Ed to handle everything. Ed can't legally sell the jointly held real estate when his father is mentally incompetent, even though he was competent when the transfer to joint ownership was made. The joint ownership of the assets will control over the will, so at the father's death, Ed will be the sole owner of those assets and Helen will not share in them. But surely Ed intends to treat Helen fairly? True, but Ed could die before doing the right thing by Helen and Ed's widow, in effective, if disputed, possession of her late father-in-law's assets, could be difficult. Titling assets in joint ownership will be a gift by Dad to Ed, subject to unwanted gift taxes. The father may avoid the court appointment of a guardian by use of joint ownership, but it is far from a satisfactory and complete solution.

Death and mental incapacity have a common result. Once they happen, we have lost the opportunity to do something about them. If we become mentally incapacitated before we plan, we leave our finances and care to the law, the judiciary, and those the court appoints as our guardians.

If a physician finds his father incompetent, Ed must turn to the Court of Chancery in Delaware where his father lives and where most of his assets are located. If there had been proper planning, which will be discussed later, the father's financial affairs and old age care could have remained a private, family matter. In the absence of such planning, Ed must seek the aid of the Delaware judiciary, under whose protection the State has placed the affairs of incompetents.

GILPIN ALLEGHENY PRESENTS . . .

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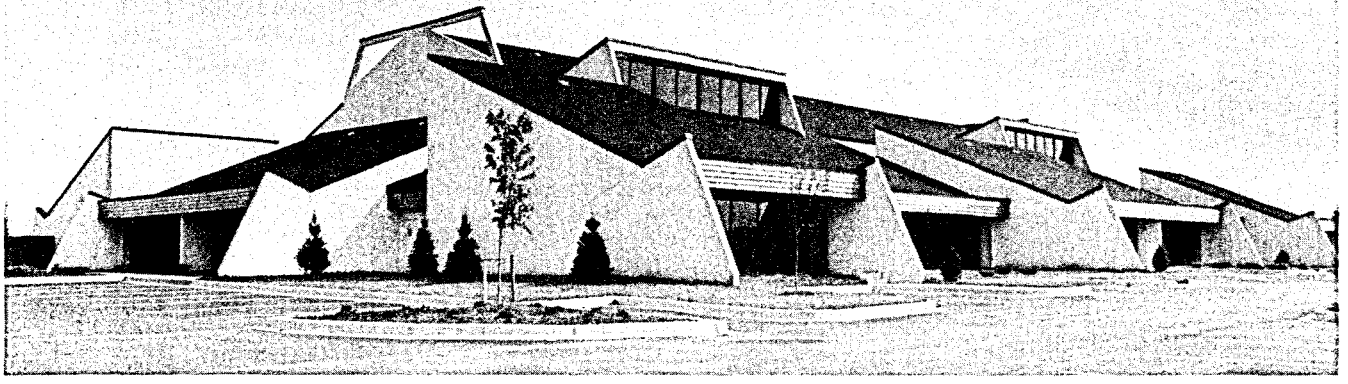

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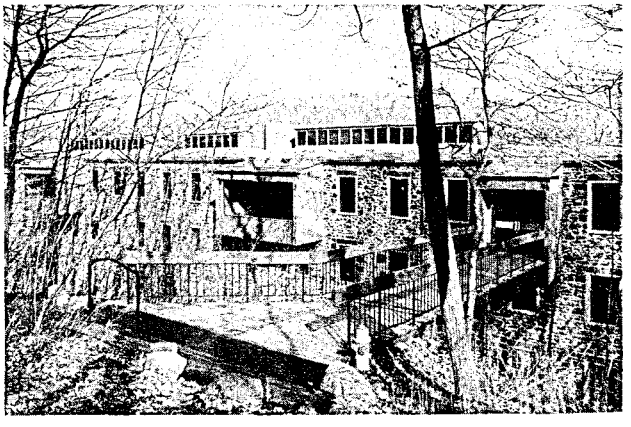
The Bancroft Building incorporates the amenities of a modern office building with the right location, away from the congestion of center city, but still close enough to do business.



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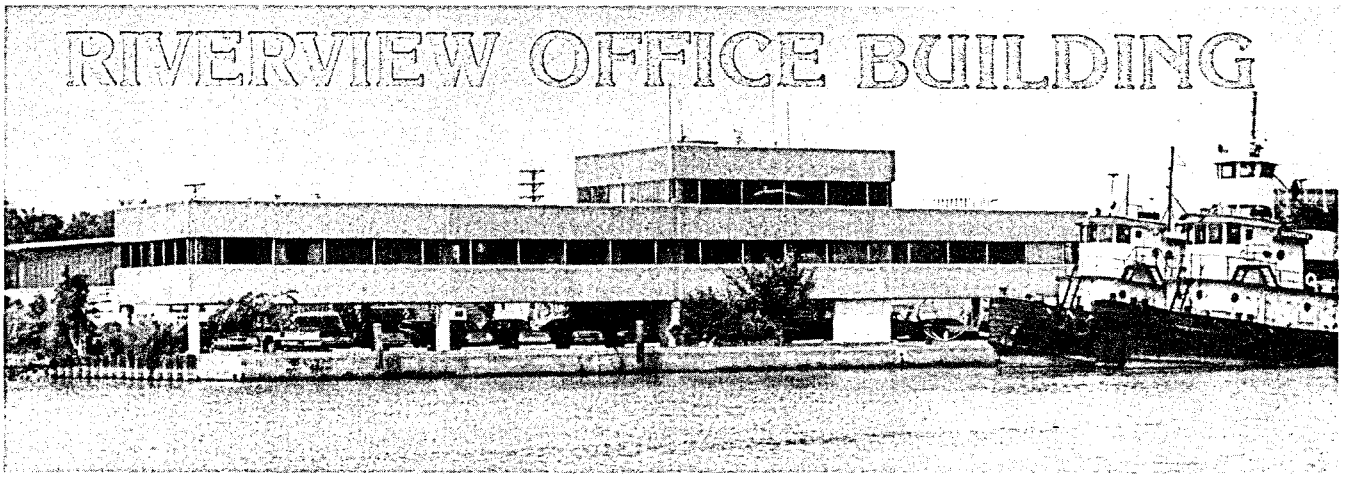

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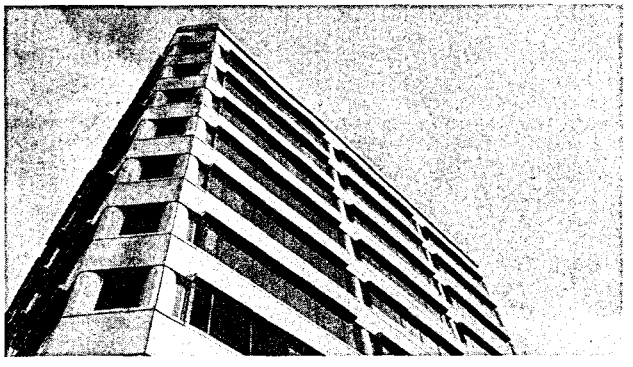

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In Delaware the Court of Chancery exercises under statutory authority a *parens patriae* jurisdiction over minors, the mentally ill, and the incapacitated.[1] The statute authorizing appointment of a "trustee" for mentally ill persons was enacted in 1793, but it was not until 1951 that the General Assembly created a "guardian" for a person not mentally ill but who "by reason of advanced age or mental infirmity or physical incapacity is":

(1) "unable properly to manage and care for his person or property", and

(2) "in consequence thereof is in danger of dissipating or losing such property or of becoming the victim of designing persons", or

(3) "in the case where a guardian of the person is so sought, such person is in danger of substantially endangering his health, or of becoming subject to abuse by other persons or of becoming the victim of designing persons..."[2]

The need for the 1951 statute was obvious. Before 1951 an elderly person in need of a guardian could have one only if he was found to be mentally ill. This could be devastating both to him and his relatives, who would be deeply troubled by such a public finding. And more and more people were coming within the purview of this statute because of the significant growth of the elderly population.*

As the elderly pass from one decade to the next, capacity, either physical or mental, tends to diminish. Better means of locating those in need of help and better diagnoses have made it possible to identify more of the incompetent aging and at earlier stages. It is in the oldest age brackets where we find many people without family members or friends who might provide sufficient help to avoid the necessity of legal guardianships. Their natural protectors may have died, moved away, or reached an age where they cannot undertake the responsibility. The legislative creation of guardians of incapacitated persons, not mentally ill, and their property answered a need for the protection of those unable to care for themselves or their property. Guardianship entrusts one's financial affairs and even one's personal well-being to another. Since guardianships were created by the State and impose fiduciary responsibilities, the State should control the appointment and functions of guardians.

The procedures for appointing trustees for the mentally ill and the guardians of the physically incapacitated differ significantly. If a person alleged to be mentally ill is not an inmate of an institution for the mentally ill, the Court of Chancery must issue a writ *de lunatico inquirendo* and conduct a hearing before a jury to determine the truth of the allegation.[3] The petition must be supported by the affidavits of at least two reputable physicians.[4] The appointment of a guardian of a physically incapacitated person has no provision for a hearing by a jury and the petition needs an affidavit of only one medical or osteopathic doctor.[5]

The practice in Delaware is to make every effort to avoid a petition alleging mental illness. Families and physicians do not want to raise an issue that could be very disturbing to the person for whom protection is sought and to his family.

The Delaware statutes cause confusion because trustees are appointed for the "mentally ill", but guardians act for the "mentally infirm". Neither term is defined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.[6] A psychiatrist is likely to testify that the terms are synonymous and that they have no recognized medical meaning.

To distinguish between mental illness and mental infirmity, the courts and the laywers rely almost exclusively on psychiatrists or psychologists. The applicability of these terms has been placed within the diagnostic sphere of the medical expert. Thus, the choice between a trusteeship or guardianship becomes a medical rather than a legal question.

In contrast to physical medicine, and other physical sciences, psychiatry is a very imprecise discipline. Combined imprecision and the vagueness of the legal terms raise serious questions about the certainty of the psychiatric diagnosis.

Assuming the first legal hurdle can be cleared by a finding that a person is not mentally ill, Delaware law does provide more than vague terms to guide the court in deciding whether a guardian should be appointed. If a person is "unable" properly to manage and care for his person or property", then a guardian of the person or property or both should be appointed. This test is stated in general terms, but it puts the

*See The Greying of Delaware at the beginning of this issue for a statistical demonstration of this radical shift over the past 80 years.

emphasis on behavior, not just a state of mind. The Court can rely on the answers to such common-sense behavior questions as:

Does he misplace his social security check?
Does he pay his fuel bill?
Is he current on his mortgage or rent payment?
Does he eat properly?
Does he care for his personal needs and appearance?
Has he arranged for someone to look after him?

Since psychiatrists make their diagnoses from observed behavioral characteristics, their opinion can be very helpful in deciding whether a person should have a guardian. However, significant behavioral characteristics can be observed by other medical experts and lay persons, which means that the court need not accept the testimony of a psychiatrist as dispositive.

If a guardian of the property is appointed for an incapacitated person, legally referred to as the "ward", it means that the guardian controls and manages his property. It is a complete removal of the ward's right to acquire, enjoy, own and dispose of property. If a guardian of the *person* is appointed (the guardian of the person and the guardian of the property may not be the same individual), it means the guardian controls the care of the ward. Since the guardian decides where the ward will live, he may choose among such alternatives as the ward's living in his own home with a live-in companion or moving to a nursing home. This power effectively deprives the ward of his personal liberty and his freedom to associate with persons of his own choice.

The role of the judiciary is extremely important. A judge must protect the fundamental rights of the proposed ward from those who would be guardians with improper motives. Also, he must determine when the proposed ward is able to properly manage and control his property or person. Thus, the court should not impose guardianships because of merely abnormal, inappropriate or irritating behavior, or merely bad business judgment or unwise decisions. In my experience petitions for guardianship filed for motives or in the interest of a still competent elderly person are rare. In fact, they are almost always filed when the proposed ward has been incapacitated for quite some time. Family members are reluctant to formally deprive the incapacitated person of his basic rights, or are late in facing the fact of incapacity, or unexpectedly and belatedly meet a legal problem that requires the appointment of a guardian. The delay in filing has made many petitions for guardianship seem routine, but the court and the bar must be ever vigilant against the rare case of improper motives or premature filing.

When filing a petition for the appointment of a guardian, the petitioner attaches a physician's affidavit, which must state whether it would be meaningless to give notice to the proposed ward. If not, he is given at least ten days notice of the time and date the petition will be presented to the Court of Chancery. If the proposed ward is in an institution, such as a nursing home or hospital, and it would be meaningless to give him notice, the administrator of the institution must be given notice. In all cases at least ten days notice must be given to the proposed ward's spouse and next of kin who are 18 years of age or older. The notice requirement does not always serve the intended purpose. There may be those who will not receive notice even though they are named in a will and have become closer to and more knowledgeable about the proposed ward than the next of kin. A petitioner without access to the proposed ward's will can hardly be expected to notify the beneficiaries. And it would be burdensome and too vague a standard to require notice to anyone assisting the proposed ward. This could include acquaintances, friends, neighbors, and health care providers.

As the Court of Chancery rule now stands, a close friend providing day-to-day care for an incompetent person will not be formally notified if a relative petitions to be appointed guardian of the incompetent's property. The rule should be broadened to include the requirement of notice to persons who may be in one of two categories. Notice should be given to those known by the petitioner who are named as beneficiaries or personal representatives in the proposed ward's will. The court presently requires the petitioner to state whether the proposed ward has a will and its location. Since the petitioner must determine the existence of a will, and, if a will exists, report its location, beneficiaries and personal representatives would be known if the petitioner

had access to the will. Obviously, there is concern about public disclosure of a living person's will. The person making a will, called a "testator", can eliminate that concern by placing the will in a safe deposit box in his name alone or filing the will with the Register of Wills in New Castle County under a newly enacted law.[7] In either case, a petitioner for appointment of a guardian would not have access to the will, but if he did, notice to the beneficiaries and personal representatives would be in their best interest and that of the testator. Beneficiaries have a legitimate stake in the good management of the ward's estate. Ideally, they should know who is proposed as guardian.

Secondly, the petitioner should be required to give notice to the person, if known to petitioner, serving as an attorney-in-fact under the proposed ward's power of attorney. As will later be discussed, the power of attorney may, under certain circumstances, terminate upon the appointment of a guardian, and the attorney-in-fact is entitled to request to be appointed guardian. If the attorney-in-fact is not the petitioner, notice would give him the opportunity to act on the proposed ward's wish that his attorney-in-fact, *not* a court-appointed guardian, manage his financial affairs.

If a person with a lawful interest in the proposed ward's estate objects to the petition, the Court of Chancery schedules a hearing to determine the capacity of the proposed ward or whether the proposed guardian should be guardian, or on both issues, depending on the objection. On occasion there will be two competing petitioners for guardianship of the proposed ward's property. If the cross-petitions can not be settled, the court will appoint a bank or a private corporation offering guardianship services, such as Supportive Care Services, Inc. If there are cross-petitions for guardianship of the person, the Court selects one petitioner after a hearing.

When a guardian of the property is appointed, he takes control of the ward's right to buy or sell property, to contract, to sue and be sued, to make gifts, to write checks, and generally engage in financial transactions of any kind. This tremendous responsibility is subject to court supervision and restraint. Before filing his petition, the would-be guardian must decide whether to place the proposed ward's liquid assets (cash, bank deposits) in a bank subject to withdrawal only by order of the court, or to use those assets without court approval of expenditures and investments. If the assets are subject to court order, the Court of Chancery will require the guardian to sign a bond in the amount of the then value of the assets, but it will not require a surety. If the guardian wants to act without court approval, he must give bond *and* obtain a surety, almost always a bonding company. A typical charge for a surety is $10 per $1,000 for bonds up to $2,000, $5 per $1,000 for bonds of $2,000 to $50,000, and $4 per $1,000 for bonds $50,000 to $120,000. The fee can be paid from the ward's estate. However, the court will question diminishing the ward's estate for the expense of a surety, unless the guardian has good reason to use liquid assets without seeking court permission. The size of the estate, the amount and regularity of expenditures, and the diversity of the investments are to be considered in seeking court approval of bond, with or without surety.

One of the first duties of the guardian is to find and take charge of the ward's assets. Locating assets should start before the petition is filed because the petition must state the nature and probable value

of the assets. Often this information cannot be obtained in full until the proposed guardian has been appointed by the court. For example, the petitioner may know that the infirm person has several bank accounts, but passbooks may have been lost or monthly statements discarded. The balances in these accounts cannot be learned by the proposed guardian until he has a certificate showing his appointment.

Within thirty days of his appointment the guardian must file an inventory of the ward's assets along with an affidavit that he has made a diligent inquiry concerning the property and estate and that the inventory contains all that has come to the guardian's knowledge.[8] Unofficially, but as a practical matter, the Register in Chancery will not require the 30-day inventory if the original petition has stated all of the ward's assets at fair values as of the date of the petition. If additional assets are discovered or the value of an asset as stated in the petition turns out to be different, the 30-day inventory must be filed.

As soon as possible after his appointment, the guardian should open a guardianship bank account for the ward's liquid assets. The Court of Chancery permits guardians to take advantage of the multiple forms of bank accounts and deposits offered by local banks. In order to maintain control the Court requires that guardianship accounts be held in Delaware banks. If the guardian later acquires or discovers additional assets, even if after the 30-day inventory, a supplemental inventory must disclose them.[9] The court will require an increased bond and, if applicable, additional surety.

The Court supervises guardians principally by requiring periodic accountings, the frequency of which depends on the size of the ward's estate. When the principal is more than $25,000 and not in excess of $100,000, an accounting is required at least once every three years. If the principal exceeds $100,000, the guardian must file at least once every two years. When the guardianship terminates, for whatever reason, the guardian must make a final accounting, a detailed statement of assets, income, expenditures, and changes in investment. It must be supported by documentary evidence such as cancelled checks, bank statements, bills, and vouchers. Those interested in the ward's estate, such as the next-of-kin listed in the petition, are given notice of the filing of the account.

If the ward's estate includes securities such as common stock, and if the guardian is not a trust company, the court requires the certificates to be deposited for safekeeping with the Register in Chancery. If the ward's estate includes real estate, it cannot be sold without court approval. The court will not only want to examine the financial aspects of the transaction, but also the reason for the sale. For example, the guardian would be required to show that the ward can no longer manage the residence, that a live-in companian may be too expensive, that selling the residence and using the proceeds to maintain the ward in a retirement home would be best for his care and his finances. Before the court will approve the sale, the guardian must present a written estimate of fair market value by a qualified appraiser unconnected with the sale.

Refining the Protective Scheme

The supervision of guardians by the Court of Chancery does not provide one hundred percent protection. During this session of the Delaware General Assembly a Uniform Protective Proceedings Act has been introduced. If enacted it will supercede the current practice in the appointment of guardians for the incapacitated and trustees for the mentally ill. Minors and missing persons will come under the protection of this Act. Some new features:

1. A parent of an unmarried incapacitated person may appoint a guardian by will or other writing attested by at least two witnesses.

2. A spouse of a married incapacitated person may appoint a guardian in the same manner.

3. Limited guardianships are authorized. The court imposes limitations on the powers of guardians.

4. Except for good cause, the court must appoint as guardian that person most recently nominated by the incapacitated person in a durable power of attorney.

5. Temporary guardians may be appointed in emergencies.

6. The Court may appoint a "conservator" to manage the property of a person under a disability, instead of a guardian, who would have broader duties and powers.

7. Incapacity is expressly defined to include chronic use of drugs or chronic intoxication.

8. The Act describes comprehensively the authority of the court, the duties of the guardian or conservator, and the procedures to be followed. It is much more detailed than current Delaware statutes and rules.

Fast social and technical changes create vacuums. We design new laws to fill them. When medical science prolonged life by artificial means, such as respirators for comatose patients, there arose a wholly new gap in the law between the duty of a doctor to preserve life and the right of the patient to control his own treatment. The law responded by authorizing a new instrument called a living will.* This document, signed by a person of full mental capacity, directs health care providers at the time of his incompetency not to use artificial means to prolong his life in the face of terminal illness.

See this author's article, "The Impetus of a Tragedy" in DELAWARE LAWYER Summer 1983.

As the numbers of the elderly grew, another gap or legal vacuum arose between the urgent need for protecting a large new populace and the public, degrading, burdensome system of court-appointed guardianship. The law has created another instrument to fill this void. It is called a durable power of attorney.

Powers of attorney have been used for a long time. A power gives written authority to a person called an "attorney-in-fact" to act on behalf of a principal, where otherwise only the principal could act. A power of attorney expires when the principal dies, revokes the power, or becomes incompetent. The last is the major drawback of the power of attorney. It is often difficult to determine if the principal *is* incompetent. A person suffering from organic brain syndrome may appear to be competent in some respects and not in others. Third parties, such as banks, dealing with an attorney-in-fact, were placed in a difficult position if they suspected the principal's incompetency. Once a principal became incapacitated or disabled, someone had to go to court to be appointed guardian in order to carry on the financial affairs of the incompetent.

All 50 states have overcome the inadequacy of powers of attorney by enacting legislation authorizing "durable" powers of attorney, effective upon or surviving the disability or incapacity of the principal. When the principal invokes the power or when the attorney-in-fact has actual knowledge of the principal's death, the power expires, but it survives the principal's incompetency. The power serves two purposes: it authorizes someone to manage the affairs of an incompetent or disabled principal and it eliminates going to court for a guardian.

The durable power of attorney generally takes one of two forms. One contains the clause: "this power of attorney shall not be affected by my subsequent disability or incapacity." The power is effective immediately. The other form is sometimes referred to as a "springing power" because it becomes effective only upon the principal's disability or incapacity. A typical provision would be: "This power shall become effective upon my disability or incapacity. I shall be deemed disabled or incapacitated upon the election by my attorney-in-fact to accept the certificate of a physician (who, in the opinion of the attorney-in-fact, is qualified) which states that such physician has examined me and that I am incapacitated mentally or physically and am therefore unable properly to manage and care for my property and business affairs." The principal intends that the power be completely inoperative while he is competent, but that, if a doctor certifies he is *not*, then and only then the power arises. If a principal is concerned about collusion between an attorney-in-fact and one physician, the instrument can require two or more physicians to certify incapacity. In the alternative the certification could be by a committee composed of a physician, the principal's spouse or other family members and a third person such as an attorney.

The durable power of attorney creates an agency relationship, which can be as general or as specific as the principal wants to make it. The usual durable power of attorney provides broad authorizations to the attorney-in-fact, some of which might include; handling bank and brokerage accounts; handling the purchase, lease or mortgage of real estate, representing the principal in tax matters, voting stock, handling benefit plans and insurance, prosecuting or settling claims, or operating the principal's business. The authorizations can

be flexible, such as a power to invest as the attorney-in-fact sees fit, or they can be tailored to meet the needs of the principal, such as limiting investment to securities with certain ratings and high yield. There can be a provision permitting the attorney-in-fact to deal with the principal's pets. These examples are just a few of the wide-ranging provisions that can be included, because the durable power of attorney is limited only by the principal's needs, state law, and public policy.

Although it is not widely done, the durable power of attorney can be used to delegate the responsibility for the health care of the principal. Except for the language making it durable, the power reads like the general power of attorney commonly used for many years. These earlier powers concerned the financial affairs of the principal, but said nothing about his health care. Delaware enacted a law allowing a principal to appoint an "agent" to make decisions regarding the principal's medical treatment if the principal became incapacitated.[10] Even in the absence of such legislation practitioners think that unless a specific statute excludes such powers, existing law permits the inclusion of health care powers.

Some of the health care provisions that might be included are powers to employ and discharge health care professionals, consent to or refuse medical or psychiatric treatment, obtain access to the principal's medical records, provide relief from pain, protect the right of privacy, and provide for companionship and spiritual and recreational needs. Such powers would permit an agent to place his principal in a nursing home or employ nurses so the principal could live at home. The agent could approve or disapprove of the medical treatment decisions and request second opinions. The durable power of attorney could include a provision similar to a living will. The principal could provide that in the event of his incompetence and irreversible terminal illness, the agent could refuse or discontinue life-sustaining measures. The durable power would have to comply with the execution and wording requirements of the living will, but this is not prohibited by Delaware law.

Even though the durable power of attorney can protect the incapacitated from problems ranging from life and death medical decisions to meeting the monthly electric bill, it is not widely used. Rather than facing the unpleasant thought of planning for incapacity, people ignore the problem. Thus, until durable powers of attorney are more prevalent, the courts will have a steady stream of petitions for appointment of guardians. Eventually, more people will realize that a durable power of attorney, granting management authority over the principal's financial affairs to an attorney-in-fact, obviate the appointment of a guardian of property. Furthermore, a durable power of attorney that confers health-care powers avoids the appointment of a guardian of the person.

A durable power of attorney allows you to select in advance of incompetence, the attorney-in-fact or agent whom you would want as a guardian in that event. Of course, this is often a difficult decision, but an incompetent person without a durable power of attorney has left it to the Court to decide who will exercise that authority. And this may not be the person whom the incompetent have wanted. If the family members cannot agree, the guardian of the property may be a bank, which only takes the job at the request of the Court. (It does receive compensation.)

Delaware law provides that once a guardian is appointed, the durable power of attorney terminates to the extent the powers held by the attorney-in-fact pass to the court-appointed guardian, whereupon the attorney-in-fact must account to his successor. This prompts a perfectly logical question: "Why use a durable power of attorney if the court-appointed guardian will assume his powers, and the attorney-in-fact must account to the guardian for any powers not assumed?" First, Delaware law provides that, absent good cause, the attorney-in-fact will be appointed guardian. If a court-appointed guardian is necessary, the attorney-in-fact will be the one selected if he requests it and so long as he has carried out his duties properly. It is very reasonable for the principal to expect that the same person will be looking after his affairs. Second, it is unlikely that a guardianship will be sought when there is a broad power of attorney in effect. Third, the use of a durable power of attorney may preclude the appointment of a guardian. The standard for appointment is that the infirm person cannot manage his property and that appointment of a guardian is desirable or necessary as a means of providing for the infirm person's supervision. Where there is a valid durable power of attorney, a strong argument can be made that it is neither desirable nor necessary to appoint a guardian.

The use of a durable power of attorney in place of a guardianship was recently upheld in a Pennsylvania case. A Mrs. Conover executed a durable power of attorney appointing her sister. Subsequently two of Mrs. Conover's cousins petitioned to have her declared incompetent and a guardian appointed. The court found Mrs. Conover incompetent, but said, "Because the evidence revealed that Mrs. Conover's affairs are being managed in an efficient manner under a durable power of attorney, we see no

necessity for the appointment of a guardian."[11]

The attorney-in-fact or agent acting under a durable power of attorney is like a court-appointed guardian, a fiduciary, that is, in a position of trust. He is liable to his principal for failure to act prudently. He can be sued for breach of his duties. He should keep detailed records, but the durable power of attorney should not require him to present an accounting to a court. If it did require accountings, the durable power would lose the intended advantage of avoiding court proceedings.

There is a further advantageous means of flexibility in using this device. A principal may appoint more than one person to serve as agents with separate functions. For example, a family member could be designated to make health care decisions and a non-relative to make financial decisions. If this is done, two separate documents are advised in order to clearly delineate the powers of each agent.

Yet another advantage of the durable power is its suitability for the elderly person who may be only partially incapacitated. He may not be capable of carrying out the *physical* tasks of banking and investing, while altogether capable of making decisions. To have a court-appointed guardian for such a person might strip him of his last measure of dignity and self esteem. He may lose his right to vote, to marry, or to enter in to contracts. The durable power of attorney can avoid this and can authorize the attorney-in-fact not only to deal with the physical tasks, but to assume full control if mental incapacity follows physical.

Partial disability illustrates another advantage of the durable power. If a physically disabled person executes a durable power, he can observe how his attorney-in-fact or the guardian is an agent for the incapacitated or disabled reason, the partially disabled principal can revoke the power if he merely dislikes the performance of the attorney-in-fact. If the attorney-in-fact properly undertakes his duties, a track record is established upon which other family members, third persons, or even a court could rely. *Estate of Ruth Conover, supra.*

The durable power of attorney is not the only alternative to court-appointed guardianships. People with large enough assets can establish a trust with a bank. Although trusts are often created primarily to avoid or decrease estate taxes, they can be written to provide financial

protection for the person creating the trust (the "settlor") or any beneficiary of the trust in the event of his incapacity or disability.

A trust differs from a durable power of attorney and a guardianship in one major particular. Upon the death of the settlor, the trust instrument can provide for the disposition of the assets in the trust. The assets of the person creating a trust are transferred into the name of the trustee. Thereafter the trustee acts, pursuant to the terms of the trust instrument, for the benefit of the beneficiaries of the trust, who may be the settlor or others. Under durable powers of attorney and guardianships, the attorney-n-fact or the guardian is an agent for the incapacitated or disabled principal. The principal or ward remains the owner of his assets. Upon the death of the principal, neither a durable power nor a guardianship affects the disposition of assets. They are distributed pursuant to a will or, if there is no will, the intestate laws.

A revocable living trust is an alternative to guardianship. A "living trust" means it is created and effective during the life of the creator, the "settlor." The settlor drafts a trust that maintains for him as much control over his affairs as is possible until such time as he becomes incapable of managing them. This may require that the settlor is a trustee along with a third party, and the third party trustee has some, but very limited, powers until the incapacity of the settlor. The trust instrument would contain strict guidelines for the trustee's conduct during any period of incapacity or disability of the settlor. The determination of incapacity or disability would be made by one or more physicians, or possibly a committee consisting of a family physician, a family member, and a well-qualified third member, perhaps the attorney. The advantage of the revocable living trust is that it avoids the cumbersome and public features of a guardianship, and it allows an elderly person to select the manager of his affair in the event of his incompetency. However, it has some disadvantages. There is the formality of transferring trust assets into the name of the trustee. If not all assets are transferred, there is a possible confusion of trust and non-trust assets. There are tax consequences. A taxpayer identification number must be acquired, fiduciary income tax returns filed, and separate accounts maintained. These formalities may be more expensive than an arrangement under a durable power of attorney.

At this time there is no legally secure method for a person to dictate to another what specific measures should be taken on his behalf regarding management and disposition of his property in the event of his incompetency. For example, if a person wanted to be sure that upon incompetency only his youngest son would have title of his residence in return for care in that house, it could not be done in a legally binding manner. Assuming a guardian knew about this wish of the ward, the guardian would have discretionary power to propose such a transfer for court approval. In other words, while guardianship purports to respect the ward's wishes, they are not necessarily heeded. If the guardian decided to recommended transferring the house to the youngest son, the Court could disapprove for many reasons, such as a finding that it would be contrary to the interests of the ward. Thus, a competent person cannot dictate the course of any guardianship established upon his later incompetency.

The durable power of attorney also lacks the statutory authority to allow the principal to dictate the course of the property management once the durable power of attorney becomes effective. A durable power of attorney does not bind the attorney-in-fact to do a specific act, but gives him discretionary authority to act on behalf of the principal. Incompetency may last for years, and the principal may want to require the attorney-in-fact during incompetency to transfer assets without consideration to other members of the principal's family or to a charity. Presently there is no law granting such authority. A revocable living trust also grants the trustee discretionary authority during incompetency, which means the trustee is not bound by the wishes of the settlor but only by that which is prudent for the settlor. *Only the living will has the legal security of requiring others to abide by the wishes of the maker during his incompetency.* However, the law limits this authority to health care decisions.[12] I foresee that statutory amendment will eventually fill this vacuum by authorizing a living will to include the maker's dictates for disposition of property in the event of his incompetency.

Like the change and growth of the elderly population, the law has been changing and growing in order to meet their needs. Growth of the law is often faltering and slow, but this should not surprise anyone who reflects on the nature and speed of the legislative and litigation processes. The challenge of providing for incapacity has prompted an excellent, if partial legislative response: the durable power of attorney. If you want to know who will manage your property should you become incompetent, sign a durable power of attorney while you are able to. Delawareans should be seeking to avoid the many disadvantages of a guardianship, and move immediately to protect themselves by signing durable powers of attorney. At the present time, they must wait for the law to allow them to dictate the course of the management of their property during incompetency.

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1. 12 *Del. C.* §3701; 12 *Del. C.*, §3901 (The jurisdiction over minors is shared with the Family Court, 10 *Del. C.* §925(16); and 12 *Del. C.* §3914.
2. 12 *Del. C.* §3914.
3. 12 *Del. C.* §3702; Chancery Rule 100.
4. Chancery Rule 102.
5. Chancery Rule 175(d).
6. J. M. Krauskopf, *Advocacy for the Aging*, 1983, at p. 49.
7. 12 *Del. C.* §2513; House Substitute No. 1 for House Bill No. 651 as amended by House Amendment Nos. 1 and 2, Approved July 18, 1984.
8. Chancery Rule 110.
9. Chancery Rule 112.
10. 16 *Del. C.* §2505(b) and (c).
11. *Estate of Ruth Conover*, 4 Fid. Rep. 2d 200 (1984).
12. 16 *Del. C.* §2502(b) and (c).

Tom Herlihy of the Wilmington firm of Herlihy & Wier is a previous contributor to our magazine. His "Impetus of a Tragedy" in the Summer 1983 issue evidences his interest in and wide knowledge of legal issues linked to mental capacity. It is a pleasure to have his deft and thoughtful comments in these pages.

ADULT PROTECTIVE SERVICES:
PARENTAL NURTURE OR TYRANNICAL RESTRAINT OF LIBERTY?

Matthew J. Lynch, Jr.

Let us begin with a quiz.

Query:
In Delaware, in order for a state social worker to break down an adult's door legally and forcibly transport that adult with a police officer to a state-operated medical facility, the social worker must possess:

a) a criminal arrest warrant;
b) a court order imposing state guardianship on the adult;
c) a written complaint that the adult is mentally ill and a danger to himself or others, as provided in 16 Del. C. § *5122;*
d) none of the above.

Since March 1, 1983 the correct answer is d). If that seems unremarkable, consider that Delaware law allows not only a social worker, but a police officer or a Deputy Attorney General to force treatment upon an unconsenting adult. If that fails to capture your attention, read no further. If you are aghast, confused, worried, or simply curious, welcome to the world of adult protective services and 31 *Del. C.* ch. 39.

The State's Role as Watchful Parent

Belief in the state's inherent ability to impose treatment on an individual "for his own good" has existed since ancient times. It furnished the excuse for Roman guardianship proceedings to protect a person's property and for forced exorcisms of evil spirits in the early American colonies. This, the *parens patriae* power of the state, gained early recognition in the United States in a decision of the Massachusetts Supreme Judicial Court, *In re Josiah Oakes,* 8 Law Reporter 122 (Mass. 1845), which held that the ". . . right to restrain an insane person of liberty, is found in that great law of humanity, which makes it necessary to confine those whose going at large would be dangerous to themselves or others." Id at 124-25.

Josiah Oakes's "dangerous" behavior, justifying his confinement under the "great law of humanity", was his marrying, at age 67, a woman of unsavory character a few days after his wife's death, omitting the period of grief to be expected from a person "in his right mind." Over 100 years after *Oakes,* the United States Supreme Court adopted its test as the only constitutional justification for commitment of the mentally ill. *O'Connor v. Donaldson,* 422 U.S. 563 (1978). (See *Developments in the Law: Civil Commitment of the Mentally Ill,* 87 Harv. l. Rev. 1190 (1974) for a full history of the use of *parens patriae* to justify the involuntary civil commitment of the mentally ill.) While this doctrine arose in the context of protecting the mentally ill from themselves and others, it has also been repeatedly applied to justify state interference with children's lives in the criminal courtroom, the classroom, and the family.[1]

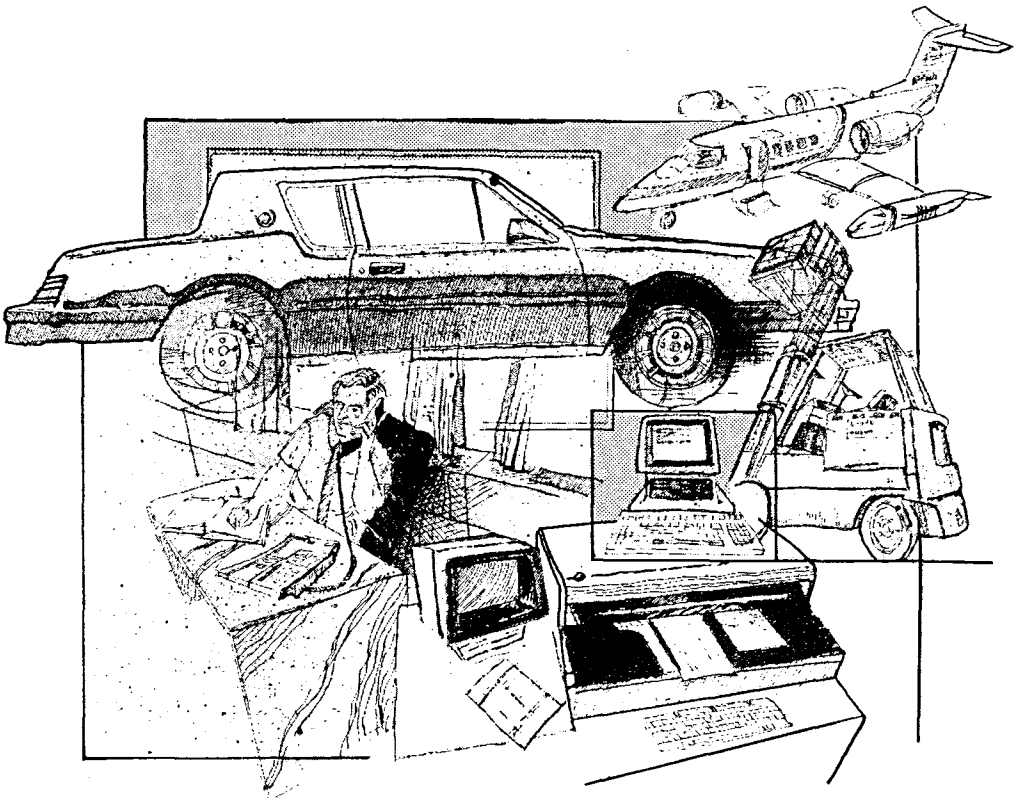
Major studies have concluded that abuse and neglect of the elderly by their primary caretakers is a serious problem. The doctrine of *parens patriae* and experience with statutes for the protection of children from parental abuse or neglect have provided the framework for adult protective services legislation to confront this problem. These laws can be generally classified as "elder abuse" statutes, affecting only those persons over a certain age, or "adult abuse" statutes, protecting all adults. They normally include provisions empowering the state to obtain custody of an adult, regardless of his wishes. Following the example of other states, our General Assembly passed an adult abuse statute, 31 *Del. C.* ch. 39. It became law on July 1, 1982.

The Delaware Adult Protective Services Statute

Thirty one *Del. C.* ch. 39 accomplished three primary objectives. First, in order to serve adults, it created an Adult Protective Services Unit (APSU) within the Division of Aging of the Department of Health and Social Services. Second, it authorized procedures for removing incompetent adults from life threatening conditions with or without their consent. Third, it required anyone with reasonable cause to believe that an adult person was infirm or incapacitated to report it to the Department of Health and Social Services.

The Delaware APSU, consisting of five social workers, has the responsibility for furnishing "protective services" throughout the State to "infirm or incapacitated adults." 31 *Del. C.* §3903. Protective services cover the entire spectrum of traditional social casework, such as referring clients to medical providers, arranging transportation, coordinating the provision of services, and providing counseling. The heart and soul of this statute is its definition of the population it is designed to serve, that is, the "infirm adult" or the "incapacitated person". An "infirm adult" is one, who by reason of physical or mental disability, is unable to perform or obtain for himself those physical, medical, social, psychiatric, or legal services necessary to maintain his well-being. 31 *Del. C.* §3902 (1). An "incapacitated person" is one who qualifies for guardian ship under 12 *Del. C.* §3914 (a). 31 *Del. C.* §3902(6).

The statute establishes two procedures for providing involuntary services to an adult "for his own good." First, under 31 *Del. C.* §§3906 and 3907, if a person refuses assistance but lacks capacity to consent to receive protective services, and a police officer, Deputy Attorney General, or social worker believes that he will suffer immediate and irreparable injury or death if not removed to a health care facility or other emergency shelter, a peace officer may →



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transport him to such a place of protection. The statute authorizes this involuntary detention until the next working day. It may only be extended beyond that time by a court order. Therefore, if an adult is involuntarily placed on the Friday of a three-day weekend, he may be held against his will for four days without judicial intervention or any medical determination that he lacks the capacity to consent to treatment.

Second, 31 *Del. C.* §3908 empowers either the Public Guardian or the APSU to petition the Court of Chancery for an order authorizing the provision of protective services. To obtain such an order, the petitioner must prove that the respondent: 1) is infirm or incapacitated as defined in the statute, 2) lacks capacity to consent to service, and 3) lives in conditions that present a substantial risk of serious harm. In addition, the petitioner must demonstrate that no one is authorized to consent to the provision of services on behalf of the subject of the petition and that there are compelling reasons for ordering services.

Thirty-one *Del. C.* §3909 gives the subject of the state's petition a variety of rights. He has the right to be present when the petition is heard, unless he knowingly waives this right or the petitioner can show that his presence would endanger his welfare. (It is unclear how an individual alleged to be incompetent to care for himself could knowingly waive any of his rights.) If indigent, he has the right to free counsel and a free medical examination. He has the right to subpoena evidence and witnesses. In addition, there are substantial limits on the court's ability to order protective services: they must be limited to one week and they may only impose the minimum amount of intrusion necessary to protect the adult. If an individual needs services for longer than one week, a guardian must be appointed to consent for these services on behalf of his ward.

Thirty-one *Del. C.* §3910 imposes a duty to report information about the infirm and the incapacitated to the Department of Health and Social Services. Breach of this duty carries no criminal penalty. Instead it frees service providers, such as doctors, from the professional limitations of confidentiality. It also requires the Department to investigate promptly any reports it receives.

Liberty vs. Quality of Life

The most controversial aspect of the Delaware statute is the provision of protective services to adults who do not want them. It is important to realize that adult protection statutes such as ours only authorize the provision of involuntary services to *incompetent* adults, that is, adults who do not have the mental capacity to make decisions about their care. These statutes do not conflict with the court cases and laws that allow competent patients to refuse treatment or empower guardians to order removal of life-support systems from comatose patients. But the statute appears at first glance to allow pervasive state interference with personal integrity by imposing a state-defined quality of life on all citizens. It appears to obliterate the "right to be let alone" recognized by Justice Brandeis as the most valued rights of civilized man.[2] John Stuart Mill argued: "The only freedom which deserves the name, is that of pursuing our own good in our own way, so long as we do not attempt to deprive others of theirs, or impede their efforts to obtain it. Each is the proper guardian of his own health, whether bodily, or mental and spiritual. Mankind are greater gainers by suffering each other to live as seems good to themselves, than by compelling each to live as seems good for the rest."[3] The fundamental precept that every man is entitled to be different and live his life as he sees fit, as long as he does not damage his neighbor, has prompted criticism of adult protective statutes.[4]

But the arguments in support of involuntary protection statutes are founded on equally fundamental principles. Looking out for one's neighbor has a tradition as old as the human species. One author observes: "[T]he elder may find this freedom a useless possession, for of what value is liberty to one buffeted by the violent inner winds of the mind? Does not liberty presume a minimum level of rationality and maturity.. .? . . . If it is true that with the best of intentions it may be difficult to determine who requires the help and protection of the state, does this amount to conceding that no one needs it unless he first asks for it? Or is this merely a rationalization for a callous evasion of responsibility?" Holper, *The Double-Edged Sword: Paternalism as Policy in the Problems of Aging,* 58 Milbank Memorial Fund Q. 472, 487 (1980).

Practical Experience Under the Delaware Statute

The primary beneficiaries of 31 *Del. C.* ch. 39 have been those adults *who voluntarily accept services.* Between March 1, 1983 and February 29, 1984, the State filed only six emergency petitions in Chancery seeking permission to remove adults from allegedly dangerous living conditions and place them in a state operated medical facility. The State has not yet been forced to carry out the horror scenario at the beginning of this article by forcibly removing someone from his home without a court order.

Two of those six court cases demonstrate poignantly the difficulties society faces in dealing with adults who, for one reason or another, cannot or will not live in optimum living conditions. In case No. 1, "M.L", a 75-year old woman was discovered living alone. The Court described her plight: "Unfortunately, during the last year — probably due to advancing age — she has failed to adequately cope with her daily living needs. The evidence is undisputed. She has refused to pay her utility bills, although she had sufficient money to do so. She walks alone at night on well-travelled highways, nearly being hit by a vehicle on one occasion. She is sometimes disoriented as to time and place and she mentions non-existent persons or blames her troubles on a sister who is not present. Her mobile home is cluttered and unsafe. She has permitted her refrigerator and freezer to become so clogged with ice that the doors cannot be closed and her home is filled with spoiled food. She has been seen walking outside in the cold in

inappropriate clothing and she has been living during the bitter cold weather in a mobile home without heat, water, electricity or telephone service. She is emaciated and has been diagnosed as suffering senile dementia." *In re: M.L.*, C.M. No. 213, at 2, Hartnett, V.C. (January 4, 1984).

In case No. 2, APSU became aware that an incompetent, elderly woman ("L.M.") suffering from leukemia and requiring tube feeding was being returned to the care of her son and his companion after a short hospitalization. Her doctors discovered that she had recently suffered a broken arm and that she was dehydrated. The State petitioned for an emergency order allowing it to place the woman in a state-operated institution, where it was felt she would get better care than with her son. The son opposed the petition. "What the present record indicates, fairly read, is that Mrs. M. is not receiving the best possible full-time care that perhaps she could receive if she was admitted to the State Home in Smyrna. The petition indicates the likelihood that the care of Mrs. M. has perhaps not been what it should have been on some occasions, but it does not indicate that she has been callously neglected, exploited, or deliberately mistreated by her son and his companion." *In the Matter of L.M.*, C.M. No. 4674, at 3, Brown, C. (June 1, 1984). In Case No. 1, the Court authorized the provision of emergency involuntary services. In Case No. 2, the Court denied the petition and L.M. returned to her son's home.

The divergent results in these cases illustrate not only the need for a protective services law allowing involuntary treatment of incompetent adults, but the limits of society's ability to inflict the unsolicited blessings of an "improved" quality of life. No society grounded in humanitarian principles could turn away from M.L., leaving her to starve or freeze to death. Thirty-one *Del. C.* ch. 39 was designed to protect M.L., and it served its purpose admirably. Not only was M.L protected from a life-endangering situation; state officials were able to diagnose her problems and address them. My seven years experience as a lawyer representing the Delaware State Hospital convince me that without 31 *Del. C.* ch. 39, the authorities probably would have felt compelled to seek commitment of M.L to the Delaware State Hospital as a mentally ill person dangerous to herself. While commitment would have provided her with housing, it would also have institutionalized her among patients with serious mental illnesses and diverted the state's attention from her real needs to "curing" her mental illness. Even though M.L.'s problems arose from senile dementia, she did not need acute inpatient psychiatric care. She needed adequate food and shelter.

The case of L.M. demonstrates the limits of the *parens patriae* powers of the state. State custody of an adult cannot be supported by an allegation that the adult is not receiving the best available medical care. If an adult is being cared for by friends or relatives who are doing the best that they can without endangering the adult's life, the state has no right to interfere, despite its good intentions. It exemplifies the tacit application of a principle long and explicitly applied in the law governing the termination of parental rights: a child cannot be snatched away from parents of marginal competence simply because foster care and adoption promises a better standard of living. This case also illustrates the effectiveness of the due process protections provided by Delaware law to challenge claims that state action is in one's best interest.

I began with a nightmare. I end with a hopeful vision. The enactment of 31 *Del. C.* ch. 39 has not caused an avalanche of state petitions seeking to force social services upon unconsenting adults. Furthermore, the statute has been sensitively and wisely construed by the Court, at least for L.M. and M.L. The readiness of the Court to discrimi-

nate between the claims of two doctrines at once beneficent and contradictory, and the realism fostered by the statute strongly suggest that we should be cautiously optimistic about the new world of adult protective services.

[1]See *In re Gault*, 387 U.S. 1 (1967) for a discussion of *parens patriae* to justify reducing the level of the process available to children charged with crimes; *Ingraham v. Wright*, 430 U.S. 651 (1977) for the assertion of *parens patriae* to allow reasonable corporal punishment in the school despite constitutional objections, and; *Santosky v. Kramer*, 455 U.S. 745 (1982) justifying on *parens patriae* grounds the ability of the state to terminate all parental rights to a child.

[2] *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., Dissenting)

[3] J. S. Mill, *On Liberty* 11 (1930).

[4] See Mitchell, *The Objects of Our Wisdom and Our Coercion: Involuntary Guardianship for Incompetents*, 52 S. Cal. L. Rev. 1405 (1979); Horstman, *Protective Services for the Elderly: The Limits of Parens Patriae*, 40 Mo. L. Rev. 215 (1975); Regan, *Protecting The Elderly: The New Paternalism*, 32 Hastings Law Journal 1111 (1981).

Matt Lynch, pressed for biographical data, furnished this pleasingly cheeky reply: "Since November 1, 1984 I have been employed as a staff attorney in the Corporate Legal Division of the Wilmington Trust Company. However, the true measure of the quality of my life is my wonderful wife, Nancy, my brilliant and beautiful two-year-old daughter Mamie, the grace of my golf swing, and the quickness of my skis—not necessarily always in that order."

BOON OR BUST
Home Equity Conversion

Kent M. Shimeall

The American Bar Association Commission on Legal Problems of the Elderly has participated in the development of home equity conversion for the past several years. One of the Commission's purposes is the education of attorneys. Older clients will need knowledgeable counsel when investigating housing alternatives.

Recently you may have read or heard about something called "home equity conversion". It may seem familiar to you but, upon your further reflection, you will probably find that it is not. Home equity conversion is not to be confused with the home equity loans, which of late have been aggressively marketed by many lending institutions. Those loans generally require immediate monthly repayments, are amortized over short periods, and are not intended to provide a steady stream of income for a period of years. Home equity conversion plans, on the other hand, allow elderly homeowners to remain in their homes while transforming their equity into supplemental income or, in some cases, funds that need not be repaid until the property is sold. Those funds may be used for rising property taxes or insurance; for home health care or long-term care for an institutionalized spouse; for an occasional meal out, movie, or concert; for trips to see children or grandchildren; or for major house repairs or improvements.

Perhaps the economic temper of the times is leading more and more homeowners to consider ways of putting the equity in their homes to work instead of leaving it idle. The most obvious candidates to benefit from a home equity conversion program are elderly homeowners, 80% of whom own their homes debt-free. Nationwide, this amounts to an estimated 700 billion dollars in equity.

In contrast to these large resources in the form of home equity, the elderly as a group face the hardship of fixed incomes, incomes which over the years have decreased in real buying power while costs of living have continued to rise. Where once these homeowners looked forward to enjoying themselves in their retirement, many now worry about how they will keep up with their bills. Currently they can sell their homes and move into rental properties where they will probably face periodic rent increases, or remain in their homes at an ever diminishing standard of living. Second mortgages are out of the question, because elderly homeowners can't repay loans on small, fixed incomes.

One might think that the easiest way to correct this situation would be for elderly homeowners simply to sell their homes and move, and apply sales proceeds and interest to an improved senior life style. For several reasons, however, such a suggestion may not be satisfactory. In many cases the elderly homeowner does not want to move. Her* home and the memories associated with it have become integral, even essential, parts of her life. The reassuring familiarity of their homes — not to mention the neighbors and the neighborhood — is important to the overall health of older people.

There is another reason: the proceeds of the sale may not outlast the seller. Faced with decreasing buying power caused by inflation, almost certain rent increases, and costs incurred in the sale of the home and investment of the proceeds, the senior must speculate about how long she can live on a finite amount of money. What will happen to her if her money runs out? Where will she live and with whom? Another common reason for not selling the home is the wish to preserve intact an estate for one's heirs. An older homeowner may feel it is necessary to "leave the children something", even though doing so impairs the homeowner's quality of life, and the children may not really need financial assistance.

Since elderly homeowners frequently are emotionally attached to their homes and live on fixed incomes, selling the home is not always an option. Accordingly, some plan must be devised to allow elderly homeowners to tap the equity in their homes while they remain in them. Toward this end Ken Scholen, director of the National Center for Home Equity Conversion[1], has led consumer education and technical studies of home equity conversion models.

Models now in operation vary from reverse mortgages to sale-leasebacks to property tax deferrals. Except in New Jersey and the Philadelphia area where the American Homestead Mortgage Corporation's "Century Plan" is being marketed by Prudential-Bache, these models are just that, models not widely available. This field is changing constantly, however, and new ideas and products are developing throughout the country. Notwithstanding the dearth of formal programs, attorneys should know what is happening in this movement in order to properly counsel clients seeking advice about any plan. Home equity conversion is not for everyone, but those for whom it is advantageous should not be deterred from participating in a responsible plan.

Several basic home equity conversion plans exist, which in many variations can theoretically be used to improve the quality of life for older Americans. The basic plans include sale and loan schemes. Although they differ

**Female gender is used throughout the article, since most often a surviving spouse is female.*

in form and substance, they share similar characteristics: they all use the equity in the home; they all cost something (in the form of interest, transaction costs, foregone appreciation, or ownership); the more equity the homeowner has, the more income is created; and they pose risks for *all* parties. In addition to increasing income, however, the benefits to seniors participating in home equity conversions include extending their independence and control, allowing them to live more comfortably, possibly reducing dependence on public programs, and maintaining the existing housing stock.

Home Equity Conversion Models

To understand how home equity conversion works, one should first become acquainted with several of the models. As noted earlier, these include programs that sell equity and those that borrow against it. Programs can vary in length and in types of immediate benefits. Some provide cash income, others in-kind assistance, and others a combination of both. With the exception of The Century Plan, the most visible programs are operated by non-profit organizations in both public and private sectors.

Loan Plans

The elderly can borrow against the equity in the homes and use the homes as collateral. There are special purpose plans for property tax deferrals and deferred payment loans. The former put off an elderly homeowner's property tax obligations until the home is sold or the owner dies, when the taxes, with interest, are paid from the proceeds of sale. Deferred payment loans enable the elderly to repair their homes or remodel them with ramps, handrails, wider doors or chair lifts for the disabled. Once again, repayment of the principal and interest is deferred until the property is sold. Delaware currently does not offer a statewide property tax deferral but other loans under similarly agreeable terms may be available. Attorneys should consult with the local county or municipality community development office to see what is available in their immediate area.

Reverse mortgages provide a stream of income for a specific term, ranging from three to forty years. (A forty-year plan is available to qualified New Jersey and Philadelphia area residents under American Homestead's Century Plan.) In a short term reverse mortgage the lending institution for a predetermined period pays the homeowner a monthly advance calculated, generally, on 80% of the appraised value of the home, to which the elderly homeowner retains title. The monthly advance will vary according to the amount of equity, the interest rate, and most important, the duration of the loan. The Century Plan also considers the number of homeowners and their ages if there is more than one homeowner as in the case of property held by the entireties. The longer the term, the less the monthly income. The full amount of the loan plus interest is due the month following the final advance; normally, unless the lender agrees to refinance another reverse mortgage loan, the home must be sold to repay the obligation. Under this type of transaction, a significant percentage of the equity is consumed in interest.

The American Homestead Mortgage Corporation is the first to offer a long term reverse mortgage loan. Its Century Plan, marketed by Prudential-Bache Securities, offers homeowners aged 62 or older a stream of income for up to 40 years. One of the reasons American Homestead is able to offer the long term loan is by pooling the risks of multiple transactions. Another reason is that the terms of the Century Plan allow for two kinds of interest to be assessed: the traditional fixed interest on the amount of principal loaned; and an additional interest in the form of shared future appreciation of the property. The mortgagor can select a shared appreciation option from 30% to 100%. In the latter case, American Homestead receives all appreciation in the value of the home from the date the loan is executed. Of course, the greater the shared appreciation, the larger the monthly advances to the homeowner.

The Century Plan is restricted to single family homes occupied as primary residences. A homeowner begins the application process by estimating what her property is worth and by telephoning American Homestead. Preliminary estimates of how much income can be expected are available over the phone. An actual appraisal by a local independent appraiser is necessary before determining the amount of the monthly advance. The final transaction is set forth in a promissory note and mortgage, both of which conform to appli-

cable "plain English" requirements.

There are several novel features in the Century Plan that are important to the consumer. Upon maturity, sale of the home or death of the borrower, if the value of the home is not sufficient to repay the full loan amount including interest, fixed and shared, American Homestead recovers only 94% of the value. The remaining 6% is retained by the homeowner or her estate for real estate commissions. The senior will not have to apply out-of-pocket funds for this purpose. She is also protected by a hyperinflation clause that restricts the amount of appreciation American Homestead may receive to a maximum of 15% per year. In times of rapid inflation, therefore, any appreciation above 15% per year accrues to the senior's benefit. For an independent analysis of the Century Plan, see the National Center for Home Equity Conversion's *"Financial Guide to the Century Plan"*, available for a nominal fee.[2]

Sale Plans

One model now attracting more attention because of recent federal legislative activity is the residential sale-leaseback. The senior homeowner sells her home to buyer-investors, who lease it back to her for life or until she moves.[3] The seller takes back a note or sells the property on a land contract. Since the monthly note payments from the buyer-landlord are greater than the monthly payments from the senior, the difference provides her with a steady stream of income. The same transaction enables her to increase her income, get out from underneath real estate taxes, property insurance, and maintenance, while remaining in her home. At the outset an annuity must be purchased to take effect following the final note payment, thereby permitting the senior to continue to live at the same income level at which she had lived during the loan term.

The purchase price of the home under a sale-leaseback is discounted to compensate for the encumbrance of the lease agreement and the conditions of the lease. The major condition of the lease pertains to occupancy rights of the senior tenant. A protective cap on rental increases safeguards the seller-lessee. Without that security a senior homeowner would be ill-advised to risk loss of the income she bargained for and even occupancy of her home.

The attorney becomes important in negotiating several parts of the transaction. He must negotiate the reduced sale price, the amount of the down payment, the interest rate payable to the seller-lessee by the buyer-lessor, the term of the note, which party purchases the annuity for the seller, the initial rental amount, and the subsequent rent schedule.

The Home Equity Conversions Act was introduced in the 98th Congress to clarify ambiguities under the Internal Revenue Code regarding the tax benefits available to participants in residential sale-leaseback transactions. The legislation did not clear the conference committee, however, and unless Congress attends to tax issues specific to residential sale-leasebacks — issues such as the investor's ability to depreciate the home and deduct expenses in renting the property, and the availability of the capital gains exclusion for the senior seller — sale-leasebacks will be infrequent.

Sale of a remainder is a legal principle well known to attorneys. A publicly-funded program — The Buffalo Home Equity Living Plans — gives an elderly homeowner a life estate, repair or rehabilitation of the property, a maintenance program, payment of hazard insurance, utilities and property taxes, and a small monthly stipend in exchange for relinquishing title to the property upon death. Exciting as this sounds, if a sponsoring entity does not get significant seed money, the plan will not become widespread.

Attorney Representation

It's the attorney's role to ensure that the homeowner or the person holding legal power to make such decisions is fully aware of the implications. The American Association of Retired Persons (AARP) is developing networks in several states to provide independent, disinterested housing information. Volunteers are being trained for service to elderly homeowners interested in converting the equity in their homes or in examining housing alternatives. However, these housing information specialists cannot provide the expertise required for a complete perspective on the effects of an equity conversion. It comes best from an attorney trained to deal with the issues that inevitably arise in home equity conversion.

Attorneys should bear in mind that home equity conversion does not suit all elderly homeowners. Seniors who would prefer to move, who do not have sufficient equity in their homes, or who don't need more income should probably not consider it. Those who dislike going into debt — even to improve their quality of life — would be ill advised to take on a reverse mortgage, and those who do not want to relinquish inherit-able ownership rights in their homes should avoid a sale-leaseback.

The legal issues in home equity conversion vary according to what plan is used. While it is not within the scope of this article to detail them, highlighting several may be useful.

The first questions you must ask yourself are: How good a deal is this for my client? What is my client giving up and what does she get in return? The details of each plan will be found in the legal documents used in the transaction, and in most cases the terms of these documents will be regulated to some extent. Reverse mortgage documents should contain disclosure statements so that the consumer is fully aware of the operation of the loan.

What about procedural protections well adapted to the needs of the older homeowner? What protections are built into the documents regarding default by either party? What are the terms

governing default? Are liens allowable, and if so, to what extent? Is there a "due on encumbrance or sale" clause? Are prepayment penalties applicable? Is the loan non-recourse? If it is a sale-leaseback, how secure is the lease? Are the senior's occupancy rights preserved? Are there terms governing rent escalation, and if so, are they right for your client? What are the estate and income tax consequences of one plan compared to those of another? Are the client's Social Security, SSI or Medicaid benefits affected, and if so, to what degree? Lawyers handling home equity conversions must bring to their tasks skills equal to complex and serious responsibilities. This branch of combined real estate and tax law may be one of the most vital legal specialities in the foreseeable future.

For those Delaware senior homeowners not interested in increasing their monthly incomes, but who would like better use of their homes or altered living arrangements, other housing forms exist. These include home sharing, accessory apartments, shared housing, congregate housing, and elderly cottage housing options (ECHO housing or "granny flats"). Your client's health, wealth, housing needs, and wishes will suggest the right choice.

A more technical examination will also determine whether a home equity conversion plan is right for the client. You must consider available interest rates, the term of the loan, and, in some plans, how much future appreciation the senior is willing to give up. Never forget that in any of these plans, equity is relinquished. While the senior must understand this clearly, if the necessity exists and the senior wishes to participate, the speed at which equity is consumed or the steepness of effective interest rates may well be irrelevant.

Each housing choice considered by the Delaware elderly will require a critical review by counsel and perhaps by family members. Here is the nexus of law, taxation, and decent regard for human wishes. Such preparation, grounded in professional skill, is particularly important. An attorney not knowledgeable about home equity conversion can ignorantly deter potentially qualified applicants from advantageous choices.

Home equity conversion is relatively new. It's exciting and innovative. It can confer great benefits on all the parties to a transaction. Because of the economic and emotional significance of the *home*, many owners are wisely reluctant to divest themselves of their equity. Proper counseling by knowledgeable lawyers can lead them to the enjoyment of that equity, thereby vastly improving the quality of their lives.

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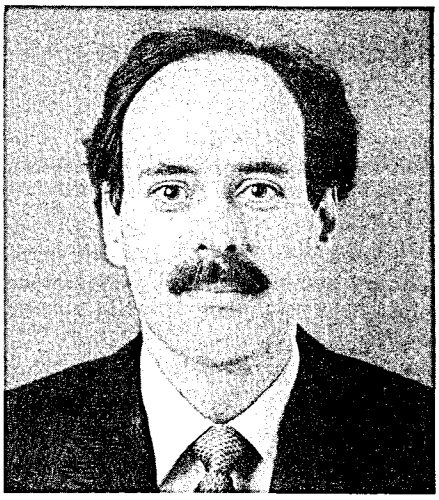
1. NCHEC is an independent nonprofit organization, which was established to serve as a home equity information clearing-house for consumers, researchers, policymakers, developers, and the media. NCHEC has conducted major research projects and has provided consulting, training, and technical assistance to national, state, and local organizations. NCHEC has recently reduced the extent of its operations and responds only to requests for its publications.
2. National Center for
   Home Equity Conversion
   110 East Main Street
   Room 1010
   Madison, Wisconsin 53703
   (608) 256-2111
3. Sample sale-leaseback forms developed by counsel for the non-profit Reverse Annuity Mortgage (RAM) Program in California can be ordered by sending $25 to National Center for Home Equity Conversion.



Until recently Kent M. Shimeall served as attorney and Assistant Staff Director of the ABA Commission on Legal Problems of the Elderly. In that role he became a recognized expert on the topic he explores in this issue. His extensive experience in poverty law served him well in grasping the problems of the aging, with which he deals so sensitively here. Kent recently left his ABA position to return to his native Ohio. We expect to hear from him again, ideally in this publication.

Planning for Retirement

Howard H. Simon

From its beginnings in the late nineteenth century retirement has appealed to institutions and social groups with differing objectives. Up until the 1930's, retirement and its benefits centered on economy, efficiency, and modernization. The employer enjoyed most of the benefits. With the advent of governmental retirement systems and the broadening of private benefits, national priorities for retirement have leaned toward security for the individual worker and the social welfare of the masses of workers.

Although the Social Security Act of 1935 has drawn criticism because of its contributory feature, the implied freedoms it offers have appealed strongly to workers. In the early part of this century pensions were used to manipulate workers. Management often kept dissidents under control by threatening loss of pensions.

Pensions have fulfilled a variety of economic needs. Retirement made it possible for employers to replace less efficient more highly paid older workers. Pensions have also allowed for the payment of lower current wages and deferral of compensation. Current compensation packages negotiated under union contracts would obviously have been costlier to management without the promise of future pensions.

Today more attention than ever is given to social and economic considerations of the worker before retirement.

When should pre-retirement planning commence? For many the process begins early in their careers when they make conscious decisions to begin saving. Voluntary contributions are made to pension plans, and Keogh and IRA plans are established. For most of us the real planning starts 10 to 15 years before retirement. Of course, there are those who never quite get around to worrying about retirement until it is upon them.

What steps should you take when you start to consider the financial aspects of retirement? I recommend that the pre-retiree start by seeking competent advice about:

- Accounting and Tax Related Matters
- Insurance
- Legal and estate planning
- Pension and related benefits
- Investments

How do you identify those experts? By this time most of us will have dealt with attorneys, accountants, insurance agents, investment brokers, trust officers and bankers, and possibly employee benefit experts within the companies where we work. Financial planners have come into vogue of late, and many individuals and companies of differing backgrounds hold themselves out as experts. Indeed there are those who are extremely knowledgeable and can, therefore, be very helpful in directing planning for the pre-retiree. But care must be exercised in selecting expert advisors. Referrals can often be obtained from professional organizations such as the Delaware Society of Certified Public Accountants, the Lawyer Referral Service of the Delaware State Bar Association, and the Delaware Chartered Life Underwriters Association, to name but a few. We can also look to associates and friends who have selected professionals to assist in the process, and profit from their experience.

To begin with, it is necessary to have a clear understanding of pre-retiree's present financial position while projecting what can be expected at retirement. This can best be accomplished through a Net Worth Statement, listing both the market value of his assets and the amount of his liabilities. Such a statement becomes the foundation for planning, since it reflects those assets that can be committed to providing for his needs when formal retirement occurs.

All assets should be considered and fairly valued. It is very important to analyze all life insurance contracts and to determine cash values. Pension benefits that have accrued must also be carefully assessed. It will also be helpful to *project*: what will one's assets and pension funds be at the time of retirement?

Once the prospective retiree's net worth is known, it is much easier to predict the likely income and cash flow that will be available at the end of his working career. His probable cost of living, measured by his expressed retirement life style, would be estimated at the same time. A cash flow projection becomes step two. The retiree will generate income from accumulated assets, pension payments, social security payments, and perhaps other sources. Armed with this information, we begin to get a feel for his expected needs and how to provide for them.

After financial data have been accumulated advisors can begin to counsel their client effectively. What are the several roles of these experts? The accountant is typically involved in gathering data and preparing the net worth and cash flow statements. The attorney reviews all legal documents, such as wills, employment contracts, pension plans, and business buy-sell agreements. The insurance agent reviews existing insurance and the client's foreseeable needs in order to make timely recommendations. The Trust officer's overall assessment enables him to make recommendations for best organizing the client's affairs. The investment advisor's evaluation of assets will lead to suggestions suited to the client's long range goals.

Tax and investment advice are essential to the planning process. Over the years the accountant who prepares tax returns for the client should make periodic suggestions about such matters as establishing an IRA or Keogh Account, tax-favored investments, and other tax devices helpful in the more rapid accumulation of assets. All concerned in the planning process should pay attention to the client's probable cost of living and retirement, measured by his expressed retirement life style.

When working with the tax attorney who is doing the client's estate planning, the accountant may also be in a position to suggest ways of minimizing estate taxes. All too often, accountants fail to advise, and confine their roles to that of tax preparer. Accountant and client need to communicate so that optimum services may be rendered, and the accountant should take the initiative in sustaining that dialogue. An accountant's past experience should also enable him to recommend other capable advisors.

The lawyer must be concerned with more than drafting wills; he must make sure that estate and income tax planning goes forward as part of the long range economic plan. For example, wills should be drafted for both spouses so that total family financial planning is provided. Often attorneys do not go far enough when working with clients in estate and personal planning. If an attorney has not written a buy-sell agreement for a shareholder client in a closely-held company, he may not ask to review it. The same might happen in the case of an employment contract, deferred compensation agreement, or other equally important legal document. This is an awesome responsibility that cannot be easily limited. To do the job right the attorney must be a vigilant and protective busybody.

The insurance agent owes the client a minute and thorough analysis of existing coverage to determine if additional or different coverage is in order. An insurance agent may sometimes be too close to a situation and slow to recognize opportunities to help his client. Many times insurance advisors do not give enough thought to disability coverages and possible needs. For example, someone who seems to have sufficient insurance for retirement could have difficulty if disabled at age 50. Keeping up with all the changes and new products that have evolved in the insurance industry requires the knowledge of an alert expert. If the client's agent doesn't measure up, he should be replaced.

As one accumulates assets and invests excess funds he needs the regular advice of an investment advisor. Most of us are virtually ignorant of the wide range of opportunities for investing and managing our assets. The investment advisor, familiar with the client's needs, must continually reassess how to achieve them in an ever changing investment market place. Sometimes an investment advisor does not dig deep enough into his client's circumstances to adequately tailor his advice. For example, someone a year away from retirement may be better served by more conservative investments unsuited to someone who still has fifteen years in which to accumulate by seizing longer term and more speculative opportunities.

And don't overlook the trust officer. He can be the renaissance man in coherent financial planning. Trust departments of most banks usually bring together a variety of talents with tax, legal, and investment backgrounds.

As people live longer and have more assets and more kinds of assets to manage and plan with, the task of planning for them becomes more complicated. Ever changing tax laws require constant review of even very recent planning. Trust officers, lawyers, and accountants have a duty (not infrequently shirked) to bring these changes to their clients' attention. Wills cannot go unreviewed for years. Trust documents and provisions must be scrutinized in light of the changing laws. And, of course, family and financial changes can render planning that once was sound useless or downright harmful.

How many people believe that joint ownership is a desirable way to hold property? Are Clifford Trusts still a valuable device in planning for the family? Should I take a lump sum distribution from my retirement plan? What changes should I make in my investment portfolio? Should I invest in zero coupon bonds, in an IRA or Keogh account? What place do tax exempt bonds have in my portfolio? Clients need to know their options in drawing down pension funds, which present the alert advisor significant opportunities in planning. Questions like these confront a professional planner daily. Let us hope he understands them and advises promptly and properly.

The reader, whether professional or potential retiree/consumer, should not think that retirement only involves finances. There are many other aspects to retirement, such as second careers, health consideration, living arrangements, family relationships, and post-retirement life styles.

In writing this article, I have attempted to identify the people who might be involved in advising the pre-retiree. I have tried to point out some of the areas with which these advisors must concern themselves. Although space does not permit a discussion of the planning tools used by these professionals, at least I can alert you to the complexities best addressed through expert counselling.

There is no one right or wrong time to be concerned with your retirement. It is the responsibility of each of us to plan his own affairs. The wise individual will do it sooner rather than later, so as to best prepare for the inevitable.

Howard Simon is the senior partner of Simon, Master & Sidlow, certified public accountants of Wilmington, Delaware. Howard makes a specialty of consulting on retirement planning.

A Lifetime of Learning

John Babiarz

I first heard of the Academy of Lifelong Learning on a bright, sunny day in the early spring of 1981. As I was walking down the Market Street Mall in Wilmington, Bill Conner, former New Castle County Executive, buttonholed me and proceeded to sell me on the idea of enrolling. Bill's wife, former State Senator Louise Conner, was working with the School of Continuing Education of the University of Delaware to establish the Academy of Lifelong Learning for retirees at the Wilcastle Center.

It came as a complete surprise to me that there was a program in Delaware offering the retired an opportunity for serious study.

I began as a student, but Louise, in a fit of bipartisanship, asked me to assist her in teaching the course in Delaware Government. Between the two of us we had more years of government experience than I care to state, knew more politicians than anyone ought to know, and had at least a few "chits" outstanding that might prove useful to our class.

Our textbook was *Delaware Government* by the late Paul Dolan and Jim Soles of the University of Delaware. As we reviewed the Chapter on the Judiciary, we decided to devote an entire semester to this subject. The Curriculum Committee approved it for the fall semester of 1983, but sadly, Louise died a short time later. The Academy lost a founding mother and I was forced to carry on alone.

But I was far from alone. The cooperation extended by the Judiciary was such that the course had to be extended through the spring semester of 1984. We started with the Justice of the Peace Courts, which handle more cases than any other courts. This phase of the course culminated in a field trip to the Justice of the Peace Court in the Carvel State Office Building to observe trials in action.

The Supreme Court, The Superior Court, and The Court of Common Pleas all sent administrators, who gave excellent presentations and answered tough questions from the class.

Perhaps the highlight of the course occurred when Vice Chancellor Maurice Hartnett* accepted an invitation to lecture on the history, background, and operation of the Court of Chancery.

Founding mother: the late Louise Connor.

During the two semesters we had visits from Attorney General Oberly and Public Defender Sullivan. We also studied the offices of Sheriff, Prothonotary, Register in Chancery, Clerk of the Peace, and Register of Wills, and were visited by incumbents. A representative of the Delaware Bar Association, Roger A. Akin, addressed one of our sessions.

The Family Court was of particular interest to our students and we devoted three sessions to its work. Herb Cobin, a retired Family Court Judge, lectured on the history of the Court. Roxana C. Arsht, also retired from the bench of that Court, and a member of our student body, shared her experiences on the bench and described the constant effort by the Court to improve its procedures. A staff person concluded our sessions on the Family Court with an explanation of the day-to-day work of support personnel.

Popular demand will probably bring back the course on the Judiciary in the 1985-86 session.

Senator Conner had established the election year practice of inviting candidates for the principal Federal, State, and County offices to appear before the class in Delaware Government. And so we devoted the fall semester of 1984 to the fundamental event of our democratic system, the Election. By this time the class had grown from 25 to over 100, and the lure of addressing 100 or more interested voters proved irresistible to candidates. We were fortunate to hear candidates of both parties for the offices of U.S. Senator, U.S. Representative, Governor, Lt. Governor, Insurance Commissioner, and County Executive discuss their positions and answer questions from the class. On the eve of the Election an informal poll was taken. The class was wrong only on the vote for Lt. Governor. We concluded the course with a trip to Return Day in Georgetown.

During the spring semester of 1985 we studied the Executive Branches of State and County Government and took our traditional field trip to Dover to meet with the Governor and the members of the General Assembly.

Our last venture into the executive branch took us into the very heart of government. In the spring of 1983 New Castle County and the City of Wilmington announced dramatic increases in sewer rates, and a field trip was arranged to the Waste Water Treatment Plant on Cherry Island to explore this issue. There was some skepticism about viewing a smelly operation, as opposed to the more glamorous types of field trips.

However, after observing the numerous basins, tanks, pumps and miles of pipes and wires, we came away with a better understanding of the cost of pollution control. One has to see the tons of sludge removed and treated to appreciate the magnitude of the project.

Later, in the fall of 1983, we arranged a trip to the Delaware Solid Waste Authority Reclamation Facility at Pigeon Point. Here we observed the processing of solid waste in huge buildings with miles of ducts, huge motors, and fans used in the stage-by-stage separation of recyclable materials. The conclusion again was that pollution control is expensive, even though there was some potential income from the sale of the salvaged materials.

I have enjoyed not only the fellowship at the Academy but also the opportunity to demonstrate to my fellow students how our government functions in its

*See cover. The Editors.

three segments—The Executive, The Legislative and The Judicial. We have taken many field trips to public installations and offices, and many officials have visited our class. Our study has helped to dispel myths and give a better understanding of how government serves our needs.

In 1983, I was elected to the governing body of the Academy, the Council. Council members now have to come to grips with the growth of the enrollment from barely 100 in 1980 to 700 in 1985. We are studying the need to expand and plan to come up with proposals to the President and the Board of Trustees of the University.

The Course Catalog for Fall and Spring 1984-1985 lists over 70 courses and 65 teachers. Among the faculty are retired engineers, teachers, professors and instructors; businessmen and businesswomen, musicians, artists, lawyers, a judge, a clergyman and so the list goes. Many have Masters and Doctoral degrees. Quite a few of our faculty teach courses in subjects outside their disciplines. Knowledge acquired through extensive reading, research, travel, and hobbies is shared in courses they have volunteered to teach.

Faculty members are part of the student body and pay the same enrollment fee of $125 per year. However, when a proposed course is approved by the Curriculum Committee, the student receives a discount of $25 for teaching. It is a cooperative effort.

In addition to the regular curriculum, there are weekly noontime special enrichment program-workshops on Wednesdays that include performances and lectures on music, art, economics, and other subjects of general interest.

Anyone enrolled at the Academy can sign up at no extra cost for one course at the University for credit or auditing.

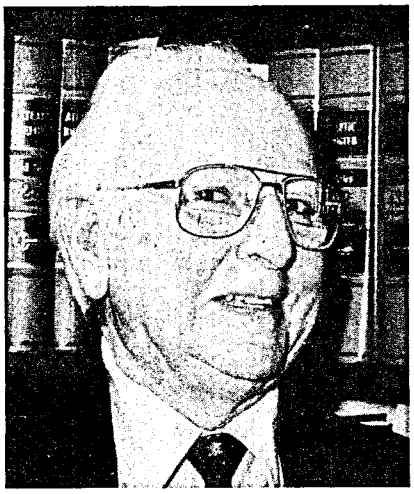
The University of Delaware can be proud of the efforts of the School of Continuing Education in helping to establish the Academy of Lifelong Learning. The Academy has enabled people in retirement not only to express their love of learning but to enhance their knowledge from in-class discussions to rewarding field trips.

Members of the Academy are grateful to the University, the teachers, and the public officials who have made our programs possible. As the Academy grows it becomes an evermore living memorial to the initiative of the late Louise Conner.

PHOTOS BY ALBERT C. JOHNS

At the Academy: a flourishing program for seniors.

John Babiarz, Sr. is one of the most indefatigably useful people in Delaware. He is a former Register in Chancery, a two-term Mayor of Wilmington and a cabinet officer in Governor Tribbett's administration. John Babiarz has a curriculum vitae of governmental, charitable, military, and public service of a packed density resembling a page in the telephone book. On the brink of his seventieth birthday, he applies undiminished zeal to the work of the Academy of Lifelong Learning.



Luis Bassols

Lawyer, Diplomat, Professional Volunteer

Judith A. Schuenemeyer

During the last two years 74-year-old former lawyer and diplomat, Luis Bassols, has driven 72,000 miles as a volunteer. Many of those miles involved his work as an advocate for migrant workers in Sussex County. He sees that they get health care and legal services, provides transportation, explains their rights and responsibilities, and translates written, and oral information from English to Spanish and vice versa.

He also translates for the Sussex County Courts, the Correctional Center, hospitals, and government agencies. He has translated the driver's license examination into Spanish and administers this test every Wednesday evening in the Georgetown office of the Division of Motor Vehicles.

He is an expert in immigration problems and sometimes drives to Philadelphia two or three times a week with people who are attempting to gain permanent residency or solve some other immigration difficulty. He boasts that he once helped 18 members of a single family obtain permanent residency. There is a gleam in his lively blue eyes as he proudly says that he has never lost an immigration case, and that private attorneys often consult him about immigration forms and procedures.

Luis also serves as a volunteer in the Senior Companion Program. He visits older people who are shut-ins, provides transportation to medical appointments, to agencies such as the Social Security office, for shopping and helps in any other way he is needed. His appointment book is filled with these and other commitments neatly noted in his beautiful handwriting.

How did this fashionably dressed, aristocratic looking gentleman from Havana, Cuba come to do social work and advocate the rights of migrant workers, poor Spanish speaking residents, and the elderly of Sussex County? After working in a Havana law firm Luis joined the Cuban government and eventually served for two years in the Cuban Consulate in Mexico. In 1954 he came to the United States to serve in the New York City Consulate.

On January 1, 1959, the day after Castro took over the Cuban government, Luis and his colleagues were summoned to the office and informed that they must return home immediately or their property in Cuba would be confiscated. All chose to remain in the United States. Luis and his family lost their home and everything in it, as well as cash and jewelry that diplomats were required to leave behind when they left the country. Luis pushes up his sleeve to display the only valuable possession he was allowed to bring with him from Cuba, a gold Omega watch by which he still tells time fifty-five years after his wife gave it to him.

After the Castro takeover, Luis remained in New York City for a couple of years, working in the accounting office of a ship company. He also raised money, collected food and clothing, helped find jobs, translated, and provided other assistance to Cuban refugees in New York. He continued these efforts in Princeton, New Jersey where he was employed as an assistant to General Patton's grandson.

In the late 1960s Luis and his wife moved to Kent County to be near their son and his family. He then began his volunteer career with migrant workers and their families, under the auspices of Catholic Social Services. Later he worked for R.S.V.P. (Retired Senior Volunteer Program), the Delmarva Ecumenical Agency, and served for five years in VISTA (Volunteers in Service to America).

As a VISTA volunteer he was assigned to the Georgetown office of Community Legal Aid Society as an outreach worker, interpreter, counselor and advocate. At the end of his VISTA service he remained as a volunteer at Legal Aid. He continues to serve as a translator, a member of the Legal Aid Board of Directors, and as the link between the Spanish speaking community in Sussex County and Legal Aid.

This tireless septuagenarian makes those of us who are younger look like slackers — and he receives no pay. It is not obvious that he is slowing down, but he says he can no longer respond to calls to translate at the Sussex Correctional Center in the middle of the night.

Don Luis, as he is called by many of those whom he serves, has received a number of awards and honors for his volunteer work. Perhaps the greatest honor he could receive was described several years ago in an article he wrote in *The Whale*: "If perhaps you would like to remember me, do so with a good deed or by saying some kind word to someone who needs you."

Photo by Marie Paulin

Marian Gibbons, longtime Delaware resident, is busily retired on Cape Cod. She is the Director of the Council on Aging in Wellfleet, a few towns away from her home in Orleans. Marian also serves as a member of the Orleans Town Planning Board. She contributed this article in the best DELAWARE LAWYER spirit of shameless nepotism at the urging of her brother, Bill Wiggin.

How One Town Copes

Marian P. Gibbons

Wellfleet, Massachusetts. A handsome small town mid-way on the forearm of Cape Cod, with Orleans at the elbow, Eastham just below, Truro at the wrist, and Provincetown the hand. Wellfleet, dominated by the famed tower of the Congregationalist Church (referred to by some locals as the "Congo Church") whose clock strikes ship's bells instead of hours. Wellfleet, reputed to have more psychiatrists as summer visitors than any other town in the country.

A few years ago archeologists, digging in an old part of the town near Cape Cod Bay, came up with artifacts strongly suggesting that they had stumbled on the remains of a once flourishing 17th century brothel. Since then the town has clearly settled into a far more sedate maturity: Of the winter population of 2,234, between 800 and 900 towns people are classified as "Senior Citizens". In Wellfleet this means sixty years old or older.

How does a town this size cope with such a large aging population, especially since two-thirds of its land surface is within the Cape Cod National Seashore and, thereby, mostly untaxable?

One could say, "With a little help from our friends". But there are legal strictures on the ways of coping. In The Elder Americans Act of 1969, as amended in 1972, Congress mandated that the care of the aging population was a public charge and required towns and cities to show that they were aware of the problems.

The Massachusetts Department of Elder Affairs required each town to establish a Council on Aging, whose mandate was to "locate the Senior Citizens of the town, to ascertain their problems, to educate the citizens of the town of the problems, and to devise ways of solving those problems".

In Wellfleet the Council on Aging, appointed by the Selectmen, began by organizing a "Senior Club". This purely social group attracted quite a few of the older citizens who knew of others, and the list grew. Also it was decided early on that a Senior Center was really essential, so a very small house was rented.

Meanwhile, the Massachusetts Department of Elder Affairs was working on ways to funnel Federal and State funds to the towns. Gradually a "network" was formed. The state contracted with so-called Area Agencies to oversee what was going on in the small localities and to inform the Councils of available assistance. Elder Services of Cape Cod and the Islands, Inc. is a non-profit organization formed specifically to disperse this information and to assist in the care of the indigent elderly, who were being identified in increasing numbers. (Other parts of the state have comparable organizations.)

One of the earliest and still one of the most popular services was that offered by the Elder Law Project, set up by Congress in the Elder Americans Act on the premise that legal advice should be available to all Seniors, regardless of ability to pay. Over the years, the Elder Law Project has become an essential service, primarily because project attorneys, paralegals, and Senior Aides have acquired in-depth knowledge of Federal and State statutes affecting the elderly. As the current director explains, no private attorney is going to waste time researching this material because there is no way he can use the knowledge to add to his income. Furthermore, the Elder Law Project has become popular with elder citizens in small towns because it enables a Senior to execute a will without letting a local, neighborhood lawyer know what he owns or what he plans to do with it.

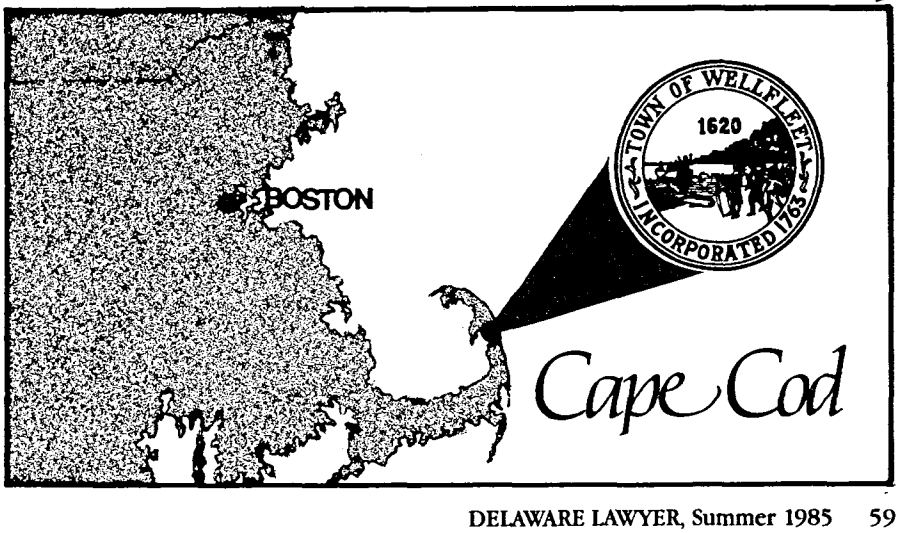
The importance of sound nutrition for the aged dictated an early decision to start a Meals-on-Wheels program. As soon as Wellfleet had a Senior Center, Elder Services provided a "meals coordinator" and began delivering hot meals at noon once a day to Seniors in Eastham, Wellfleet, and Truro. The drivers all were and still are volunteers, who are reimbursed only for mileage. The hardest part of the whole nutrition program was convincing recipients that this was not charity—each pays what he or she can afford, with anonymity guaranteed.

Originally it was thought by most of the Councils on Aging that all programs could be managed by volunteers, but it soon became evident that some sort of overall supervision was necessary.

The towns of Cape Cod acquired paid "Directors", first by applying for state grants and then with monies voted at regular or special town meetings. In Wellfleet, as in most towns, the position of director is part-time. Originally the town paid for 12 hours a week and the Council obtained grants to pay for an additional eight hours. Now the Director is a "permanent part-time" town employee. That designation means that the Director serves a minimum of 20 hours a week and is entitled to benefits. A distinct "temporary part-time" classification means under 20 hours and no benefits.

The various Senior Centers have developed in different ways. Some are largely entertainment centers, some stress an artsy-craftsy life-style, and some just try to help whenever a problem arises.

The Wellfleet Senior Center is, more and more, heading in the direction of the last category. Originally it was thought



that entertainment and care could be combined, but after it was discovered that it was impossible to find forty Wellfleet Seniors who all wanted to go to the same place at the same time, plans for trips off-Cape were dropped. Gradually even the high teas died out. And, on one occasion, when a program on make-up for the older woman was planned only one person, a man, showed up to hear the speaker, who had come from out-of-town.

Care-giving at the Wellfleet Senior Center started almost by accident. By 1978, the Center had been forced to move to a tiny three-room apartment, which meant curtailing much of the established program. Meals-on-Wheels continued. By planning carefully, the meals coordinator somehow managed to dispatch 30 to 40 meals daily from a kitchen not much larger than a closet. Blood Pressure Clinics were held twice a month and a representative from Legal Aid was at the Center for two hours each month. Outside of those services little else could be handled because of lack of space.

So, instead of bringing people to the Center, a new approach was tried: Outreach. One Senior Aide proved exceptionally skilled at visiting seniors (especially the quite elderly) in their homes and solving problems in consultation with the director, who could call on various Elder Services supports.

Problems? For instance, what do you do for a widow who refuses any medical intervention, who refuses to leave her house, but who will allow people to visit? Well, first of all, you start Meals-on-Wheels, so that you have a daily check on her condition. You put her on a regular schedule of visits by the outreach worker, you talk with her family, you try to introduce her to a psychological social worker—and you keep your fingers crossed. In one particular case, there was an ironically happy ending. The widow managed to set her house on fire. Two teenagers, passing her house, saw the smoke and rescued her and her dog. The Chief of Police reported to the Senior Center Director that he was proud of the teens, because they had been in minor trouble in the past. So an awards ceremony was held at a Center luncheon and the town honored the boys. As for the widow, her daughter-in-law persuaded her to enter a retirement center where she made a remarkable physical and emotional recovery.

While efforts were being made to assist the widow, the Council was in the process of receiving a new Senior Center. This created some interesting legal problems. The Cape Cod Child Development Program, which operated "Head Start", purchased, for $2.00 one of the World War II vintage Coast Artillery barracks from the Marconi Site of the National Sea Shore. Program officials then asked the town of Wellfleet if they might move the building to town-owned land. The decision of Town Council was that this would be legal *only* if a town office were housed in part of the building. What "town office" needed space? Aha! The Council on Aging. Great! said all hands. And then another problem: rent. Town counsel ruled that no town office could pay rent for a building on town-owned land. But it was fine to pay for heat and electricity up to the limit of previous rentals.

With all that out of the way, and with grant money, monies raised by the Friends of the Wellfleet Council on Aging, Inc., and some matching funds from a Town Meeting, a bright, airy, and roomy Senior Center was outfitted. At last adequate programs could be instituted. Two small offices allowed for the privacy needed by such groups as Overeaters Anonymous and the Cancer Support group. And the big main room could accommodate up to fifty people for luncheons and many more for meetings.

The Council offers multiple services. Because the handicapped do not have access to the Wellfleet Town Library, the Senior Center put up shelves for 100 books. These are changed every two to three months and the honor system use is heavy.

Some silly things prove very popular, such as the once-a-month knife sharpener in his specially equipped truck. Twice a month there are blood pressure clinics, once a year a flu-shot clinic, and once a year a rectal/colon clinic. The Center conducts hearing tests about every month. Legal aid is provided once a month.

We also hold a monthly party for all those who have turned 80. Each person may invite as many friends and relatives as he or she wishes. The parties are so popular that those who have to miss one because of travel or illness frequently ask to be included in a later party.

The move to the new Center has not decreased the outreach program in the least. In fact, the program has expanded,

especially since the Town Meeting voted to add a part-time outreach worker to the roster of paid Town personnel. And it is the outreach worker who frequently finds things that are going badly for Seniors.

Mental abuse, for example. This takes many forms. One vivid example was the case of an elderly woman who occupied a basement apartment in the house of her late husband's nephew. The nephew's wife denied the aunt access to her acquaintances, to congregate luncheons at the Senior Center, and other such mind stimulants. The outreach worker was able to help the woman visit a retirement home in a nearby town, to decide she wanted to live there, to put her money into an independent bank account, and, eventually, with a little help from the Wellfleet police, to get her moved and settled in the home. Now she is able to come to lunch at the Senior Center every week. She has regular visits from friends, and she has made many new friendships.

In such a case the Senior Center is able to marshal much help—from the legal aide office, social workers, the town nurses, the county elder abuse counselor, and the town police.

There are times when the police turn to the Senior Center as well. Is it possible to convince the male half of an over-80 couple that taking pokes at his wife, which might have been the pattern of their entire marriage, is just not a good idea now that she is old and frail? Even if she does refuse to wear her hearing aid so she won't have to listen to him? The Wellfleet Police have shown sensitivity and tact in dealing with the problems—occasionally bizarre—of disturbed Seniors. One elderly lady complained to the police department that she was "seeing strangers" in her house. The police listened respectfully to her complaint and with becoming gravity suggested to her that she change the locks on her doors. She did so and felt better immediately. She now feels so secure that she isn't locking any doors!

The police bring other interesting questions to the Center. Has the Senior Center any undemanding job that a late sixtyish, mildly alcoholic woman can do as a volunteer? What about jobs for teens who have been told by juvenile court to give so many hours of community service?

It is a fact that without true volunteers no Senior Center could function. In Wellfleet, the monthly NEWSLETTER is addressed by volunteers—all 500 copies that go into the mail. In addition a volunteer mimeographs it. Meals-on-Wheels, as mentioned above, are delivered to three towns by volunteers. The Congregate Lunch originally cooked and served entirely by volunteers still depends on many volunteers to set tables, assist with serving, and even clean-up afterwards.

And then there is transportation. This is a major problem for a place as remote from large population centers as Wellfleet. There is a Regional Transportation Association ("RTA"), which operates a fleet of so-called "B-Buses". These 12-passenger vans, some with wheelchair lifts, provide free rides to medical appointments and nutrition sites. Seniors who wish to use them for other purposes pay $23.00 a quarter, for which they receive door-to-door service for such things as shopping and beauty parlor or barber shop trips. The biggest drawback is that the buses do not run in the evenings—and there is a mileage fee for out-of-town trips.

In Wellfleet we have a Diabetes Support Group, which meets at the Senior Center one Monday afternoon a month. We use volunteer transportation for these sessions, because the bus could not be scheduled for the necessary time. On the other hand, Wellfleet Seniors use the bus once a week to go to Orleans to shop. They pay no mileage fees for this out-of-town transportation. The RTA decided that this was fair, since the only large market in Wellfleet is closed all winter. This trip has become so popular that of late two trips have had to be made.

Besides the Congregate Lunch and the shopping trips, the bus transports participants to both the Stroke Recovery Club and the Vision Foundation meetings, each once a month.

There are regularly scheduled volunteers and there are the casual volunteers. Many people will phone the Center and say, "I'm going to the hospital in Hyannis tomorrow to see someone. Who from Wellfleet is there I could visit?"

One of the most rewarding volunteers is a woman over ninety who telephoned one day and announced, "You know that I had a stroke last year, don't you? And you know that I couldn't speak for quite a while afterwards. As you can tell, I'm able to talk again and I'm so grateful that I got to thinking there must be some lonely people in Wellfleet who would like to chat now and then. If you find anyone like that, won't you please give her my number and tell her to call me up?"

Then there are the helpful friends and neighbors who would vehemently reject the idea that they are volunteers, but who form a very important network. Some people might just call them "nosey". They are the ones who phone the Senior Center with bits of information, some of it only rumor, but much of it very important to the well being of the Seniors of the town.

A caller may advise the Center, "I don't know whether I ought to tell you this. Really, it probably should be kept quiet. But I think you should take a look at so-and-so. My husband and I took her to Grange last night and she is really very confused." Or a caller will report that an elderly man is not getting dressed and not keeping himself very clean. When the Center gets enough of these reports, it can call on its back-up helpers (such as town nurses) for an appraisal. Relatives can be notified, steps taken and, sometimes, this situation can be managed.

But what does the Center do when there are no relatives? Here is where friends and neighbors become increasingly important. And the Center uses the guidance of the Elder Law Project attorneys. This could create a conflict between our determination to help someone at risk and our concern for observing his freedom. If a group of friends decides that a confused Elder needs to be declared legally incapable of caring for him or herself, it is the mandate of the Elder Law to defend the Senior. To date, the Wellfleet Council on Aging has not needed to take such a step, but, because it might happen, the Senior Center has explored methods for dealing with the problem if it arises.

So, with the help of friends and the wholehearted support of the town government, the Wellfleet Council on Aging continues to expand its services in an effort to fill observed needs.

JOSEPH H. FLANZER

On June 5, 1985 the Delaware State Bar Association conferred its First State Distinguished Service Award upon William Poole, Esquire and Joseph H. Flanzer, Esquire. The Flanzer award was made posthumously. In making the award to Mr. Flanzer, who died in 1984, Bar Association President, Frank Biondi spoke of Flanzer's long career of generous public service, including his two term presidency of the Association. So much has been said about his generous work as a Board member and the president of the Wilmington Board of Education, and the services to his profession and other charitable and religious organizations, it is pleasant to recount an occasion when he demonstrated great professional skill in helping someone in deep trouble. Accordingly, we are pleased to print a reminiscence of his co-counsel on that occasion, Carroll F. Poole, Esquire.

About twenty years ago Joe Flanzer and I were appointed senior and junior counsel, respectively, to represent a man charged with second degree murder. I approached this assignment with respect for Joe's abilities; I left it with admiration for his skill.

On the evening of the events leading to the death, the defendant's brother-in-law, a soldier on leave, was visiting. During that evening four minors gathered outside the apartment and shouted from the pavement below that the wife of the soldier had been unfaithful while he was away. They dared him to come downstairs. When, eventually, he did so he was attacked by all four minors. They knocked him down and proceeded to kick him viciously. (Later he learned he had sustained several broken ribs and a fractured collar bone.)

The defendant, seeing the beating, picked up a knife and went to his brother-in-law's aid. Almost at once one of the minors was fatally stabbed. The others ran away, were arrested later, and turned over to Family Court.

Before the trial began the Deputy Attorney General offered a plea to manslaughter. He did so because it was not clear from the evidence whether the stabbing was intentional, or whether it occurred when the defendant tripped over the fallen body of his brother-in-law.

The defendant declined the offer, saying that he had a clear conscience. Joe's reaction was immediate: "If you want to play dice we will do so. But you must know that is what we will be doing when we go before a jury."

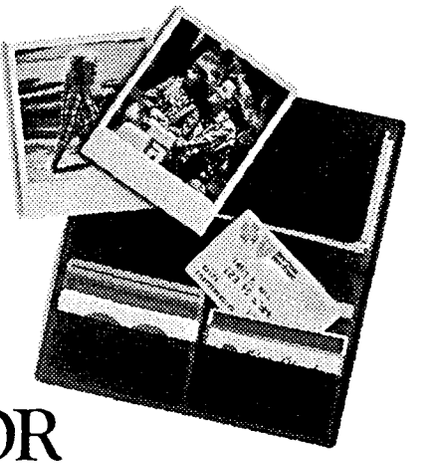
Joe's trial tactics were to force the minors to testify in detail on cross examination, eliciting admissions that they had been aggressors and that they were in custody as a result. The defendant also took the stand. His testimony was that he had tripped and that the stabbing had been quite unintentional.

The jury returned after a brief deliberation with a verdict of not guilty. Joe's handling had been masterly. Quietly, without "oratory" he had painted a convincing picture for the jury. The major problems faced by the defense revolved around the failure of anyone to call the police before leaving the apartment and the selection of a weapon by the defendant. The potential for a negative jury reaction was great; it was compounded by the inability to present the live testimony of the injured soldier, who, by the time of the trial, was stationed in Europe. Joe's deftness in dealing with these difficulties was an education.

Indeed, it was enlightening to work with Joe from the time of our appointment. His thoroughness of preparation was impressive. He quickly gained the entire confidence of the defendant. His well organized presentation both in and out of court was extremely effective. He welcomed my input and suggestions, although after consideration, many of them were not adopted. His patience with junior counsel was much appreciated.

It was a valuable experience to work with Joe professionally and a particular pleasure to get to know him better as a fine gentleman.

Carroll Poole



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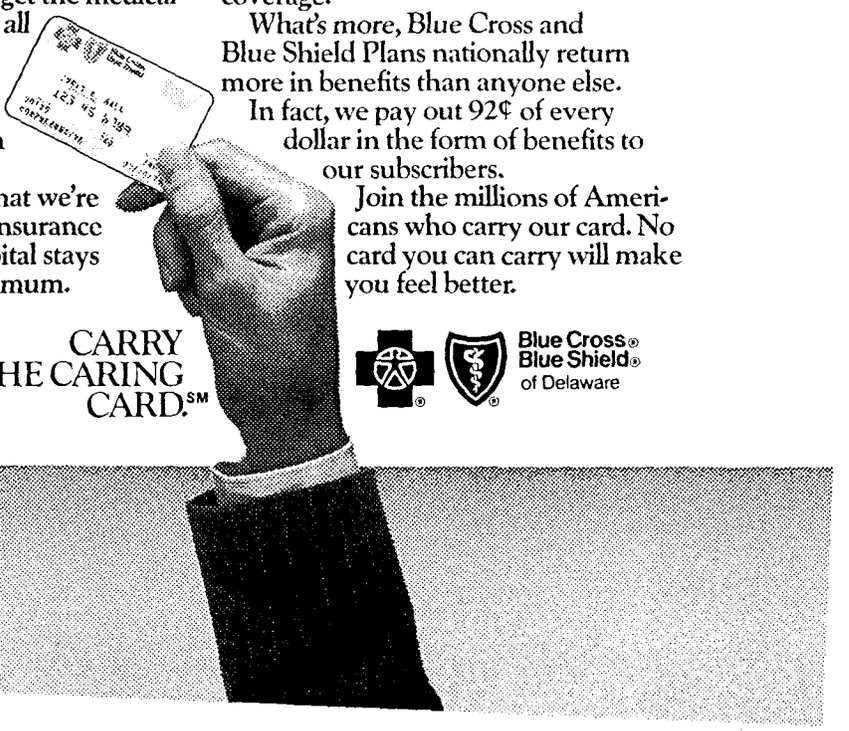

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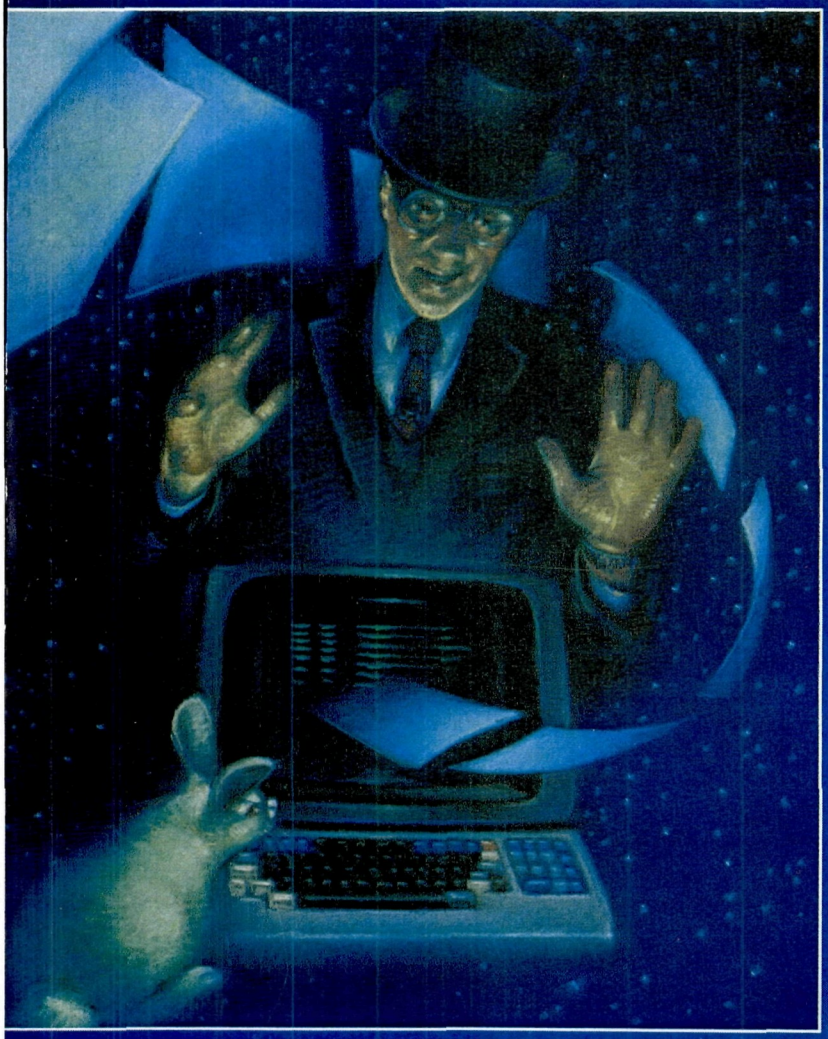

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