GREY MATTERS: PERSPECTIVES ON AGING LAWYERS AND
COGNITIVE IMPAIRMENT

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AMERICAN BAR ASSOCIATION
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For over 20 years, OLAP has assisted Ohio’s lawyers, judges and law students obtain appropriate treatment for substance abuse, chemical dependency, and mental health issues. Over the past 10 years there has been a dramatic increase in the number of professionals and students who have no drug and/or alcohol problems, but suffer from various mental health issues.

OLAP receives referrals from a variety of sources, including colleagues, co-workers, opposing counsel, ethics/certified grievance committees, Disciplinary Counsel, defense counsel in disciplinary cases, admissions committees, counsel in admissions cases, judges, magistrates, court administrators, law schools, family and friends.

Over the last few years OLAP has received many referrals regarding elderly attorneys and their diminished capacity to practice law. We know that these referrals are only going to increase as the years continue. The "baby boomer" generation is now into its 60's, and more lawyers continue to practice longer.

In 2006, 37.3 million Americans were 65 and older; this equates to one in every 8 Americans. In 2030 this number will increase to approximately 71.5 million older persons, which is more than two times the numbers in 2000.(1) It is estimated that a quarter of a million America's practicing lawyers are already over the age of 55. This number is expected to triple over the next two decades.(2)

People in the United States are living longer than ever before. The average life expectancy is now approaching 80 years. There has been a change in the way our health care system manages its patients, and the focus has shifted to making our later years healthier and more productive. We are living longer and healthier lives, and people are postponing retirement for emotional and financial reasons.(3)

The legal profession is going to have attorneys practicing well beyond previously expected retirement age of 65-70. Most large and midsized firms have policies in place on how to accommodate their aging lawyers, with mandatory retirement requirements in place. But this generally is not the case for smaller firms, office-sharing arrangements, and solo practitioners, who make up the majority of Ohio’s lawyers.
Medical Implications of Aging

Regardless of the area of practice, the aging attorney inevitably will struggle with health issues as they age. For many, the aging process is what will impact their ability to continue to practice law in the same manner in which they have grown accustomed over the years. Each person is unique, and there is no stereotype as to how we age. Not all age-related changes are harmful or negative. Scientists suggest that aging is likely a combination of many factors. Genetics, lifestyle and disease all affect the rate at which we age.

Normal aging brings about the following:

- **Eyesight** - loss of peripheral vision and decreased ability to judge depth. Decreased clarity of colors (for example, pastels and blues).
- **Hearing** - loss of hearing acuity, especially sounds at the higher end of the spectrum. Also, decreasing ability to distinguish sounds when there is background noise.
- **Taste** - decreased taste buds and saliva.
- **Touch and Smell** - decreased sensitivity to touch and ability to smell.
- **Arteries** - stiffen with age. Additionally, fatty deposits build up in your blood vessels over time, eventually causing arteriosclerosis (hardening of the arteries).
- **Bladder** - increased frequency in urination.
- **Body Fat** - increases until middle age, stabilizes until later in life, then decreases. Distribution of fat shifts - moving from just beneath the skin to surround deeper organs.
- **Bones** - somewhere around age 35, bones lose minerals faster than they are replaced.
- **Brain** - loses some of the structures that connect nerve cells, and the function of the cells themselves is diminished. "Senior moments" increase.
- **Heart** - is a muscle that thickens with age. Maximum pumping rate and the body's ability to extract oxygen from the blood both diminish with age.
- **Kidneys** - shrink and become less efficient.
- **Lungs** - somewhere around age 20, lung tissue begins to lose its elasticity, and rib cage muscles shrink progressively. Maximum breathing capacity diminishes with each decade of life.
- **Metabolism** - medicines and alcohol are not processed as quickly. Prescription medication requires adjustment. Reflexes are also slowed while driving, therefore an individual might want to lengthen the distance between him and the car in front and drive more cautiously.
- **Muscles** - muscle mass decline, especially with lack of exercise.
- **Skin** - nails grow more slowly. Skin is more dry and wrinkled. It also heals more slowly.
- **Sexual Health** - Women go through menopause, vaginal lubrication decreases and sexual tissues atrophy. In men, sperm production decreases and the prostate enlarges. Hormone levels decrease. (4)
Cognitive Impairment

Symptoms/signs of cognitive impairment include: missed deadlines, repeatedly making the same mistakes and not remembering the first one, confusion, forgetfulness, disheveled appearance, loss of skill set, irritability, dissatisfied clients, disciplinary problems, family member's concerns, and office staff upset/angry, and court concerns. Often times family members or other professionals have noticed a significant decline in one's cognitive abilities. These cognitive changes are referred to as cognitive impairment. Cognitive impairment occurs when there is a problem with perceiving, thinking and remembering. Physical illness, mental health issues, alcohol and drug interactions are all possible causes of cognitive impairment.

Once cognitive impairment is identified, it is essential for the person to receive a full medical evaluation to determine the cause of the impairment. Dementia, Alzheimer's Disease and Delirium are all possible medical-related issues that need to be ruled out. While there are many qualifiers and sub-types for each of the disorders listed above it is important to have a working definition of the following disorders.

Dementia

The development of multiple cognitive deficits manifested by both (1) memory impairment (impaired ability to learn new information or to recall previously learned information), (2) one (or more) of the following cognitive disturbances:

a) aphasia (language disturbance)
b) apraxia (impaired ability to carry out motor activities despite intact motor function)
c) agnosia (failure to recognize or identify objects despite intact sensory function)
d) disturbance in executive functioning (i.e., planning, organizing, sequencing, abstracting)

** The cognitive deficits listed above each cause significant impairment in social or occupational functioning, and represent a significant decline from a previous level of functioning. There will be a gradual onset and continuing decline. Also, these symptoms are not due to any other central nervous system conditions that cause deficits in memory and cognition.
Alzheimer's Disease

Alzheimer's Disease a brain disease that causes problems with memory, thinking and behavior. It is the most common cause of dementia. It is not a normal part of the aging process, and it is not the only cause of memory loss. Alzheimer's disease worsens over time and there is no cure. The treatments available try to slow progression and lesson the symptoms. (Alzheimer's Association).

Delirium

Delirium is a disturbance of consciousness (i.e. reduced clarity of awareness of the environment), with reduced ability to focus, sustain, or shift attention. There is also a change in cognition (such as memory deficits, disorientation, language disturbance) or the development of perceptual disturbance that is not better accounted for by a preexisting, established, or evolving dementia. The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day. Lastly, upon evaluation this disturbance is caused by the direct physiological consequences of a general medical condition. (5)

Mental Health Implications

As a person ages there are several losses associated with getting older. While many aging people go through the later stages of life successfully and embrace their new phase of life, some people experience mental health issues at this time. There are many mental health issues one may face as they age, but depression can be the most significant and under diagnosed.

While depression and suicide rates among the elderly are significant, depression is not a normal part of the aging process. Suicide is more common among older adults than any other age group, accounting for 16 to 25 percent of the suicides in the U.S. (6). Depression is one of the issues most commonly associated with suicide in older adults. However, it is under-recognized and under-treated. Studies have shown that up to 75% of older adults who kill themselves visited a physician within a month before their death. The risk of suicide increases with other illnesses, and when the ability to function become limited. (7)
Over the last several years, OLAP has assisted aging attorneys navigate the difficult process of changing how they practice, or retiring, from the practice of law. The point at which an attorney needs to make changes or retire, is dependent upon how much decline they are experiencing. Each case must be assessed individually. Regardless of the issues facing the attorney, it is essential those involved with the aging attorney create a positive environment and good rapport. It is essential to uphold the dignity of the individual. We must respect how much one's self worth, self esteem, and self confidence are all connected to their identity of being a lawyer. This difficult life transition can be made more tolerable if we allow the aging lawyer as much control and input as possible during this process.

Relevant Ohio Supreme Court Rules

Prof. Cond. R. 8.3 Reporting Professional Misconduct (ABA MRPC 8.3)

Judicial Cond. R. 2.14 Disability and Impairment (ABA CJD 2.14)


References

1. Administration on Aging (www.aoa.gov)
2. American Geriatric Society (www.americangeriatrics.org)
3. The Complete Lawyer (Volume 3, Number 4) "No Senior Discount at the Ethics Bar", David Giacalone
RULE 8.3: REPORTING PROFESSIONAL MISCONDUCT
(a) A lawyer who possesses unprivileged knowledge of a violation of the Ohio Rules of Professional Conduct that raises a question as to any lawyer’s honesty, trustworthiness, or fitness as a lawyer in other respects, shall inform a disciplinary authority empowered to investigate or act upon such a violation.
(b) A lawyer who possesses unprivileged knowledge that a judge has committed a violation of the Ohio Rules of Professional Conduct or applicable rules of judicial conduct shall inform the appropriate authority.
(c) Any information obtained by a member of a committee or subcommittee of a bar association, or by a member, employee, or agent of a nonprofit corporation established by a bar association, designed to assist lawyers with substance abuse or mental health problems, provided the information was obtained while the member, employee, or agent was performing duties as a member, employee, or agent of the committee, subcommittee, or nonprofit corporation, shall be privileged for all purposes under this rule.

Comment
[1] Self-regulation of the legal profession requires that a member of the profession initiate disciplinary investigation when the lawyer knows of a violation of the Ohio Rules of Professional Conduct involving that lawyer or another lawyer. A lawyer has a similar obligation with respect to judicial misconduct. An apparently isolated violation may indicate a pattern of misconduct that only a disciplinary investigation can uncover. Reporting a violation is especially important where the victim is unlikely to discover the offense.
[2] A report about misconduct is not required where it would involve the disclosure of privileged information. However, a lawyer should encourage a client to consent to disclosure where it would not substantially prejudice the client’s interests.
[3] [RESERVED]
[4] The duty to report professional misconduct does not apply to a lawyer retained to represent a lawyer whose professional conduct is in question. Such a situation is governed by the rules applicable to the client-lawyer relationship. See Rule 1.6.
[5] Information about a lawyer’s or judge’s misconduct or fitness may be received by a lawyer in the course of that lawyer’s participation in an approved lawyers or judges assistance program. In that circumstance, providing for an exception to the reporting requirements of divisions (a) and (b) of this rule encourages lawyers and judges to seek treatment through such a program. Conversely, without such an exception, lawyers and judges may hesitate to seek assistance from these programs, which may then result in additional harm to their professional careers and additional injury to the welfare of clients and the public.
Comparison to former Ohio Code of Professional Responsibility
Rule 8.3 is comparable to DR 1-103 but differs in two respects. First, Rule 8.3 does not contain the strict reporting requirement of DR 1-103. DR 1-103 requires a lawyer to report all misconduct of which the lawyer has unprivileged knowledge. Rule 8.3 requires a lawyer to report misconduct only when the lawyer possesses unprivileged knowledge that raises a question as to any lawyer’s honesty, trustworthiness, or fitness in other respects. Second, Rule 8.3 requires a lawyer to self-report.

Comparison to ABA Model Rules of Professional Conduct
Rule 8.3 is revised to comport more closely to DR 1-103. Division (a) is rewritten to require the self-reporting of disciplinary violations. In addition, the provisions of divisions (a) and (b) are broadened to require reporting of (1) any violation by a lawyer that raises a question regarding the lawyer’s honesty, trustworthiness, or fitness, and (2) any ethical violation by a judge. In both provisions, language is included to limit the reporting requirement to circumstances where a lawyer’s knowledge of a reportable violation is unprivileged.

Division (c), which deals with confidentiality of information regarding lawyers and judges participating in lawyers’ assistance programs, has been strengthened to reflect Ohio’s position that such information is not only confidential, but “shall be privileged for all purposes” under DR 1-103(C). The substance of DR 1-103(C) has been inserted in place of Model Rule 8.3(c).

In light of the substantive changes made in divisions (a) and (b), Comment [3] is no longer applicable and is stricken. Further, due to the substantive changes made to confidentiality of information regarding lawyers and judges participating in lawyers’ assistance programs, the last sentence in Comment [5] has been stricken.
RULE 2.14 Disability and Impairment

(A) A judge having a reasonable belief that the performance of a lawyer or another judge is impaired by drugs or alcohol, or by a mental, emotional, or physical condition, shall take appropriate action, which may include a confidential referral to a lawyer or judicial assistance program.

(B) Any information obtained by a member or agent of a committee or subcommittee of a bar or judicial association or by a member, employee, or agent of a nonprofit corporation established by a bar association, designed to assist lawyers and judges with substance abuse or mental health problems, shall be privileged for all purposes under this rule, provided the information was obtained while the member, employee, or agent was performing duties as a member, employee, or agent of the committee, subcommittee, or nonprofit corporation.

Comment

[1] “Appropriate action” means action intended and reasonably likely to help the judge or lawyer in question address the problem and prevent harm to the justice system. Depending upon the circumstances, appropriate action may include, but is not limited to, speaking directly to the impaired person and notifying a partner, a colleague, or an individual with supervisory responsibility over the impaired person, or making a referral to an assistance program.

[2] Taking or initiating corrective action by way of referral to an assistance program may satisfy a judge’s responsibility under this rule. Assistance programs have many approaches for offering help to impaired judges and lawyers, such as intervention, counseling, or referral to appropriate health care professionals. Depending upon the gravity of the conduct that has come to the judge’s attention, however, the judge may be required to take other action, such as reporting the impaired judge or lawyer to the appropriate authority, agency, or body. See Rule 2.15.

Comparison to Ohio Code of Judicial Conduct

There is no Ohio Canon comparable to Rule 2.14(A). Rule 2.14(B) corresponds to Ohio Canon 3(D)(4).

Comparison to ABA Model Code of Judicial Conduct

Model Rule 2.14 is modified to add division (B) that is taken from Ohio Canon 3(D)(4).
Aging Attorneys

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Colorado Physician Health Program
Objectives

1. Discuss implications of an aging population
2. Review aspects of normal aging
3. Discuss Mild Cognitive Impairment (MCI)
4. Identify warning signs of cognitive impairment
5. Discuss cognitive screening controversies
6. The Colorado Physician Health Program
   Malpractice Risk Study – Brooks et al
7. Graceful transitions
Aging Boomers

Number of Americans 65 Years of Age and Older: 1900-2050

Source: U.S Census Bureau
Disincentives for Retirement

- Baby boomers face financial pressures and will want/need to continue to work past traditional retirement age
- In some professions this will be supported due to shortages
- Generations X and Y prefer “balance”
Setting the context: Healthcare

- Elderly patients are more complicated:
  - Proportion of the population over 65 expected to grow rapidly over the next 15 yrs;
  - Increased use of medical services: 3 to 5 times the rate of the middle aged
  - GME funding deficits
  - Physician shortages
Normal Aging
Risks for Impairment

- **Sleep deprivation**
  - Earlier wake time
  - Difficulty initiating sleep
  - More night time awakenings
  - Lighter sleep
  - More difficulty adjusting to shift changes and jet lag

- **Sensory Loss**
  - Vision
  - Hearing

- **These are treatable conditions**
Normal Aging: Neuropsychological Changes

Decision making
Differences in how decision reached
More reliance on prior knowledge

Changes in Memory
Decreased episodic memory (specific events)
- recall worse than recognition
Slower pace of learning
Increased need for repetition

Decreased Speed
Processing speed
Reaction time
Psychomotor speed
Fine motor skills/dexterity
Safety Sensitive Employment

The underlying principle for fitness-for-duty assessment is the protection of the public

- Health Profession
- Legal Profession
- Transportation Industry
- Other (i.e. nuclear power plant operator)
Impairment Definition

Unable to practice law with reasonable skill and safety to the public as a result of illness or injury

**Illness is not synonymous with impairment!**
Sudden Onset Impairment

- Acute myocardial infarction
- Cerebral vascular accident
- Seizure
- Trauma – Emotional (grief/shock)
- Trauma - Physical
  - Falls
  - Motor vehicle accident
  - Sporting accident
Gradual Onset Impairment

- Mood/Anxiety Disorders
- Substance Use Disorders
- Obstructive Sleep Apnea
- Visual/Hearing Loss
- Polypharmacy
- Stress and Burnout
Inside the Human Brain

Neurons

- The brain has billions of neurons, each with an axon and many dendrites.
- To stay healthy, neurons must communicate with each other, carry out metabolism, and repair themselves.
The Concept of Cognitive Reserve

- Refers to brain size
- Also synapse count
- The amount of damage that can be sustained before reaching a threshold for clinical expression (ex = slow growing tumor)
- The ability to use brain networks more efficiently
- The ability to employ alternative strategies in response to task demand (mental flexibility)
The Concept of Cognitive Reserve

Physicians, Attorneys, Executives
- High IQ
- Lengthy and challenging education
- Premorbidly – high level of cognitive resources
- High level of verbal resources
- Good health habits (i.e. no tobacco)

Reserve allows compensation and masking of decline
Different Reserve, Same Insult

Attorney A

Attorney B
Neurodegenerative Disorders: Gradual Onset Impairment

The affected individual, family and colleagues may adapt due to the *insidious* nature of changes.
Cognitive Domains

Sensorimotor
Executive Functioning
Intelligence (IQ)
Attention/Concentration
Language
Emotion
Memory
Visuospatial
Mild Cognitive Impairment

- **Dementia** (abnormalities of at least **two** cognitive domains)

- **Mild cognitive impairment-MCI** (abnormalities of only **one** cognitive domain)
Mild Cognitive Impairment

- Not normal, but not dementia
- Executive function deficits often precede memory lapses or loss
- 12% convert to dementia annually
- 80% convert to dementia at 6 years
- ADLs largely preserved
Alzheimer’s Disease Trajectory

- Normal Aging
- IQ-MI
- MCI
- Amyloid accumulation
- AD

Time
Potential Clues to Cognitive Deficits

- Late payments/poor business decisions
- Loss of skill (bad outcomes, legal errors)
- A failure to remediate skills following competency assessment
- Office staff concerns (or turnover)
- Lawsuits or complaints to regulatory agencies
- Dissatisfied clients
- Professional boundary problems (judgment)
- Irritability, impatience, mood swings
- Family, institutions, colleagues may collude with impaired one because of:
  - Power differential
  - Fear of loss (practice, license, prestige)
  - Hesitancy to “betray” colleague
  - Social Stigma of dementia/other illness
Controversies

Commercial pilots must undergo health screening at 40 and must retire at age 65

Air traffic controllers must retire at age 55

Should health screening be included in maintenance of competency requirements for physicians and attorneys?
Supreme Court Justices Are Seated for Life
Age and Disciplinary Action

- Length of time since graduation predicts greater risk of disciplinary action among physicians:
- There is a positive association between aging and disciplinary action but unable to ascertain whether this is related to:
  - Greater number of patients seen over time
  - Risk due to more complex patients (an aging practice)
  - Cognitive deficits
  - Other

Morris and Wickersham, JAMA 1998;279:1889-1894
U.S.
Alzheimer Incidence
(4 million / 8yr)

- **male** = 170,603
- **female** = 329,115

JW Ashford, MD PhD, 2003
Cognitive Screening: The Challenges

- There is no single universally accepted screen that satisfies all the needs in the detection of cognitive impairment
- Many screening tests but few have been well validated
- Many have low accuracy for mild levels of impairment
- Many have demographic biases in score distribution
- Many over emphasize memory dysfunction
- Cannot be used to create a differential diagnoses because they are designed to identify specific subtypes of dementia
Subtypes of Dementia
Patterns of Impairment

- **Alzheimer’s**: memory deficits before other deficits
- **Vascular**: executive functioning problems precede memory deficits
- **Frontotemporal**: behavioral problems (disinhibition)
- **Lewy Body**: attention deficits
Evaluating the Professional

- Important to utilize **screening** instruments that will adequately challenge cognitive resources

- **Emphasis on:**
  - Ability to problem solve
  - Judgment
  - Decision making
  - Executive Functioning
Clock Drawing Test

- CDT of 4 approximates a MMSE of near 30 or mild cognitive impairment
- CDT of 2 puts patient in the moderate impairment of MMSE scores of high teens.
- CDT of 1 reflects moderate-to-severe scores on MMSE (low teens)
- Abnormal results suggest need for further assessment
Clock Draw Examples:

Figure: Examples of clock drawing by a normal elderly control (A) and patients with dementia (B-E). For these examples, patients were instructed to draw in the hands at twenty minutes after eight. Respective CDT and MMSE scores are shown below each drawing.
Rule Out Reversible Causes of Cognitive Impairment

- CNS Infections
- Hypothyroidism
- Vitamin deficiencies (Vit D, B12 and Folate)
- Tumor
- Polypharmacy
- Psychiatric Illness
- Substance Abuse/Dependence
- Sleep Disorders..................to name a few!
When to Pursue Neuropsychological Testing?

Any age if clinical/occupational signs support

Age 60?
  Low yield and expensive
  What to do with incidental findings?

Age 70-75?
  A good quality screen
  Formal neuropsychiatric testing if screen is +
Probability Not Demented

Proportion of population

Age

JW Ashford, MD PhD, 2003
The Neuropsychiatric Exam
What does it provide?

- A precise quantification of various cognitive functions
- A profile of deficits and extent
- A profile of strengths useful for rehabilitation/compensation
- A baseline for future assessments (ex. = MS)
- Determination of functional status (i.e. areas needing accommodation)
- Assistance in assessing competency for legal issues
Interventions: Preserving Dignity

- Talk with trusted colleagues about your concerns

- Arrange a meeting with the professional identified as having a potential problem
  - Best to have a power differential
  - Include trusted friend/colleague of (potentially) impaired individual

- Utilize professional peer assistance programs
  - Most knowledgeable about expert evaluators
  - Physician Health Programs can also be a resource
  - Preserve confidentiality/boundaries
Compensatory Measures

- Avoid solo practice
- Work fewer hours
- Increase staff assistance
- Monitoring (Lawyers Assistance Programs)
- Reorganization of a practice
  - Utilize knowledge/experience of the professional
  - Encourage continued professional involvement
  - Maintain respect for the professional
Young Attorneys:

- **Fluid intelligence/reasoning:** the capacity to think logically and solve problems in novel situations, independent of acquired knowledge.
  - necessary for all logical problem solving, especially scientific, mathematical and technical problem solving
  - Sensitive to age related changes
    - analytic/effortful processing
Older Attorneys

Crystallized intelligence: knowledge and skills that are accumulated over a lifetime, for example vocabulary.

- Less affected by age and disease
  - Involves less effortful tasks
  - Acquired through education and life experience
  - Nonanalytic/automatic/implicit mental processes
Mixed Age Practices are Ideal

- Younger
  - Tolerate sleep deprivation
  - Rely more on analytical reasoning
    - (less experience)
    - May move too slowly w/ excessive analysis

- Older
  - The “sages”
  - Rely more on decades of experience, and historical memory
Colorado Medical Practice Act

Historically, merely having an illness was grounds for discipline

Revisions
  Discipline risk if illness not treated
  Colorado Physician Health Program is a safe harbor

Self referrals exceed mandatory referrals

Early interventions protect physician and the public
Types and Sources of New Referrals 2011-2012

- Voluntary (62%)
- Mandatory (38%)

<table>
<thead>
<tr>
<th>Source</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>PA Program</td>
<td>.5%</td>
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<tr>
<td>Attorney</td>
<td>.5%</td>
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<tr>
<td>Family</td>
<td>1%</td>
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<tr>
<td>Other</td>
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<td>Malpractice</td>
<td>1%</td>
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<tr>
<td>Administration</td>
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<td>Treatment Provider</td>
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<tr>
<td>Resident Program</td>
<td>5%</td>
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<tr>
<td>Self</td>
<td>40%</td>
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<tr>
<td>Medical School</td>
<td>4%</td>
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<tr>
<td>Proactive</td>
<td>7.5%</td>
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<tr>
<td>Hospital</td>
<td>9.5%</td>
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<tr>
<td>CMB</td>
<td>19%</td>
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Discipline *does not* make a sick professional well

- Peer assistance programs
  - Fewer professionals go “underground”
  - Confidential assessments by (true experts)
  - More self referrals
  - Earlier intervention
  - Less harm to the public
  - Unlike a complaint driven investigation
- Leverage for assuring compliance (reporting)
- Advocacy for the professional’s health
  - Preserve dignity, reduce shame/fear, protect public without disciplinary measures
Malpractice Risk Study Results

- 818 physicians available for analysis
  - COPIC and CPHP matched physicians (blinded)

- Retrospective examination of administrative data

- 20% reduction in malpractice risk in physicians who had been monitored for a health problem ($p < 0.01$)

- This is likely to be true for attorneys who utilize Lawyers Assistance Programs
Graceful Exits……..
The Transition to Retirement

Ideally, a gradual, stepwise process before impairment develops

It usually takes a few years to do this

Ways to Accomplish This:
- Begin to integrate more hobbies
- Reduce workload
- Consultation with:
  - Other retired professionals
  - Executive Coaches/therapist
  - Financial experts
Graceful Exits…….
Suggestions for Coping with Change

- Find interests outside of profession
  - Clarify personal values
  - Activities that make the professional feel valued
  - Activities that have meaning
    - Reestablish humane and altruistic connections to society
  - Physical Activity
  - Creativity

- Enhance social support
  - Church/Synagogue
  - Family/Friends
  - Volunteer work
Quiz Question:

What activity has shown the greatest benefit in reduction of risk for Alzheimer’s disease and other dementias?
Ballroom Dancing

76% relative risk reduction from frequent participation in ballroom dancing by 130 avid dancers was the highest score of all hobbies and physical activities measured.

-Verghese J et al. NEJM 348;25
Graceful Exits

Health may actually improve during retirement

- Better nutrition
- More exercise
- Less stress
- Greater balance
- Spousal relationships tend to improve
Concluding Remarks

- Competent practice rather than age should be the guiding principle in any final practice determinations.

- We need absolute rather than age-adjusted performance standards to be applied to all professionals in safety sensitive positions.

- Complaint driven evaluations identify professionals who are (most likely) already impaired.

- Earlier intervention can occur with the assistance of LAPs.

- Earlier intervention is more likely to occur with confidentiality.

- The critical role of cognitive health research.
GREY MATTERS: PERSPECTIVES ON AGING LAWYERS & COGNITIVE IMPAIRMENT

A Disciplinary Perspective
OVERVIEW

- Demographics
- Model Rules Implicated
- Ideas for the Future
Aging Lawyer Population

- 2012 – ABA Market Research Department Lawyer Demographics survey:
  - 2005 - 34% of practicing lawyers were age 55 or over compared to 25% in 1980
  - 2005 - median age of practicing lawyer was 49 compared to 39 in 1980
AGING LAWYER POPULATION

By Jurisdiction – “Senior Tsunami”

- Michigan – 2010
  - 53.4% of the active members of the State Bar were born before 1961, 11.1% born before 1944
- Washington – 2012
  - 71% are 50 or older, 21% are 61 or above
- Florida – 2012
  - 33% are 55 or older, 21% are 60 or older and 11% are 65 and older
- California – 2013
  - 244,016 attorneys – 20% of lawyers are 65 or older, 22% are 55-64
RULES IMPLICATION

1.1 – Competence
- Legal Knowledge & Skill
- Thoroughness & Preparation
- Maintaining Competence

1.3 & 1.4 – Diligence & Communication

1.6 – Confidentiality of Information
- Communication with EAP and LAP Programs
RULES IMPLICATION

- 1.16 – Declining or Terminating Representation
- 1.17 – Sale of a Law Practice
- 5.1 – Responsibilities of Partners, Managers, & Supervisory Lawyers
- 8.3 – Reporting Professional Misconduct
IDEAS FOR THE FUTURE

- Traditional Discipline Models
  - Permanent Retirement Status
  - Transfer to Disability Inactive Status
  - Motions to Compel Evaluation
  - Receiverships

- Alternatives to Discipline Models
  - Inactive, Retired and Emeritus Status
  - Succession Planning
  - Education/Outreach
Malpractice Claims

Most Common Alleged Errors - 2012

<table>
<thead>
<tr>
<th>Error</th>
<th>2012</th>
<th>2007</th>
<th>Percentage Change</th>
</tr>
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<tbody>
<tr>
<td>Failure to Know/Properly Apply Law</td>
<td>13.57%</td>
<td></td>
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<tr>
<td>Procrastination in Performance/Followup</td>
<td>9.68%</td>
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<tr>
<td>Inadequate Discovery/Investigation</td>
<td>7.82%</td>
<td></td>
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</tr>
<tr>
<td>Planning Error - Procedure Choice</td>
<td>7.39%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lost File, Document Evidence</td>
<td>7.05%</td>
<td>0.60%</td>
<td></td>
</tr>
</tbody>
</table>

Source: ABA Standing Committee on Lawyers’ Professional Liability 2012
## Malpractice Claims

### Claims by Type of Alleged Error - 2012

<table>
<thead>
<tr>
<th>Substantive Errors</th>
<th>45.07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to know law</td>
<td>13.57</td>
</tr>
<tr>
<td>Planning error</td>
<td>7.82</td>
</tr>
<tr>
<td>Inadequate discovery</td>
<td>7.39</td>
</tr>
<tr>
<td>Failure to know deadline</td>
<td>6.91</td>
</tr>
<tr>
<td>Conflict of interest</td>
<td>4.28</td>
</tr>
<tr>
<td>Error in record search</td>
<td>3.03</td>
</tr>
<tr>
<td>Failure to understand tax</td>
<td>1.37</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intentional Wrongs</th>
<th>10.19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraud</td>
<td>4.53</td>
</tr>
<tr>
<td>Abuse of process</td>
<td>3.43</td>
</tr>
<tr>
<td>Violation of Civil Rights</td>
<td>1.27</td>
</tr>
<tr>
<td>Libel or Slander</td>
<td>.96</td>
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<table>
<thead>
<tr>
<th>Client Relations</th>
<th>14.61</th>
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<tbody>
<tr>
<td>Failure to obtain consent</td>
<td>7.02</td>
</tr>
<tr>
<td>Failure to follow client instruction</td>
<td>5.71</td>
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<tr>
<td>Improper withdrawal</td>
<td>1.87</td>
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</table>

<table>
<thead>
<tr>
<th>Administrative Errors</th>
<th>30.13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to file document</td>
<td>3.17</td>
</tr>
<tr>
<td>Failure to calendar</td>
<td>4.34</td>
</tr>
<tr>
<td>Procrastination</td>
<td>9.68</td>
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<tr>
<td>Failure to react to calendar</td>
<td>2.34</td>
</tr>
<tr>
<td>Clerical error</td>
<td>3.54</td>
</tr>
<tr>
<td>Lost file, document, evidence</td>
<td>7.05</td>
</tr>
</tbody>
</table>

Source: ABA Standing Committee on Lawyers’ Professional Liability 2012
Malpractice Claims

Succession Planning:

• Your untimely passing would create a firm crises so plan for it.

• Small firm practitioners and solos – have a reciprocal agreement to look after client matters in the event of your death or incapacitation.

• Memorialize the arrangement and document details of the plan including the scope of the assisting attorney’s duties.
Malpractice Claims

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