CHAPTER 4

Dementia, Alzheimer's Disease, and the Elderly

4-1 What is Dementia?

Dementia is the name given to a group of symptoms including memory loss, reduced ability to reason, impaired judgment, and progressive loss of the ability to understand either spoken or written language.[1] One could liken dementia to a fever: A "fever" is not a disease; it is merely a symptom that someone is suffering from a thus-far unidentified disease. In the same manner, dementia serves as an indication that someone is suffering from some form of impaired judgment.

This, though, is where the similarities end. In the final analysis, fevers and dementia manifest themselves in quite dissimilar ways. If we consider the manifestations as points along a spectrum, on one end of the spectrum, we find someone who may be "burning up with a fever." The person may be delirious and may say things he or she does not mean or does not remember after the fever has abated. On the other end of the spectrum, we find someone suffering from dementia. Generally, the person behaves in ways others may find irrational.[2] He or she suffers from severe mood or personality changes, is physically aggressive, becomes easily agitated, and suffers from altered perceptions such as hallucinations, misperceptions, and delusions.[3] As time passes by and the disease settles in "for the long haul," the person may become disoriented in time (i.e., not knowing what day of the week, day of the month, or month of the year it is), place (not knowing where he or she is), and person (not knowing who he or she is—or who anybody else is, for that matter).[4]

4-1:1 Diagnosing Dementia

The Alzheimer's Association reports that disorders grouped under the general term "dementia" are caused by abnormal brain changes. These changes trigger a decline in thinking skills, also known as cognitive abilities, severe enough to impair daily life and

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[1] Vaughn E. James, The Alzheimer's Advisor: A Caregiver's Guide to Dealing With the Tough Legal and Practical Issues, 8 (AMACOM Books 2009).

[2] Vaughn E. James, The Alzheimer's Advisor: A Caregiver's Guide to Dealing With the Tough Legal and Practical Issues, 8 (AMACOM Books 2009).

[3] Vaughn E. James, The Alzheimer's Advisor: A Caregiver's Guide to Dealing With the Tough Legal and Practical Issues, 8 (AMACOM Books 2009).

[4] Vaughn E. James, The Alzheimer's Advisor: A Caregiver's Guide to Dealing With the Tough Legal and Practical Issues, 8 (AMACOM Books 2009).

independent function. They also affect behavior, feelings, and relationships.[5] Alzheimer's disease accounts for 60–80% of cases. Vascular dementia, which occurs because of microscopic bleeding and blood vessel blockage in the brain, is the second most common cause of dementia. But many other conditions can also cause symptoms of dementia, including some that are reversible, such as thyroid problems and vitamin deficiencies.[6] Symptoms of dementia can vary greatly. Examples include:

- problems with short-term memory;
- keeping track of a purse or wallet;
- paying bills;
- planning and preparing meals;
- remembering appointments; and
- traveling out of the neighborhood.[7]

No single test exists to determine whether someone has dementia. Doctors diagnose Alzheimer's and other types of dementia based on a careful medical history, a physical examination, laboratory tests, and the characteristic changes in thinking, day-to-day function, and behavior associated with each type. They can determine that a person has dementia with a high level of certainty. But it is harder to determine the exact type of dementia because the symptoms and brain changes of different dementias can overlap. In some cases, a doctor may diagnose "dementia" and not specify a type. If this occurs, it may be necessary for the patient to see a specialist such as a neurologist or geropsychologist to determine the type of dementia he or she is suffering from.[8]

A dementia diagnosis can have serious implications for the patient, his or her family members, and other informal caregivers, if any. Many dementias are progressive; the symptoms start out slowly and gradually get worse. In essence, though, once the disease steps in, the patient's daily activities begin to be restricted, and as time goes by, these restrictions increase to the point that the patient will face a need for long-term care.

4-1:2 Relationship Between Dementia and Age

In a 2002 article, Professor Marshall Kapp opined that almost 5% of persons aged 65 and older were severely demented, and that 10% of that group could be labeled as suffering from moderate dementia.[9] According to Professor Kapp, among persons 85 and older, more than 15% were severely demented.[10] Eight years later, in an article

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[5] Alzheimer's Association, What is Dementia?, *available at* https://www.alz.org/alzheimers-dementia/what-is-dementia (last visited May 5, 2020).

[6] Alzheimer's Association, What is Dementia?, *available at* https://www.alz.org/alzheimers-dementia/what-is-dementia (last visitedMay 5, 2020).

[7] Alzheimer's Association, What is Dementia?, *available at* https://www.alz.org/alzheimers-dementia/what-is-dementia (last visited May 5, 2020).

[8] Alzheimer's Association, What is Dementia?, *available at* https://www.alz.org/alzheimers-dementia/what-is-dementia (last visited May 5, 2020).

[9] Marshal Kapp, Legal Standards for the Medical Diagnosis and Treatment of Dementia, 23 J. Legal Med. 359, 366 (2002).

[10] Marshal Kapp, Legal Standards for the Medical Diagnosis and Treatment of Dementia, 23 J. Legal Med. 359, 366 (2002).

appearing in the *Elder Law Journal*, Professor Lisa Brodoff noted the prediction that because the incidence of one type of dementia—Alzheimer's disease—in the population increases as people age, the number of people with this disease will rise dramatically as the Baby Boomers age.[11] Professor Brodoff noted that the number of new cases of Alzheimer's disease was expected to rise from 411,000 in 2000 to 615,000 by 2030, and to almost 1 million by 2050.[12]

4-1:3 Types of Dementia

While people often speak of dementia as a single disease, in reality, at least 50 distinct diseases belong to the group of symptoms we call dementia. Dementia itself can be split into two broad categories: the cortical dementias and the subcortical dementias. The categorization depends on which part of the brain the disease affects. Cortical dementias arise from a disorder affecting the cerebral cortex, the outer layers of the brain that play a critical role in thinking abilities like memory and language. Examples of this type of dementias include Creutzfeldt–Jakob disease and Alzheimer's disease. People with cortical dementia typically show severe memory loss and aphasia—the inability to recall words and understand language.[13]

The second type of dementias, subcortical dementias, results from dysfunction in the parts of the brain that are beneath the cortex. This type of dementias includes Parkinson's disease, Huntington's disease, and AIDS dementia complex. People who suffer from one of these subcortical dementias do not exhibit the forgetfulness and language difficulties characteristic of the cortical dementias. Instead, they tend to show changes in their speed of thinking and ability to initiate activities.[14]

Of all the dementias currently known to humans, Alzheimer's disease is the most prevalent, accounting for more than two-thirds of all dementia cases.[15]

4-2 Alzheimer's Disease

Although Alzheimer's disease is the most prevalent form of dementia, it is not synonymous with other forms of dementia. As an initial matter, unlike other forms of dementia, Alzheimer's disease is a brain disease that physically attacks the brain itself. Accordingly, the memory loss experienced by the Alzheimer's patient is merely a symptom or function of the brain disease, not the disease itself.

Because Alzheimer's physically attacks the brain, the disease is, in all senses of the word, irreversible. Over the course of its progression, it robs the patient of memory and cognitive skills, and causes him or her to have severe changes in personality and behavior. While the disease itself does not cause death, it causes conditions that will

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[11] Lisa Brodoff, Planning for Alzheimer's Disease With Mental Health Advance Directives, 17 ELDLJ 239, 247 (2010).

[12] Lisa Brodoff, Planning for Alzheimer's Disease With Mental Health Advance Directives, 17 ELDLJ 239, 247 (2010).

[13] J.H. Kramer & J.M. Duffy, Aphasia, Apraxia, and Agnosia in the Diagnosis of Dementia, 7 Dementia. 23–6 (Jan–Feb. 1996).

[14] Leonard F. Koziol et al., Frontal-Subcortical Dementias, in Chad A. Noggle & Raymond S. Dean, The Neuropsychology of Psychopathology, 405, 410 (Springer 2013).

[15] National Institute on Aging, 2000 Progress Report on Alzheimer's Disease, NIH Pub. No. 00-4859 (2001).

eventually lead to the patient's death. Although some people have lived up to 20 years with the disease, the average post-diagnosis life span for an Alzheimer's patient is 4–8 years.

The disease takes its name from a German physician, Dr. Aloysius Alzheimer. On November 26, 1901, Dr. Alzheimer began treating a 51-year-old woman at the Städtische Anstalt für Irre und Epileptische (Asylum for Lunatics and Epileptics) in Frankfurt. Dr. Alzheimer noticed that the woman, Auguste Deter, suffered from memory loss, progressive deterioration of her cognitive functions, and severe alterations in her personality. She died on April 8, 1906. Following his patient's death, Dr. Alzheimer had her records and brain brought to Munich where he was working at Dr. Emil Kraepelin's lab. Dr. Alzheimer performed an autopsy on Ms. Deter's brain. He noticed many unusual lesions and entanglements therein, lesions and entanglements that resembled those he had seen in older people who had been diagnosed with senile dementia. Dr. Alzheimer named the condition pre-senile dementia.[16] Dr. Kraepelin took the naming one step further: In one of his textbooks, he named the condition "Alzheimer's disease." The name caught on and became so popular that by 1911 the Alzheimer–Kraepelin description and name of the disease was being used by European physicians to diagnose patients in the United States.[17] Hence, by the time Dr. Alzheimer died in 1915, the disease named after him already had its name. What he did not know was just how significant the disease would become over the next few years.

4-2:1 Causes of Alzheimer's Disease

Notwithstanding the hard work done by Drs. Alzheimer and Kraepelin and the many others who have worked in this field over the years, today, Alzheimer's disease remains the most common form of dementia in people aged 65 or older. The Centers for Disease Control and Prevention reports that at the end of 2014, as many as 5 million Americans were living with Alzheimer's disease.[18] The Centers also reports that the number of people with the disease doubles every 5 years beyond 65. Accordingly, the Centers project that unless scientists are able to find a cure or somehow slow down the disease's rate of increase, by the year 2060, 14 million Americans will be suffering from Alzheimer's disease.[19]

What causes the disease?

The answer is bleak: No one knows. While many theories abound, they are simply theories. More disheartening is the fact that scientists cannot say for certain that a living person has Alzheimer's disease because the only way to know for sure is by a microscopic examination of a sample of the person's brain. This, however, can be done only *after* the person has died.

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[16] Vaughn E. James, The Alzheimer's Advisor: A Caregiver's Guide to Dealing With the Tough Legal and Practical Issues, 7 (AMACOM Books 2009).

[17] Konrad Maurer & Ulrike Maurer (Trans. By Neil Levi & Alistair Burns), Alzheimer: The Life of a Physician and the Career of a Disease (Colombia University Press 2003).

[18] Centers for Disease Control and Prevention website, Healthy Aging, *available at* https://www.cdc.gov/prc/study-findings/healthy-aging.html (last visited May 5, 2020).

[19] Centers for Disease Control and Prevention website, Healthy Aging, *available at* https://www.cdc.gov/prc/study-findings/healthy-aging.html (last visited May 5, 2020).

4-2:2 Risk Factors for Alzheimer's Disease

Although the cause or causes of Alzheimer's disease remain a mystery, scientists have been able to determine certain risk factors that may increase someone's chances of developing this debilitating disease. The Alzheimer's Association has identified five risk factors: (old) age, family history, genetics, history of head trauma, and poor heart health.

4-2:2.1 Age

The greatest known risk factor for Alzheimer's disease is advancing age. Most individuals with the disease are 65 years of age or older. The likelihood of developing Alzheimer's doubles about every 5 years after age 65. After age 85, the risk reaches nearly one-third.[20]

4-2:2.2 Family History

Family history presents another strong risk factor for contracting Alzheimer's disease. People who have a parent, sibling, or child with Alzheimer's disease are more likely to develop the disease than people who have no such family history. The risk increases if more than one family member has the illness.[21]

4-2:2.3 Genetics

Scientists now know that genes play a part in the spread of Alzheimer's disease. Generally, two types of genes play a part in determining whether a person develops a disease—risk genes and deterministic genes. Scientists have found Alzheimer's genes in both categories. These scientists estimate that less than 1% of Alzheimer's cases are caused by deterministic genes (i.e., genes that cause a disease, rather than increase the risk of developing a disease).[22]

4-2:2.4 History of Head Trauma

The Alzheimer's Association cautions that a strong link may well exist between serious head injury and future risk of Alzheimer's disease, especially when the trauma occurs repeatedly or involves loss of consciousness.[23]

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[20] Alzheimer's Association website, Alzheimer's Disease—Causes and Risk Factors, *available at* https://www.alz.org/alzheimers-dementia/what-is-alzheimers/causes-and-risk-factors (last visited May 5, 2020).

[21] Alzheimer's Association website, Alzheimer's Disease—Causes and Risk Factors, *available at* https://www.alz.org/alzheimers-dementia/what-is-alzheimers/causes-and-risk-factors (last visited May 5, 2020).

[22] Alzheimer's Association website, Alzheimer's Disease—Causes and Risk Factors, *available at* https://www.alz.org/alzheimers-dementia/what-is-alzheimers/causes-and-risk-factors (May 5, 2020).

[23] Alzheimer's Association website, Alzheimer's Disease—Causes and Risk Factors, *available at* https://www.alz.org/alzheimers-dementia/what-is-alzheimers/causes-and-risk-factors (last visited May 5, 2020).

4-2:2.5 Poor Heart Health (the Heart–Head Connection)

The Alzheimer's Association writes of a heart–head connection. The simple analysis makes sense. Our brains are nourished by one of our body's richest networks of blood vessels, with the heart at the center. Every heartbeat pumps about 20–25% of our blood to our head. Once the blood gets to our heads, our brain cells use at least 20% of the food and oxygen it carries.

Now, imagine a damaged heart or damaged blood vessels caused by high blood pressure, heart disease, stroke, diabetes, or high cholesterol. Then imagine the flow of blood carrying much needed food and oxygen to the brain being slowed down because of this damaged heart and/or damaged blood vessels. It seems reasonable to conclude that a brain deprived of proper nutrition would suffer from some sort of disease. The risk of developing Alzheimer's disease or vascular dementia appears to be increased in these conditions.

In fact, the Alzheimer's Association reports that studies of donated brain tissue have provided evidence supporting this heart–head connection. According to the Association, these studies suggest that plaques and tangles are more likely to cause Alzheimer's symptoms if the individual has a history of strokes or other damage to the brain's blood vessels.[24]

4-3 Stages of Alzheimer's Disease

Alzheimer's disease typically progresses slowly in three general stages—mild (early stage), moderate (middle stage), and severe (late stage). The disease affects people in different ways; each person experiences symptoms—or progresses through Alzheimer's stages—differently. The following summary of the stages of Alzheimer's disease is taken from the Alzheimer's Association's website, and is presented here with the Association's permission.

4-3:1 Overview of Disease Progression

The symptoms of Alzheimer's disease worsen over time, although the rate at which the disease progresses varies. On average, a person with Alzheimer's lives 4–8 years after diagnosis, but some people live as long as 20 years, depending on other factors.

Changes in the brain related to Alzheimer's begin years before any signs of the disease become manifest. This time period, which can last for several years, is referred to as preclinical Alzheimer's disease.

4-3:2 Mild Alzheimer's Disease (Early Stage)

In the early stages of Alzheimer's, a person may function independently. He or she may still drive, work, and be part of social activities. Despite this, the person may feel as if he or she is having memory lapses, such as forgetting familiar words or the location of everyday objects.

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[24] Alzheimer's Association website, Alzheimer's Disease—Causes and Risk Factors, *available at* https://www.alz.org/alzheimers-dementia/what-is-alzheimers/causes-and-risk-factors (last visited May 5, 2020).

Friends, family, or neighbors begin to notice difficulties. During a detailed medical interview, doctors may be able to detect problems in memory or concentration. Common difficulties include:

- problems coming up with the right word or name;
- trouble remembering names when introduced to new people;
- having greater difficulty performing tasks in social or work settings;
- forgetting material that one has just read;
- losing or misplacing a valuable object; and
- increasing trouble with planning or organizing.[25]

4-3:3 Moderate Alzheimer's Disease (Middle Stage)

Moderate Alzheimer's is typically the longest stage and can last for many years. As the disease progresses, the person with Alzheimer's will require a greater level of care.

The Alzheimer's patient may begin confusing his or her words, getting frustrated or angry, or acting in unexpected ways, such as refusing to bathe. Damage to nerve cells in the brain can make it difficult for the patient to express his or her thoughts and perform routine tasks.

At this point, symptoms will be noticeable to others and may include:

- forgetfulness of events or about one's own personal history;
- feeling moody or withdrawn, especially in socially or mentally challenging situations;
- being unable to recall his or her own address or telephone number or the high school or college from which he or she graduated;
- confusion about where he or she is or what day it is;
- the need for help choosing proper clothing for the season or the occasion;
- incontinence;
- changes in sleep patterns, such as sleeping during the day and becoming restless at night;
- an increased risk of wandering and becoming lost; and
- personality and behavioral changes, including suspiciousness and delusions or compulsive, repetitive behavior like hand-wringing or tissue shredding.[26]

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[25] Alzheimer's Association website, Alzheimer's & Dementia—Stages of Alzheimer's, *available at* https://www.alz.org/alzheimers-dementia/stages (last visited May 5, 2020).

[26] Alzheimer's Association website, Alzheimer's & Dementia—Stages of Alzheimer's, *available at* https://www.alz.org/alzheimers-dementia/stages (last visited May 5, 2020).

4-3:4 Severe Alzheimer's Disease (Late Stage)

In this final stage of the disease, the patients lose the ability to respond to their environment, to carry on a conversation, and, eventually, to control movement. They may still say words or phrases, but communicating pain becomes difficult. As their memory and cognitive skills continue to worsen, the patients experience personality changes that cause them to need extensive help with daily activities.

At this stage, an individual suffering from Alzheimer's disease would most likely:

- require full-time, around-the-clock assistance with daily personal care;
- lose awareness of recent experiences as well as of his or her surroundings;
- require high levels of assistance with daily activities and personal care;
- experience changes in physical abilities, including the ability to walk, sit, and, eventually, swallow;
- have increasing difficulty communicating; and
- become vulnerable to infections, especially pneumonia.[27]

4-4 Legal Implications of Dementia and Alzheimer's Disease

Generally, Alzheimer's patients suffer from an impaired ability to make decisions. This impairment has serious consequences for the patient and his or her family members and caregivers. From a legal standpoint, family members and caregivers must be concerned with whether the patient possesses the mental capacity to engage in certain transactions or make certain decisions or has the legal competency to retain his or her autonomy.

An autonomous individual has a number of different capacities, including the legal capacity to:

- enter into a contract'
- prepare (or have prepared on his or her behalf) and execute a Last Will and Testament;
- make gifts of his or her property;
- consent to medical treatment; and
- manage his or her financial or personal affairs or appoint agents to make such management decisions on his or her behalf.

Each of these capacities involves a distinct combination of functional abilities and skills. Accordingly, the mental capacity—or level of alertness or functional ability—for each one is different. Not surprisingly, the legal capacity for each task is also different.

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[27] Alzheimer's Association website, Alzheimer's & Dementia—Stages of Alzheimer's, *available at* https://www.alz.org/alzheimers-dementia/stages (last visited May 5, 2020).

4-4:1 Capacity to Contract

Because this text is about elders (sometimes referred to as "seniors" or "senior citizens"), we shall limit our discussion of the capacity to contract to the capacity of elders to enter into contracts.

In Texas as elsewhere, only people with the requisite mental capacity may enter into valid contracts. That having been said, we note that all Texans who enter into contracts are covered by a presumption of competency.[28] Unless a court of competent jurisdiction has adjudicated someone incompetent, that person retains all his or her rights under Texas law and has full legal capacity to enter into a contract.[29]

But what, exactly, does "capacity to enter into a contract" entail? The Texas legislature has thus far failed to address the matter. Meanwhile, Texas courts have developed a definition: A contracting party has capacity for executing a contract if the person can appreciate the effect of what he or she is doing and understands the nature and consequences of his or her acts and the business he or she is transacting.[30]

Notwithstanding this development, the courts address the matter of mental capacity to contract on a case-by-case basis. The more complicated a transaction, the higher the level of mental capacity required to engage in the transaction. Accordingly, someone who cannot understand a highly complex transaction—and thus would lack the capacity for entering into a contract concerning this transaction—may still have the requisite capacity to engage in simpler contracts.[31]

In analyzing mental capacity to contract, Texas courts have also said that we can look to certain circumstantial evidence to assess whether a party had capacity at the time he or she entered into the contract.[32] This circumstantial evidence includes: (1) the person's outward conduct and whether it is manifesting an inward and causing condition; (2) any pre-existing external circumstances that tend to produce a special mental condition; and (3) the prior or subsequent existence of a mental condition from which the person's mental capacity (or incapacity) at the time in question may be inferred.[33] However, the courts have been rather loosely applying these factors,[34] and one would do well to proceed with caution.

4-4:2 Testamentary Capacity

To execute a Last Will and Testament, a testator needs to be of "sound mind."[35] This means that the testator understands the Last Will and Testament and the effect of executing such an instrument; knows the general nature and extent of his or her property, the person or persons to whom he or she wishes to give the property, and the person or persons dependent upon him or her for support; and must be able to

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[28] Tex. Health & Safety Code § 576.002.

[29] Tex. Health & Safety Code § 576.002(a), (b).

[30] *Mandell & Wright v. Thomas*, 441 S.W.2d 841, 845 (Tex. 1969).

[31] *In re Jack*, 390 B.R. 307, 321 (Bankr. S.D. Tex. 2008).

[32] *Bach v. Hudson*, 596 S.W.2d 673, 675–76 (Tex. Civ. App.—Corpus Christi 1980, *no writ*).

[33] *Bach v. Hudson*, 596 S.W.2d 673, 675–76 (Tex. Civ. App.—Corpus Christi 1980, *no writ*).

[34] *See, e.g., In re Jack*, 390 B.R. 307 (Bankr. S.D. Tex. 2008); *Lerer v. Lerer*, No. 05-99-00474-CV, 2000 WL 567020 (Tex. App.—Dallas May 3, 2000, *pet. denied*) (not designated for publication).

[35] Tex. Est. Code § 251.001.

keep the above-mentioned information in his or her mind long enough for him or her to understand how they relate to each other, and then to form a reasonable judgment about how he or she wishes to dispose of his or her property when he or she dies.[36] At probate or in a will contest, the proponent of a will bears the burden to prove the testator's capacity.[37] Testamentary capacity is a lower standard than contractual capacity. Texas law does not require testators to be capable of managing all of their affairs or daily business transactions. What is important to the execution is the time of execution: A testator may lack capacity immediately before and immediately after signing a will, but not at the time of execution.[38] However, the testator's capacity can be negated by a showing that he or she suffered from an "insane delusion"—an irrational perception of particular persons or events—if the delusion materially affects the Last Will and Testament.[39] Generally speaking, then, for the Last Will and Testament to be valid and for the testator to be considered as having had the requisite testamentary capacity at the time he or she executed the instrument, the testator must "know" and "understand" facts, and must possess knowledge or understanding based on reality material to the disposition.

4-4:3 Donative Capacity

It is easy—too easy—for an unscrupulous person to take advantage of an elderly person suffering from Alzheimer's disease or some other form of dementia and then somehow get that person to make him or her a large gift. To prevent this, it would make sense for the law to establish rules for donative capacity beyond the realm of wills.

To date, neither the Texas legislature nor any Texas court has articulated any rules governing donative capacity. However, some states have adopted a higher standard for donative capacity than for testamentary capacity, requiring that the donor knows the gift to be irrevocable and that it would result in a reduction of the donor's assets or estate.[40] To the extent Texas follows these standards, donative capacity in Texas would require a higher degree of cognition and understanding than contractual capacity, if only because, unlike a contract, it is difficult to evaluate whether a donation is "fair."[41]

4-4:4 Capacity to Consent to Medical Treatment

Capacity in health care is based on the doctrine of "informed consent." This concept dictates that patients have the ultimate right to prevent unauthorized contact with

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[36] *See Tieken v. Midwestern State Univ.*, 912 S.W.2d 878 (Tex. App.—Fort Worth 1995, *no writ*) (citing *Prather v. McClelland*, 12 S.W. 543, 546 [Tex. 1890]).

[37] *In re Estate of Vackar*, 345 S.W.3d 588, 595 (Tex. App.—San Antonio 2011, *reh'g overruled*) (citing *Seigler v. Seigler*, 391 S.W.2d 403, 404 [Tex. 1965]).

[38] *See Carr v. Radkey*, 393 S.W.2d 806, 814 (Tex. 1965).

[39] John Parry & F. Phillips Gilliam, Handbook on Mental Disability Law, 147–8 (Amer Bar Assn 2002).

[40] *See* Arthur C. Walsh, Mental Capacity: Legal and Medical Aspects of Assessments and Treatment (West 2nd ed. 1994) for a discussion of the case law concerning the lawyer's malpractice liability for knowingly allowing an incapacitated person to execute legal documents.

[41] *See* Michael H. Ward, The Ethics of Capacity: What Lawyers Need to Understand When Dealing With Mental Health Issues, 77 Tex. B.J. 975, 976 (2014).

their bodies, and that health care providers have a duty to disclose relevant information to allow their patients to make informed decisions. Consent to treatment must be competent, voluntary, and informed. Though persons may have mental capacity, if their decisions were either involuntary or unknowing, they may not meet the standard.[42]

4-4:4.1 Exceptions to the Doctrine of Informed Consent

The law provides three exceptions to the Doctrine of Informed Consent:

1. **The Emergency Care Exception.** If the patient is unable to communicate, his or her life is threatened by injury or illness, and the time necessary to obtain consent would place the patient in immediate danger, medical practitioners can act without the patient's consent.

2. **The Therapeutic Privilege Exception.** A medical practitioner may also administer treatment without the patient's consent if the practitioner invokes "therapeutic privilege": the belief that the disclosure of the diagnosis or treatment choice would so upset the patient that he or she would be unable to make a rational decision. By asserting the therapeutic privilege, the practitioner is freed from the requirement of informed consent to promote his or her primary duty of doing what is beneficial for the patient.

3. **Patient Waiver.** A patient may also waive the right to informed consent. However, to give a valid waiver, the patient must be aware of the rights he or she is giving up. The patient may waive both the right to information ("Doctor, I've heard enough; please don't tell me anything more.") and the right to decide ("Doctor, you are the expert; you know what is best. Just go ahead and decide what must be done."). Patient waivers recognize the patient's autonomy, but at the same time allow the patient to defer to the professionalism of the physician.

4-4:4.2 The Doctrine of Informed Consent and the Alzheimer's Patient

The Doctrine of Informed Consent remains valid even if a court has adjudicated the patient mentally incapacitated (or, as some would say, legally incompetent), and is unable to grant consent. In such a situation, a surrogate decision maker would make the decision for the patient. Accordingly, when someone has Alzheimer's disease, his or her surrogate decision maker gives the necessary consent on the patient's behalf.

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[42] No Texas case exists to guide us on this Doctrine of Informed Consent. The doctrine finds its genesis in a 1914 case in which doctors operated on Mary Schloendorff, a patient, without her consent. In determining whether the patient had a valid cause of action against the hospital in which the operation was performed, Judge Benjamin Cardozo, writing for the New York Court of Appeals, wrote:

> In the case at hand, the wrong complained of is not merely negligence. It is trespass. Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages. *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

The identity of the surrogate decision maker is found in the patient's advance directives. Chapter 7 discusses the law governing advance directives in Texas.

4-4:5 Power of Attorney

Texas has no statutory requirement regarding the requisite capacity for executing a power of attorney. However, Texas courts appear to use the contract standard for determining whether principals had the requisite capacity to execute powers of attorney.[43] That being said, someone who challenges the principal's mental capacity when signing the power of attorney has the burden of showing that the principal "did not understand the nature or consequences of his [or her] act at the moment the power of attorney was executed."[44]

4-5 Estate Planning for Patients With Alzheimer's Disease and Other Forms of Dementia

People typically put off estate planning until they experience a health crisis. Because of the emotional toll of the ongoing crisis, such a time is not best for engaging in estate planning. When the potential client is suffering from Alzheimer's disease or some other form of dementia, the memory loss and other conditions that accompany the disease make it extremely difficult for an attorney called upon to assist the individual to put together an estate plan.

That said, to the extent the individual has recently begun exhibiting symptoms of Alzheimer's disease—which would indicate that the disease is probably in its early stage—his or her family members, acting on the patient's behalf, would most likely be the ones who contacted the attorney to discuss the issue of estate planning. Of course, this raises ethical issues, ranging from a determination of who is the client to conflicts of interest issues. Assuming the attorney can overcome the ethical issues, he or she can develop an estate plan that should include at least three parts—a durable power of attorney, a Last Will and Testament, and a set of medical advance directives. Depending on the value and complexity of the patient's assets and the availability of funds to pay for it, the plan may also include a revocable living trust.

4-5:1 The Texas Durable Power of Attorney

Like all other durable power of attorney statutes, the Texas statute allows an adult principal to designate another person as attorney in fact or agent to make financial decisions on the principal's behalf.[45] The Texas statute provides that the power may be either "regular" or "springing." The "regular" durable power of attorney grants authority to the agent to act as soon as the principal executes the document.[46] The "springing" power of attorney grants the agent authority to act only if the principal

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[43] *See In re Estate of Vackar*, 345 S.W.3d 588, 597 (Tex. App.—San Antonio 2011, *reh'g overruled*).

[44] *In re Estate of Vackar*, 345 S.W.3d 588, 597 (Tex. App.—San Antonio 2011, *reh'g overruled*) (citing *Tomlinson v. Jones*, 677 S.W.2d 490, 492–93 [Tex. 1984]; *Mandell & Wright v. Thomas*, 441 S.W.2d 841, 845 [Tex. 1969]).

[45] Tex. Est. Code § 751.0021.

[46] Tex. Est. Code § 751.0021(a)(3)(A)(i).

loses the ability to act for himself or herself—that is, when the principal becomes disabled or incapacitated.[47] For the power of attorney to be valid, at the time he or she signs it, the principal must possess the requisite mental capacity. In that regard, Texas law simply requires that the principal have the ability to understand the nature of the document he or she is signing and the significance of signing it.[48] It is also necessary that the power of attorney be notarized.[49]

4-5:1.1 Forms of the Power of Attorney

Texas provides a form for the durable power of attorney known as the "Statutory Durable Power of Attorney."[50] We provide a copy of this form in Appendix 7. However, the form prescribed by the Texas Estates Code is not exclusive, and attorneys are free to draw up their own or to use other formats.[51]

4-5:1.2 The Agent of the Durable Power of Attorney

The Texas statute is clear: The agent is a fiduciary with a duty to account for actions he or she takes under the power of attorney.[52] Accordingly, the agent is obligated to perform his or her duties pursuant to the standards of good faith and trustworthiness.[53] Under normal circumstances, a principal who believes that an agent is not behaving according to those standards may revoke the power of attorney and/or seek restitution from the agent for misused funds or other property.

However, Alzheimer's disease presents a circumstance that is far from normal. A principal who develops Alzheimer's disease after having appointed an agent and subsequently progresses into an advanced stage of the disease would lack the mental capacity to object to the agent's self-serving or unscrupulous acts, or to challenge the agent in any way. How, then, can the principal's property and income be protected?

Texas law attempts to protect the mentally incapacitated principal by requiring the agent to maintain records of all actions he or she takes with reference to the principal's property, and to make these records available to the principal or to a court.[54] Even with these safeguards, though, the attorney representing an elderly client in preparing a durable power of attorney should counsel the principal to choose his or her agent wisely. The principal should appoint as agent someone who strikes a balance between having skills and knowledge in asset management and being trustworthy and willing to always act in the principal's best interest.[55]

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[47] Tex. Est. Code § 751.0021(a)(3)(A)(ii).
[48] *Mandell & Wright v. Thomas*, 441 S.W.2d 841, 845 (Tex. 1969).
[49] Tex. Est. Code § 751.0021(a)(4).
[50] Tex. Est. Code § 752.051.
[51] Tex. Est. Code § 752.003.
[52] Tex. Est. Code § 751.101.
[53] Vaughn E. James, The Alzheimer's Advisor: A Caregiver's Guide to Dealing With the Tough Legal and Practical Issues, 64 (AMACOM Books 2009).
[54] Tex. Est. Code § 751.103.
[55] *See* Vaughn E. James, The Alzheimer's Advisor: A Caregiver's Guide to Dealing With the Tough Legal and Practical Issues, 65 (AMACOM Books 2009).

But what if, notwithstanding all the safeguards put in place and precautions taken, the agent acts or continues to act in a manner contrary to the best interest of the principal? What hope exists for the principal and his or her family members?

Texas law provides an avenue whereby, notwithstanding the principal's mental incapacity, the agent can be removed. If, after a principal has executed a durable power of attorney, a court sitting in the principal's domicile appoints a guardian of the estate of the principal—either permanent or temporary—the powers of the agent will terminate and the agent will turn over to the guardian all of the principal's property in his or her possession.[56]

4-5:1.3 Termination of the Power of Attorney

Several circumstances can give rise to a termination of a durable power of attorney:

1. The principal dies.[57]
2. The principal revokes the power of attorney.[58]
3. The power of attorney provides that it terminates.[59]
4. The purpose of the power of attorney is accomplished.[60]
5. The agent's authority to act under the power of authority terminates and the power of attorney does not provide for another agent to act in his or her stead.[61]
6. A court of competent jurisdiction appoints a guardian of the principal's estate and such guardian is qualified to serve in this capacity.[62]

Notwithstanding the aforementioned provisions, a revocation of a durable power of attorney is not effective as to a third party relying on the power of attorney until the third party receives actual notice of the revocation.[63]

To ensure that all parties are aware that the principal has terminated the power of attorney, the Texas Bar recommends that the principal mails a form to all concerned parties. A copy of this form is included in Appendix 8.

4-5:1.4 Termination of the Agent's Authority

Just as the power of attorney can be terminated, the agent's authority can also be terminated. The following circumstances can give rise to such termination:

1. The principal revokes the agent's authority.[64]
2. The agent dies, becomes incapacitated, is no longer qualified, or resigns.[65]

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[56] Tex. Est. Code § 751.133.
[57] Tex. Est. Code § 751.131(1).
[58] Tex. Est. Code § 751.131(2).
[59] Tex. Est. Code § 751.131(3).
[60] Tex. Est. Code § 751.131(4).
[61] Tex. Est. Code § 751.131(5).
[62] Tex. Est. Code § 751.131(6).
[63] Tex. Est. Code § 751.134.
[64] Tex. Est. Code § 751.132(a)(1).
[65] Tex. Est. Code § 751.132(a)(2).

3. The agent's marriage to the principal is terminated through divorce or annulment or is declared void and the power of attorney does not provide for the agent to continue in this role notwithstanding such an occurrence.[66]
4. The agent's authority terminates.[67]

4-5:2 The Last Will and Testament

To be valid in Texas, a Last Will and Testament must satisfy four requirements: (1) the testator must possess legal capacity,[68] (2) he or she must also possess testamentary capacity,[69] (3) the testator must also demonstrate the necessary testamentary intent,[70] and (4) the testator and all parties involved in the will execution ceremony must adhere to certain formalities.[71]

4-5:2.1 Legal Capacity

Someone has legal capacity to execute a Last Will and Testament in Texas if the person is either 18 years of age or older, is or has been married, or is a member of the armed forces of the United States of America, an auxiliary of the armed forces of the United States, or the United States Maritime Service.[72]

4-5:2.2 Testamentary Capacity

Testamentary capacity refers to the "sound mind" part of Texas Estates Code § 251.001. Someone possesses testamentary capacity to execute a Last Will and Testament in Texas if he or she has the mental ability to understand:

1. the business in which he or she is engaged;
2. the effect of making a Last Will and Testament;
3. the nature and extent of his or her property;
4. the persons who are the natural objects of his or her bounty (e.g., his or her relatives);
5. the fact that he or she is disposing of his or her assets; and
6. how all these elements relate so as to form an orderly plan for the disposition of his or her property.[73]

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[66] Tex. Est. Code § 751.132(a)(3).
[67] Tex. Est. Code § 751.132(a)(4).
[68] Tex. Est. Code § 251.001.
[69] Provided in Tex. Est. Code § 251.001 and related case law.
[70] Derived from case law.
[71] Attested wills under Tex. Est. Code § 251.001 and holographic wills under Tex. Est. Code § 251.052.
[72] Tex. Est. Code § 251.001.
[73] *Tieken v. Midwestern State Univ.*, 912 S.W.2d 878 (Tex. App.—Fort Worth 1995, *no writ*); *Wilkinson v. Moore*, 623 S.W.2d 662 (Tex. Civ. App.—Houston [5th Dist.] 1981, *dismissed*).

4-5:2.3 Testamentary Intent

A testator possesses testamentary intent if, at the time of signing his or her Last Will and Testament, the testator intends to make a revocable disposition of his or her property.[74]

4-5:2.4 Formalities

Texas requires that certain formalities be followed for a Last Will and Testament to be valid. The formalities that need to be followed depend on the type of Last Will and Testament the testator is making.

Texas recognizes two types of wills: attested and holographic.

4-5:2.4a Attested Will

To be valid, an attested Last Will and Testament must be in writing, signed by the testator or by another person at the testator's direction and in the testator's presence, and attested to by at least two credible witnesses who are over the age of 14.[75]

4-5:2.4b Holographic Will

A holographic Last Will and Testament must be written completely in the testator's handwriting and be signed by the testator; attesting witnesses are not necessary.[76]

4-5:2.4c Self-Proving Affidavit

Either of the two types of wills recognized by Texas can be self-proved by the attachment of a self-proving affidavit.[77] The self-proving affidavit is signed by the testator and two witnesses before a notary.[78] At probate, the self-proving affidavit substitutes for in-court testimony of witnesses as to the validity of the Last Will and Testament.[79]

Appendix 9A presents a sample self-proving affidavit.

4-5:2.4d Simultaneous Execution, Attestation, and Self-Proving

Prior to 1991, Texas courts strictly adhered to the rule that the Last Will and Testament and the self-proving affidavit were two separate documents and that, as a result, if the testator and/or the witnesses signed the affidavit and not the Last Will and Testament—which they sometimes did—the will was not validly executed.[80] The 1991 Legislature amended the predecessor to Estates Code § 251.105 to alleviate this harsh result. Accordingly, today, if either the testator or one of the witnesses signs

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[74] *Preston v. Preston*, 617 S.W.2d 841 (Tex. Civ. App.—Amarillo 1981, *ref. n.r.e.*); *In re Estate of Romancik*, 281 S.W.3d 592 (Tex. App.—El Paso 2008).

[75] Tex. Est. Code § 251.051.

[76] Tex. Est. Code § 251.052.

[77] Tex. Est. Code §§ 251.101, 251.107.

[78] Tex. Est. Code § 251.104.

[79] Tex. Est. Code § 251.102.

[80] *See Boren v. Boren*, 402 S.W.2d 728 (Tex. 1966).

the self-proving affidavit instead of the Last Will and Testament, the affidavit will be used to prove the will. However, the affidavit would then not be considered a self-proving affidavit, and to admit the will to probate, the court would have to listen to the testimony of the witnesses regarding the will execution ceremony and the testator's capacity.

The 2011 Legislature went one step further, adding a new section to the Estates Code that allows a testator to include the self-proving affidavit language within the body of the Last Will and Testament, thus making only one set of signatures necessary.[81] Appendix 9B presents a sample simultaneous execution, attestation, and self-proving document.

4-5:2.5 Application to Alzheimer's Disease and Other Forms of Dementia

The sad truth is that many people die intestate. For various reasons, they see no need to execute a Last Will and Testament during their lives. When they die, however, confusion reigns in the family as various members fuss and fight over what appears to outsiders to be mere triviality.

If an elderly person who is exhibiting signs of dementia chooses to prepare and execute a Last Will and Testament, the attorney representing the elder must ensure that the client is lucid both whenever they discuss the provisions of the instrument and when they and the witnesses come together for the will execution ceremony. It is advisable that all meetings with the client be conducted in the morning so as to avoid the negative effects of *sundowning*—a phenomenon from which Alzheimer's patients suffer, causing them to experience increased confusion, agitation, and memory impairment toward the end of the day, while they are at their best during the early part of the day.[82] During that early time, Alzheimer's patients may hold reasonably intelligent conversations, read and understand books or documents, or watch television with a fairly high level of comprehension. As the day progresses, however, the patients' memory and ability to perform tasks deteriorate, and, as a result, they suffer increased confusion and agitation.[83]

4-5:2.6 Potential for Undue Influence

Because Alzheimer's disease affects its victims' memory and other cognitive functions, these victims sometimes become susceptible to undue influence perpetrated by persons who would normally be considered their close friends or loving relatives. Typically, these persons very slyly get the Alzheimer's patient to give to them substantial bequests originally intended for other persons.

However, the Alzheimer's patient's susceptibility to undue influence should not be taken as an indication that he or she lacks testamentary capacity. In fact, Texas courts

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[81] Tex. Est. Code § 251.104.

[82] Jonathan Graff-Radford, Sundowning: Late-Day Confusion, Mayo Clinic website, *available at* https://www.mayoclinic.org/diseases-conditions/alzheimers-disease/expert-answers/sundowning/faq-20058511 (last visited May 5, 2020).

[83] Vaughn E. James, The Alzheimer's Advisor: A Caregiver's Guide to Dealing With the Tough Legal and Practical Issues, 44 (AMACOM Books 2009).

have made it clear that undue influence surrounding the execution of a will implies the existence of testamentary capacity on the testator's part; the problem is that at the time of will execution, the capacity was subjected to and controlled by a dominant power or influence.[84]

4-5:3 Texas Advance Directives

Chapter 7 will explain in detail the law governing advance directives in Texas. Here, we shall discuss the concept of advance directives and whether—and how—an individual suffering from Alzheimer's disease or some other form of dementia could benefit from these directives.

4-5:3.1 Patient Self-Determination and Informed Consent

The march toward advance directives for patients was driven by two events: the passage by Congress of the Patient Self-Determination Act (PSDA) in 1990[85] and the development of the doctrine of informed consent first addressed by Justice Cardozo in *Schloendorff v. Society of New York Hospital*.[86]

4-5:3.1a The Patient Self-Determination Act

Today, the only federal law dealing with advance directives is the PSDA of 1990.[87] Technically, the statute is merely an amendment to federal Medicare and Medicaid law. It does not substantively change health care decisions law; it is primarily an information and education mandate.

Effective December 1, 1991, the PSDA required all Medicare and Medicaid provider organizations (specifically, hospitals, skilled nursing facilities, home health agencies, hospices, and prepaid health care organizations) to do five things:[88]

1. provide written information to patients at the time of admission concerning their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;
2. maintain written policies and procedures regarding advance directives (e.g., living wills and health care powers of attorney) and inform patients of these policies;
3. document in an individual patient's medical record whether he or she has executed any advance directives;
4. ensure compliance with the requirements of state law respecting advance directives at facilities of the provider or organization; and

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[84] *In re Estate of Livingston*, 999 S.W.2d 874 (Tex. App.—El Paso 1999).

[85] Enacted on November 5, 1990, as Section 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990, P.L. 101 508; *codified at* 42 U.S.C. §§ 1395cc(a)(1)(Q), 1395mm(c)(8), 1395cc(f), 1396a(a)(57), (58), and 1396a(w).

[86] 105 N.E. 92 (N.Y. 1914).

[87] 42 U.S.C. §§ 1395cc(a)(1)(Q), 1395mm(c)(8), 1395cc(f), 1396a(a)(57), (58), and 1396a(w).

[88] 42 U.S.C. §§ 1395cc(a)(1)(Q), 1395mm(c)(8), 1395cc(f), 1396a(a)(57), (58), and 1396a(w).

5. provide (individually or with others) for staff and community education on issues related to advance directives.

4-5:3.1b The Doctrine of Informed Consent

In Section 4-4:4, we noted that capacity in health care is based on the doctrine of "informed consent," a concept which holds that patients have the ultimate right to prevent unauthorized contact with their bodies, and that health care providers have a duty to disclose relevant information to allow their patients to make informed decisions. Then in Section 4-4:4.2, we discovered that a patient's right to informed consent remains intact even though a court has adjudicated the patient mentally incapacitated and is thus unable to grant consent. Such a patient's decisions are made by a surrogate decision maker. Thus, when someone has Alzheimer's disease or some other form of dementia, his or her surrogate decision maker gives or withholds consent to medical treatment on the patient's behalf. The identity of the surrogate decision maker is found in the patient's advance directives.

4-5:3.2 Texas Law on Advance Directives

Texas has enacted two laws that could impact patients with Alzheimer's disease and other forms of dementia as they prepare—or have prepared for them—the various advance directives allowed by these laws. The laws are the Texas Consent to Medical Treatment Act (CMTA)[89] and the Texas Advance Directives Act.[90]

4-5:3.2a Texas Consent to Medical Treatment Act

In Texas, absent an emergency, all patients have the right to be informed by their medical care providers about their condition and any treatment the provider recommends so that they may decide whether to have the treatment.[91] To be informed, a patient would need to know the risks and hazards involved in the treatment, alternate forms of treatment, and the risks and hazards involved with the alternate forms of treatment or with no treatment.[92] The patient has the right to know these things before deciding about the treatment. He or she also has the right to refuse medical treatment for personal or religious reasons, although the law may impose certain limitations on the exercise of these rights.[93]

4-5:3.2a1 Texas Responds to the Patient Self-Determination Act

Following passage of the PSDA in 1990, Texas enacted its state counterpart, the CMTA.[94] The statute effectively makes decisions for the patients under its ambit, first, by selecting a medical decision maker—called a surrogate—for those patients who

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[89] Tex. Health & Safety Code, tit. 4, Subt. F, Ch. 313.
[90] Tex. Health & Safety Code, tit. 2, Subt. H, Ch. 166.
[91] Tex. Civ. Prac. & Rem. Code § 74.102, 104.
[92] Tex. Civ. Prac. & Rem. Code § 74.101.
[93] Tex. Health & Safety Code § 166.051.
[94] Tex. Health & Safety Code, tit. 4, Subt. F, Ch. 313.

have not selected their own,[95] second, by determining what the surrogate may or may not do,[96] and third, by deciding just who may serve as surrogate.[97]

4-5:3.2a2 State-Provided Surrogates

The CMTA provides a list of people who may act on the patient's behalf as surrogate. After the patient's physician declares that he or she cannot provide his or her own medical consent, a court of competent jurisdiction can appoint a surrogate to make the decisions on the patient's behalf. Once that decision is made and the surrogate has been appointed, the surrogate does not need to obtain the patient's permission to make medical decisions on his or her behalf; all he or she must do is ensure that, to the extent he or she knows, the medical treatment decisions made are based on what the patient would desire.[98]

Following is the list of potential state-selected surrogates:

- the patient's spouse;
- a sole child who has written permission from the other children to act alone on the patient's behalf;
- the majority of the patient's children (if they have not selected a sole representative);
- the patient's parents, if any;
- someone the patient "clearly identified" before becoming ill;
- the patient's nearest living relative (if the patient's children or parents are not available); and
- any member of the clergy, whether or not the patient knows him or her.[99]

4-5:3.2a3 Decisions Withheld From the Surrogate

The CMTA forbids the surrogate from making two types of medical decisions. Specifically, the surrogate may not:

1. make a decision to admit the patient to an inpatient mental health facility; or
2. authorize electroconvulsive therapy.[100]

4-5:3.2a4 Summary of the Texas Consent to Medical Treatment Act

The provisions of the CMTA pose problems for persons suffering from Alzheimer's disease and other forms of dementia where the patient loses his or her mental capacity. First, the statute covers only adult patients of home and community support

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[95] Tex. Health & Safety Code § 313.004(a).
[96] Tex. Health & Safety Code § 313.004(d).
[97] Tex. Health & Safety Code § 313.004(a).
[98] Tex. Health & Safety Code § 313.004(c).
[99] Tex. Health & Safety Code § 313.004(a).
[100] Tex. Health & Safety Code § 313.004(d).

services agencies, hospitals and nursing homes, and inmates of county and municipal jails.[101] A patient who is in any other care setting (such as at home, which is where most Alzheimer's patients are cared for until they enter the final stage of the disease) is not covered.

Second, the CMTA forbids the surrogate from consenting to (1) voluntary inpatient mental health care for the patient or (2) electroconvulsive treatment.[102] Yet, although Alzheimer's disease and other forms of dementia are not synonymous with insanity, these diseases affect mental capacity and can sometimes be treated by the same medical practitioners who treat mental illness. It would make sense, then, for the surrogate to be able to make decisions regarding this important aspect of health.

Third, the list of surrogates provided by the statute is not ideal. For example, the statute lists the patient's spouse as the first choice for surrogate. But what if the patient and spouse are estranged? What if they are going through a divorce? Will the surrogate spouse properly care for the incapacitated spouse? It would be better if the statute allowed the potential surrogate to petition the court for appointment, and then have the petitioner convince the court that he or she would be the best surrogate.

Given the uncertainties of the CMTA, it is better for the patient to select his or her own surrogates by executing his or her own advance directives. The key is to execute these documents before mental incapacity strikes. If mental incapacity has struck before the documents have been executed, the attorney should seek to have the documents executed during one of the patient's lucid moments. This would most likely be early in the morning, before the effects of *sundowning* have begun to manifest themselves.

4-5:3.2b Texas Advance Directives Act

Effective September 1, 1999, the Advance Directives Act consolidated three areas of Texas law that had previously been found in three different statutes operating without any coordination with each other: (1) the Directive to Physicians and Family or Surrogates (formerly found in the Natural Death Act), (2) the Medical Power of Attorney (formerly the Durable Power of Attorney for Health Care), and (3) the Out-of-Hospital Do-Not-Resuscitate (DNR) Order. If executed prior to the onset of Alzheimer's disease or any other form of dementia that results in the patient's loss of mental capacity, the Texas advance directives would serve their singular purpose of providing instruction about an individual's wishes regarding the provision of care to him or her when he or she is incapacitated and cannot orally express his or her wishes and decisions. We shall discuss these advance directives in detail in Chapter 7.

4-6 Conclusion

As people live longer, more and more of us will be stricken with Alzheimer's disease and other forms of dementia. It is important that the Texas legislature, as it plans for the elderly of Texas, enact forward-thinking legislation to protect the rights of the many Texans who will be affected by these diseases in the future.

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[101] Tex. Health & Safety Code § 313.004(a).

[102] Tex. Health & Safety Code § 313.004(d).