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Clinical and Ethical Aspects of Financial Capacity in Dementia: A Commentary

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Abstract

In contrast to issues like treatment and research consent capacity, financial capacity has received relatively little clinical and ethical attention in the dementia literature. Yet issues of financial capacity emerge frequently in patients with Alzheimer's disease (AD), Parkinson's disease (PD) and related dementias, and commonly present ethical and clinical challenges for clinicians treating these patients. These issues include whether a patient with possible dementia has sufficient capacity independently to manage their financial affairs, needs referral for financial capacity assessment, and/or is being financially exploited or abused by others. The accurate identification, assessment and successful handling of such financial capacity issues can have a substantial impact on the financial and psychological well-being of patients and their family members. The present commentary presents an overview of financial capacity and associated clinical and ethical issues in dementia, and describes a set of possible clinician roles regarding these issues as they arise in clinical practice. The commentary concludes with a section describing educational resources available to clinicians and bioethicists seeking additional guidance in handling financial capacity issues. The ultimate goal of the paper is to focus clinical and ethical attention on a neglected capacity that is of fundamental importance for patients, families, and health care and legal professionals.

I. What Is Financial Capacity?

Financial capacity is a medical-legal construct that represents the ability to independently manage one's financial affairs in a manner consistent with one's personal self-interest and values¹⁻³. For purposes of the present commentary, financial capacity may be viewed and understood from clinical, legal, and ethical vantage points in the area of neurodegenerative disease.

Clinical Aspects

From a clinical standpoint, financial capacity is a highly cognitively mediated capacity that is vulnerable to neurological, psychiatric, and medical conditions that affect cognition such as dementia, stroke, traumatic brain injury, and schizophrenia^{2,4}. In particular, financial capacity issues arise frequently in the context of older adults with neurodegenerative diseases like Alzheimer's disease (AD), Parkinson's disease (PD), and frontotemporal

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dementia (FTD). Recent studies have demonstrated that financial skills are highly vulnerable to the early cognitive changes found in mild cognitive impairment (MCI) and early Alzheimer's disease^{5,6}. In fact, declines in financial skills are often the very first functional changes to be identified in incipient dementia. A recent study showed that declines over one year in checkbook management and overall financial skills predicted conversion to Alzheimer's disease in patients with amnesic MCI⁶.

Not surprisingly, family members of older adults presenting in clinic often raise concerns about an elderly person's declining financial skills, including new problems managing household finances, making poor financial decisions, or being exploited³. As a result, these clinicians are increasingly being asked by families, other clinicians, attorneys, and judges to evaluate and offer clinical opinions regarding financial capacity^{1-3,7}. In particular, internists and geriatricians, who function on the front lines of dementia care, are increasingly confronted with financial capacity issues in older adult patients³.

Legal Aspects

From a legal standpoint, financial capacity represents the financial skills sufficient for handling one's estate and financial affairs, and is the basis for determinations of conservatorship (or guardianship of the estate, depending on the state legal jurisdiction). Broadly construed, financial capacity also conceptually encompasses more specific legal capacities such as contractual capacity, donative capacity (capacity to make gifts), and testamentary capacity (capacity to make a will).⁷ Thus financial capacity is an important area of assessment in the civil legal system^{1,7}, and judges and other legal professionals frequently seek clinician expertise to help resolve associated legal questions and disputes. These clinical findings and judgments regarding financial capacity are one form of evidence considered by judges and legal professionals. They should be distinguished from legal findings judgments of capacity, which are primarily made by judges and have the power to alter an individual's legal status with respect to control over his assets and estate².

Ethical Aspects

Despite its importance, very little attention in bioethics has been paid to financial capacity and the issues that it raises for clinicians, patients and families. This is somewhat surprising, insofar as considerable energy in bioethics has been devoted in recent years to issues of decisional capacity—specifically, treatment consent capacity and research consent capacity—in individuals with dementia, schizophrenia and other severe neuropsychiatric disorders⁸⁻¹². In its report *Research Involving Persons with Mental Disorders That May Affect Decision-Making Capacity*, the National Bioethics Advisory Commission focused attention on, and made substantive recommendations regarding, informed consent procedures in research with persons with mental disorders such as schizophrenia and dementia¹³. However, the bioethics and clinical literature has been largely silent concerning financial capacity¹⁴. For example, as trenchantly noted by Frank and Degan, “the literature of law and psychiatry is unaccountably mute on the subject of patients' competence to handle money”¹⁵.

This silence signals a key knowledge gap for bioethics, insofar as financial capacity implicates core issues of personal autonomy in adults¹⁶. Financial capacity is critical to, and possibly the single best litmus for, a person's ability to function independently in the community¹⁷. When financial capacity issues go unresolved, patients are at risk for significant financial losses that can endanger their residential setting, long term care, and personal autonomy¹⁸. Loss of financial capacity also makes patients vulnerable to exploitation and abuse by others, and thus can present challenging situations for clinicians who may be morally and legally responsible to report such abuse. Thus loss of financial

capacity presents a number of ethical, as well as clinical and legal, concerns for clinicians treating older adults with dementia.

II. Conceptual Aspects of Financial Capacity

Construct of Financial Capacity

The capacity to manage financial affairs comprises a broad range of conceptual, pragmatic, and judgment abilities across a range of everyday settings that are critical to the independent functioning of adults in our society^{4,19,20}. Studies have suggested that financial capacity is an “advanced” or instrumental activity of daily living (IADL)^{19,21}. Advanced ADLs are mediated by higher cognitive functions and can be distinguished from “household” ADLs (e.g., meal preparation, shopping, housekeeping) and “basic” ADLs (e.g., bathing, dressing, walking)²¹. Financial capacity entails a broad set of abilities, ranging from basic skills of identifying and counting coins/currency, to conducting cash transactions, to higher level abilities of managing a checkbook and bank statement, to very complex activities of making investment decisions. As might be expected, such abilities can vary enormously across individuals, depending on a person's socioeconomic status, occupational attainment, and overall financial experience^{19,20}. Along with medical decision-making, driving, and mobility, financial capacity is a core aspect of individual autonomy in our society^{4,19,20}.

Legal and Clinical Definitions of Financial Capacity

As noted above, from a legal standpoint financial capacity represents the financial skills sufficient for handling one's estate and financial affairs, and is the basis for determinations of conservatorship⁷. Historically, the legal standard for financial capacity in conservatorship statutes was generally (and vaguely) cast as the capacity to manage “in a reasonable manner all of one's financial affairs”⁷. A more modern and specific standard is set forth in Section 410(2) of the Uniform Guardianship and Protective Proceedings Act (UGPPA), which states that a court may appoint a conservator if the court determines that “the individual is unable to manage property and business affairs because of an impairment in the ability to receive and evaluate information or make decisions, even with the use of appropriate technological assistance”; and the individual has property that will be wasted or dissipated unless management is provided, or funds are needed for the support of the individual or of others entitled to the individual's support^{4,7,19,20}.

From a clinical standpoint, there is not yet a widely accepted clinical definition for financial capacity. Since the time of Lawton's seminal 1969 paper on definitions of IADLs²² until recently, very little conceptual and definitional work was conducted in the area of financial capacity. Our group has recently proposed the following definition: “the capacity to manage money and financial assets in ways that meet a person's needs and which are consistent with his/her values and self-interest.”^{3,4,19,20}. This working definition incorporates performance and judgment aspects characteristic of financial capacity (see below), as well as consideration of a person's longstanding values.

Performance and Judgment Aspects of Financial Capacity

Financial capacity can be understood to have both a performance aspect and a judgment aspect. In order to possess financial capacity, a person must be able to *perform* a variety of tasks and skills in order to meet his/her needs. Such tasks and skills include understanding basic financial concepts, possessing basic monetary skills, carrying out cash transactions in a grocery store, and paying bills. However, in addition to such performance skills, an individual must also be able to exercise *judgment* and decision-making to promote his/her own financial well-being. Thus, in addition to performance skills, the individual must be

able to carry out financial activities in ways that promote and protect his/her self-interest^{4,19,20}.

These performance and judgment dimensions of financial capacity are distinct. By way of example, a patient with Parkinson's disease dementia or early FTD may have a number of intact financial performance skills (count coins/currency, carry out cash transactions, use a money order or checkbook), but due to frontal dysfunction, may also be unable to exercise good judgment and utilize the skills in ways that meet basic needs and protect his/her self-interest. Such a patient may impulsively spend available funds, resulting in financial losses, overdrafts at the bank, and possible endangerment of financial resources for personal long term care and estate planning.

Differences between Financial Capacity and Consent Capacity

Insofar as the theme of the present special issue is decisional capacity in the elderly, with a focus on treatment consent and research consent capacities, it is useful at this point to note some conceptual differences between financial capacity and these other decisional capacities. These conceptual differences include focality/breadth of activity, duration of activity, setting of activity, and respective cognitive components of the activity.

Treatment consent and research consent activities involve discrete decision-making at a particular time point by a patient (decisions to select or refuse treatment) or research candidate (decisions to enroll or not in a study). These decisions also occur in specific settings such as a hospital or clinic (treatment consent), or an academic medical center (research consent). Both of these consent abilities are highly verbal in nature, and indeed a neuropsychologically based factor analytic study has suggested a two factor structure for treatment consent capacity of verbal conceptual knowledge, and short term verbal memory²³.

In contrast, financial capacity encompasses a much broader range of activities and time frames, a diverse community setting, and arguably a far broader range of cognitive abilities and processes. While financial capacity certainly contemplates specific key decisions (eg., purchase of a home, or investment transactions), it also embraces a range of ongoing, everyday performance tasks such as handling coins/currency, conducting cash transactions, bill payment, and checking and banking transactions. It also continually taps crucial judgment skills, such as avoiding telephone, email, and other money scams. These diverse financial activities occur across extended time frames (weeks, months, years) and multiple home and community settings.

In addition, the cognitive components of financial capacity appear more multi-dimensional than those of the consent capacities, encompassing not only verbal conceptual knowledge and memory, but also visual attention and scanning, visual memory, mental and written arithmetic abilities, executive abilities (eg., organizing and retaining tax documents), procedural learning (using a checkbook register or an ATM), and varieties of judgment. Finally, in contrast to the consent capacities, where the clinical focus is primarily on the quality of the decisional processes employed and arguably less so on the actual decision, with financial capacity the clinical focus is squarely on the quality of the resulting financial outcomes in relation to the individual's pragmatic needs and personal values.

For these reasons, financial capacity appears to be a capacity construct that differs in key respects from the consent capacities, and accordingly has its own corresponding clinical and bioethical aspects and issues.

III. Clinical and Ethical Roles for Clinicians Regarding Financial Capacity

Growing Challenges for Clinicians

Older adults age 65 and older currently comprise 13% of the population²⁴ and 21.4% of family households in the U.S.^{25,26} but hold 34% of the nation's wealth^{25,26}. Given that overall household wealth in the U.S. in 2009 was estimated at \$53.1 trillion, the amount of wealth currently held in older adult households amounts to a staggering \$18.1 trillion²⁶. With the continued aging of our society, and the tidal wave of Alzheimer's and related dementias descending in the next few decades, both this percentage and overall amount of older adult wealth will only grow, and issues of financial capacity in the elderly will become even more prevalent and urgent than they are today. It is anticipated that patients and families will continue to turn increasingly to their internist, geriatrician and other primary providers for initial guidance and direction as to how to manage these emerging issues³. As a result, physicians and other providers will increasingly experience and feel clinical and ethical responsibilities to respond to these concerns. In recognition of this situation, an article was recently published in the *Journal of the American Medical Association (JAMA)* by clinician investigators from the University of California at San Francisco, and the University of Alabama at Birmingham. This article described these tensions in the context of dementia and aging, and set forth some initial recommendations and possible roles for clinicians regarding identifying and responding to financial capacity issues in their patients³. The next section of this commentary briefly presents and elaborates these possible roles, which represent an initial effort to develop clinical and ethical parameters for improving geriatric practice in this area.

Financial Capacity: Five Different Roles for Clinicians

The Widera article in *JAMA* described five different roles that clinicians may choose to adopt in responding to issues of impaired financial capacity. The five roles are: (1) education, (2) detection of financial impairment, (3) assessment of financial impairment, (4) supporting financial independence, and (5) referral. The authors understood and made clear at the outset that financial capacity is not an area of training or expertise for most clinicians, and that only very limited time in a busy clinic visit might occasionally be allocated to such an issue³. Nonetheless, the authors believed that articulating each of these roles would have value for clinicians, as different situations call for different kinds of clinician responses.

Education

A key role that a clinician can adopt with almost all patients and families is that of educator and advocate for advance financial planning³. This conversation ideally might occur at the time an internist first takes on the care of an elderly patient, well in advance of any subsequent cognitive decline and capacity loss. The physician or other clinician may simply note that capacity loss is a not uncommon consequence of the aging process in our society, and that as part of every initial encounter, he/she recommends that patients consider executing a durable power of attorney for financial matters (DPOAF), as these provide for flexible and inexpensive transfer of decisional authority to a designated party at the appropriate time³. This particular conversation might take less than a minute, but if timely acted upon by the patient and family while the patient has decisional capacity, can have enormous positive future benefits. A DPOAF represents the "ounce of prevention" that is much preferable to the "pound of cure" (attorneys, guardianship, expense, delay, and loss of control) linked to situations of financial incapacity and advanced dementia.

Recognizing Possible Impaired Financial Capacity

A second role is clinical rather than educational. Clinicians need to develop sensitivity to signs of impaired financial capacity in their elderly patients³. Direct complaints of declining financial capacity are unlikely to come from patients themselves, for reasons of pride, denial, and in particular anosognosia²⁷. Family members and caregivers may provide valuable information or clues in this regard, although at times the veracity and credibility of such collateral report has to carefully be considered in light of possible family self-interest. Certainly diagnoses like Alzheimer's disease or frontal lobe dementia signal conditions that may adversely affect financial skills and signal possible impaired financial capacity. However, the clinician needs to move beyond diagnoses (which by themselves convey no capacity specific information for a particular patient other than risk)⁴, and learn to recognize more subtle signs of decline in this key IADL.

These signs may be cognitive, and involve changes from a previous baseline in short term memory, arithmetic skills, and executive functions⁷. The signs may also be neuropsychiatric, and present in the form of uncharacteristic depression, indifference and apathy, and/or lack of insight and judgment. Marson and his group at the University of Alabama at Birmingham have recently identified five warning signs of financial impairment²⁸. To be true warning signs, the following should again reflect decline from an individual's prior baseline level of financial functioning:

- *Memory*: increasing memory lapses resulting in failure to fulfill financial obligations (failing to pay bills, paying the same one several times);
- *Disorganization*: increasing disorganization and misplacement of financial and other documents in the home setting, with associated failures such as missing tax and other deadlines;
- *Confusion*: increasing confusion and loss of general knowledge regarding basic financial terms and concepts such as mortgage, will, or annuity;
- *Math Skills*: noticeable declines in everyday math skills, such as those employed when making change to pay for things at the store, or when computing an appropriate tip in a restaurant; and
- *Judgment*: loss of judgment about financial investments and use of money, manifested frequently as a new and abiding interest in get-rich-quick schemes, as well as increasing unfounded anxiety about the nature and extent of one's personal wealth.

Once a clinician identifies signs of financial decline or incapacity, he/she arguably has a clinical and moral responsibility to share these capacity concerns with patients and families in a carefully considered way³.

Brief Clinician Assessment of Financial Impairment

Upon recognizing signs of potential financial impairment, some clinicians may wish to take an additional step and conduct a brief assessment of financial skills in order to validate or elaborate upon this impression³. This may involve simply asking patients and caregivers a few additional targeted questions about financial activities (eg., any failure to pay bills, lapses in judgment, scams, new estate plans), or actually presenting some limited arithmetic and financially oriented performance tasks (counting money, mental computations). As noted by Widera, "brief assessment may be necessary because patients with AD...are often unaware of or in denial about the nature and extent of their decline in financial function. In addition, family and caregivers often give inaccurate or fluctuating estimates of patients' financial abilities." (Widera, p. 703). (see also Wadley et al 2003)²⁷. Clinicians are not

expected to conduct a formal capacity evaluation here, but rather are briefly probing for additional information which may support, or disaffirm, their initial concern or misgivings about the patient's financial capacity. As discussed below, it is usually best that formal issues of financial capacity be referred out to a clinician experienced and skilled in such assessments.

One area of assessment that implicates a clear ethical responsibility for clinicians is financial abuse of elderly patients²⁹⁻³¹. As stated by Widera, "physicians have an ethical and professional obligation to assess for and address elder financial abuse." (Widera, p. 703). Carrying out this ethical responsibility, however, can be very difficult in practice. It is often very hard for a clinician to discriminate, for example, between a caregiver who is simply "very hands on" from one who is controlling and taking unfair advantage of an older patient's finances. Some potential indicators of financial abuse include a caregiver's efforts to isolate an elderly person from other members of her family, the sudden presence of a previously unknown individual at clinical appointments or in the patient's home, new interest and pressure from a caregiver for the physician to find the elderly person incapable, and of course reports of others taking or mismanaging the patient's assets^{3,7}. A valuable, albeit time intensive approach is for the clinician to interview the caregiver and the patient separately, in order to speak with the patient independently about any financial concerns, and avoid possible domination of the patient by the caregiver or third party in a joint interview.

Helping Support Financial Independence

A fourth role for physicians and other clinicians involves suggesting approaches to patients and families which can support and sometimes extend financial independence of an elderly loved one³. Clinicians can briefly point out that in addition to DPOAFs, a range of potentially valuable interventions exist that can serve to protect the patient's financial well-being while he is still living in the community. Such interventions generally are tied to the patient's financial institution and include automatic deposit, joint checking with dual signatures for transactions above a certain amount, overdraft protections, third party notifications of overdue payments or financial irregularities, and representative payees³. Such institutionally based protections can be a particular boon for family members who may live out of town and who may not be able to exercise the level of financial oversight that can be provided by a caregiver living next door or in the same community.

Making Referrals for Financial Capacity Assessment

A fifth role for physicians and clinicians involves making outside referrals for assessment of financial capacity and possible financial exploitation. In some cases, informal approaches to addressing issues of financial capacity are simply not feasible or workable and a formal capacity judgment is needed. Most front line clinicians, however, are not experienced or knowledgeable in capacity assessment, and are not qualified to offer such a judgment, which can carry inordinate weight with families, financial institutions, and legal professionals⁷. In addition, from a civil liberties standpoint much is at stake when an individual's competency is called into question³².

Thus a clinical judgment of incapacity by an inexperienced clinician may do considerable harm by resulting unfairly in a loss of autonomy and financial independence, or alternatively, by supporting more individual autonomy than is warranted by the patient's declining financial abilities.

For these reasons, there are situations where outside referral is clearly called for. Physicians may wish to refer for financial capacity evaluation in situations of family conflict over

finances, when there are concerns about abuse, or if the physician wishes to obtain an expert consultation before offering a capacity judgment herself. A range of professions, including neuropsychology, geropsychology, and clinical and forensic psychiatry, may be able to offer a sound formal consultation of this type. In the area of capacity assessment, the qualifications of the assessor are usually more important than his or her discipline.

Other referrals may need to immediately engage the legal system or adult protective services, with financial capacity assessments following later in due course. One such situation is when an elderly patient is steadily dissipating her estate through poor financial decisions, or is being repeatedly scammed thereby endangering her resources and long-term security, but the individual adamantly denies problems and refuses to alter behavior due to anosognosia and advanced cognitive loss. In such a case, the physician or other clinician may consider working with the family to refer the patient to a lawyer and the local probate court for a possible emergency guardianship/conservatorship proceeding, or to adult protective services to assess the need to designate the patient as a person “in need of protection.”

IV. Educational Resources on Financial Capacity in Older Adults

As noted above, until recently there has been very little scientific or clinical work in the area of financial capacity. Beginning in 2000, Marson and his group at UAB have published a series of scientific papers addressing issues of financial capacity in patients with Alzheimer's disease and its precursor stage mild cognitive impairment (MCI)^{6,18,20,27,33-34}. Using a clinical conceptual model of financial capacity, and associated informant report²⁷, psychometric^{28,35}, and clinician interview³⁴ assessment instruments, these papers have begun to elucidate the trajectory of financial capacity loss in older patients with neurodegenerative disease. Findings to date indicate that financial capacity shows emerging impairment in patients with MCI, widespread impairment in patients with mild AD, and advanced global impairment in patients with moderate AD^{35,34,36}. In addition, financial capacity shows relatively rapid decline over one year in patients with mild AD³⁷. Clinical predictor studies have indicated that written arithmetic abilities are the primary predictor of financial capacity performance in groups across the dementia spectrum: normal elderly, patients with amnesic MCI, and patients with mild AD³⁸.

Finally, a recent neuroimaging paper has associated volume loss in the left angular gyrus of patients with amnesic MCI to diminished performance of these patients on a psychometric measure of financial capacity, with written arithmetic skills and executive function as cognitive abilities mediating this association³⁹. This study represents an exciting new direction for capacity research, and suggests a possible future neuroscience of financial and other capacities in the elderly, with associated important clinical and ethical implications.

Thus, as a group, the above scientific papers have started to lay the groundwork for an emerging field of financial capacity assessment in the elderly, and represent a starting point for clinicians and ethicists interested in additional education in this area.

In the meantime, a readily accessible and highly topical educational resource that addresses financial capacity in the elderly is available to clinicians and other professionals, including attorneys, judges and bioethicists interested in capacity. This resource is the series of American Bar Association/American Psychological Association handbooks on assessment of older adults with diminished capacity. There are three handbooks: one developed for use by attorneys⁴⁰, one for use by judges handling guardianship cases⁴¹, and one for use by psychologists⁷. All three of these handbooks have sections addressing issues of financial capacity in older adults, although the handbook for psychologists has the most fully and formally developed material and supporting literature on this topic, with specific chapters

addressing assessment of financial capacity and also testamentary capacity⁷. Specific instruments for assessing financial capacity are discussed in the attorney handbook⁴⁰ and the psychologist's handbook⁷, and the latter also includes on line appendices addressing other helpful topics and resources such as a glossary of legal and other terms, values assessment, interventions to support diminished capacity, and other informational websites. The handbook for psychologists is available without charge through the APA website at http://www.apa.org/pi/aging/capacity_psychologist_handbook.pdf.

V. Summary

Financial capacity has been a neglected topic in dementia ethics and clinical research. Issues of financial incapacity emerge frequently in patients with AD, PD, FTD, and related neurodegenerative dementias, and commonly present ethical and clinical challenges for clinicians treating these patients. Physicians in particular are increasingly being called upon by families to identify, assess, and help handle financial capacity issues, and their actions can have a substantial impact on the financial and psychological well-being of patients and family members. The present commentary has presented an overview of financial capacity and associated clinical and ethical issues in dementia, and has also described a set of potential roles that a clinician may choose to carry out in regard to these issues as they arise in clinical practice. We believe that these roles represent an initial platform for improving geriatric medical practice in this area of dementia care. Finally, the commentary has pointed the reader to scientific papers and educational resources that can provide further guidance and information on this important topic. The ultimate goal of this commentary has been to focus clinical and ethical attention on a neglected decisional capacity that is of fundamental importance for patients, families, and health care and legal professionals.

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