THE STATE OF CONFUSION: RESOLVING FIRST- AND THIRD-PERSON LIABILITY CAUSED BY DEMENTIA PATIENTS

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Millions of Americans suffer from Alzheimer's/dementia. Not only does the disease take a physical and emotional toll on the person diagnosed, their families experience emotional hardship as their loved one's mental capacity declines. Additionally, patients and their families bear the burden of financing expensive care. Potential tort liability currently imposed on Alzheimer's/dementia patients and their families only exacerbates financial security concerns. With respect to Alzheimer's/dementia patients' liability, tort law is currently in a state of confusion.

This Note discusses the current state of first- and third-person liability imposed on Alzheimer's/dementia patients and their informal caretakers—often the patient's family members. Possible reforms, such as updating the intent standard applied to determine whether an Alzheimer's/dementia patient is liable for an intentional tort and shielding familial caretakers from vicarious negligence liability, are addressed in detail. This Note advocates for new insurance options designed to produce equitable results between individuals impaired by the disease and potential tort victims. The proposed modifications to tort liability are aimed at alleviating the hardship Alzheimer's/dementia causes patients and their families.

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I. Introduction

"Jack, what state do you live in?" "The state of confusion," he answered. Jack was a Korean War Veteran and dementia patient known for his one-liners.[1] He was married for sixty-three years, a marriage that resulted in eight children and seventeen grandchildren. Before dementia, Jack loved reading, cross-country road trips, and Irish music. He worked on mechanical instruments for the military in the Korean War and was known to tinker with electronics. There was never a remote, thermostat, or device left untouched with Jack around. He would take apart and rebuild anything he could get his hands on.

Jack was a quiet, jovial man but dementia made him forgetful and aggressive. Eventually, he started getting lost and the family took away his car keys. He once stole them and drove anyway, causing his family significant concern. Jack even went so far as to call a locksmith to copy the key and hid the copies around his home. But he would forget where he hid the copies. Whenever he was told he could no longer drive, he would get agitated. On some occasions, he physically assaulted those around him, including caregivers and family members.

Eventually, Jack moved to a memory care center as the concerns regarding his physical aggression and memory increased. During his placement interview, the staff asked him, "Jack, what state do you live in?" to which he replied, "the state of confusion." Through the fog of Alzheimer's, Jack maintained his sparkling sense of humor. Initially, he seemed to do well in memory care; his memory and behavior improved. Occasionally he would attempt a dashing "escape," and pack all his clothes in his suitcase. He once claimed he was going to stack chairs so he could jump over the outside wall. At eighty-seven years old, this was a physical impossibility for Jack, but he was convinced he could do it. Eventually, he attacked another resident because the resident "took a swing at him," which turned out to be false.

Due to quality of care concerns, Jack's family moved him to a newer memory care facility. His dementia symptoms improved, but Jack deteriorated physically. He also encountered issues with other residents there. Other dementia patients would enter his room and refuse to leave. One resident tried to take Jack's walker away from him and

1. Jack [last name omitted] was the author's grandfather and the inspiration for this Note. The facts included in the introduction are all true accounts of Jack's experience with Alzheimer's.

Jack had to defend himself. It resulted in Jack falling and needing a trip to the hospital.

Jack represents just one dementia story of millions. Like other dementia patients, Jack is not immune from tort liability. When a dementia patient causes an accident resulting in tort liability, there is a possibility they could be sued.[2] There are no legal protections for dementia patients in tort contexts.[3] Under current tort standards, Jack could have been sued for his physical aggressions against family, caregivers, and other residents.[4] If he had gotten into an accident while driving, he could have been sued as well.[5] Alzheimer's has become extremely pervasive and is not discriminatory in whom it affects.[6]

Alzheimer's has affected many famous individuals, including President Ronald Reagan.[7] In 1994, President Reagan announced to the public he had been diagnosed with Alzheimer's.[8] He noted in a letter to the public, "Unfortunately, as Alzheimer's Disease progresses, the family often bears a heavy burden. I only wish there was some way I could spare Nancy from this painful experience."[9] The first female Supreme Court Justice of the United States, Sandra Day O'Connor, also suffers from Alzheimer's.[10] Justice O'Connor's husband similarly suffered from Alzheimer's, and she left the bench to care for him when he was diagnosed.[11]

2. *See generally* Vaughn E. James, *No Help for the Helpless: How the Law Has Failed to Serve and Protect Persons Suffering from Alzheimer's Disease*, 7 J. OF HEALTH & BIOMEDICAL L. 407 (2012) [hereinafter James] (discussing how the law in its current state fails to adequately protect the dementia population).

3. *Id.*

4. *Id.*

5. *Id.*

6. *Id.*

7. Lily Rothman, *Read Ronald Reagan's Letter to the American People About His Alzheimer's Diagnosis,* TIME (Sept. 1, 2016), http://time.com/4473625/ronald-reagan-alzheimers-letter/.

8. *Id.*

9. *Id.*

10. Ariane de Vogue & Veronica Stracqualursi, *Justice Sandra Day O'Connor Announces She Has Been Diagnosed with Dementia,* CNN (Oct. 23, 2018, 3:49 PM), https://www.cnn.com/2018/10/23/politics/justice-sandra-day-oconnor-dementia-alzheimers/index.html.

11. *Id.*

Alzheimer's is the sixth leading cause of death in the United States.[12] Approximately six million Americans are living with Alzheimer's and by 2050 the number is expected to reach fourteen million.[13] One in three senior citizens dies with Alzheimer's or another form of dementia.[14] This number will escalate rapidly in coming years, as the population of Americans age sixty-five and older is projected to grow from fifty-three million in 2018 to eighty-eight million by 2050.[15]

Tort law, as it relates to the mentally incapacitated and specifically Alzheimer's and dementia patients, is also in a state of confusion. It has long been an issue that tort law has no affirmative defense for mental incapacity but accepts an affirmative defense for physical disability.[16] This presents difficulties for dementia patients who are more likely to commit tortious acts, are mentally incapacitated, and are likely under financial constraints due to the specialized care they have or will need.[17] Similarly, this burden extends to the patients' families and caregivers.[18] Family, familial caregivers, and third-party caregivers can all be held liable through third-party liability concepts.[19] This Note will address the gaps in tort law and how to protect against first-person liability (caused by patients themselves) and third-person liability (against family and caregivers). This Note will not address liability as it relates to caregivers in nursing home settings.

Dementia already causes significant hardships on families. Tort liability should be modified to accommodate the mental incapacity of dementia patients and to limit the liability their families take on as caregivers.[20]

This Note is comprised of four parts. Part II discusses what Alzheimer's/dementia is and how it affects the daily lives of Americans. Part III reviews how tort law approaches mental impairment. Part IV suggests tort law should exclude Alzheimer's and dementia patients

12. ALZHEIMER'S ASS'N, 2018 ALZHEIMER'S DISEASE FACTS AND FIGURES 25 (2018), https://alz.org/media/HomeOffice/Facts%20and%20Figures/facts-and-figures.pdf [hereinafter ALZHEIMER'S ASS'N].
13. *Id.*
14. *Id.*
15. *Id.*
16. *See* James, *supra* note 2.
17. *See* ALZHEIMER'S ASS'N, *supra* note 12.
18. James, *supra* note 2, at 432.
19. *Id.*
20. *Id.*

from liability by instituting an Alzheimer's insurance policy to make amends for any dementia-related liability. Part V concludes by arguing that an insurance policy and more public policy is needed to protect dementia patients from torts.

II. Background

Alzheimer's and dementia are a series of neurological diseases that affect millions of Americans, both elderly and non-elderly. This section first describes what Alzheimer's and dementia are and how they are diagnosed. Next, it discusses who primarily cares for Alzheimer's/dementia patients. Finally, this section concludes by discussing the common law development of mental impairment defenses.

A. What is Alzheimer's Dementia?

Alzheimer's disease was first described in 1906.[21] Roughly seventy years passed before it was recognized as a common cause of dementia and a major cause of death.[22] Alzheimer's and dementia are pervasive neurological diseases that severely impact America's elderly.[23] The incidence of the Alzheimer's dementia complex is strongly correlated to age.[24] Ten percent of people sixty-five and older have Alzheimer's or dementia.[25] The percentage of people with Alzheimer's dementia increases with age: 3% of people age 65–74, 17% of people age 75–84, and 32% of people age 85 and older have Alzheimer's dementia.[26] Of those who have Alzheimer's dementia, 81% are age seventy-five or older.[27]

21. Alzheimer's Ass'n, *supra* note 12, at 5.
22. *Id.*
23. *Id.* at 14 (analyzing several management techniques, the Alzheimer's Association does identify pharmacological ways of managing the effects of the disease as well as several other active management techniques. These active management techniques can improve quality of life for patients and caregivers. Strategies include: "Appropriate use of available treatment options; Effective management of coexisting conditions; Coordination of care among physicians, other health care professionals and lay caregivers; Participation in activities that are meaningful and bring purpose to one's life; Having opportunities to connect with others living with dementia; support groups and supportive services are examples of such opportunities; Becoming educated about the disease; & Planning for the future.").
24. *Id.*
25. *Id.* at 17.
26. *Id.*
27. *Id.*

Alzheimer's is a degenerative brain disease and the most common cause of dementia.[28] Dementia is defined by a group of symptoms.[29] The main characteristic symptoms of dementia are memory issues, language deficiencies, lack of problem-solving, and a decline in other cognitive skills that affect a person's ability to perform everyday activities.[30]

Alzheimer's is a progressive disease.[31] The Alzheimer's Association has identified several stages of the disease: mild, moderate, and severe.[32] During the mild stage, Alzheimer's patients may still function independently.[33] They may start experiencing memory lapses, but the disease itself is often still undetectable.[34]

At the moderate stage, symptoms become more noticeable to others.[35] Patients become much more confused and begin forgetting significant details about their lives.[36] At this point, patients show significant personality and behavioral changes and are at risk for wandering and getting lost.[37]

During the severe stage, "[i]ndividuals lose the ability to respond to their environment, to carry on a conversation and, eventually, to control movement."[38] Alzheimer's/dementia patients require extensive

28. *Id.*
29. *Id.*
30. *Id.*
31. *Stages of Alzheimer's*, ALZHEIMER'S ASS'N, https://www.alz.org/alzheimers-dementia/stages (last visited Oct. 28, 2019) ("On average, a person with Alzheimer's lives four to eight years after diagnosis, but can live as long as twenty years, depending on other factors. Changes in the brain related to Alzheimer's begin years before any signs of the disease. This time period, which can last for years, is referred to as preclinical Alzheimer's disease.").
32. *Id.*
33. *Id.*
34. *Id.*
35. *Id.*
36. *Id.*
37. *Id.*
38. *Id.*

round-the-clock care and become more vulnerable to infection and disease.[39] Often, they become incapable of basic tasks, including eating, drinking, and using the restroom.[40]

Alzheimer's/dementia patients have difficulty with both long and short-term memory.[41] The early symptoms of Alzheimer's include difficulty remembering recent conversations, names, or events as well as apathy and depression.[42] Later symptoms include impaired communication, disorientation, confusion, poor judgment, and behavioral changes.[43] Some behavioral changes include: aggression, hiding things, imagining things that are not there, wandering away from home, and physically attacking others.[44] These behavioral changes can expose dementia patients to liability when it results in tortious action, particularly physical aggression and wandering away. But the overall confusion caused by dementia generally presents problems in determining and imposing tort liability.[45] The pervasiveness of Alzheimer's will inevitably lead to more accidents and intentional injuries related to dementia; this, in turn, will lead to heightened public pressure to compensate the injured and restrict the liberty of those with dementia.[46]

Several kinds of mental impairment fall under the dementia umbrella: Alzheimer's, Vascular Dementia, Dementia with Lewy Bodies,

39. *Id.* ("Individuals [at the severe state of Alzheimer's] 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 memory and cognitive skills continue to worsen, significant personality changes may take place and individuals need extensive help with daily activities.").

40. *Id.*

41. ALZHEIMER'S ASS'N, *supra* note 12.

42. *Id.*

43. *Id.*

44. *Managing Personality and Behavior Changes in Alzheimer's*, NAT'L INST. ON AGING (May 17, 2017), https://www.nia.nih.gov/health/managing-personality-and-behavior-changes-alzheimers.

45. *Aggression and Dementia,* ALZHEIMER'S SOC'Y, https://www.alzheimers.org.uk/about-dementia/symptoms-and-diagnosis/symptoms/aggression-and-dementia (last visited Oct. 28, 2019) [hereinafter ALZHEIMER'S SOC'Y] (discussing the different types of aggression typical of dementia including: swearing, screaming, shouting or making threats, hitting, pinching, scratching, hair-pulling or biting).

46. Edward P. Richards, *Public Policy Implications of Liability Regimes for Injuries Caused by Persons with Alzheimer's Disease*, 35 GA. L. REV. 621, 626 (2001) [hereinafter Richards].

Mixed Dementia, Fronto-Temporal Lobar Degeneration, and Parkinson's Disease.[47] These diseases all have a wide range of symptoms and often overlap, causing difficulty when it comes to accurate diagnoses.[48]

Testing and diagnosing Alzheimer's dementia also presents difficulties to doctors. No singular test exists to determine whether a patient is exhibiting the symptoms of dementia.[49] To assess the likelihood of a dementia diagnosis, a team of physicians often analyzes the patient's medical history of neurological and behavioral changes through neurological examinations and blood tests.[50]

Recently, dementia care and detection has improved.[51] Researchers at the University of California have utilized brain scanning technology and programmed a machine-learning algorithm to diagnose early-stage Alzheimer's disease about six years before a clinical diagnosis is made—potentially giving doctors a chance to intervene with treatment.[52] There is currently no cure for Alzheimer's/dementia and due to the progressive and severe neurological effects of the disease, treatment

47. ALZHEIMER'S ASS'N, *supra* note 12.

48. *What Is Dementia? Symptoms, Types, and Diagnosis,* NAT'L INST. ON AGING (Oct. 28, 2017), https://www.nia.nih.gov/health/types-dementia.

49. ALZHEIMER'S ASS'N, *supra* note 12.

50. *Id.*

51. *Id.* at 19 ("Many researchers believe that future treatments to slow or stop the progression of Alzheimer's disease and preserve brain function will be most effective when administered early in the disease process, either at the [Mild Cognitive Impairment Stage] due to Alzheimer's or preclinical stage. Today we recognize that diseases begin many years before symptoms appear, and Alzheimer's is no different. The revised guidelines acknowledge that the disease begins decades prior to symptom onset, allowing for the early identification of those with Alzheimer's disease biomarkers who may be at risk for symptoms of Alzheimer's dementia and who should be treated with experimental therapies aimed at delaying or preventing symptoms. Biomarker tests will be essential to identify which individuals are in these early stages and should receive treatments that slow or stop the disease when such treatments are available. They also will be critical for monitoring the effects of treatment. Furthermore, biomarkers will play an important role in developing treatments because they will enable researchers to identify which individuals to enroll in clinical trials of potential new therapies. By using biomarkers, researchers can enroll only those individuals with the brain changes that treatments target. It is important to note that the most effective biomarker test or combination of tests may differ depending on the stage of the disease and other factors."); Dana Smith, *Artificial Intelligence Can Detect Alzheimer's Disease in Brain Scans 6 Years Before a Diagnosis,* U.C. (Jan. 4, 2019), https://www.universityofcalifornia.edu/news/artificial-intelligence-can-detect-alzheimer-s-disease-brain-scans-6-years-diagnosis?utm_source=news-clips&utm_medium=internal-email&utm_campaign=article-general&utm_content=text&fbclid=IwAR1c-D3GMX0an1wNkuWnj8bxq9zJSVODsHtUhCctrJa7Hx1uYS_6i0RQS4U [hereinafter Smith].

52. Smith, *supra* note 51.

becomes a race against the clock.[53] Dr. Jae Ho Sohn, a resident in the Department of Radiology and Biomedical Imaging at the University of California-San Francisco, made this discovery.[54] Dr. Sohn combined neuroimaging with machine learning to try to predict whether or not a patient would develop Alzheimer's disease when they first exhibited signs of memory impairment, which is the best time to intervene for optimal outcomes.[55]

Dr. Sohn utilized this process to correctly identify Alzheimer's patients far in advance of when the patients start showing signs of neurological disease.[56] The process correctly identified 92% of patients who developed Alzheimer's disease in the first test set and 98% in the second test set.[57] Not only was it capable of identifying the disease, but it made these correct predictions on average 75.8 months—a little more than six years—before the patient received their final diagnosis.[58] Dr. Sohn noted the importance of early diagnosis: "One of the difficulties with Alzheimer's disease is that by the time all the clinical symptoms manifest and we can make a definitive diagnosis, too many neurons have died, making it essentially irreversible."[59]

Alzheimer's is a disease that is difficult to accurately diagnose quickly enough to prevent its degenerative effects.[60] Despite Dr. Sohn's discovery, there is still no cure for Alzheimer's/dementia.[61] Even with early diagnosis and treatment, the disease will still progress and make it difficult for patients to lead normal lives.[62]

Diagnosing Alzheimer's/dementia is not the only problem. The burden of caring for an Alzheimer's/dementia patient weighs heavily on family and caregivers.

B. Who Cares for Alzheimer's Dementia Patients?

Several care settings are available for Alzheimer's patients. Some patients opt for in-home care and hire a professional caregiver, but this

53. *Id.*
54. *Id.*
55. *Id.*
56. *Id.*
57. *Id.*
58. *Id.*
59. *Id.*
60. *See id.*
61. *Id.*
62. *See id.*

can be a very costly option.[63] Dementia patients may also live in a care community such as Alzheimer's special care units (memory care), assisted living, or a nursing home.[64] Ultimately, because of the prohibitive cost, many dementia patients end up being cared for at home by family members.[65] Eighty-three percent of the help provided to elderly adults in the United States comes from family, friends, or other unpaid caregivers.[66] Forty-eight percent of those caregivers are providing care for someone with Alzheimer's or dementia.[67]

Specialized care, such as a memory care facility, can be very costly.[68] When dementia patients run out of money, they end up relying on Medicare or Medicaid to pay for their care.[69] This often results in dementia patients transferring to lower quality facilities that will accept Medicare and Medicaid.[70]

In 2018, the total cost of Alzheimer's care exceeded a quarter of a trillion dollars for the second year in a row.[71] By 2050, the amount is expected to exceed $1.1 trillion dollars.[72] The total lifetime cost of care for someone with dementia is estimated at $341,840, with the costs associated with family care to be 70% of that estimate.[73]

In 2017, relatives of dementia patients provided 18.4 billion hours of unpaid assistance valued at $232 billion.[74] Generally, 83% of the care provided to adults with dementia comes from family members and

63. *Residential Care,* ALZHEIMER'S ASS'N, https://www.alz.org/help-support/caregiving/care-options/residential-care (last visited Oct. 27, 2019) [hereinafter *Residential Care*].

64. *Id.*

65. ALZHEIMER'S ASS'N, *supra* note 12, at 31.

66. *Id.*

67. *Id.*

68. *Residential Care*, *supra* note 63.

69. *Id.*

70. *See* Angela Stringfellow, *Memory Care Options for Low-Income Seniors*, SENIORLINK BLOG (Mar. 6, 2018, 3:34 PM), https://www.seniorlink.com/blog/memory-care-options-for-low-income-seniors.

71. Kathleen Fifield, *Huge Savings Seen in Early Alzheimer's Diagnosis*, AARP (Mar. 20, 2018), https://www.aarp.org/health/conditions-treatments/info-2018/alzheimers-cases-increasing-fd.html.

72. Alissa Sauer, *How Dementia's Financial Costs Take a Toll on Families,* ALZHEIMERS.NET (Aug. 3, 2018), https://www.alzheimers.net/5-09-16-dementia-financial-costs-take-toll-on-families/ [hereinafter *Sauer*] ("[E]arly diagnosis could save the U.S. as much as $7.9 trillion over the lifetime of all living Americans.").

73. *Id.*

74. *Id.*

other informal caregivers.[75] Dementia care imposes significant financial and emotional burdens on caregivers and patients themselves. Care burdens on families are only worsened by the lack of defenses available to those who suffer from mental impairments.

C. Common Law Basis for a Lack of Mental Impairment Defenses

The common law has long regarded mentally disabled adults as being held to the reasonable person standard.[76] This stems from two cases, *Weaver v. Ward* (English Common Law) and *Ward v. Conatser* (American Common Law).[77]

Weaver v. Ward is a 1616 English case which originally set the boundary that mentally disabled defendants are held to the reasonable person standard.[78] The pre-eminent American cases addressing the reasonable person standard began with *Ward v. Conatser*.[79]

In *Ward*, an 1874 Supreme Court of Tennessee case, Conatser sued Ward for shooting and wounding him.[80] Ward conceded he shot Conatser and relied almost entirely on insanity as a defense.[81] The Tennessee Supreme Court held:

> It is very ingeniously argued, that an insane man ought not to be held liable for an act done without intent to do wrong or injury. And there is much plausibility in the argument. But on the other hand, if a lunatic, having inflicted an injury upon the person or property of another, is not held to make reparation, the party suffering would be without redress.[82]

The court held that allowing an insanity defense would leave those who were wronged in the lurch.[83] Ultimately, those who caused injury, whether willful or not, still caused an injury and therefore

75. *Id.*

76. Harry J.F. Korrell, *The Liability of Mentally Disabled Tort Defendants*, 19 L. & PSYCHOL. REV. 1, 3 (1995) [hereinafter Korrell].

77. *Id.*

78. *Id.*

79. *Id.*

80. Ward v. Conatser, 63 Tenn. 64, 65 (1874) (discussing how the Ward case is most frequently cited by American courts and the rule of law developed in that case has continuously been used throughout American jurisprudence. It has been applied in "a nearly unbroken line of cases."); Korrell, *supra* note 76, at 3.

81. *Ward*, 63 Tenn. at 65.

82. *Id.*

83. *Id.*

should be held liable.[84] The court found that "insanity cannot be looked to as a justification."[85] Cases post-*Ward* have continued to apply this standard.[86]

Following *Ward*, *Williams v. Hays* applied the Tennessee Supreme Court's analysis for insanity defenses.[87] *Williams*, an 1894 New York Court of Appeals case, involved a ship captain's insanity.[88] The captain was driven mad after a forty-eight hour struggle to save his ship from a storm.[89] The court subsequently would not relieve him of liability for his negligently refusing offers of help from passing ships and his failure to acknowledge the ship's rudder damage.[90] The court wrote:

> There can be no distinction as to the liability of infants and lunatics, between torts of nonfeasance and of misfeasance—between acts of pure negligence and acts of trespass. The ground of the liability is the damage caused by the tort. That is just as great, whether caused by negligence or trespass; the injured party is just as much entitled to compensation in the one case as in the other; and the incompetent person must, upon principles of right and justice and of public policy, be just as much bound to make good the loss in the one case as the other; and I have found no case which makes the distinction.[91]

The court likened the liability of children to the mentally incompetent and found that they are both similarly liable for their tortious conduct.[92] In the court's eyes, regardless of their awareness of the wrongfulness of their conduct, both children and the mentally deficient caused a harm that required reparation.[93]

Courts have offered several justifications for the disparate treatment of mentally disabled tort defendants.[94] Some of these include:

> (1) Between two innocent parties, the one who caused the damage must bear the loss; (2) the purpose of tort law is compensation; (3) it is unfair to the victim not to be compensated when the insane person can pay; (4) if "mental defectives" are to live in society, they

84. *Id.* at 66.
85. *Id.* at 65.
86. *See, e.g.*, McClellan v. Tennessee Elec. Power Co., 123 S.W.2d 822, 824 (1938).
87. *See* Korrell, *supra* note 76, at 4–5.
88. *Id.*
89. *Id.*
90. *Id.*
91. *Id.*; Williams v. Hays, 38 N.E. 449, 451–52 (N.Y. 1894).
92. *Williams*, 38 N.E. at 451–52.
93. *Id.*
94. *See* Korrell, *supra* note 76, at 26.

> should pay for the damage they cause; (5) in the absence of liability, tortfeasors will feign insanity; (6) granting immunity to the insane would introduce into civil cases the chaos surrounding the insanity plea in criminal law; (7) the insanity defense would cause severe evidentiary problems in many cases; (8) in imposing liability, it is too difficult to draw a line between mental disability and mere variations of temperament and ability which cannot practically be considered; (9) imposing liability serves the modern aim of integration and community treatment of the mentally disabled by minimizing public resistance; (10) imposing liability will make the guardians of the mentally disabled exercise more care in supervising them.[95]

Tort liability for the mentally impaired has divided courts on these grounds, and the ambiguity of whether to institute any kind of solution deserves attention.[96] Because of the cost of dementia care and the vulnerability of dementia patients, tort law should reevaluate the application of mental incapacity rules to dementia patients.

III. Analysis

Tort law is generally split into two categories, intentional and unintentional torts.[97] Intentional torts are "intentional, voluntary misdeeds that one person commits against another."[98] Unintentional torts are "the result of actions or one's failure to act as a reasonably prudent person would under similar circumstances, as a result of which another person suffers harm."[99] Dementia patients' tort liability is most often the result of unintentional torts, as will be examined below.[100] Tort law has carved out protections for "children of tender years" and those with physical handicaps.[101] But it has still not taken those with mental disa-

95. *Id.* at 27–28.
96. *Id.* at 28.
97. James, *supra* note 2, at 426–27.
98. *Id.*
99. *Id.*
100. *See, e.g.*, Elizabeth Bemis, *How to Afford Senior Living When the Money Runs Out*, UMH (June 7, 2017), https://www.umh.org/assisted-independent-living-blog/bid/302278/how-to-afford-senior-living-when-the-money-runs-out.
101. Richards, *supra* note 46, at 631 (discussing Holmes's theories: "These are blanket exceptions for liability but are based on the standard for reasonable behavior by a person with the particular disability. Thus, a blind man who chose to drive a wagon through town would be liable for any injuries caused to bystanders, but a blind man who was injured because he did not dodge a runaway horse could not be charged with contributory negligence. At least in the case of children, early courts imputed the negligence of their caregivers to the child, finding that even if a child

bilities into account because it rejects affirmative defenses based on insanity.[102] An insanity theory of mental impairment would protect Alzheimer's/dementia, but this theory is flawed and would likely not withstand judicial scrutiny.

This section will analyze how tort law fails Alzheimer's/dementia patients and some of the ways the law has reacted. First, this section will examine how tort law requires a duty of care from the mentally impaired and how this might be changed through the intent requirement. Next, this section will discuss how a duty of care is similarly required from family members and caregivers. Then, this section will look at how sudden incapacitation has been used in the context of the mental incapacity defense. Finally, it will discuss the pitfalls of using an affirmative defense for those who are mentally impaired by Alzheimer's/dementia.

A. The Law Requires a Duty of Care from Alzheimer's Patients that They Often Cannot Meet.

Currently, most jurisdictions do not accept an affirmative defense on the basis of mental incapacity/disability or insanity, but they often allow affirmative defenses for physical disabilities.[103] Some scholars suggest that negligence is the most burdensome tort facing dementia patients.[104] The mentally impaired are often incapable of rising to the standard of care required for tortious conduct.[105] No court has thus far made an explicit exception excusing Alzheimer's patients for their intentional torts.[106] Thus, mentally deficient adults are held liable for their tortious conduct.[107] Patients impaired by dementia, especially those with Alzheimer's disease, may be unaware of their impairment itself,

was not old enough to know to stay out of the road, the child would be charged with the negligence of his caregivers. The courts also rejected an assumption of risk defense when persons were injured through dealings with persons known to be insane. This is consistent with Holmes's view that the tort law must not be tailored to the individual circumstances of each defendant and that the plaintiff is entitled to assume reasonable behavior from all persons.").

102. *Id.* at 632.
103. *Id.* at 634.
104. *See* James, *supra* note 2, at 426.
105. *Id.*
106. *Id.*
107. *Id.*

which makes it difficult to determine what constitutes a reasonable precaution against harm.[108] One way of resolving the issue of an affirmative duty may be through changing the intent requirement.

1. CHANGING THE INTENT REQUIREMENT

Intentional torts require that the individual—including Alzheimer's patients—have the requisite intent to commit harm. Though their mental state might suggest dementia patients lack intent, dementia patients have still been found to have the intent necessary for intentional torts.[109] Intent requires either purpose or knowledge.[110] To satisfy purpose, the actor must "purposefully cause[] harm by acting with the desire to bring about that harm."[111] To satisfy knowledge, the actor must "knowingly cause[] harm by engaging in conduct believing that harm is substantially certain to result."[112] Arguably, though a dementia patient does not knowingly cause harm—depending on the level of their impairment—they still might purposefully cause harm.[113] Regardless of intent issues, mentally impaired defendants have been held liable for the intentional torts they cause, including dementia patients.

Some scholars have suggested a solution that requires changing the intent requirements of intentional torts.[114] "While the law defines intent the same for everyone, it often applies to persons with cognitive disabilities somewhat presumptively which leads to unfair results with little or no real analysis."[115] This presents several problems as it

108. Trevor Ryan & Wendy Bonython, *Whose Fault in an Aging World?: Comparing Dementia-Related Tort Liability in Common Law and Civil Law Jurisdictions*, 27 WASH. INT'L L.J. 407, 420 (2018) [hereinafter Ryan & Bonython].

109. *See generally* Johnny C. Chriscoe, *A Plea to North Carolina: Bring Fairness to the Assessment of Civil Battery Liability for Defendants with Cognitive Disabilities*, 39 CAMPBELL L. REV. 241, 246 (2017) [hereinafter Chriscoe] (explaining that "persons with cognitive disabilities being liable for their torts is firmly rooted in American tort law").

110. RESTATEMENT (THIRD) OF TORTS: GEN. PRINCIPLES § 1 DD (AM. LAW INST. 1999).

111. *Id.*

112. *Id.*

113. *See* Marlo Sollitto, *Dealing with an Elderly Parent's Bad Behavior*, AGINGCARE (Oct. 11, 2019), https://www.agingcare.com/articles/how-to-handle-an-elderly-parents-bad-behavior-138673.htm [hereinafter Sollitto].

114. Chriscoe, *supra* note 109, at 264.

115. *Id.* at 246.

blanketly applies a standard of intent without consideration of the varying degrees of capacity or the cognitive ability of the defendant.[116] Older cases "labeled the individuals as lunatics, mentally incompetent, or insane and held them liable without regard to the nature or extent of their cognitive disabilities."[117] This line of reasoning has even held infants liable for their tortious conduct without regard to their intent.[118]

One potential resolution is the adoption of a dual intent standard.[119] Courts should "require proof that (1) the defendant acted with actual, subjective intent—meaning to act with purpose or substantial certainty—and, at least for purposes of battery, (2) that the defendant's intent was not only to cause contact but also to cause either harm or offense."[120] In 2000, the Supreme Court of Colorado followed this dual intent standard in *White v. Muniz*.[121] In *White*, Ms. Everly lived in an assisted living facility where Ms. Muniz was a shift supervisor.[122] Everly attacked Muniz, and it was later determined Everly suffered from Alzheimer's.[123] Muniz sued Everly for assault and battery and also sued White, her personal representative, for negligence.[124]

The trial court found under the second prong of the dual intent standard that Everly did not appreciate the offensiveness of her conduct, and therefore ruled in her favor.[125] However, the appellate court overturned this decision reasoning that "insanity may not be asserted as a defense to an intentional tort, and . . . the trial court erred in 'instructing the jury that [White] must have appreciated the offensiveness of her conduct.'"[126] Though the dual standard was initially applied by the lower court, it was rejected in the appellate court because jurisdictions still require "insane" persons, like dementia patients, be held liable for their tortious conduct.[127] However, the Supreme Court of Colorado agreed with the trial court in finding that mentally disabled

116. *Id.* at 246, 250.
117. *Id.* at 250.
118. *Id.* at 246.
119. *Id.* at 259.
120. *Id.* at 259–60.
121. Chriscoe, *supra* note 109, at 260 (citing White v. Muniz, 999 P.2d 814 (Colo. 2000)).
122. *Id.*
123. *Id.*
124. *Id.*
125. *Id.*
126. *Id.* at 260–61 (quoting Muniz v. White, 979 P.2d 23, 25–26 (Colo. App. 1998)).
127. *Id.*

persons may be held liable for intentional torts, but the court must first conclude that actor intended to cause offensive or harmful consequence of his act.[128]

However, even with the addition of dual intent, dementia patients face other issues. "If the accused has a diagnosed mental illness or impairment, for example, but the impairment did not affect . . . [the] ability to understand the nature or criminality of his or her act at the time of commission, the defense will not be available."[129] If the patient can still appreciate the offensiveness of their conduct absent the impairment, a dual intent standard and affirmative defense does nothing.

A dual intent requirement would potentially provide further protection to those suffering from mental impairments. Like Everly, a dementia patient often cannot appreciate the offensiveness of their conduct.[130] By amending the intent requirement to a two-step standard, Alzheimer's/dementia patients would be less likely to be held liable for the tortious acts they cause. This theory, however, would likely be rejected by the courts and is still not a catch-all solution. Regardless of intent, however, the unintentional tort of negligence is where Alzheimer's/dementia patients can find themselves at fault.

2. THE MAIN CULPRIT: NEGLIGENCE

Unlike intentional torts, unintentional torts do not have an intent requirement. Negligence is an unintentional tort and one area of tort law where dementia patients are most at risk.[131] To prove negligence, a plaintiff must show that the defendant "(1) owed him a duty of care, (2) breached this duty of care, (3) the breach caused actual harm, and (4) the breach was the proximate or 'not too remote' cause of the harm."[132] Most likely, when third-party caregivers or dementia patients are sued under a tort theory of liability, they would be sued under a theory of negligence.[133]

Negligence is a gray area when it comes to resolving liability of Alzheimer's/dementia patients. Because there is no intent requirement, a dual intent approach would not move the needle. If an affirmative

128. White v. Muniz, 999 P.2d 814, 818–819 (Colo. 2000).
129. Ryan & Bonython, *supra* note 108, at 416.
130. *See* Sollitto, *supra* note 113.
131. James, *supra* note 2, at 426.
132. *Id.*
133. *See id.*

defense was implemented, it would protect patients. However, a full affirmative defense removing liability from dementia patients would not likely succeed because it gives way to a full mental impairment defense and does not protect victims.[134] Therefore, an affirmative defense would harm victims and be an unfair solution. A more comprehensive approach is necessary to protect Alzheimer's patients who commit unintentional torts.

B. The Law Requires a Duty of Care from Family Members, Familial Caregivers, and Third-Party Caregivers.

Tort law requires that once a duty exists, it must be carried out non-negligently.[135] This can present problems for caregivers.[136] Some jurisdictions have granted personal immunity from negligence suits to people with impaired capacity, and instead impose secondary "caregiver" liability on those who were negligent in exercising control over the individual with dementia.[137] This could be a public or private institution, community care provider, family member, or other volunteer.[138] Caregiver liability does not specify what kind of caregiver is susceptible to liability.[139] Nor is there a defined standard amount of caregiving necessary to impose liability.[140] If the person with mental impairment is an unsuitable defendant for "legal, moral, or economic reasons, a plaintiff may look to a caregiver as an alternative or joint defendant."[141] Therefore, caregivers of Alzheimer's patients can be held liable for negligent harm that their patients or family members cause to others.[142]

134. *See id.*
135. *See id.*
136. Richards, *supra* note 46, at 623–24.
137. Ryan & Bonython, *supra* note 108, at 409.
138. *Id.* at 410.
139. *Id.* at 420.
140. *Id.* at 417–18.
141. *Id.* at 422.
142. *Id.*; William P. Donaldson, *Innocence, Negligence, and Common Sense: Tort Liability of Mentally Impaired Persons,* 1 MARQ. ELDER ADVISOR 33, 37 (1999) ("Alzheimer's disease and related conditions sap the very essence of the individual. Memories disappear. Frustration and rage are frequently the replacements. In the mind of a formerly calm and loving father or mother, a new and frightening personality may appear. Families, when trying to cope with these changes, are forced at some point to seek professional help in some degree. The prospect that the professional consulted will one day be able to assert a liability claim arising out of the condition they

The law differentiates between formal caregivers and informal caregivers.[143] If formal caregivers are aware of the patients' propensities to injure others, they are under a legal obligation to protect members of the general public from such harm and are liable for damages to the people the patients do injure.[144] There are numerous cases relating to care institutions where a person was released from institutional care and then proceeded to harm a third party.[145] In these cases, courts have required specific evidence that the person posed a threat before liability is imposed.[146]

Recently, there has been a shift in the standard regarding third-party tort liability.[147] The Second and Third Restatements of Torts address these changes.[148] The Second Restatement of Torts states:

> One who undertakes to render services to another which he should recognize as necessary for the protection of a third person or his things, is subject to liability to the third person for physical harm resulting from his failure to exercise reasonable care to protect his undertaking, if (a) his failure to exercise reasonable care increases the risk of such harm, or (b) he has undertaken to perform a duty owed by the other to the third person, or (c) the harm is suffered because of reliance of the other or the third person upon the undertaking.[149]

This standard imposes absolute liability on a third-party caregiver for any duties they undertake.[150]

The Third Restatement of Torts shifted from this position, but only slightly.[151] It states that an actor in a special relationship with another owes a duty of reasonable care to third parties with regard to risks posed by the other that arise within the scope of the relationship.[152] The

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are supposed to alleviate may be enough to cause families to delay seeking treatment. This is not the effect that the law should have. The law should help to protect and preserve the rights of the most vulnerable among us.").

143. *Id.*; Ryan & Bonython, *supra* note 108, at 423.

144. *Id.* at 425.

145. *Id.* at 423.

146. *Id.* at 424.

147. *See* RESTATEMENT (SECOND) OF TORTS § 324A (AM. LAW INST. 1965); RESTATEMENT (THIRD) OF TORTS § 41 (AM. LAW INST. 2012).

148. *Id.*; *see* RESTATEMENT (SECOND) OF TORTS § 324A (AM. LAW INST. 1965); RESTATEMENT (THIRD) OF TORTS § 41 (AM. LAW INST. 2012).

149. RESTATEMENT (SECOND) OF TORTS § 324A (AM. LAW INST. 1965).

150. *Id.*

151. RESTATEMENT (THIRD) OF TORTS § 41 (AM. LAW INST. 2012).

152. *Id.*

special relationships giving rise to the duty provided include: (1) a parent with dependent children, (2) a custodian with those in its custody, (3) an employer with employees when the employment facilitates the employee's causing harm to third parties, and (4) a mental-health professional with patients.[153] Though this standard does not explicitly impose liability on third-party caregivers, the exceptions for parents with dependent children and mental-health professional relationships could create liability for dementia caregivers.

Driving is one major concern with moderate to severe Alzheimer's/dementia patients.[154] The American Academy of Neurology and the American Association for Geriatric Psychiatry both recommend that patients with mild dementia should stop driving.[155] The Alzheimer's Association, however, believes that the determination should be based on driving ability rather than a medical diagnosis.[156] Even outside of the legal issues that arise from Alzheimer's/dementia, medical professionals disagree as to the best method of handling these patients.[157]

Brown University conducted a study regarding the deterioration of driving ability and decision-making in Alzheimer's/dementia patients.[158] The study found:

> All healthy controls passed an initial on-road driving test, compared with 88% of patients with very mild Alzheimer's, and 78% of those with mild Alzheimer's. At a subsequent road test eighteen months later, driving skills in all participants—even healthy controls—had deteriorated, and many patients had stopped driving for safety reasons. However, patients with mild Alzheimer's became unsafe drivers about twice as fast as those with very mild Alzheimer's, based on tests conducted every six months. Patients with mild Alzheimer's failed the driving test after roughly eleven

153. *Id.*

154. *Alzheimer's and Driving Ability*, HARV. HEALTH PUB. (Sept. 2008), https://www.health.harvard.edu/mind-and-mood/alzheimers-and-driving-ability ("As Alzheimer's progresses, for instance, a patient may have trouble remembering how to get somewhere, or may become confused such as stopping at a green light or stepping on the gas pedal instead of the brake. Although most experts agree that anyone with moderate to severe Alzheimer's or another dementia should stop driving, no consensus exists about patients at earlier stages of cognitive decline.").

155. *Id.*

156. *Id.*

157. *Id.*

158. *Id.*

> months, while those with very mild Alzheimer's failed the test after roughly twenty months.[159]

The driving ability of Alzheimer's patients ultimately deteriorates very quickly once the patient becomes moderately impaired by the disease.[160] Because these patients deteriorate so quickly, family members and caregivers must pay close attention to how the patient behaves. This becomes a very difficult challenge for the patient's family.[161]

Family caregivers who have no legal duty to prevent patients with dementia under their care from driving may be liable for unsuccessfully stopping them.[162] This could become a huge risk for family members and caregivers of dementia patients.[163] There is a strong link between dementia and car accidents.[164] Disallowing dementia patients from driving would prevent them from causing accidents and prevent negligence claims from being brought against patients and family members.[165] However, a complete ban would severely inhibit the liberty of both caregiver and patient.[166]

In addition to liberty concerns, a complete ban on driving is difficult because of the progressive nature of dementia. The best solution is knowing when to take the car keys away, which is no easy feat.[167] There are several warning signs that caregivers can watch for to determine when an Alzheimer's patient should no longer be driving.[168] These signs include: forgetting how to get to familiar places, failing to observe traffic signs, poor traffic decision-making, driving at an inappropriate

159. *Id.*

160. *Id.*; Erika Redding, *Medicare Should Cover In-Home Care for Dementia Patients,* BALT. SUN (Nov. 29, 2017, 10:45 AM), https://www.baltimoresun.com/news/opinion/oped/bs-gafdasg-20171128-story.html [hereinafter Redding].

161. Richards, *supra* note 46, at 626–27.

162. *Id.* at 623.

163. *Id.*

164. *See Elderly Dementia Patients Have High Car Accident Risk*, CTV NEWS (Oct. 8, 2008, 1:09 PM), https://www.ctvnews.ca/elderly-dementia-patients-have-high-car-accident-risk-1.331995.

165. *See* Richards, *supra* 46, at 639.

166. *Id.*

167. LORI A. DAILLEO & BRIAN R. OTT, *How Does Dementia Affect Driving in Older Patients,* AGING HEALTH 1, 2 (2010) ("Owing to similar but more severe deficits, drivers with dementia are at a high risk of unsafe driving, particularly if examined on a per miles driven basis. Studies have demonstrated that drivers with dementia have an approximately two to five times greater risk of involvement in a crash compared with age-matched controls. The risk of crashing for a driver with Alzheimer's disease rises above that of the highest risk group (teenage males) beyond the third year of disease.").

168. *Id.*

speed, becoming angry or confused while driving, and forgetting the destination one is driving to during the trip.[169] Occupational therapy driving rehabilitation specialists can also conduct evaluations to determine whether an Alzheimer's patient should still be driving.[170]

But, avoiding third-party liability resulting from car accidents and other dementia-related torts often means institutionalization.[171] The end result of this is over-institutionalization.[172] Families institutionalize their dementia-suffering family members to ease concerns over driving and other dementia-related risk factors.[173]

One such example is Erika Redding's grandmother.[174] Redding's grandmother's memory loss began slowly; she initially forgot where she put her car keys or when she was supposed to pick up Redding.[175] "Over time, her condition worsened."[176] This eventually led to a car accident. Redding's grandmother became confused while trying to exit the highway, and she crashed as a result.[177] Her family suspected she was ill, and the official dementia diagnosis came soon after the accident.[178] Redding's family was lucky; no one was seriously hurt in the accident.[179] Because of the Reddings' diligence, they were able to prevent any further dementia-related accidents.

Informal caregivers also do not have the tools necessary to handle dementia patients.[180] Accordingly, informal caregivers end up having to call the police to handle dementia patients.[181] Informal caregivers are then faced with a choice of either calling the police or bearing the brunt of the patient's issues.[182]

169. *Dementia and Driving,* Alzheimer's Ass'n, https://www.alz.org/help-support/caregiving/safety/dementia-driving (last visited Oct. 28, 2019).
170. *Id.*
171. Ryan & Bonython, *supra* note 108, at 422 (discussing over-institutionalization); Redding, *supra* note 160 (discussing how because of the intense level of care associated with dementia, Redding's grandmother had to move to a care facility).
172. Ryan & Bonython, *supra* note 108, at 422.
173. *Id.*
174. Redding, *supra* note 160.
175. *Id.*
176. *Id.*
177. *Id.*
178. *Id.*
179. *Id.*
180. James, *supra* note 2, at 431; Redding, *supra* note 160.
181. James, *supra* note 2, at 431.
182. *Id.* at 433.

This only creates more problems.[183] When informal caregivers call the police or emergency medical personnel, the police may arrest the patient.[184] Police departments do not have proper facilities to hold or care for Alzheimer's patients.[185] "Meanwhile, these caregivers can, and are, sometimes held liable for the torts their patients commit against members of the general public."[186]

A further question is the type of liability to impose on a third-party caregiver. This depends on his or her relationship to the patient. Strict liability typically requires a demonstration of fault.[187] Neither strict liability nor vicarious liability is precisely applicable to caregiver liability where harm is caused by a person with mental impairment and ultimately had nothing to do with the caregiver's actions.[188]

Imposing liability on dementia caregivers poses a risk of overburdening them.[189] Caregivers, especially family members, are at great risk for significant well-being issues because of the hardships Alzheimer's presents.[190] Subjecting family members to liability, and therein compensatory damages, would only worsen the problem.[191]

In addition, the current liability structure does not give incentive to informal caregivers to step in and undertake a duty of care.[192] It may actually discourage caregivers from undertaking a duty of care because the courts may see these steps as creating a duty where one does not otherwise exist.[193] Professor Edward P. Richards suggests that "[a] more rational policy would impose liability for inaction, but near-immunity for caregivers who attempt to prevent injury but nonetheless fail."[194]

Providing liability protections for informal caregivers and third parties further prevents instances of dementia-related torts. Even with an all-inclusive affirmative defense for tortfeasors, caregivers could still

183. *Id.* at 431.
184. *Id.* at 433.
185. *Id.*
186. *Id.*
187. Ryan & Bonython, *supra* note 108, at 422.
188. *Id.*
189. ALZHEIMER'S ASS'N, *supra* note 12.
190. *Id.*
191. *Id.*
192. Richards, *supra* note 46, at 622–23.
193. *Id.*
194. *Id.*

be liable. The best way to incentivize caregivers to step in and prevent these incidents is to give them some protection in the event of a suit.

C. Using Sudden Incapacitation as a Defense to Alzheimer's Induced Tort Liability

Some jurisdictions have adopted the sudden incapacitation doctrine as a defense in Alzheimer's tort cases.[195] North Carolina is one such jurisdiction.[196] This defense presents several challenges for dementia patients.

The Supreme Court of North Carolina was one of the first courts to apply sudden incapacitation as a defense for Alzheimer's patients.[197] In *Word v. Jones ex rel. Moore*, Ms. Jones, the defendant, caused an accident when she drove into the opposite lane and hit the plaintiff's car.[198] Jones raised a sudden incapacitation defense on the basis of several incapacitation theories including "a sensory overload caused by Alzheimer's disease . . . ."[199] Jones was diagnosed with Alzheimer's after the accident and had been cleared by her physician a week beforehand to drive.[200] At trial, she presented evidence showing "she had no recollection of the collision, that she had to be told she was traveling the wrong way . . . and that [she] did not apply the brakes either before or after the accident."[201] The court allowed Jones to assert the sudden incapacitation defense.[202]

The Supreme Court of North Carolina used the following test for sudden incapacitation in Jones's case:

> To prevail on a sudden-incapacitation defense in an auto accident case, the defendant has the burden of proving each of the following elements by a preponderance of the evidence: (i) the defendant was stricken by a sudden incapacitation, (ii) this incapacitation was unforeseeable to the defendant, (iii) the defendant was unable to control the vehicle as a result of this incapacitation, and (iv) this sudden incapacitation caused the accident.[203]

195. James, *supra* note 2, at 428–31.
196. Word v. Jones *ex rel.* Moore, 516 S.E.2d 144, 145 (N.C. 1999).
197. James, *supra* note 2, at 428–29 (discussing Word v. Jones *ex. rel.* Moore).
198. *Id.*; *see also* Word, 516 S.E.2d at 145.
199. Word, 516 S.E.2d at 145.
200. James, *supra* note 2, at 428–29.
201. *Id.* at 560.
202. *Id.*
203. *Id.*

Though North Carolina allowed sudden incapacitation as a defense to first-person liability resulting from Alzheimer's related incidents, the court still left open the question of when to apply the sudden incapacitation doctrine. Jones, for example, had not been diagnosed with Alzheimer's at the time of the accident.[204] It seems plausible for an Alzheimer's related incapacitation defense to be applicable to Jones because the incapacitation that resulted from her Alzheimer's was "unforeseeable."[205] But, it is unclear how the sudden incapacitation defense could apply to Alzheimer's patients who already have a diagnosis, are aware of that diagnosis, but due to their dementia, forget and act in ways that present risk to others.[206] Under North Carolina's standard, these patients would not be able to claim the incapacitation was "unforeseeable."[207]

If dementia patients can utilize and prove the sudden incapacitation defense by showing an unforeseeable loss of consciousness, it would be a complete defense. But ultimately, the patient bears the burden of establishing the defense,[208] and the defense will not be applicable in most or all cases.

D. Does Allowing an Affirmative Defense for Dementia Patients Cause the Patients More Strife?

As dementia diagnoses become more prevalent, the testing for Alzheimer's dementia has become more sophisticated.[209] Today, dementia can be diagnosed much earlier than in years past.[210] But, dementia patients could still be living their daily lives without knowledge of

204. *Id.*

205. *Id.*

206. *Id.* (Since states have not used the sudden incapacitation defense as a blanket defense for torts caused by dementia, it is unclear how this would work practically across the board. Only the few cases discussed in this Note show how the defense might work practically).

207. *Id.*

208. Shiner v. Ralston, 64 A.3d 1, 5 (Pa. Super. Ct. 2013).

209. *How Is Alzheimer's Disease Diagnosed?*, NAT'L INST. ON AGING, https://www.nia.nih.gov/health/how-alzheimers-disease-diagnosed (last visited Oct. 28, 2019) [hereinafter *How Is Alzheimer's Disease Diagnosed?*] (discussing the different types of tests including memory tests involving problem solving, attention, counting, and language; standard medical tests, such as blood and urine tests, to identify other possible causes of the problem; and brain scans, such as computed tomography, magnetic resonance imaging, or positron emission tomography, to rule out other possible causes for symptoms).

210. *See* ALZHEIMER'S ASS'N, *supra* note 12.

their mental impairment.[211] If a patient were to get into an accident, and then discover after the fact that they suffered from dementia or Alzheimer's, it could lead to them requiring a tort defense in any subsequent suit. At what point does an individual become "impaired enough" to constitute utilizing the defense to avoid liability? If it is retroactive, it would protect more patients. But this formulation could encourage more fraudulent diagnoses to avoid liability.

Alternatively, labeling someone as judgment-proof because of their dementia makes it easier for fraudulent actions unrelated to tort liability. Relatives could easily come into the picture and question the patient's actions on the basis of their mental impairment, even if they are not severely impaired.[212] A relative or other caregiver could point to a patient's dementia diagnosis and the mental impairment defense, and use it to scrutinize significant choices made by the patient.[213] This could cause significant disruptive intervention by family members and those seeking favorable changes to the patient's will when the patient is still mentally competent.[214]

Tort law provides several possible solutions. First, like North Carolina, states could permit a sudden incapacitation defense for Alzheimer's dementia patients in negligence cases.[215] This would be a useful solution in that it would completely remove liability from dementia patients and their families. But it presents other issues and has not been widely adopted.[216]

211. *See How Is Alzheimer's Disease Diagnosed?*, *supra* note 209.

212. *See generally* James, *supra* note 2, at 420 (discussing how the law in its current state fails to adequately protect the dementia population).

213. *Id.*

214. *Id.*

215. *See, e.g.*, Word v. Jones *ex rel*. Moore, 516 S.E.2d 144, 146 (N.C. 1999).

216. Timothy E. Travers, Annotation, *Liability for Automobile Accident Allegedly Caused by Driver's Blackout, Sudden Unconsciousness, or the Like*, 93 A.L.R.3d 326 (1979) [hereinafter Travers] (describing the different standards for incapacity while driving and whether liability attaches, many states' standards would now allow a sudden incapacitation defense for Alzheimer's. For example, in Hawaii "factors considered in determining whether driver's sudden incapacity to control his vehicle was foreseeable include extent of driver's awareness or knowledge of condition that caused incapacity, whether driver had sought medical advice or was under physician's care for condition, whether driver had been prescribed, and had taken, medication, whether incapacity had previously occurred while driving, number, frequency, extent, and duration of prior incapacitating episodes, temporal relationship of prior episodes to accident, any guidance or advice by physician regarding driving, and medical opinions regarding nature of condition, adherence to treatment, foreseeability of incapacitation, and potential advance warnings which driver would have

Second, states can institute a general mental impairment affirmative defense for Alzheimer's patients. This presents the same positive and negative qualities as sudden incapacitation, a complete defense, with no recovery for plaintiffs.

Third, states could institute more statutory procedural safeguards to prevent negligent actions by Alzheimer's/dementia patients.[217] By heightening requirements for driving—especially for the elderly and dementia patients—the opportunity for accidents related to dementia would likely decrease as would the opportunity for suit. At the same time, it might be overly burdensome for the government to administer and track testing for the elderly and those with Alzheimer's.[218]

The best solution to resolve first-person and third-person tort liability in relation to dementia patient issues is to create an insurance policy that families can purchase voluntarily to protect against tort liability. This option is voluntary, and if similar in price to car insurance or tacked on as an aspect of homeowner's insurance, would not be extremely costly.[219] Because damages can bankrupt a dementia patient and their family, insurance policies can prevent this at a low cost.

Instituting more safeguards and finding a solution to assist Alzheimer's patients is the best way to prevent liability from passing on to family members and informal caregivers. Both options limit liability for both the patient and their caregivers. Limiting liability generally through the vehicle of procedural safeguards mitigates the likelihood that patients and their families will be sued for tortious conduct. These options are all fully explored in the Recommendation section below.

IV. Recommendation

How should states resolve the issue of first- and third-person tort liability for dementia patients? Revising tort liability for Alzheimer's patients presents a dual issue. It is difficult to prevent financial harm to

experienced immediately prior to accident." This standard would likely exclude many Alzheimer's patients from using this defense.).

217. *License Renewal Procedures,* INS. INST. FOR HIGHWAY SAFETY: HIGHWAY LOSS DATA INST. (Feb. 2019), https://www.iihs.org/topics/older-drivers/license-renewal-laws-table [hereinafter *License Renewal Procedures*].

218. *See* KATHY H. LOCOCO ET. AL., MEDICAL REVIEW PRACTICES FOR DRIVERS LICENSING (Apr. 2017).

219. *See* Korrell, *supra* note 76, at 56.

dementia patients and their families while also making those who have been tortiously wronged whole again.

Several options exist for resolving this folly of tort law. First, states could adopt the sudden incapacitation doctrine as a defense for torts caused by Alzheimer's. Second, states could create an absolute affirmative defense for patients with Alzheimer's akin to the physical disability affirmative defense. Third, states could institute more safeguards to prevent dementia-related accidents. The best option is to create elderly insurance policies. Adopting a new insurance policy would best make plaintiffs whole and prevent defendants with dementia from insolvency.

A. Sudden Incapacitation

Like North Carolina, other states could allow dementia patients to utilize the sudden incapacitation doctrine as an affirmative defense. California and Wisconsin have adopted the sudden incapacitation defense but have yet to apply it to dementia-related tort cases.[220] Sudden incapacitation is most often used in motor vehicle cases.[221]

Motor vehicle drivers are expected to exercise ordinary, reasonable, or due care in driving the vehicle.[222] The driver is expected to keep the vehicle under control at all times to prevent collision with pedestrians or other vehicles.[223] These types of cases do have one exception, and this is when the driver becomes suddenly incapacitated and causes an

220. James, *supra* note 2, at 429.

221. Travers, *supra* note 216 (describing the different standards for incapacity while driving and whether liability attaches and acknowledging that many states' standards would now allow a sudden incapacitation defense for Alzhiemer's. For example, in Hawaii "factors considered in determining whether driver's sudden incapacity to control his vehicle was foreseeable include extent of driver's awareness or knowledge of condition that caused incapacity, whether driver had sought medical advice or was under physician's care for condition, whether driver had been prescribed, and had taken, medication, whether incapacity had previously occurred while driving, number, frequency, extent, and duration of prior incapacitating episodes, temporal relationship of prior episodes to accident, any guidance or advice by physician regarding driving, and medical opinions regarding nature of condition, adherence to treatment, foreseeability of incapacitation, and potential advance warnings which driver would have experienced immediately prior to accident." This standard would likely exclude many Alzheimer's patients from using this defense.)

222. *Id.*

223. *Id.*

accident.[224] In that instance, when a driver has a sudden and unforeseen loss of consciousness, sudden incapacitation is a complete defense.[225]

For this affirmative defense, many courts require the defendant to show that they lost consciousness prior to the accident and that the loss of consciousness was not foreseeable.[226] The foreseeability aspect presents issues for Alzheimer's patients who might invoke this defense. If they were diagnosed prior to an accident, it is likely the accident would be deemed "foreseeable" by a court of law.[227] This becomes a difficult aspect that attorneys must face when defending cases on a theory of sudden incapacitation.[228] Testimony that a doctor discouraged a patient from driving prior to any incapacitation can be the turning point in this kind of case.[229] This kind of testimony, however, can be troublesome for Alzheimer's patients and their families to obtain. Many Alzheimer's/dementia patients are still physically capable of driving but should not because they get confused.[230] Therefore, although their doctor may recommend they stop driving at the request of their family, they often forget and still try to drive.[231] Sometimes they may even get angry and aggressive when they are told by family members and informal caregivers that they cannot and should not drive.[232]

Though sudden incapacitation seems like a potential response to tort liability, it does not cover the entire landscape of patients with dementia. Since sudden incapacitation is meant to apply to illness that comes on suddenly, it would not necessarily apply in every instance of dementia-related torts.[233] Though it is one option, it is not necessarily the best option.

224. *Id.*
225. *Id.* (discussing the defense of sudden incapacitation and summarizing the defense. The defense differs on state-by-state basis but is generally understood to be described as above).
226. *Id.*
227. *Id.*
228. *Id.*
229. *Id.*
230. *Driving Safety and Alzheimer's Disease*, NAT'L INST. ON AGING (last updated May 18, 2017), https://www.nia.nih.gov/health/driving-safety-and-alzheimers-disease.
231. *Id.*
232. ALZHEIMER'S SOC'Y, *supra* note 45.
233. Travers, *supra* note 216.

B. Creating a General Mental Impairment Affirmative Defense for Alzheimer's Patients

Another potential option is to institute a complete affirmative defense for dementia patients on the basis of mental impairment. This defense is most akin to the physical disability affirmative defense.[234] This opens the door to affirmative defenses for other types of mental incapacity. Tort law currently does not accept this theory of affirmative defense and this solution has not been proposed except in academic settings.[235] The concern is that it would become too wide-sweeping and allow anyone to avoid tort liability.[236]

This defense has not been used at all, likely because it is too difficult to make work. Furthermore, creating the defense would allow defenses for all types of mental impairment. This would potentially open the floodgates and make it difficult to ever recover in tort cases. Therefore, this option is probably the worst and least practical option for lessening dementia-related liability.

C. Instituting More Safeguards

Since car accidents are one large concern for dementia-related torts, state agencies and their departments of motor vehicles can create more institutional safeguards. Certain states already have some safeguards for elderly drivers since elderly drivers present more driving risk factors regardless of whether they suffer from dementia.[237]

In eighteen states, there are shorter renewal periods required for drivers older than a specified age.[238] Eighteen states also require more frequent vision screening/testing for older drivers.[239] In those states that

234. James, *supra* note 2, at 16.
235. *See, e.g.*, Ryan & Bonython, *supra* note 108; Chriscoe, *supra* note 109.
236. James, *supra* note 2, at 16.
237. *License Renewal Procedures*, *supra* note 217.
238. *Id.*
239. *Id.* (Several states have created further safeguards by requiring vision testing for the elderly population at every renewal, and these states include: Arizona, Arkansas, Colorado, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Kansas, Minnesota, Missouri, Montana, New Hampshire, New York, North Carolina, North Dakota, Ohio, Rhode Island, South Carolina, Washington, West Virginia, Wisconsin. Several others have requirements depending on age. Alaska requires proof of adequate vision every license renewal for drivers sixty-nine and older. California requires the same test for drivers seventy and older and Florida, eighty or older. While some states require it every ten years, Maryland by far provides the

allow drivers to renew their licenses by mail or online, sixteen states and the District of Columbia do not allow this option for older drivers.[240] Colorado limits drivers age sixty-six and older to renewing only by mail every other renewal cycle.[241] Drivers under age sixty-six, however, can renew by mail or online up to two consecutive renewals.[242] In addition, the District of Columbia requires a physician's approval for drivers seventy and older to renew their licenses.[243] Illinois requires applicants older than seventy-five to take a road test at every renewal.[244]

To prevent accidents related to dementia and the imposition of liability, states could increase the license renewal cycle requirements for elderly citizens.[245] By mandating elderly drivers to get testing regarding their decision-making ability more frequently, they can potentially prevent more Alzheimer's-related car accidents.[246] States could also impose more reporting requirements from doctors in terms of Alzheimer's and driving.[247] Though this would potentially infringe on doctor-patient privilege, having doctors report when a patient has Alzheimer's to the point at which they should no longer drive can help states coordinate taking away driver's licenses.[248] Since doctors cannot simply take away driver's licenses, and it is up to state agencies, having doctors report more often would prevent more accidents and convince Alzheimer's patients to give up their right to drive.[249]

D. Elderly Insurance Policies and Creating a "Dementia" Policy

Insurance is one option available to Alzheimer's/dementia patients as a means of protecting themselves from tort liability. Patients with Alzheimer's have several types of insurance available to them.[250]

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most protection in terms of preventing accidents with vision tests required for every renewal after age forty.)

240. *Id.*
241. *Id.*
242. *Id.*
243. *Id.*
244. *Id.*
245. *Id.*
246. *See id.*
247. *See id.*
248. *See id.*
249. *See id.*
250. *Insurance*, ALZHEIMER'S ASS'N, https://www.alz.org/help-support/caregiving/financial-legal-planning/insurance (last visited Oct. 28, 2019) (discussing several

Often, they utilize Medicaid or Medicare, long-term care insurance, and disability insurance.[251] Alzheimer's patients may also apply for COBRA insurance.[252] However, these insurance plans are mainly intended for medical or health-related costs and do not cover tort liability.[253] Long-term care insurance, in most instances, cannot be purchased by Alzheimer's patients once they have been diagnosed.[254]

Dementia patients could also use car insurance when they get into dementia-related accidents to protect themselves. When physical aggression by dementia patients occurs on family property, the family's homeowner's insurance should also protect against tort liability.[255]

However, there are still gaps in protection for dementia patients and their families. If they were sued because of an accident outside of their home, there is no protection available.[256] Families should be able to purchase a new kind of insurance somewhere between health insurance and homeowner's insurance. This specific insurance would protect against instances where dementia patients and their families are unprotected and susceptible to first- or third-person liability. This insurance would be most effective during the moderate stage of dementia. Since moderate dementia is the longest and most volatile stage of dementia,[257] it would give families peace of mind regarding any liability they could potentially face. It would also protect dementia patients

different times of insurance available to the elderly and Alzheimer's patients including: Medicare, Medicaid, Medigap, Social Security Disability Insurance, Supplemental Security Income, COBRA, disability insurance, life insurance, and long-term care insurance. Long-term care insurance is available for dementia sufferers and "[m]ost policies say they cover it" but it is not definitive. In terms of collecting, "Most policies require a defined level of physical or cognitive impairment." So even under long-term care insurance there are gaps depending on the level of impairment.).

251. *Id.*

252. *Id.* ("COBRA must be activated within sixty days of when the person with dementia receives written notice from his or her insurer that COBRA is an option. Some private health care plans will extend coverage under a disability extension of benefits. That is even though the medical plan may lapse, an insured's disability (in this case, Alzheimer's disease) remains covered.").

253. *See id.*

254. *Id.*

255. James, *supra* note 2, at 447 (discussing how homeowner's insurance policy would compensate any tort victims, and "[t]his would be a better result to having the caregiver endure tort liability for an act he or she did not commit.").

256. *Id.*

257. *See Stages of Alzheimer's*, ALZHEIMER'S ASS'N, https://www.alz.org/alzheimers-dementia/stages (last visited Oct. 28, 2019).

financially, because the insurance would pay out any sums necessary to make a plaintiff whole, and not force a dementia patient to dip into their own piggy bank.

There would need to be limits on how much one could recover from an Alzheimer's/dementia insurance policy. But that is best left to the insurance industry to calculate on a case-by-case basis taking into consideration the costs and harms associated with the tortious conduct.

E. Defenses for Family Members and Informal Caregivers

Since familial caregivers and informal caregivers take on a duty of care once they undertake to prevent harm by a dementia patient, preventing liability from falling on them becomes difficult.[258] The very purpose of a familial caregiver or informal caregiver is to care for the patient and prevent any harm that may come to them, whether physical or financial.[259]

Even if a caregiver took every precaution and acted perfectly, it is a difficult task to control an Alzheimer's/dementia patient without institutionalizing them.[260] The best method of preventing liability from falling on those caregivers who do adhere to a duty of care is by instituting more safeguards generally for Alzheimer's patients and via an Alzheimer's/dementia insurance policy.

Ultimately, anything that protects and prevents Alzheimer's/dementia patients from becoming liable or prevents them from shouldering the entire financial burden from their tortious conduct, will similarly shield family and caregivers.

F. What Is the Best Solution?

Ultimately, there is no one correct solution for every state or every case of dementia-related torts; some combination of the above is best to achieve these goals. Particularly, a combination of optional dementia-based insurance and the creation of more safeguards is the best solution.

Standing alone, a dementia insurance policy is the optimal solution because it provides the most protection without being financially

258. *See generally* Ryan & Bonython, *supra* note 108 (discussing personal and caregiver liability).

259. *Id.*

260. Ryan & Bonython, *supra* note 108, at 423–24; Redding, *supra* note 160.

cumbersome. It is also optional, so families can decide for themselves whether to take out the policy.

Combining more procedural safeguards with a dementia insurance policy would further prevent any tortious acts from occurring and lessen financial burden. In the event of a dementia-related tort, insurance would not necessarily cover all the financial bases and because of insurance ceilings. Procedural safeguards prevent accidents and torts, while insurance is the parachute for any liability that falls through the cracks. Instituting an optional insurance policy and more procedural safeguards would be the best solution to first- and third-person liability resulting from dementia related torts. This combination will prevent these instances from occurring but still allow compensation for victims if and when these torts occur.

V. Conclusion

Since dementia and Alzheimer's affect the elderly far more than the younger population, there is a significant risk of the elderly being bankrupted by tort liability. The elderly already encounter significant burdens in financially providing for their own care in retirement.[261] When they are diagnosed with dementia, there are even higher financial costs associated with dementia-related care.[262] Therefore, there is a need for a solution that will not burden dementia sufferers and make victims whole.

In addition, their families and informal caretakers face significant liability concerns.[263] Protecting informal caregivers from tort liability with an insurance policy would make caregiving easier; caring for dementia patients is a difficult and necessary task.

As time goes on, the number of dementia patients will only continue to rise, as will the costs of caring for those patients.[264] Jack ulti-

261. Sauer, *supra* note 72 ("Soaring prevalence, rising mortality rates and lack of an effective treatment all lead to enormous costs to society. Alzheimer's is a burden that's only going to get worse. We must continue to attack Alzheimer's through a multidimensional approach that advances research while also improving support for people with the disease and their caregivers.").

262. *See id.*

263. Richards, *supra* note 46, at 647–58 (discussing the duty of care required from caregivers).

264. *See* ALZHEIMER'S ASS'N, *supra* note 12.

mately passed away due to a dementia-related illness. Nonetheless, alleviating the burden of tort suits would protect people like Jack, his family, and the millions of Americans who suffer from Alzheimer's/dementia.