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ROUNDTABLE DISCUSSION ON GUARDIANSHIP

WORKSHOP

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

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WASHINGTON, DC

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GUARDIANSHIP ROUNDTABLE DISCUSSION

TUESDAY, JUNE 2, 1992,

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, in the Dirksen Office Building.

Staff present: Portia Porter Mittelman, staff director; Anna Kindermann, counsel; Kirkley Thomas, professional staff; and Tracy Gay, minority professional staff.

OPENING STATEMENT OF PORTIA PORTER MITTELMAN, STAFF DIRECTOR

Ms. MITTELMAN. Good morning, everyone. I think we can get started. I apologize for the late start. We were waiting just a few minutes to see if our boss, Senator Pryor, was going to make it, and it looks like he won't, so I'll apologize for his absence at the outset, and introduce myself. I'm Portia Mittelman, the staff director for the Committee, and we are truly delighted that all of you would come out and share with us this morning. To have all of these very distinguished legal minds in one room is very intimidating, but we do thank you for being here.

Before I turn it over to my colleague, Anna Kindermann, I'd like to acknowledge some of the other staff who are here. First of all, Tracy Gay, who is from Senator Cohen's staff. Senator Cohen is our ranking member. Also, Kirkley Thomas, who is our colleague on the majority staff. And also I would like to recognize Diane Lifsey, who is back in the corner. Diane is with Senator Glenn's office. Senator Glenn has led the charge on this issue of guardianship in the Senate, and so we wanted to make a special acknowledgement to all of his efforts.

And now I'd like to turn over this morning's proceedings to Anna Kindermann, who is counsel for our Committee.

ANNA KINDERMANN, COUNSEL FOR COMMITTEE

Ms. KINDERMANN. Good morning. Thank you. We really do appreciate all of you coming, especially those of you who had to travel some distance to get here on such short notice. To reiterate what Portia said, the purpose of today's forum is to educate the Committee about what role the Federal Government might play in guardianship law, an area that's been traditionally left to the States, and we look forward to hearing your comments.

Just a few housekeeping details before we start. For those of you who have already sent any kind of statement or presentation that you've given prior to today, we will insert that in the record. Also, the presenters' statements will be inserted in the record. For those of you who would like to submit further informational materials for the record, please feel free to do so. You can send it to my attention at the Committee by the end of June.

Before we get started, I'd like to run around the table and have everybody introduce themselves. Then we'll turn to our presenters.

You know I'm Anna Kindermann, counsel for the Senate Special Committee on Aging.

Mr. THOMAS. Good morning. I'm Kirkley Thomas. I'm also with the majority staff of the Aging Committee.

Mr. PICKERING. I'm John Pickering. I chair the ABA Commission on Legal Problems of the Elderly.

Ms. STIEGEL. I'm Lori Stiegel on the staff of the ABA Commission on Legal Problems of the Elderly.

Ms. PLAINE. Lloyd Leva Plaine. I'm secretary of the real property probate and trust law section of the American Bar Association.

Judge BENTON. I'm Field Benton. I'm a judge from Denver, Colorado, and I'm President of the National College of Probate Judges.

Mr. FROLIK. I'm Larry Frolik. I am a professor of law at the University of Pittsburgh School of Law, and I'm the Committee Chairman for the ABA Committee on Special Problems of Guardians and Conservators.

Judge GRANT. I'm Isabella Grant. I'm a Superior Court judge in San Francisco, and I'm presently presiding over the Probate Department.

Ms. O'SULLIVAN. I'm Joan O'Sullivan. I'm managing attorney of the Senior Citizens Law Project in Annapolis, Maryland.

Ms. MILER. I'm Susan Miler. I work at AARP's Legal Counsel for the Elderly, and I developed the Guardian Monitoring Project there.

Mr. MASON. DaCosta Mason. I'm with the American Association of Retired Persons Legal Counsel for the Elderly Department and also on the steering committee of the estates, trust, and probate section of the D.C. Bar.

Mr. LOMBARD. Jack Lombard. I'm the immediate past-chair of the American Bar Association's real property probate and trust law section.

Mr. KAPP. Marshall Kapp. I teach at Wright State University in Dayton, Ohio.

Ms. HOMMEL. Penny Hommel. I'm the director of the Center for Social Gerontology in Ann Arbor, Michigan.

Mr. JOHNS. Frank Johns, a practicing attorney in Greensboro, North Carolina.

Mr. REGAN. John Regan. I teach law at Hofstra Law School in New York.

Mr. KEILITZ. I'm Ingo Keilitz, and I'm with the National Center for State Courts.

Ms. MILLER. I'm Martha Miller, and I'm a practicing attorney in Little Rock, Arkansas.

Ms. LYNN. I'm Joanne Lynn. I'm a physician who takes care of disabled and dying elderly and have worked some in ethics.

Ms. McCue. Judy McCue. I'm chair of the Elder Law, Guardianship, and Health Law Committee of the American College of Trust and Estate Counsel.

Ms. Hurme. I'm Sally Hurme with the Legal Counsel for the Elderly at the American Association of Retired Persons.

Mr. Hall. I'm John Hall. I'm with the Senior Citizens Law Project in Vermont.

Ms. Gottlich. Vicki Gottlich, National Senior Citizens Law Center.

Mr. Chiplin. I'm Alfred Chiplin with the National Senior Citizens Law Center.

Ms. McMahon. I'm Susan McMahon with the Ray Graham Association for Persons With Disabilities. I'm also a member of the National Guardianship Association Board of Directors and past president of that board.

Mr. Lukens. I'm Ralph Lukens. I'm the Probate Court Administrator for the State of Connecticut.

Ms. Gay. Tracy Gay with the minority staff of the Senate Special Committee on Aging.

Ms. Kindermann. Also, for those staff who are present, if you could run down what office you're from.

Two other things just before we start. Inadvertently, it says that Mr. Johns' statement is not in your package of materials. It is in your package of materials. Mr. Regan's is not in your package of materials but will be available for the Committee record. Also, Ms. Miller's will not be available until the Committee record is printed.

Why don't we go ahead and get started. Mr. Johns is a partner with the North Carolina firm of Booth, Harrington, Johns & Campbell. He's a recipient of the Paul Lichterman Award recognizing his significant contributions to the advancement of law and aging, at the 1991 Joint Law and Aging Conference. He has worked most extensively in the area of improving guardianship and alternative systems, and he will discuss the need for data, the need for Federal intervention in the guardianship arena, and a possible hook for Federal legislation.

Mr. Johns.

A. FRANK JOHNS, ATTORNEY, GREENSBORO, NC

Mr. Johns. Thank you, Anna. I appreciate the invitation from Senator Pryor, and I do appreciate the way in which the committee is attempting to address what is currently developing both within the States and, from organizational perspectives, data, and statutory changes that occur that involve guardianship.

Senator Pryor, in his letter to me, asked that I address the first three of the issues that were written out for consideration of this roundtable, and as I was preparing for it, first of all, I didn't realize how short the time was to get ready, and I must footnote the fact that even though my statement may be there, I want the opportunity to work on it some more before it's published, of course.

I was sitting in my office looking at all the different texts that I have that address capacity and guardianship, and I picked up one book. Some of you are familiar with this book, however, I had not looked at it lately: "Mental Impairment and Legal Incompetency," by Allen, Ferster & Weihofen (if that's the correct pronunciation of that distinguished professor's name from George Washington University). And I started thumbing through the preface of the text, which is a statement of the empirical research that was done by these very competent and visionary people in the middle 1960's. The introduction addresses eight specific categories that concerned the researchers.

If I did not tell you that this was from 26 years ago, you would think I was talking about what we are dealing with today at this roundtable. Those eight categories include population growth; the aging population growth; conservatorship growth; the concept that mental weakness is something less than that of an unsound mind as a threshold for incapacity; the increase in wards and the decrease in conservators; mobility of the world of elder citizens (this is a topic that I'm currently working on that I thought was frontier-oriented stuff, and 26 or 27 years ago it was being addressed by these distinguished researchers); middle-class growth; population shifts; the impersonalization of life; and two footnotes addressing the impact of the Social Security and Veterans Administration on representative payees and other areas of administration, citing the Lieman & Mathiason text that was published in 1963.

And then I was just thumbing through the text, and I looked at the bibliography, and I noted, as I say in my statement, that there were 15 direct citations to work done about capacity or guardianship.

On another table was another text I hadn't looked at in the last year or so. This text was "Guardianship and Alternative Interventions: A Compendium for Training and Practice," done by the Center for Social Gerontology, directed by none other than Penny Hommel. Penny's annotated and extensive bibliography addressed over 100 authors and titles regarding capacity and guardianship, and it was published in 1986.

Closer to me on my desk were the text that Sally Hurme did that's an excellent piece of work, "Steps to Enhance Guardianship," and the text "Court-Related Needs of the Elderly and Persons with Disability."

In addressing the first issue, then, I wondered whether or not there's enough data. The answer to the question of whether or not there's enough data—and the issue, if you'll recall, is broken out into two areas: one, sufficient documentation of the abuses within the system, and then data to make informed policy decisions about the manner in which guardians should be appointed and monitored. The answer to the issue of whether or not there's enough data—my answer is I agree there's not enough data. But my answer may be structured a little bit differently in terms of the data that's being gathered.

I think there is plenty of information available, but I'm not sure that the Congress or those who are gathering the data are spending enough time assessing how it has been gathered, what it's actually saying, what in fact it means, what it tends to show. In "Steps to Enhance Guardianship," there is a tremendous piece of work in the back, which is a set of tables that shows how all 50 States address guardianship as a process, from beginning in terms of procedural safeguards and notice to the end, addressing monitoring and standards and application.

As I was looking at that, what I was thinking about was, well, for all of the work that's done and for sort of the threat that's been made by some of the legislation that's been written in this Congress that couches the title as a matter of intervention—you know, we're going to come in and intervene because there's something wrong—how much has changed in just the last few years even since the AP report? And in my assessment as to the first issue, I believe that we need to look at what's been done now.

That brings me to the second issue. The second issues reads, "Assuming we can document the problems, the advisability and feasibility of Federal intervention," and I think the last word just tends to set such a negative tone for those in the States receiving a mandate, if you will, that "intervention" I think is too strong. I think the Federal Government and this Congress has a tremendous part to play, but if it's a global mandate of legislation that covers all of the waterfront, then I would assert it may not be productive.

My assertion in terms of why it would not be productive is historical over the last decade. I litigate rights of developmentally disabled people in a lot of situations. I can remember couching a class action lawsuit based on the Developmental Disabilities Act, and then the *Pennhurst* decision came down. I can remember putting as a part of my cause of action in litigation of the educational rights of handicapped children a cause of action asserting a claim under section 504 of the Rehabilitation Act, and then *Atascadero* came down. I can remember arguing against the State of North Carolina in the 4th Circuit Court of Appeals that they waived sovereign immunity as a matter of receiving Federal funds for exceptional education services, and then the *Dellmuth* v. *Muth* decision came down.

All three cases clearly show what the Rehnquist court will demand of the writing if in fact Congress attempts intervention through a Federal mandate to the States, that the declaration of the waiver of sovereign immunity under the 11th Amendment must be very clear and explicit, and in none of the legislation that I've been reading is there any hallmark that says, "The way we're going to get to you, States, is to make it very clear that whatever source you're using, whatever funding is there or whatever right may be declared, you are waiving your right to sovereign immunity if you participate in this particular process."

And so it gets to the third issue, and that is what hook may be used. My suggestion for discussion purposes is that you try not to create a global or a completely modeled text that would declare safeguards and then attempt to declare some concept of enforcement within the States on what is clearly a States rights law over which States have for so many years had exclusive control. Instead, I think that there is a cooperative relationship here that could be honed where specific pieces of law that can help States might be written and then use those laws as models by which the Congress could be a source of both funding and of focusing with the States on how to make their laws more effective. Because I think there are a lot of laws that have changed that tend to reflect what we think is correct in terms of guardianship process, but the application and the implementation of these laws may not be found in the States where the law has been changed.

My last point I care to make—and I hope my time has been judicious. I understand the limitations. The last point I care to make is that so much of what seems to be going on here is from above, and I would offer that consideration be given to a more sophisticated process on a grassroots level, that the organizations represented here could come together and rather than splinter yourselves off into research projects and grant applications and trying to go in and look at the States, you organize a coalition that goes out and invites the States and those who work in guardianship in each State to be partners with the local task force designing political routes to success that would not only change the writing of the law in each State, but would actually get you to implementation.

Thank you.

[The prepared statement of Mr. Johns follows:]

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THE UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING
GUARDIANSHIP ROUNDTABLE DISCUSSION
WASHINGTON, DC
JUNE 2, 1992

WRITTEN STATEMENT
BY
A. FRANK JOHNS[1]

The issues addressed in this written statement are the following:

I. <u>The need for data</u>: Currently Congress lacks data sufficient to document the extent of abuses within state guardianship systems and to make informed policy decisions regarding the manner in which guardians should be appointed and monitored.

II. <u>The need for federal legislation</u>: Assuming we can document the problems, the advisability and feasibility of federal intervention.

III. <u>"Hook" for federal regulation</u>: Since few federal funds flow directly to the state courts which administer guardianships, there is no obvious federal financial compliance incentive -- as there are in Federal health care (Medicare/Medicaid) statutory reforms.

I. <u>The need for data</u>: This first issue asserts that Congress lacks data in two areas of the guardianship process: (1) data sufficient to document the extent of abuses within state guardianship systems; and (2) data to make informed policy decisions regarding the manner in which guardians should be appointed and monitored. I agree.

There has been much written about guardianship over the last thirty years, most of it in the last ten. In 1968, the bibliography of the seminal book, <u>Mental Impairment and Legal Incompetency</u>[2], listed fifteen writings, dating from 1897 to 1966, that specifically addressed guardianship or incompetency. By 1986, The Center for Social Gerontology published an annotated bibliography of writings concerning guardianship that numbered in excess of one hundred.[3]

The writings herald milestones in guardianship work: The drafting of the Uniform Probate Code[4], The Mental Competency Study[5], The ABA Comm'n. on Mental Disability's Model Guardianship and Conservatorship Act[6], The Uniform Guardianship and Protective Procedures Act ("UGPPA")[7], Adopted Statement of Recommended Judicial Practices of the National Conference of the Judiciary on Guardianship Proceedings for the Elderly[8], Wingspread - a National Guardianship Symposium[9], and The National Conference on the Law-Related Needs of the Elderly and Persons with Disabilities[10].

Writings multiplied after the Associated Press special report in 1987. As did studies, research and congressional legislation. The ABA Commissions on Mentally Disabled and Legal Problems of the Elderly have been responsible for a lot of the work.[11] However, there is neither comprehensive statutory analysis of how the 50 states and the District of Columbia are addressing the need for restructure of guardianship systems, nor is there current data and comprehensive surveys of all 50 states and the District of Columbia.

There are many recent charts and exhibits of the 50 states' and the District's guardianship statutes. Cursory inspection reflects that over the last several years there has been positive movement by most of the states to address the guardianship system abuses that have been identified. It is not clear to this writer that the advances made within each of the states over the last several years are known to Congress, and have been given adequate consideration. The state statutory data that has been gathered needs to be thoroughly analyzed. The analysis needs to focus on assessment of voluntary state initiatives to overcome system abuses in the guardianship laws, and determine whether or not the direction in which the states are headed on their own is sufficient. Most state legislative changes are attempting to confront abuses and to implement safeguards that are consistent with what Congress hopes to accomplish by the passage of federal legislation. Many of the surveys have been initiated by the states themselves.

In order for Congress to make informed policy decisions regarding the manner in which guardians should be appointed and monitored, it needs to expand the kind of work done by Hurme, and attempt to examine more comprehensively all of the states' guardianship laws, with careful analysis of the data received. Professors Allen, Ferster and Weihofen noted long ago that "... sufficient funds ...and personnel can[not] be obtained to conduct empirical legal research in all 50 states [and the District]." Even then, their study of ten states took three years and cost $291,000.[12]

In addressing the need for data, Congress should gather its information from the states themselves. Many states have legislative task forces studying guardianship, and others would organize them if invited to participate in the process. The states would more readily accept the results if their own citizens were responsible for gathering the data and assisting in the analysis. If states are reluctant to implement policy decisions that address guardianship appointment, and the subsequent monitoring of the guardians, then that reluctance will surely become a "states rights" oriented, defensive position from which the states would resist congressional statutory declarations that would be mandated through some enforcement mechanism.

II. The need for federal legislation: The issue assumes that documentation of the problems may be accomplished, and the question then arises whether it is advisable and feasible for federal intervention. Federal intervention may be offered in an inobtrusive and productive way. The intervention may be better received through the planned initiative of commissions and national organizations who, under Congress's direction, could organize a coalition that would work with each state in assisting advocates, local organizations and legislative organizations of the states to gather and analyze the data, and then implement strategies of reform from the ground up within each state. The Congress should be a facilitator, and a resource to the states in addressing legislative change internally. That is a practical consideration. There is a need for federal involvement, rather than intervention. Federal legislation may be needed for specific (but not all) areas of guardianship.

III. "Hook" for federal regulation. One example of a "Hook" available to Congress would be one which asserts the need for uniformity of jurisdictional laws, addressing interstate transfers of vulnerable and incompetent adults.

For example, this writer has been working with Vicki Gottlich of the National Senior Citizens Law Center in researching and writing about the potential for a federal law that would address the uniformity of jurisdiction and custody as it relates to the interstate transfer of vulnerable and incompetent adults. Attachment I is this writer's most recent written presentation on interstate transfers.[13] Additionally, the most recent issue of Elder Law Report has an article written by a Kentucky attorney about guardianship across state lines.[14] These articles identify cases that may be the tip of the iceberg when the difficulties of interstate transfer of guardianship is involved. Many of us were made aware of the case of "elder dumping" at a race track in Idaho. The incompetent elder was taken from one state to another. He was then escorted to a race track and left, abandoned.

Two case studies, one in which this writer was involved, highlight the problem and are appended to this statement. See Attachment II.

If Congress is going to intervene in what has always been a state function, then first intervene with specific federal law that assists the states in dealing with situations that are not intrastate oriented.

Otherwise, legislation such as H.R. 800 must either be amended to explicitly declare the states' waiver of sovereign immunity, or be doomed in light of cases such as *Pennhurst State School & Hospital v. Halderman (Pennhurst II)*, 104 S. Ct. 900 (1984); *Atascadero State Hospital v. Scanlon*, 105 S. Ct. 3142 (1985); and *Dellmuth v. Muth*, 109 S. Ct. 2397 (1989).

Respectfully submitted,

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ATTACHMENT II
CASE STUDIES

CASE STUDY - SEIZE DADDY AND RUN

John Johnson is a 74 year old citizen of the state of Virginia. He lived with his wife Sarah in Virginia for over 35 years. They raised their children in the same house in Virginia, and all of their assets, liquid and nonliquid are in the state of Virginia. John has severe mental deficiency due to Alzheimer's disease, and Sarah his wife had a bout with cancer and lost. During Sarah's last illness, her daughter Anne could not take care of both of them. Anne sent John down to be with her brother Tom on a temporary basis while she tended to her mother.

Brother Tom, the black sheep, had not had much contact with his parents, and was not mentioned in their wills. While John was with Tom in North Carolina, Tom found out that he had been disinherited. For no reason but vindictive resentment, he filed a petition for a hearing to determine capacity, and for guardianship of his father, and he placed him in a skilled nursing facility in North Carolina. When Anne found out about Tom's attempt to gain legal control over their father, she removed her father from North Carolina before the hearings were conducted. But he had been served with notice of the hearing and summons.

At the incompetency hearing, Anne appeared and argued that the state of North Carolina lacked subject matter jurisdiction over her father to conduct an incompetency hearing and appoint a guardian because John was not domiciled in the state of North Carolina, and he did not have the requisite mental capacity to declare a change of his domicile during his temporary stay in North Carolina. An order was entered anyway, declaring John incompetent and appointing Tom guardian. However, John remained in Virginia with his daughter Anne.

During one of the freezing cold days of the following winter, Tom surreptitiously removed his father from Virginia and took him back to North Carolina where he acquired a court order enjoining Anne from removing John Johnson from the state of North Carolina.

Anne subsequently filed appeal. The North Carolina Superior Court declared that there was a lack of subject matter jurisdiction because John Johnson was not a domiciliary of the state of North Carolina. However, on rehearing below another order was entered for guardianship of John Johnson in North Carolina. Anne has subsequently filed a state Writ of Habeas Corpus, attempting to gain control of her father. She contended her father would best be served in his home in Virginia.

It seems that in the above case study, there was some "home cooking". The local petitioner (the brother) was going to prevail over the out-of-staters no matter what (especially since the lower court decision maker was sitting as judge with some degree of prejudice for the locals).

CASE STUDY - THE PSYCHOTIC TRANSIENT

Cossie Matthews married Mattie in 1924. They lived in Virginia. Mattie drove Cossie crazy. Their marriage was a war, and after many confrontations, a final battle occurred in June of 1953, when Mattie declared, "I told him if he didn't like the way we was (sic) living he might as well get his things and move, so when I came [home] that afternoon he had moved." Cossie moved into the garage and lived there for over two years before he was adjudicated incompetent and mentally ill and committed to the Eastern State Hospital at Williamsburg, Virginia. On the same date that Cossie was declared psychotic, his wife attacked him with threats and fraud to force him to convey his interest in their joint property, which he did. To make matters worse, Mattie was appointed Cossie's guardian. In January of 1956, Cossie just "walked out" of the state hospital and ended up in Florida where he resided for over five years before he filed for a decree of final divorce in the state of Florida. Mattie contested the jurisdiction of the state of Florida to enter the divorce decree because she contended Cossie was incompetent, and mentally incapable of changing his domicile; and, therefore, he was not a bona fide resident of the state of Florida as required by law.

The Florida Supreme Court relying on the general rule as to incompetence of insane persons in the state of Florida, found that Cossie was not of such degree of lunacy that he did not have the presence of such mental faculty as would allow him to change domicile. The Florida Supreme Court concluded that the mere fact that a person is of unsound mind does not necessarily preclude him from changing his state domicile, if he still has lucid intervals, or sufficient mental capacity to elect a new domicile.

END NOTES

1 © Copyright by A. Frank Johns, All Rights Reserved.

2 R. Allen, E. Ferster and H. Weihofen, Mental Impairment and Legal Incompetency, (Prentice-Hall, Inc., 1968).

3 P.A. Hommel, Project Director, Guardianship and Alternative Legal Interventions - A Compendium for Training and Practice (The Center for Social Gerontology, Inc., 1986).

4 W. F. Fratcher, Toward Uniform Guardianship Legislation, 64 Mich. L. Rev. 983 (1966).

5 Allen, Ferster, and Weihofen, Ibid, at xiii. The Mental Competency Study was a three-year empirical research project conducted by The George Washington University Institute of Law, Psychiatry and Criminology, under a grant from the National Institute of Mental Health. Professor Weihofen's idea for the study has been replicated several times, the most recent in 1991. (Although none of the studies actually address the same state guardianship systems.)

6 ABA Model Guardianship and Conversatorship Act, 2 MDLR 441 (1978); 3 MDLR 264 (1979).

7 The National Conference of Commissioners on Uniform State Laws adopted the UGPPA in 1982 as either a separate statute, or integrated in a statute adopting the Uniform Probate Code.

8 E. Wood, editor, Statement of Recommended Judicial Practices, (ABA Commission on Legal Problems of the Elderly and National Judicial College, 1986).

9 ABA Commission on the Mentally Disabled and the Commission on Legal Problems of the Elderly, Guardianship: An Agenda for Reform (1989).

10 National Judicial College and ABA Commissions on Legal Problems of the Elderly and Mental Disability, Court-Related Needs of the Elderly and Persons with Disabilities (1991).

11 For example, in the excellent work of Sally Hurme, a series of six statutory charts track how each state defines capacity, initiates guardianship, conducts proceedings, monitors guardians, implements temporary, emergency procedures and provides for independent restoration procedures. S.B. Hurme, Steps to Enhance Guardianship Monitoring, a publication made possible by a grant from the State Justice Institute through the American Bar Association's Fund for Justice and Education (American Bar Association, 1991).

12 Allen, Ferster, and Weihofen, Ibid, at 16.

13 A. Johns and S. Perlis, Guardianship--Advanced Issues--Interstate Transfer of Incompetent Adults, 4th Annual Symposium, National Academy of ElderLaw Attorneys, Section 23 (1992).

14 M. Ceridan, Guardianship Across State Lines, 3 ElderLaw Report 1 (May 1992).

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INTERSTATE TRANSFER OF INCOMPETENT ADULTS[1]

Over the last several years published articles[2] and cases from all over the country have reported an increase in, and addressed the problem of the movement of incompetent adults from state to state.

A. The Increase. The increase of interstate transfers of incompetent adults is attributed to many causes: (1) One cause for the increase is the need to relocate the incompetent adult to the community of the family member who will provide care; (2) A second cause for the increase is medicaid shopping. Many states have declared more stringent eligibility requirements,[3] including placing a cap on income;[4] (3) A third cause for the increase is interfamily conflict. One child attempting to gain access and control over a parent (and his or her estate) may move the parent out-of-state. Once in another state, the child initiates legal process for the adjudication of incompetency of the parent, which usually results in guardianship appointment of the child; and, (4) A fourth cause for the increase is forum shopping those issues that address death with dignity, right to die, or suicide . In this time of self-determination, many people are comparing the laws of the various states to determine which ones have state constitutional mandates of "pro-life" that dilute, or severly restrict the right of privacy, placing priority on the continuation of life no matter how artificial or spiritless.[5]

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[1] © Copyright 1992 by A. Frank Johns. All Rights Reserved. The able assistance of Martha Chasten is acknowledged.

[2] See, V. Gottlich, Finders, Keepers, Losers Weepers: Conflict of Laws in Adult Guardianship Cases, 23 Clearinghouse Rev. 1415 (Mar. 1990); A. F. Johns, Subject-Matter Jurisdiction, Domicil(e) and the Jet-Age Independance of Vulnerable Adults, 1 National Guardianship Journal 291 (Fall 1990); C. Barrett, Taking the Elderly from the Home State and Preventing the Elderly from Moving, 3 NAELA Quarterly 3 (Winter 1991).

[3] "209(b)" states: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Mississippi, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, and Virginia. See, S. G. Haines and J. T. Combs, Income Caps In Medicaid Eligibility, Vol. III, No. 5, The ElderLaw Report 1 (Dec. 1991).

[4] "Income Cap" states: Alabama, Alaska, Arizona, Colorado, Delaware, Idaho, Mississippi, Nevada, New Mexico, Ohio, South Dakota and Wyoming. Id.

[5] Take for example Nancy Cruzan. State of Missouri v. Cruzan, 110 S. Ct. 2841 (1990). Once Nancy's family member had guardianship, and the family subsequently determined that her spirit and soul had long since passed, the Missouri officials of the state hospital were asked to withdraw life sustaining support. It was a logical request. Since the State had sought the family's consent to attach Nancy's body to life support, it was logical that the State would honor the family's request to withdraw the life support. As is well documented, Missouri is a pro-life state and declined the family's request. The Cruzan family then contemplated a move to Kansas where instead of a constitutional pro-life impediment, there was a constitutional right to privacy. However, because of a possible jurisdictional problem, and the probable conclusion that the guardian did not have the power to unilaterally change domicile of the ward to another state, the Cruzan family was appropriately advised by counsel to seek an alternative legal remedy.

B. **The Problem.** In many causes above (especially the first one) movement of the incompetent adult will already have occurred before legal counsel is sought. The attorney must then assess whether or not the move itself is based on legal authourity, or based on the informed consent of the incompetent adult. The components of that assessment should be a mix of fact and law, including but not limited to the laws of the state from where an interstate transfer begins, the laws of the state where the interstate transfer ends, and the facts surrounding the incompetent adult and his or her family. Attorneys must first use in the assessment a component that first determines if the state in which the incompetent adult is located will exercise jurisdictional control. This requires an understanding of the Conflict of Laws Doctrine.

C. General Considerations of the Conflict of Laws Doctrine. Generally, there are two ways by which state courts gain control over people: (1) the exercise of principles established under English Common law, and guided by precedent cases considered the law of the land (the doctrine of *stare decisis*); and (2) state statutory law legislating a pre-emption of common law and *stare decisis*.

The control that a state court may take over a person becomes more complex when the legal exercise involves a foreign element; i.e. other states. The Conflict of Laws Doctrine is that part of the law dealing with the extent to which the law of a state operates and determines whether the [laws] of one or another state should govern a legal situation.[6] And when the causes for the increase in interstate transfers addressed above are coupled with the jet age, rapid transit and mass mobility of people heading into the second millennium, there will be new pressures on the various states when considering the delivery of legal or human services to transient, incompetent adults.[7]

D. Subject Matter Jurisdiction. Most legislatures and state courts have the unique freedom to chart their own Conflict of Laws destinies when dealing with the practical aspects of applying subject matter jurisdiction to transient residents, incapacity and guardianship. However, States have exercised quite sparingly the power to enact Conflict of Laws statutes that statutorily apply subject matter jurisdiction. The result has been the production of several variations of law and policy by which states address subject matter jurisdiction in this same area of law.[8] States have exercised quite sparingly the power to enact Conflict of Laws statutes.

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[6] 15A C.J.S., *Conflict of Laws - General Considerations*, Sec. 1(1); see also *Lamar v. Micou*, 112 U.S. 458, 5 S. Ct. 221, 28 L. Ed. 751, *reh. den.* 114 U.S. 218, 5 S. Ct. 857, 29 L. Ed. 94 (1884).

> ...But it is very doubtful, to say the least, whether even a guardian appointed in the state of the domicile of the ward (not being the natural guardian or a testamentary guardian) can remove the ward's domicile beyond the limits of the state in which the guardian is appointed, and to which his legal authority is confined...as the law of the domicile of the ward has no extraterritorial effect, except by the comity of the state where the property is situated, or where the guardian is appointed, it cannot, of course, prevail against a statute of the state in which the question is presented for adjudication, expressly applicable to the [person or] estate of a ward domiciled elsewhere. *Id.*

[7] S. Wurfel, *Choice of Law Rules in North Carolina*, 48 N.C.L. Rev. 243, 246 (1970).

> Peripatetic persons who traverse the earth or outerspace at supersonic speeds, who divide their time between Bar Harbor, Palm Springs and Miami, live in house trailers or boats and keep on the move, or regularly commute by air between London and Paris have inevitably proliferated in the jet age, seemingly to the point of rendering obsolete the ancient Roman legal concept of domicile. *Id.*

[8] *Id.*

The variations include three model statutes and the common law Rule of Domicile providing courts subject matter jurisdiction power to adjudicate capacity and to appoint guardians. Where two models give the power to exercise jurisdiction when the incompetent adult is "present"[9], the third model empowers courts to exercise jurisdiction with no reference to any required factual nexus between the incompetent resident (or transient) and the state:

> . . . Some of the legislatures in these states may have addressed themselves to the conflict-of-laws problem and have meant explicitly to decide that this exercise of power ought to be used only in cases of resident persons. But most statutes really seem to be solving a venue problem, i.e., deciding the question of which local court should exercise whatever power the court system may have been given rather than determining the limits of power in a case having important out-of-state facts. . .[10]

And then there is a group of states whose incompetency and guardianship statutes make no reference to the territorial scope of the law's application, and therefore must be construed to operate only within the ambit of the state's power. This group relies on the common law Rule of domicile.[11]

1. Uniform Guardianship and Protective Procedures Act ("UGPPA"). The UGPPA has been the most widely accepted model statute, adopted (substantially, if not totally) by fourteen states, and the District of Columbia.[12]

The National Conference of Commissioners on Uniform State Laws adopted the UGPPA in 1982 as either a separate statute, or integrated in a statute adopting the Uniform Probate Code. The UGPPA is found to be as expansive as the Restatement (Second) when dealing with guardianship of the person. The UGPPA applies to "(1) Affairs and estates of disappeared persons, and persons to be protected, domiciled in this state; (2) Property located in the state of non-domiciliaries who are disappeared persons or persons to be protected, or property coming into the control of a guardian or conservator who is subject to the laws of this state; and (3) Incapacitated persons and minors in this state." (Emphasis added)[13]

As you have read above, the UGPPA applies the Rule of Domicile only to property and estates of incompetent persons. One writer notes that the drafters of the uniform law presumed that the guardianship provisions would be used less frequently than the conservatorship provisions.[14]

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[9] See Uniform Guardianship and Protective Procedures Act ("UGPPA") Sec. 1-301, and Restatement (Second) Conflict of Laws, Sec. 79.

[10] M.G. Paulsen and J. Best, Appointment of a Guardian in the Conflict of Laws, 45 Iowa L. Rev. 212, 213-214 (1960).

[11] S. Wurfel, Choice of Law Rules in North Carolina, 48 N.C.L. Rev. 243, 246 (1970).

[12] See Exhibit "A", showing the states that have adopted the Act.

[13] UGPPA Sec. 1-301.

[14] V. Gottlich, Ibid, at 1416.

2. The Restatement (Second) of Conflict of Laws Sec. 79 (1971). Adopted by at least one state, the Restatement (Second) addresses custody of persons jurisdictionally with the same rationale. "A state has power to exercise judicial jurisdiction to determine the custody, or to appoint a guardian, of the person or of a child or adult (a) who is domiciled in the state, or (b) who is present in the state, or (c) who is neither domiciled nor present in the state, if the controversy is between two or more persons who are personally subject to the jurisdiction of the state."[15]

Although not law, except to the extent cited by judicial approval, the principles expounded in another section of the Restatement (Second) (Secs. 11 - 23) directly pertain to any domicile problem routed in complex, factual situations involving multi-state consideration. The drafters should have left well enough alone, and applied these sections on domicile to Section 79.

The Paulsen and Best law review article, and the cases cited, written prior to Restatement (Second) support a flexibility rule regarding domicile, underscoring the point that because judges speak in terms of "power to act" they do not address themselves to the wisdom of placement.[16]

The comment to the Restatement (Second) of Conflict of Laws, Sec. 79, states that the subject of jurisdiction over custody and guardianship is made complex by the different interests involved, and by the number of states which may be concerned.

The comment addresses three bases of jurisdiction under the Restatement (Second). The first proceeds on the basis that incompetency is a question of status, and hence subject to the control of the state where the child [incompetent] is domiciled. The second basis is the presence of the child [incompetent] in the state. The third basis is the state's power to determine guardianship as between persons competing for it and over whom the state has personal jurisdiction. This third jurisdictional basis places emphasis on the interests of those who are seeking control, without losing sight of the person's welfare.[17]

> When all three bases of jurisdiction are found in a single state, that state may exercise jurisdiction to determine the [incompetent's] custody. So a state may determine . . . custody if the state has personal jurisdiction over the contending parties and the [incompetent] is both domiciled

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[15] Kansas incorporated Restatement Second's recommendations into its guardianship statute, specifically separating jurisdiction and venue, thereby providing its Supreme Court with the statutory power to declare that, even though the state of Nebraska had an active guardian in place for many years, the state of Kansas had authority under its statute to appoint a guardian in Kansas because the ward had been physically present there in excess of 16 years, although incompetent upon arrival and throughout his stay in Kansas.

> K.S.A. 59-3009 gives specific authority to any person to file in the district court of the county where the proposed ward resides or is present a petition for appointment of a guardian. It appears that the intent of the legislature in 59-3009 was to expand the court's jurisdictional bases to conform to the recommendation ultimately adopted in Restatement (Second) of Conflict of Laws Sec. 79 (1971).[37]

Matter of Miller, 620 P. 2d 800, 803 (1980).

[16] The Restatement (Second) of Conflict of Laws, Sec. 79, addresses the concept of custody and status only as to children. It seems that as an afterthought the reporters for the Restatement (Second) added adult incompetents to the section. The comment only discusses children, but it is clear, and it should be noted that throughout this manuscript incompetents and children are viewed as similar under the Rule.

In Paulsen and Best, Ibid, n. 10, it is further asserted that the converse is also true, citing In re Plucar's Guardianship, 247 Iowa 394, 72 N.W. 2d 455 (1955), as an example of the rigid application of jurisdiction based on where the person is "found", and that this may not be in the best interests of the person. Yet, in many states that is how the statute is applied. The authors contend such a narrow position deprives the court of information from witnesses and social investigative reports to determine what constructive action may need, or ought to, be taken under the concept of parens patriae. (Emphasis on the child, but applicable to incompetent adults).

[17] Restatement (Second), Ibid, Sec. 79, at 237.

and physically present within its territory. Complexities arise, however, when these bases are divided. Statements are often to be found in the opinions that one or another of these bases must be regarded as exclusive and that no other one will do.[18]

3. ABA Model Guardianship Act. The ABA's Model Guardianship Act asserts the same principle as the UGPPA and the Restatement (Second). It declares a broad power to appoint guardians based on the physical presense of the person and the descretion of the judge. It has yet to be accepted in any state. Although the graph in Exhibit "A" shows many states with similar statutes.

4. Common Law Rule of Domicile. For many states, subject matter jurisdiction is determined by domicile in the forum state.[19] Under the general rule that the law of domicile governs as to the status of a person and the disposition and management of his movable property, the domicile of the...incompetent is regarded as the fittest place for the appointment of a guardian of his person and estate...[20]

In a general way, domicile means dwelling house or home - a place where one lives. 25 Am. Jur. 2d, Domicil, Sec. 1, at 5. It has also been described as the pre-eminent headquarters, Williamson v. Osenton, 232 U.S. 619, 625, 34 S. Ct. 442, 443, 58 L. Ed. 758 (1914), which is the essence of technical domicile. Texas v. Florida, 306 U.S. 398, 427, 59 S. Ct. 563, 577, 83 L. Ed. 817 (1939). Domicile implies a nexus between person and place of such permanence as to control the creation of legal relations and responsibilities of the utmost significance. 25 Am. Jur. 2d, supra, at 5, n.5, citing Williams v. North Carolina, (citations omitted); 39 Proof of Facts, Person's Domicil, Sec. 2 at 595.

Many federal and state courts have long declared that the term domicile rests on residence, and the intention to make it a home - the fact and the intent. Horne V. Horne, 31 N.C. 79, 85, 86, 11 Irdell 99 (1848). The North Carolina Supreme Court in Horne relied in part on Justice Joseph Story's

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[18] Id. at 238.

[19] See Exhibit "A" identifying those states whose statutes either specifically declare "domicile" as the rule, or declare nothing. See generally, 4 Proof of Facts 2d, Nonestablishment of Domicil in Foreign Jurisdiction 595; 25 Am. Jur. 2d, Domicil, Sec. 37 at 6; 39 C.J.S., Guardian and Ward, Sec. 12, at 29; Griffin v. Matthews, 310 F. Supp. 341 (M.D.N.C. 1969), aff'd., 423 F. 2d 272 (4th Cir. 1969).

[20] 15A C.J.S., Conflict of Laws-Guardian and Ward, Sec. 14(5), at 476, n. 40, citing Lamar v. Micou, supra.

Commentaries to espouse the principle that presence plus intent constitutes domicile.[21]

a. Domicile and the Burden of Proof. The general rule is well settled that the burden of proof is on the one alleging a change in domicile. In Texas v. Florida, supra, 306 U.S. at 427, the U.S. Supreme Court addressed the issue of domicile to determine which state Texas, New York, Massachusetts or Florida had subject matter jurisdiction. Green (the subject of the Texas v. Florida decision) had established substantial contacts in Massachusetts. Green built an enormous estate in Massachusetts, and had all of the circumstances of his life revolving around it - the Massachusetts residence was the place most associated with his family history and his chief interests. So when Florida asserted that Green changed his domicile to that state, Florida carried the burden of showing that the earlier domicile was abandoned in favor of a later one. The Supreme Court declared that the burden that Florida carried had not beensustained when it only showed a period of winter residence there in obedience to the demands of HEALTH, in the absence there of the activities associated with the decedent's chief interests and the objects of those interests and of intimate family association, with which he had surrounded himself... Id.

1. Intent. If the person is not competent, then in most situations the requisite ability to formulate an intent to change abode is lacking. A primary component lacking in the rule of domicile would bar a court's power over the individual even if present.

(a) Mental Incompetency and Changing Domicile. If it is concluded that an adult was mentally incompetent upon entry into a state under the rule of domicile, then there are several contentions that may be raised by the opposing party that the change in domicile might be perfected - including the acquisition of a domicile of choice by his voluntary act, or change of domicile by the act of a guardian or another having actual or constructive custody or control over the person. 96 A.L.R. 2d, Mental Incompetent - Domicil - Change, 1236, 1245, citing Foster v. Carlin, 200 F.2d 943 (4th Cir. 1952).

(b) Incompetent's Voluntary Act to Change Domicile. It has been written that it may be beyond question that an incompetent who has not been adjudged so, and for whom no guardian has been appointed, may acquire a new domicile of choice if he in fact has sufficient mentality to do so. 5 N.C. Index 3d, Domicil, Sec. 2, at 383, n.13 citing Bryant v. Bryant, 228 N.C. 287, 45 S.E.2d 572 (1947); and 1989 Supp., at 292, citing Wilson v. State Residence Comm. of Univ. of North Carolina, 92 N.C. App. 355, 374 S.E.2d 415 (1988); 28 C.J.S., Domicile, Sec. 19 at 48, citing In Re Marks' Will, 259 N.C. 326, 130 S.E.2d 673 (Supp. 1981). Not every person who suffers from a mental disease or defect which makes him incompetent to perform some acts of legal significance is necessarily so functionally impaired as to be incapable of electing a new domicile. Thus, if it can be further established by satisfactory evidence that the incompetent's condition did not in fact deprive him of the power to form an intent or to make a choice, and that he had retained or regained sufficient mentality to do so, his acquisition of a new domicile of choice may be recognized. 96 A.L.R. 2d, supra, 1243, n.11. And, the actual mental capacity may be much less than that generally for the management of an individual's affairs so that the ability to merely express a preference with respect to the location of home has been held sufficient to enable an incompetent to select his domicile. Restatement (Second) supra, Sec. 15(1), at 37. See also, Layton v. Pribble, 200 Va. 405, 105 S.E.2d 864 (1958); 25 Am. Jur. 2d Domicile, Sec. 77; 96 A.L.R. 2d, supra, Sec. II 4(b) at 1253, 1254.

Facts in many cases describe adults shown to be mentally incompetent at the time they departed previously established domiciles for new residences or places of abode, and would be presumed to be incapable of acquiring domiciles of choice absent affirmative showings that they in fact each had sufficient mentality to choose new domiciles, and if no such affirmative showing, then each domicile would continue to be what it was when the person became incompetent. Matthews v. Matthews, 141 So. 2d 779 (1962); 96 A.L.R. 2d, supra, at 1231.

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[21] Horne, supra, 31 NC at 86, quoting J. Story, Commentaries on the Conflict of Laws, Foreign and Domestic, in Regard to Contracts, Rights and Remedies 40 (1834) (reprint Arno Press, New York (1972).

Three cases illustrate the legal rule: Federal Trust Co. v. Allen, In Re McCormick, and Miller v. Nelson. 96 A.L.R. 2d, supra, at 1246, citing Federal Trust Co. v. Allen, 110 Kan. 484, 204 P. 747 (1922), In Re McCormick, 260 Ill. App. 36, rev. den. on other gds. 345 Ill. 461, 178 N.E. 195 (1931), and Miller v. Nelson, 160 Fla. 410, 35 So. 2d 288 (1948). In Federal Trust, the incompetent, a Nebraska domiciliary who had been enticed by her stepson, after he had first taken all of her personal property from her safe-deposit box, to accompany him to his home in Kansas for a temporary visit, where upon he applied for appointment of guardian of her person and property, and attempted to prevent other relatives and her attorney from seeing her. The court held that the incompetent did not have sufficient mentality to acquire a domicile in Kansas, so that the Nebraska guardian rather then the Kansas guardian was entitled to her custody. Federal Trust Co. v. Allen, supra, at 485. cf., Matter of Miller, 228 Kan. 606, 620 P.2d 800 (1980) (case based on specific rewrite of Kansas law to reflect Restatement (Second) of Conflict of Laws, Sec. 79, addressed supra, n.15, in this manuscript).

In McCormick, supra, the respondent had been born and continuously resided in the state of Illinois prior to becoming insane while temporarily in another state. He remained in the other state on the hope that the climate would be favorable to his recovery. The other state was California, where he resided for 20 years under the care and control of guardians of his person appointed by a California court, which had acted under a statute permitting the appointment of the guardian for a non-resident incompetent temporarily within the state, thereby continuing to retain his Illinois domicile. In Re McCormick, supra, at 196.

And the Miller case, supra, included a man who lacked such soundness of mind as to lack the capacity to choose a new domicile. The court observed that an incompetent's mind may be so weak as a result of extreme age as to make him incapable of forming a settled intent to change his home or his domicile. 96 A.L.R. 2d, supra, n.77.

Federal Trust, McCormick and Miller all stand for the proposition that each case must stand on its own facts to determine capacity sufficient for anyone to declare a change of domicile. Those facts include self-help skills, daily needs, awareness of time, place, routine and other facts making up the cognitive state of mind of the person who is being assessed as to his or her ability or inability to make a choice of domicile. Miller v. Nelson, supra, 35 So. 2d at 293.

What the cases show is that the makeup of any person's mental capacity and the facts in each case will dictate the determination whether or not the incompetent had the requisite ability to knowingly make a choice that changed his or her domicile. See, G.A. Locke, 4 Proof of Facts, supra.

The courts and health care professionals consider a variety of factors when weighing the mental deficiency of a respondent alleged to be incompetent, and incapable of declaring a new domicile. Factors include the degree of helplessness, the kind of care required, and the incompetent's ability to make and adhere to his own decisions. In determining his actual capacity to make a choice, the primary question is whether he is able to choose and not whether his choice is a wise one. 96 A.L.R. 2d, supra, 1252; Foster v. Carlin, supra, 200 F.2d at 946; Matthews v. Matthews, supra; Miller v. Nelson, supra; See generally, H.R. Turnbull, III, A. P. Turnbull, G. J. Bronicki, J. A. Summens and C. Rolder-Gordon, Disability and the Family, A Guide to Decisions for Adulthood, chs.4-6, (Brookes Publ. Co., 1989).

(c) The Act of a Guardian or Another to Change Incompetent's Domicile. Where an incompetent has been found incapable, either as a matter of fact or of law, of changing his own domicile voluntarily and by his own act, it has been held that his domicile could be changed by the act of another under certain circumstances. 25 Am. Jur. 2d supra, Sec. 80 at 59.

Although most of the cases address the domicile of the wife, and whether it follows her husband, there has been authority cited that where a husband has become incompetent and no guardian has been appointed for him, his spouse has a superior right to determine his domicile. 25 Am. Jur. 2d supra, at 59, n.16, citing Robinson v. Frost, 54 Vt. 105 (1881).

When a husband becomes mentally incompetent and incapable of acquiring a domicile of choice, it has been held or recognized that the wife becomes head of the family and has power to select a place of abode. 96 A.L.R. 2d supra, at 1276, n.17, citing McKnight v. Dudley, 148 F. 204 (6th Cir., 1906).

There appears to be no authority for the proposition that an incompetent's domicile may be changed under any circumstance by a relative other than a spouse or parent. The case law seems to support that at a minimum the wife may at least establish the matrimonial domicile. 96 A.L.R. 2d supra, at 1276, n. citing Kuphal v. Kuphal, 177 Misc. 255, 29 N.Y.S. 2d 868 (1941); Robinson v. Frost, supra. Few, if any, family members or other relatives may exercise a change of domicile for a nonadjudicated incompetent adult. Id.

The facts in Miller, supra, should be compared to the other cases. That one Otto Zetterlund had established domicile in Florida was undisputed. During the latter years of his life, Zetterlund became plagued with senility. He was over eighty, had difficulty talking and writing, and eventually had to rely on others to sign his name for him. His care-taker took him to numerous places for medical treatment, climate change and sabbatical from stressful business in Florida. On one such trip, a home was purchased in California in 1944, and Zutterlund lived in the home until his death in late 1945. Shortly before his death, Zetterlund was adjudged incompetent by a California court. California had a statute permitting the appointment of a guardian for a non-resident incompetent temporarily within the state. Florida's Supreme Court sustained its lower court's finding that Zetterlund was domiciled in Florida at the time of his death:

> a person of unsound mind does not have the ability to acquire a new domicile...one's mind may be so weakened, whether by nature or by extreme age, as to be unable to form a settled intent to change his home and in that case cannot change his domicile.

Miller v. Nelson, supra, 35 So. 2d at 293.

2. Physical Presence.

(a) Actual Presence. Of critical import in all of the writings is that the person for whom domicile has professed to be changed be actually physically present in the alleged domicile. The first requirement of establishing a domicile is an actual physical presence in the locality of the alleged domicile. In this regard, "physical presence" merely involves the requirement that the person in question be located in the area in which domicile is sought to be established. It is immaterial whether that person has a permanent or fixed place to stay in the locality, so long as he is present there. His residence may be a temporary shack, a rented house, a boarding house, or hotel, the house of a relative or friend, or any other resident of either a permanent or temporary nature. Proof of Facts, 2d, supra, Sec. 5 at 601. The physical presence necessary for acquisition of a new domicile need not be narrowed to a particular building, municipality, or county within the state. Proof of Facts 2d, supra, Sec. 3 at 604. But physical presence must be within the state at the time of adjudication.

In many cases, the emphasis is sharply placed on the necessity of actual presence and residence in the new location as essential conditions or prerequisites to a change of domicile.

> Whensoever the intention is conceived the home does not exist until the intention is executed under an actual, concurring bodily presence." (citation omitted)
>
> In order to accomplish a change of residence, there must be not only the intention to change but the fact of the removal. Neither is sufficient without the other. (citations omitted) (emphasis supplied in the text)

Reynolds v. Lloyd Cotton Mills, supra, 99 S.E. at 245, 246.

Actual residence in a place is a circumstance which tends to prove domicile in that place; it is prima facie evidence of domicile. 25 Am. Jur. 2d supra, Sec. 81, at 59, Sec. 84, at 61.

While the length of residence is a factor in determining when the requisite intention occurs, the intent must be unqualified and not conditioned on the happening of a future event like the death of a spouse, or regaining memory loss. The converse is also true, the temporary removal from one's domicile, without the intention of changing it does not in any way erode the original domicile. The law does not contemplate continuous presence, not even when the case is one where an alien was charged by the Immigration and Naturalization Service, restrictively interpreting a federal statute, with having to maintain continuous residence in order to acquire citizenship. Hantzopoulos v. United States, 20 F.2d 146 (M.D.N.C. 1927), citing as authority Reynolds v. Lloyd Cotton Mills, supra.

(b) Residence. The Court of Appeals of North Carolina recently addressed the difference between residence and domicile in Vinson Realty Company, Inc. v. Honig, Vinson Realty Company, Inc. v. Honig, 88 N.C. App. 113, 362 S.E.2d 602 (1987), reaffirming the distinction between residence and domicile as stated in Hall v. Board of Elections, supra.

There are specific statutes that use only the word residence where domicile is inferred to be synonymous. One such statutory use of "residence" was construed to mean "domicile" sufficient to file an action for divorce. Williams v. North Carolina (I), supra; Andris v. Andris, 309 S.E.2d 570, 571 (N.C. App. 1983); See also, Martin v. Martin, 253 N.C. 704, 118 S.E.2d 29 (1961); Rector v. Rector, 4 N.C. App. 240, 166 S.E.2d 492 (1969). See Exhibit "A" for those states that use "residence" or "resident" instead of domicile.

EXHIBIT "A"

Restatement (Second)	UGPPA	Similar ABA	Domicile	Similar to Domicile	"Resides"
Kansas	Alabama	Arkansas	Alaska	Illinois	Tennessee
	Arizona	California	Connecticut	Indiana	Vermont
	Colorado	Georgia	North Carolina	Massachusetts	Wisconsin
	DC	Louisiana	Delaware	Oregon	Missouri
	Hawaii	Minnesota	Florida	South Dakota	
	Idaho	Nevada	Iowa	New York	
	Maine	Wyoming	Kentucky		
	Montana		Maryland		
	Nebraska		Michigan		
	New Mexico		Washington		
	North Dakota		New Hampshire		
	South Carolina		New Jersey		
	Utah		Ohio		
			Pennsylvania		
			Virginia		
			Rhode Island		
			Texas		
			West Virginia		
			Oklahoma		

Note: The author acknowledges the collaboration of Vicki Gottlich of the National Senior Citizens Law Center, and the work of her research assistant, Marlis Carson.

Ms. KINDERMANN. Thank you.

I'm going to ask people to hold questions and any discussion until after all our presenters have proceeded.

Our next speaker is Mr. John Regan, currently the Jack and Frieda Dicker Distinguished Professor of Health Care Law at Hofstra University. He's the author of numerous papers and lectures on legal problems in health care, social services, and aging. He will also address the first three issues: the need for data, Federal intervention, and a possible hook for Federal legislation.

JOHN REGAN, PROFESSOR OF HEALTH CARE LAW, HOFSTRA UNIVERSITY

Mr. REGAN. Thank you.

I boil the questions for discussion today down to two: Is there a need for Federal legislation concerning State systems that authorize surrogate decisionmaking—not just guardianship—for disabled persons? And coming through it all, is such legislation feasible, whether we talk of hooks or other devices for doing it? My written statement will review some of the studies that have identified problems and the few examples of empirical data that have been put together over the last 10, 15, or 20 years.

I guess my initial position, given this background, would suggest that maybe there is a case to be made for Federal legislation in this area. Sorry to disappoint you, but that's not my goal today. Indeed, I believe that the legislative approach which was exemplified in the bills Senator Glenn and the late Congressman Pepper introduced is both unnecessary and lack usefulness. Those bills would have set substantive procedural and evidentiary standards for State guardianship law and have used the draconian sanction of the States' Medicaid programs and the cutoff of funds as ways of assuring compliance.

I think those bills and that approach—and perhaps I'm in very close agreement with Mr. Johns—address the wrong issues. Many States over the past decade have reformed their State guardianship laws, they have eliminated many of the most objectionable features, definitions of incapacity have been modernized, hearing procedures tightened up, limited guardianships are encouraged, even mandated. The problem is not poorly drafted legislation. I'm not suggesting that it's a perfect world out there by any means, but the States have carried the ball to a large extent.

What I would like to focus on today instead are the remaining problems, which, as I see it, are in four areas in the administration of guardianship law, which, truth be told, tend to undercut the progress that's been made in crafting the better statute. And of course, these remarks are based on impressions, anecdotes, snatches of evidence, not broad-based empirical studies of the type that grant-getters love to produce and which simply don't exist by and large in this area.

The first problem area is the way judges administer guardianship law in their courtrooms. If a statute gives the court discretion to waive a requirement, such as the presence of the prospective ward or the attendance of a medical witness at the hearing, many courts will routinely exercise this discretionary power for the convenience of the petitioner, the witness, and even the court themselves, without due regard for the primary presumptions written into the law. Though designed by statute to have an adversarial quality, guardianship proceedings become transformed or continue to remain little more than an administrative function designed to get the petition processed as quickly as possible. The fault is not in the statute, but in its implementation by the courts.

Another example is the principle of limited guardianship. Most modern statutes express a strong preference for conferring on the guardian only those powers needed to compensate for the proven functional deficiencies of the ward. Plenary guardianship is supposed to be only a last resort. But again, much anecdotal evidence suggests that plenary guardianships are routinely granted in many States despite the statutes, while limited guardianship is an occasional exception. As before, the fault is not in the statute as drafted, but in the court's view of its and the petitioner's own priorities.

A second problem area is the way in which guardianships are monitored once the guardian has been appointed. Most States provide for some type of oversight, whether through annual financial reports or personal status reports, and that has been well-documented in Sally Hurme's study for the ABA.

While these reporting requirements could be strengthened in some States, the real problem lies not in drafting a stricter law, but in court oversight of compliance with the terms of the already existing laws.

Reports abound of the failure of courts to demand that guardians file the reports on a timely basis and, more importantly, that someone in the courthouse actually read these reports and flag those cases where a followup inquiry or hearing seems appropriate. The burdens on courts of caseload congestion and the shortage of funds appear to have pushed the oversight responsibility of the courts even further to the back of the courthouse burner. The result is ironic. As law reform tries to bring more protection to the prospective ward in the courtroom, that protection tends to vanish once the guardian has been appointed. But again note my thesis. The problem is essentially an administrative one, not one of legislative drafting.

The third area of concern is the increasingly large number of elderly persons who are incapacitated that lack so-called natural guardians, such as family or close friends who are available and willing to serve as guardians. In many cases, these elderly persons have outlived those who would ordinarily have helped them in this fashion. Visit any nursing home and you will see many such persons totally dependent on the staff or the administration of the facility for all types of surrogate decisionmaking. The question—and it's a hard one—is whether some form of public guardianship needs to be created to protect the interests of these dependent elderly.

I realize that public guardianship is a dirty word, has a bad reputation in many communities and deservedly so. I'm not suggesting that a new bureaucracy be created which substitutes one form of oppression for another. What troubles me, however, is the growing number of disabled elderly who are ripe for abuse and exploitation because they simply have no one to look out for their interests. That's the problem. I don't know precisely what the solution is.

The fourth and final problem area is not confined to guardianship, although it's most prominent in that respect. Guardianships are typically expensive and time-consuming procedures. Ironically, the tougher the law, the more expensive the process becomes. A simple guardianship can take several months. In New York it's running up to 8 months to get a conservatorship, and it costs several thousands of dollars in many jurisdictions.

The consequences of these burdens are predictable. First, guardianship tends to be utilized only where a substantial estate is present, meaning that all others don't get whatever advantages guardianship may have, and secondly, in the vast majority of these other cases, property and personal management and surrogate decisionmaking are provided on an informal basis by the disabled person's next of kin, friends, neighbors, or service providers, but often they lack any legal authority and with important gaps in their powers to aid the disabled person. So the question here, then, it seems to me, is whether there are ways of improving access to competent surrogate decisionmaking for the incapacitated.

Note that I'm not referring just to guardianship but to a wider range of alternative mechanisms for empowering persons of good will to act with legal authority on behalf of the disabled. Ideally, of course, a person anticipates the need for help, executes a durable power of attorney in advance, and hopefully all goes well. The Patient Self-Determination Act is helping to generate awareness of this mechanism among persons entering health care facilities, and many States have expanded or clarified their durable powers for health care. And we're now seeing the trend toward family consent laws both by statute and by judicial decree to make surrogate decisionmaking easier for those who are incapacitated but failed to execute an advance directive.

The fact remains, however, that for those who fail to make advance provisions for incapacity and who live in States which lack family consent authorization, guardianship is still the only game in town. It's the only valid way to provide long-term surrogate decisionmaking. But given the burdens of cost and delay in the courts, one wonders whether there isn't an easier way to accomplish this goal without sacrificing necessary protection for the incapacitated.

Now, I realize that some people believe that intervention should be hard, if not impossible, to accomplish and that guardianship should be discouraged. This position, I think, is unrealistic in that it ignores the fact that the need for intervention doesn't go away by ignoring it; exploitation and abuse are often the substitutes from self-appointed surrogates. I suggest, therefore, that some way needs to be found for improving access to surrogate decisionmaking without foregoing the hard-fought protections for disabled people that have been won over the past decade. Some better mix of durable powers, joint tenancy, living trusts, and guardianship seems desirable.

Now, having laid out the problems, the next question is, is Federal legislation the proper response to these problems? What are the possible purposes of a Federal guardianship law? One would be to establish basic constitutional standards, which the previous bills have done, and as I mentioned earlier, without rehashing that, I don't think that's the way to go.

Another possible purpose would be to promote uniformity in guardianship proceedings and appointments across the Nation. Again, I'm not sure that there's any utility in pursuing the goal of uniformity at this time. There doesn't seem to be an enormous pressing need for uniformity. Guardianships, despite the mobility factor, still tend to be highly local in nature. Wards still don't travel necessarily that much, and decisions concerning their affairs often have a highly local character. So to the extent that there's no strong interstate dimension, I don't see the need for uniform legislation.

A third possible purpose, however, does seem to be on target, but I'll leave the judgment as to its political correctness or political feasibility to others in this room more experienced in such matters than a simple academic. This method that I'm suggesting would address deficiencies in the oversight and monitoring of guardians by providing Federal financial support for developing new methods for both simplifying but toughening judicial scrutiny of guardians. The recent ABA study in guardianship monitoring described a number of initiatives which the States might employ to improve oversight. In the same vein, I wonder whether other Federal carrots might not be offered to State court systems to experiment with improvements in the procedures they use for the processing of petitions for guardianship. Similarly, we need to find ways to overcome the barriers to use of limited guardianships rather than simply allowing the courts to dismiss them as an expensive frill.

The worst possible approach, it seems to me, would be to tie in Federal reform efforts with State Medicaid plans unless there were additional funding provided to finance the effort, which I doubt would happen. As you know, Medicaid is already stretched to the limit to do its primary job of providing health care to the poor, and I would hate to see it converted into a vehicle for mandating social measures, however desirable, that divert funds from the program's targeted clientele.

Is there a need for more data, as suggested by the staff, to document the extent of abuses to help Congress make informed policy decisions, et cetera? Perhaps. Let me suggest in the same vein as I suggested last year to the House Committee on Aging regarding elder abuse, I think we've spent enough time identifying abuses and seeing all the problems out there. I think it's time to get on with discovering those systems that work, of model-building, of publicizing, and of helping to get those systems spread across the country. If we discovered tomorrow with the end of the Cold War that we had a big pool of money available, would we really know what to do with it in terms of promoting real effective guardianship programs out in the States? I don't think so. We can spend an awful lot of time identifying abuse and really not know what it is that we want in a positive way and what works. I think it's time to get on with the job of discovering what works, of promoting efforts to get people working in that direction, and to publicize it to other jurisdictions across the country.

Thanks very much for the opportunity to share these ideas with you. I'm sure that over the next couple of hours you'll quickly find all the flaws and errors in them, but at least I've said my piece, and hopefully the exchange of ideas from others here will sort out all the good things that we might offer to the staff. Thank you.

[The prepared statement of Mr. Regan follows:]

SOME THOUGHTS FOR A ROUNDTABLE DISCUSSION ON GUARDIANSHIP

by

John J. Regan

Professor of Law
Hofstra University School of Law

The basic questions for discussion today are whether there is a need for federal legislation concerning state systems which authorize surrogate decision-making for disabled persons and, if so, is such legislation feasible? I've been asked to comment specifically on the issues of the need for federal law concerning guardianship and the possible ways in which state compliance with such legislation could be achieved.

Beginning about 20 years ago, advocates for the elderly and the disabled identified a number of significant problems in state guardianship laws. Some of these defects were so fundamental that they raised questions about the constitutionality of the basic criteria and procedures utilized to determine incompetency and to appoint a guardian. Other problems grew out of the failure of many states to update their guardianship laws to reflect emerging insights into the nature of incapacity and the appropriate evidence for determining whether a person could no longer function as an independent decision-maker. Still another set of problems arose out of the administration of guardianships both in and out of the courtroom.

Empirical data demonstrating the prevalence and scope of these problems, however, have been sparse. In the late 60's, George Alexander identified the self-interest which motivated petitions for guardianship in several upstate New York counties. Bill Bell and others wrote of the inadequacies in Florida guardianship law. Julia Spring and Nancy Dubler graphically illustrated the delays, sloppiness and lack of oversight in New York conservatorship proceedings, as has Madelyn Iris regarding Illinois guardianship practice. Most importantly, the Associated Press found in many parts of the country rampant and pervasive abuse in the way the courts handle guardianships.

This brief sketch probably suggests that I am building the case for federal legislation setting federal standards for protecting the vulnerable people who are sometimes the victims of the guardianship system. Sorry to disappoint you, but this is not my goal today. I believe that the legislative approach exemplified by the bills that Senator Glenn and the late Congressman Pepper have introduced is unnecessary and not useful. These bills, you may recall, would set substantive, procedural and evidentiary standards for state guardianship law. A state's failure to comply would lead to the imposition of sanctions on the state's Medicaid program, even the cutoff of funds.

I am opposed to the approach exemplified by these two bills because they address the wrong issues. The primary problems with state guardianship law are no longer state statutes which on their face fail to protect the fundamental rights of the prospective ward. During the past decade, especially since the Associated Press expose, many states have drastically reformed their guardianship laws to eliminate their most objectionable features. Definitions of incapacity have been modernized, hearing procedures are been tightened up, and limited guardianships are encouraged and even mandated where appropriate. The leadership provided by the American Bar Association's Commission of the Legal Problems of the Elderly and the Commission on the Mentally Disabled has borne much fruit. Of course, I'm not suggesting that all states have revised their laws, but the problem of poorly drafted legislation is no longer in the forefront.

Many other problems still remain, however. Let me describe for your discussion today four areas in the administration of guardianship law where major problems tend to undercut the progress that has been made in crafting better statutes. Let me also hasten to add that my remarks are based on impressions and snatches of evidence, not on broad-based empirical studies.

The first area is the way judges administer guardianship law in their courtrooms. If a statute gives the court discretion to waive a requirement, such as the presence of the prospective ward or the attendance of a medical witness at the hearing, many courts will routinely exercise this power for the convenience of the petitioner, the witness, or even themselves, without due regard for the primary presumptions written in the law. Though designed by statute to have an adversarial quality, guardianship proceedings are thus transformed into little more than an administrative function designed to get the petition processed as quickly as possible. The fault is not in the statute but in its implementation by the courts.

A similar fate seems to await the principle of limited guardianship in many courtrooms. Most modern statutes express a strong preference for conferring on the guardian only those powers needed to compensate for the proven functional deficiencies of the ward. Plenary guardianship is supposed to be only a last resort

But again much anecdotal evidence suggests that plenary guardianships are routinely granted in many states, while limited guardianships are the occasional exception. As before, the fault is not in the statutes as drafted, but in the court's view of its and the petitioner's priorities.

The second problem area for guardianships lies in the way guardianships are monitored once the guardian has been appointed. Most states provide for some type of oversight, whether through annual financial reports or personal status reports. While these reporting requirements could be strengthened in some states, the real problem lies not in drafting a stricter law but in court oversight of compliance with the terms of the already exising laws. Reports abound of the failure of courts to demand that guardians file these reports on a timely basis and, more importantly, that someone in the courthouse actually read these reports and flag those cases where a followup inquiry or hearing seems appropriate. The burdens on courts of caseload congestion and a shortage of funds appear to have pushed the oversight responsibility of the courts further to the back of the courthouse burner. The result is ironic: as law reform tries to bring more protection to the prospective ward in the courtroom, that protection tends to vanish once the guardian has been appointed. But again note my thesis: the problem is essentially administrative, not one primarily of legislative drafting.

A third area of concern is the increasingly large number of elderly persons who are incapacitated but lack so-called natural guardians, such as family or close friends, who are available and willing to serve as guardians. In many cases, these elderly persons have outlived those who would ordinarily have helped them in this fashion. Visit almost any nursing home and you will see many such persons totally dependent on the staff or the administration of the facility for surrogate decision-making. The question is whether some form of public guardianship should be created to protect the interests of these dependent elderly. I realize that public guardianship has a bad reputaion in many communities, and deservedly so. I'm not suggesting that some new bureaucracy be created which substitutes one form of oppression for another. What troubles me is the growing number of disabled elderly who are ripe for abuse and exploitation because they have no one to look out for their interests.

The fourth and final problem area is not confined to guardianship, although it is most prominent here. Guardianships are typically expensive and time-consuming procedures. Ironically, the tougher the law, the more expensive the process becomes. A simple guardianship may take several months and cost several thousand dollars in many jurisdictions. The consequences of these burdens are predictable: 1) guardianship tends to be utilized only where a substantial estate is present; and 2) in the vast majority of other cases, property and personal management and decision-making are provided on an informal basis by the disabled person's next-of-kin, friends, neighbors or service-providers, but often without any legal authority and with important gaps in the powers needed to aid the disabled person.

The question is whether steps are necessary to improve access to competent surrogate decision-making for the incapacitated. Note that I am not referring just to guardianship but to a wider range of alternative mechanisms for empowering persons of good will to act with legal authority on behalf of the disabled. Ideally, a person will anticipate the need for such help and execute a durable power of attorney in advance of incapacity. The Patient Self-Determination Act is helping to generate awareness of this mechanism among persons entering health care facilities. Many states have expanded or clarified their laws concerning durable powers for health care. For persons who have failed to execute an advance directive, the trend toward permitting members of a patient's family or close friends to serve as health care decision-makers, so-called family consent laws, is also making surrogate decision-making more accessible and less burdensome, at least in the health care area.

The fact remains, however, that for those who have failed to make advance provision for incapacity and for those who live in those states lacking family consent authorization, guardianship is the only valid way to provide surrogate decision-making. Given the burdens of cost and delay, one wonders whether there isn't an easier way to accomplish this goal without sacrificing protection for the incapacitated. I realize that some people believe that intervention should be hard to accomplish and that guardianship should be discouraged. This position ignores the fact that the need for intervention doesn't go away by ignoring it; exploitation and abuse are often the substitutes. I suggest, therefore, that some way needs to be found for improving access to surrogate decision-making without forgoing the hard-fought protections for disabled persons won over the past decade. Some better mix of durable powers, joint tenancy, living trusts and guardianship seems desirable.

Is federal legislation the proper response to these four sets of problems? Let's examine the possible purposes of a federal law concerning guardianship. One possible purpose would be to establish basic constitutional standards for the states to assure protection for the fundamental rights of prospective wards. This was the rationale for previous federal proposals. As I mentioned earlier, I think we're past the stage where the states need to be forced to revamp their laws to achieve this goal. This approach doesn't address the problems I've described in the interpretation, implementation and administration of state guardianship laws, even though these laws on their face are models of constitutional propriety.

Another possible purpose for federal legislation might be to promote uniformity in guardianship proceedings and appointments across the nation. Again I fail to see the utility of pursuing this goal at this time. There doesn't seem to be a great need for such uniformity. Guardianship tends to be highly local in nature. Wards don't travel very often; decisions concerning their affairs have a local character. Only in rare cases do guardians of the property manage estates with significant interstate assets, certainly not to the extent to call for uniform legislation.

A third possible purpose for federal legislation, however, does appear to be on target, but I'll leave the judgment as to its political feasibility to those in the room more experienced in such matters. This method would address deficiencies in the oversight and monitoring of guardians by providing federal financial support for developing new methods for simplifying but toughening judicial scrutiny of guardians. The recent ABA study on Guardianship Monitoring describes a number of initiatives which the states might employ to improve oversight.

In the same vein, I wonder whether other federal carrots might not be offered to state court systems to experiment with improvements in the procedures used they use for the processing of petitions for guardianship. Similarly, we need to find ways to overcome the barriers to use of limited guardianships, rather than allow the courts to dismiss them as an expensive frill.

Let me hasten to add that the worst possible approach to federal legislation, if there is to be any at all, would be tying in federal reform efforts with state Medicaid plans, unless additional funding were provided to finance the additional effort. As you know, Medicaid is already stretched to the limit to do its primary job of providing health care to the poor. I hate to see it converted into a vehicle for mandating social measures, however desirable, that divert funds from the program's target clientele.

Is there a need for more data, as suggested by the Senate Committee staff, "to document the extent of abuses" and to help Congress "make informed policy decisions regarding the manner in which guardians should be appointed and monitored"? Perhaps. Let me suggest, however, that the more profitable approach would be to identify those guardianship systems which work, to learn what it is that makes them work, and to encourage the replication of these features elsewhere in the country.

Thank you for the opportunity to offer these ideas for you discussion today. I'm sure that this distinguished group will quickly find the flaws and errors in them, but hopefully out exchange of ideas will provide some useful guidance for the Committee.

Ms. **Kindermann**. Thank you.

Our next speaker is Mr. Ingo Keilitz. Since 1981 he's been the Director of the Institute on Mental Disability and Law at the National Center for State Courts. He's also the Director of the National Probate Court Standards Project. He will discuss States' resistance to Federal intervention in the area of guardianship. He is our only speaker on this issue.

INGO KEILITZ, NATIONAL CENTER FOR STATE COURTS

Mr. **Keilitz**. Thank you very much. I thank the committee for giving me this opportunity. Let me begin by bidding a good morning to all my friends and colleagues here. Good morning.

As the introduction noted, I'm with the National Center for State Courts. It is perhaps the biggest think tank for the State courts system, which is responsible for administering the guardianship area. Perhaps that's why I've been asked to address this issue. There's going to be quite a bit of agreement between what I have to say and what the previous two speakers had to say.

First, I want to tell you a little bit about this resistance from the States with regard to Federal intervention. Second, I want to make the point that there are many reforms already in place and there are many under way. Third, I place a heck of a lot more emphasis on the law in practice, and much less on the law on the books, and I also want to suggest that a carrot is going to be better than a stick with regard to Federal legislation. Finally, even though it's not in my assigned topic area, I do want to say a little bit about the need for data. (I am a researcher, so I'm very interested in data.)

The States, as you know, have in the past opposed, resisted, or, at the very least, not supported Federal initiatives in this area. The resolutions (and the deliberations of various organizations that came short of formal resolutions) reflect the view that while guardianship systems throughout the country are ailing and need help, reform should be spearheaded by the States and not necessarily by the Federal Government. If I may, permit me to read verbatim the formal resolution of the Conference of Chief Justices, the leading jurists in each of the 50 States, that was adopted in August 1991. It is entitled "The Responsibility of the States to Improve Guardianships and Conservatorships."

> Whereas guardianship and conservatorship proceedings traditionally have been matters of State law; and whereas the problems of guardianships and conservatorships practice throughout the Nation are well-documented by the American Bar Association and other interested groups; and whereas the States have voiced their concerns and have responded to these problems with initiatives and programs that address these problems and that acknowledge the complexity of guardianship and conservatorship in the context of State and local practices; and whereas the American Bar Association, the National Center for State Courts, the National Judicial College, and other interested groups have over the last several years assisted the States in improvements of guardianship and conservatorship; and whereas Federal guardianship legislation is likely to impose unneeded rigidity on current flexible State and local statutes and regulation of guardianship and conservatorship and, importantly, is likely to stifle innovation in improvements already under way; now therefore be it resolved that the Conference of Chief Justices opposes Federal initiatives that impose unnecessary rigidity upon flexible State and local regulation of guardianship and conservatorship.

Now, to require the States to either reform their laws, procedures, and practices to Federal mandates or face a loss of significant Federal benefits, many fear, would convert guardianship from a judicially operated system to a bureaucratic enterprise, a paper shuffle. Federal regulation would leave little room for and may actually discourage much-needed experimentation and innovation by the States, as John Regan (the previous speaker) has already mentioned. Rather than devising the means whereby the guardianship systems achieve access to justice, expedition and timeliness, fairness and integrity, and equality, independence and accountability, and engender public trust and confidence, local and State officials who administer these programs on a day-to-day basis would be forced into a bureaucratic enterprise with the major aim of technical compliance with regulations—and those of you that have been in courts, you know that the people who run them are very good at this.

My point is that many reforms are already in place, and there are quite a few under way. The issues that are addressed by the Federal legislations are certainly not new ones. They have been bandied about for quite a long time. They are dealt with in uniform codes, and they're dealt with in State statutes that were changed within the last 10 years in response to the same kinds of issues that are addressed by the Federal legislation. Provisions are now in place in many States that include remedies to the types of issues that we're all very concerned about. Nevertheless, and as we all know, even when the necessary laws are established, the local components and elements that comprise the guardian system may not be sufficiently established and organized, implementation of laws may be problematic, and conflicts of interest, abuse of power, mistakes, and ignorance may still occur.

Perhaps more important than legal reform, the initiatives of a number of organizations and groups have led and are currently continuing to lead to significant innovative changes in the day-to-day operations of the guardianship system, and that's where I think the rubber meets the road. For example, some localities have developed video presentations for guardians and prospective guardians outlining duties and responsibilities. Other courts are attempting to deal with the enforcement and monitoring system by playing around with a randomized system very much like the IRS, i.e., not all reports are monitored but the message is sent that you are likely to be monitored if you are not doing a good job. The Denver Probate Court has developed a video presentation for use in training court visitors and investigators. Judge Field Benton, who presides over that court, is here with us. The American Association of Retired Persons has established a pilot project with probate courts in Denver, Houston, and Atlanta that involves the training and utilization of volunteers. Finally, and this is just a few among a long list of innovations in the day-to-day operations of the courts, the National College of Probate Judges, in cooperation with the National Center for State Courts and with funding from the State Justice Institute, is conducting a 2-year project to develop, disseminate, and promulgate standards for probate court operations. Those standards are not only going to set the performance standards that indicate what optimum performance is all about, but will begin to set the stage where we can have a common language to talk about performance.

Third point. I think there needs to be increased emphasis on the law in practice. Implementation of the laws, viz., the law in practice, is the problem, not the ideas and the principles expressed in substantive and procedural standards, viz., the law on the books. There is little disagreement about those principles and those goals. Much of the legislative and regulatory framework needed for courts and allied agencies to improve the guardianship system is already on the books, or State and local courts alternatively possess the equitable powers necessary to make it happen. The trick is to find innovative ways with scarce resources that will accomplish these ideas set forth in legislation and regulation.

Improvement of the guardianship system depends primarily upon the narrowing of the gap between the nobilities of the ideals that we purport to cherish and the deficiencies and the downright meanness of the procedures that we allow to occur despite our espousal of these high ideals. Improvements of the guardian system depends upon an adoption of a systems orientation, a paradigm, if you will, including an emphasis on the actual processes, the series of related tasks, and systems—a group of related processes operating within the administrative structure at the local level—instead of the legal doctrine and the written law and the constitutional principles. An empirical inquiry instead of a rational analysis.

Let me make the fourth point. I think a carrot in terms of Federal initiatives is going to work better than a stick. Federal legislation, no matter how well intended, that imposes rigid substantive and procedural standards and forces the States either to conform to those standards or face the loss of significant Federal benefits is likely to be resisted by the States today, tomorrow, and the day after. Such resistance in what has always been a State prerogative is not just a matter of resistance per se. Instead, it stems from a legitimate and defensible belief that the components of the 50 diverse State guardianship systems cannot fit into a single mold, and attempting to fit them into that mold will do more harm than good. It would stifle the creativity, experimentation, risktaking, and innovation that is so much needed in government today.

In their book, "Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector," David Osborne and Ted Gaebler assert that governments, including the courts, are in deep trouble today largely because they are huge entrenched bureaucracies that impede the very things that are likely to get them out of trouble: Creativity, experimentation, risktaking, innovation, customer orientation—what a strange concept in government—and future forecasting.

I submit that Federal incentives rather than mandates should encourage these efforts. Through its grant-making capacities, the Federal Government should provide States with funds for self-assessment, for self-improvement, consistent with the models and guidelines established by the American Bar Association, the National Center for State Courts, and other organizations.

The U.S. Senate Special Committee on Aging could assume a leadership role in stimulating this grant-making process and working with those entities that are responsible for running the system or at least represent that system: The Conference of Chief Justices, the Conference of State Court Administrators, and other organizations.

The last and final point is the need for data. Building the capacity for data collection is one area where I think the Federal Government can play a great part. Neither the justice system nor the social service system, which each in their own way have a longstanding history and programs for building data, has the capacity for data collection where those two systems overlap, i.e., guardianship. As already acknowledged by this committee, without such information, questions fundamental to reform and improvements of the State guardianship system are difficult to answer.

The Associated Press discovered—and reporters are often more astonished about this than the people in this room—that there are no statewide records of something as basic as the number of individuals in a State subject to guardianship proceedings. There is no such data available on a nationwide basis. How many individuals are subject to guardianship proceedings annually in the United States? How many are subject to guardianship proceedings per 100,000 in the population? Do State guardianship case loads correlate with population? Do they correlate with the elderly population? If so, why? How do case load levels adjusted for population compare across different States, different jurisdictions, and according to different administrative structures? And what social, economic, and legal and systemic factors affect the rates in which guardianship files are introduced into the courts?

The level of public debate, policy, and action on various justice and mental health system interactions tend, as you know, to wax and wane dramatically as the Nation's media highlight particularly heinous or unfortunate cases involving claims of disabilities, especially when there's some major abuse involved. Consider Hinkley, consider Jeffrey Dahmer, consider some of the cases in your own community. The rush to reform often leads to proposed solutions based primarily on ideology or doctrinal analysis. The absence of a national data base on guardianship precludes answering critical broad-based questions about the scope of the problem—are we talking about a big problem, are we talking about a little problem; what is the nature of the problem—how does it manifest itself; and also possible solutions. We simply don't have the information available to ensure these questions.

Those of you who don't live in Washington, who live in other communities, if you were to find out tomorrow that the crime rate in your community has reached the rate of crime in Washington, D.C., do you have any doubt that there are going to be energies devoted to trying to address the problem? We don't have that kind of information available in the guardianship name. If I tell you that one community has 10 times the number of guardianship filings than another community and in the same State and under the same law, would you ask why?

We don't have a national data base on guardianship. The Federal Government is well positioned to build the capacity for establishing and maintaining a national data base on guardianship proceedings in obvious ways that the individual States are not. If nothing else, the Special Committee on Aging would do well to stimulate and support the establishment and maintenance of a national data base on guardianship.

Let me conclude with a saying my parents used as I grew up: "Never look a gift horse in the mouth." I think in this context it's unwise to rebuff offers of help that address widely shared concerns, that identify real problems, that are given in good faith, even when the particulars of that help may be found wanting. Such is the dilemma that the States face with regard to Federal legislation. That is they feel that they need all the help that they can get, but the help that they're being offered is not exactly what they need. On the one hand, the proposed Federal regulation is but a small part of a modern trend toward much greater scrutiny of the guardianship system. The States, unquestionably, are leading this trend. To reject Federal help at this stage may be viewed as indifference, even hostility to reform. In my work with the court systems, I don't find that kind of indifference and hostility to reform. Quite the contrary.

On the other hand, the particulars of the help may do more harm than good by imposing unnecessary rigidity and undermining much-needed experimentation and innovation.

In keeping with sound management practices, those closest to the problem should be given the first opportunities to solve those problems, with a little bit of help from their Federal friends. The problem of the elderly and individuals with physical and mental disabilities to which an improved guardianship system, including alternatives to guardianship, must respond demand both State and Federal involvement in a working partnership, and it is that partnership that I really would like to encourage and to suggest that we move toward.

Thank you.

[The prepared statement of Mr. Keilitz follows:]

States Have Responsibility For Improving Guardianship But Federal Government Can Help

Statement by Ingo Keilitz, Director of the
Institute on Mental Disability and the Law,
National Center for State Courts

Guardianship Roundtable Discussion
United States Senate Special Committee on Aging
Russell Senate Office Building
June 2, 1992

The Guardianship Roundtable Discussion, sponsored by the United States Special Committee on Aging, is focused on five broad issues: (1) the need for empirical data about State guardianship systems upon which to make informed policy decisions; (2) the need for Federal legislation; (3) the "hook" for such Federal regulation that would provide incentives for States to improve guardianships; (4) the States' resistance to Federal intervention in an issue traditionally within exclusive state jurisdiction; and (5) the reliance upon informal alternatives to guardianship. This Statement,[1] which supports an oral presentation by the author, deals primarily with the fourth issue but makes reference to the other issues, especially the first, i.e., the need for empirical data to inform policy in the area of guardianship.

Overview

It is unwise to rebuff offers of help that address widely shared concerns, that identify legitimate deficiencies and problems, and that are made in good faith, even when the particulars of that help may be found wanting. Such is the dilemma faced by the States in regard to proposed Federal bills S.352, H. R. 930, H.R. 800 and similar Federal bills. On the one hand, the proposed Federal regulation is but a small part of a modern trend toward much greater scrutiny of guardianship, including stricter procedures and greater protections for unprotected wards, more precise limits on guardians' powers, and much better monitoring and enforcement of guardianships by the courts. The States unquestionably are leading this trend.[2] To reject Federal help may be viewed as indifference, even hostility, toward needed reform.

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[1] The views expressed in this Statement are those of the author. They do not necessarily reflect the position, views and opinions of the organizations, agencies, and professional groups with which the author is affiliated. For more information contact: Ingo Keilitz, Director, Institute on Mental Disability and the Law, National Center for State Courts, 300 Newport Avenue, Williamsburg, Virginia, 23187-8798, (804) 253-2000.

[2] Various divisions of the American Bar Association--including the Commission on Mental and Physical Disability Law, the Commission on Legal Problems of the Elderly, the Division for Public Services, the Young Lawyers' Division and the Committee on Delivery of Legal Services to the Elderly--the National Center for State Courts, the National College of Probate Judges, the American Association of Retired Persons, and the National Judicial College have been particularly active in guardianship reform. One funding agency, the State Justice Institute (SJI), which is authorized to award grants, cooperative agreements, and contracts to State and local courts, nonprofit organizations, and others for the purpose of improving the administration of justice in the state courts, has been particularly responsive to the need for repairing an ailing guardianship system. In previous funding cycles, the SJI has supported: several projects to examine, identify and test procedures to improve the monitoring and enforcement of guardianship orders; a project to develop guidelines for judges in considering cases regarding the withdrawal of life-sustaining treatment; several projects to develop training materials on guardianships for judges and potential guardians; and a major project to develop national standards for probate courts. The SJI also supported a national conference on the court-related problems of elderly persons and persons with disabilities, and is supporting technical assistance and educational programs to disseminate and help implement the findings and recommendations of that conference

On the other hand, the particulars of the Federal help may do more harm than good by imposing unnecessary rigidity and undermining much needed experimentation and innovation by the States. In keeping with sound modern management practices, those closest to the problems should be given the first opportunities to find solutions--with a little help from their Federal friends. The problems of the elderly and individuals with physical and mental disabilities to which an improved guardianship system (including alternatives to formal guardianships) must respond, demand both State and Federal involvement in a working partnership.

Past State Resistance to Federal Initiatives

States have in the past opposed, resisted or (at the least) failed to support federally mandated standards for guardianship. Resolutions (and deliberations that fell short of formal resolutions) by organizations that represent judges and attorneys practicing in the guardianship area reflect the view that while the guardianship system is in need of improvement, improvements should be spearheaded by the States. The following resolution, adopted as proposed by the Guardianship and Conservatorship Committee of the Conference of Chief Justices (CCJ) at the forty-third annual meeting of the Conference of Chief Justices in Philadelphia, Pennsylvania, on August 8, 1991, illustrates the States' resistance to proposed Federal legislation.

The Responsibility of the States to
Improve Guardianship and Conservatorship

> *Whereas,* guardianship and conservatorship proceedings traditionally have been matters of state law; and, *Whereas,* the problems of guardianship and conservatorship practices throughout the Nation are well documented by the American Bar Association and other interested groups; and, *Whereas,* the states have voiced their concern and have responded to these problems with initiatives and programs that address these problems and that acknowledge the complexity of guardianship and conservatorship in the context of state and local practices; and, *Whereas,* the American Bar Association, the National Center, the National Judicial College and other interested groups have over the last several years assisted the states in improvements of guardianship and conservatorship; and, *Whereas,* Federal guardianship legislation--such as HR 800, HR930, and SB352 - is likely to impose unneeded rigidity on currently flexible state and local statutes and regulation of guardianship and conservatorship, and important, is likely to stifle innovation and improvements already underway; *Now, Therefore, Be It Resolved* that the Conference of Chief Justices opposes Federal initiatives that impose unnecessary rigidity upon flexible state and local regulation of guardianship and conservatorship.

To require the States to either conform their laws, procedures and practices to Federal mandates or face the loss of significant Federal benefits, many fear, would convert guardianship from a judicially operated system to a bureaucratic enterprise. Federal regulation would leave little room for, and may actually discourage, much needed experimentation and innovation by the States. Rather than devising the means whereby the guardianship systems achieve access to justice, expedition and timeliness, fairness and integrity, independence and accountability, and engenders public trust and confidence, state and local officials would be forced into a bureaucratic enterprise with the major aim of technical compliance with regulations. Federal regulation is likely to shift efforts away from the actual operation of guardianship laws at the state and local level to the generation of substantial paperwork to establish technical compliance with mandated Federal statutory procedures.

Reforms Already In Place, Others Underway

The issues addressed by the Federal bills are not new: the adequacy of notice, the bases for finding of incompetence, the qualifications of guardians, the use of limited guardianships, investigations prior to appointment of guardians, and procedural safeguards including the right to counsel, and guardianship monitoring and enforcement. These issues are dealt with in state statutes that were changed within the last ten years in response to the same broad concerns expressed in the Federal bills. For example, in August 1980, the American Bar Association, in a resolution put forth by the Commission on the Mentally Disabled (now the Commission on Mental and Physical Disability Law), endorsed limited guardianships:

> [T]he American Bar Association calls upon all states to assist persons of diminished mental capacity to live with maximum self-sufficiency in the general community, by enacting laws allowing court appointments of limited or partial guardians, where persons of diminished capacity need some, but not total, assistance in making decisions concerning their personal affairs or estate.[3]

Few states included explicit provisions allowing limited guardianships when this resolution was adopted in 1980. In 1991, however, 42 states have legislation which directs the designated courts in those states to at least consider establishing a limited form of guardianship before using the traditional "plenary" model.[4] A number of groups and organizations, most notably the American Bar Association, the National Center for State Courts, and the American Association of Retired Persons, supported by a number of funding agencies (e.g., the SJI), have played a leadership role in prompting significant reform in State guardianship laws and practices. At least half of the States are contemplating new legislation or have amended existing laws since 1987 to ensure protection of incapacitated persons' rights and to make the imposition of guardianships less restrictive. Provisions now in place in many states include the incapacitated person's presence at the appointment hearing, the right to counsel or a guardian ad litem, limited guardianship, provisions for temporary or emergency guardianships, review of reports required after appointment of guardians, provisions modifying notice requirements, provisions for visitors' reports, requirements for evidence to establish incapacity, and changes in definitions or language. Nevertheless, even when the necessary law is established, state and local elements that comprise the guardianship system may not be sufficiently

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[3] Report to the House of Delegates from the ABA's Commission on the Mentally Disabled (1980).
[4] Parry & Hurme, Guardianship Monitoring and Enforcement Nationwide, 15 MENTAL AND PHYSICAL DISABILITY LAW REPORTER 304, 304-317 (1991).

established and organized, implementation of laws may be problematic, and conflicts of interest, abuses of power, mistakes and ignorance may still occur.

Perhaps, more importantly, the initiatives of a number of organizations and groups have lead and are currently leading to significant innovative changes in the day-to-day operations of guardianship systems at the state and local level. For example, some localities have developed video presentations for guardians and prospective guardians, outlining their duties and responsibilities. The Denver Probate Court has developed a video presentation for use in training court visitors and investigators. The American Association of Retired Persons (AARP) has established a pilot project with the probate courts in Denver, Houston, and Atlanta which involves the training and utilization of volunteers to monitor and follow-up on guardianships. With funds from the State Justice Institute (SJI), the Superior Court of Arizona for Maricopa County (Phoenix) is creating a partnership between the court and the Sun Cities Area Community Council to establish an innovative mechanism for regular review of cases involving individuals whose lives are governed by the actions of their court appointed fiduciaries. The project takes advantage of the fact that the Sun Cities Community in Arizona has a large cadre of retired professionals, who will serve on an Adult Review Board. Finally, the National College of Probate Judges (NCPJ), in cooperation with the National Center for State Courts (NCSC), with support from the SJI, is conducting a two-year project to develop, refine, disseminate and promulgate national standards of probate courts. The proposed national standards will provide a philosophy of what optimum performance, operations, and administration of probate court entails; a conceptual framework for understanding and improvement of probate courts; a common language to facilitate description, classification, and communication of probate court activities; and, most importantly, a management and planning tool for self-assessment and self-improvement of probate courts throughout the country.

Emphasis on Law in Practice

Implementation of laws (the "law in practice") is the problem, not the ideals and principles expressed in substantive and procedural standards (the "law on the books"). Much of the legislative and regulatory framework needed for courts and allied agencies to improve the guardianship system is already on the books, or state and local courts possess the equitable powers necessary to make it happen. The trick is to find innovative ways with scarce resources that will accomplish the ideals set forth in legislation and regulation.

Improvement of guardianship depends upon the narrowing of the gap between the nobility of the ideals and principles we purport to cherish and the deficiencies and downright meanness of the proceedings we permit to continue despite our embrace of those principles and ideals.[5] Improvement of the guardianship system depends upon the adoption of a "systems" paradigm including an emphasis on processes (a series of related tasks) and systems (a group of related processes operating within administrative structures) instead of legal doctrine and written law, and empirical inquiry instead of rational analysis. The various steps, processes, structures and mechanisms that make up the guardianship system in state and local contexts are not given the attention they deserve in Federal proposals.

Carrot Likely to Work Better Than Stick

Federal legislation, no matter how well intended, that imposes rigid substantive and procedural standards and forces the States either to conform their diverse guardianship systems to Federal mandates or face the loss of significant Federal benefits is likely to be resisted by the States in the future. Such resistance *per se* into what has always been a State prerogative, is not just a matter of resistance. Instead, it stems from a legitimate, defensible belief that the components of the 50 diverse state guardianship systems cannot fit into a single mold, and that attempting to make them fit would do much more harm than good. It would stifle the creativity, experimentation, risk-taking, and innovation that is so much needed in Government today.[6] Federal incentives, rather than mandates, would encourage such efforts.

Through its grant making capacities, the Federal government should provide states with the funds for self-assessment and self-improvement consistent with models, guidelines and standards established by the American Bar Association, the National Center for State Courts, the National College of Probate Judges, and other groups and associations. The United States Senate Special Committee on Aging could assume a leadership role in directing the grant making of the various Federal agencies--with the advice of organizations and groups involved in the administration of state guardianship systems including the Conference of Chief Justices, the Conference of State Court Administrators, the National Center for State Courts, the American Bar Association, and the American Association of Retired Persons, to name just a few--in these self-assessment and self-improvement efforts at the state and local levels.

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[5] Some of these same words and phrases are used by Yale Kamisar to describe the needed improvement in the criminal justice system. Kamisar, Equal Justice in the Gatehouses and Mansions of American Criminal Procedure. In A. E. Howard (Ed.), CRIMINAL JUSTICE IN OUR TIME (1965).

[6] In their ground-breaking book, REINVENTING GOVERNMENT: HOW THE ENTREPRENEURIAL SPIRIT IS TRANSFORMING THE PUBLIC SECTOR (Addison-Wesley, 1992), [redacted] assert that governments, including the courts, are in deep trouble today largely because they tend to be huge, sluggish, entrenched bureaucracies that impede the very things--creativity, experimentation, risk-taking, innovation, customer-orientation, and future forecasting--that are likely to get them out of trouble.

The Need for National Data

There is one area in which the Federal government can play a fundamental and critical role: building the capacity to collect and maintain meaningful data upon which to base informed policy regarding guardianship. Neither the justice system nor the social service system--both of which have long-standing programs for the development and reporting of "case" statistics, (e.g., number of arrests; volume of civil, criminal and juvenile court cases; average daily jail census; admissions to inpatient hospitals)--possess a meaningful statistical portrait of the volume and composition of court cases in the United States in which claims of disability are made, including guardianships. As already acknowledged by the Special Committee on Aging, without such information, questions fundamental to reform and improvements of the state guardianship systems are difficult to answer.

In the report of its nationwide study in 1987, "Guardians of the Elderly: A Failing System," the Associated Press discovered that there were no statewide records of something as basic as the number of individuals in a state subject to guardianship proceedings. Such data have not played a central role in public debate and action in the area of guardianship because no reliable database exists that defines the scope and nature of the problems central to the public debate. How many individuals are subject to guardianship proceedings annually in the United States? Do state court guardianship caseloads correlate with population? How do caseload levels, adjusted for population, compare across different states, different jurisdictions and according to different administrative structures? What social, economic, legal and systemic factors effect the rates of filing cases?

The level of public debate, policy and action on various justice and mental health system interactions tends to wax and wane dramatically as the nation's media highlight particularly heinous or unfortunate cases involving claims of disability (e.g., insanity defenses against charges of homicide, release of committed patients who subsequently are charged with serious crimes, and neglected or abused wards in guardianship proceedings). The rush to reform often leads to proposed solutions based more on ideology and doctrinal analysis than empirical fact. The absence of a national database on guardianship precludes answering critical broad-based questions about the scope of the problem, the nature of the problem, and possible solutions.

The pragmatic justification for caseload statistics on guardianships is compelling. Caseload statistics are the single best way to describe what courts are doing currently and to predict what they are likely to do in the future. Skillfully deployed caseload statistics, for example, are powerful evidence of justifying claims of needed resources.

The Federal government is positioned to build the capacity for establishing and maintaining a national database on guardianship proceedings in obvious ways that individual states are not. Accurate and reliable baseline data on the nature and extent of involvement of persons with the guardianship systems are most likely to be generated successfully from existing court caseload data from the 50 states, the District of Columbia, and Puerto Rico. Published and unpublished reports supplied by state court administrators constitute the most reliable and valid available. Published data are typically state court annual reports which assume a variety of forms and vary widely in detail. They derive from statistical data filed monthly, quarterly, or annually by local courts. These caseload statistics are primarily collected to assist states in managing their own systems and are not prepared specifically for inclusion in national databases. The adaptation of this reporting systems which relies primarily on official state court administrative reports appears to be the most promising source of data for the development and maintenance of a uniform set of statistical tabulations on the volume and composition of guardianship cases. If nothing else, the Special Committee on Aging would do well to stimulate and support the establishment and maintenance of a national database on guardianship, tied to the existing reporting system of state and local courts, that would inform public policy regarding the scope of the problem, the nature of the problem and possible solutions.

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Larry L. Sipes
President

Ingo Keilitz, Director
Institute on Mental Disability and the Law

June 12, 1992

The Honorable David Pryor
Chairman
U.S. Senate Special Committee on Aging
Russell Senate Building, Room 267
Washington, DC 20510-6400

Dear Senator Pryor:

Thank you for giving me the opportunity to participate in the June 2, 1992 Guardianship Roundtable Discussion sponsored by the United States Senate Special Committee on Aging. I hope that the "roundtable" proves to be of value to the Committee in its efforts to review and improve the state guardianship systems.

I write to underscore two recommendations upon which there was general agreement, if not consensus, among the roundtable discussion participants. Both recommendations are ones in which, I believe, the Federal government can play a fundamental role, while the States, on the other hand, are not well positioned to take the lead: (1) establishing the capacity to collect, analyze and interpret meaningful data about the operation of the nation's guardianship systems, and (2) establishing a clearinghouse and/or information exchange focusing on good current practices and successful model approaches for future improvement of the state guardianship systems. Because the guardianship systems have developed independently in the 50 "laboratories" of the States, central resources for data collection and information exchange are not currently available.

Data Upon Which To Base Informed Policy. As I noted during the June 2 roundtable discussion, neither the justice system nor the social service system--both of which have long-standing programs for the development and reporting of "case" statistics--possess a meaningful portrait of the volume and composition of guardianship cases throughout the country. In its 1987 report of a nationwide study of guardianship, the Associated Press lamented that there were no statewide records of something as basic as the number of individuals in a state subject to guardianship proceedings. How many individuals are subject to guardianship proceedings annually in the United States? Do guardianship caseloads correlate with population? How do caseload levels, adjusted for population, compare across different states, jurisdictions, and administrative structures? What social, economic, legal and systemic factors affect the rates of filing guardianship cases?

As I'm sure you are well aware, the level of public debate, policy and action on various social issues tends to wax and wane dramatically as the Nation's media highlight particularly heinous or unfortunate cases. Proposed solutions often are based more on ideology and anecdote than on empirical facts. The absence of a national database on guardianship precludes answering critical broad-based questions about the scope of the problem, the nature of the problem and possible solutions. Systematic on-going data collection and evaluation are needed to understand the workings of the guardianship system, its shortcomings, and the effectiveness of reform efforts.

Fortunately, the basis for the establishment and maintenance of a national database on guardianship proceedings already exists. The Conference of State Court Administrators (COSCA) and the National Center for State Courts (NCSC) have jointly developed a model approach over the past 14 years for reporting the volume and composition of state court caseloads and trends in litigation. This approach is most recently described in *State Court Caseload Statistics: Annual Report 1990* (NCSC, 1991) (copy enclosed). Information for this national caseload database comes from published and unpublished sources supplied by state court administrators. Although guardianship is a recommended caseload category, actual data collection is spotty. Some states (e.g., Connecticut) and some courts (the Maricopa County Superior Court, Arizona) do report guardianship data now, most do not. Because of the diversity of the state guardianship systems, the data that are collected are difficult to interpret and virtually impossible to compare across jurisdictions. However, it is my belief that accurate and reliable caseload data on the nature and use of guardianship systems throughout the country can be successfully established in the 50 states, the District of Columbia, and Puerto Rico. An adaptation of the existing COSCA/NCSC reporting system, which relies primarily on the cooperation of state court administrative offices, is the most promising approach for the development and maintenance of a uniform database on the volume and composition of guardianship cases throughout the country.

Clearinghouse and Information Exchange. The June 2 roundtable discussion participants agreed that much good work in the guardianship area is already being accomplished and that successful efforts should be replicated to avoid needless duplication. It is important that information about good practices and successful model approaches be disseminated to facilitate emulation. In 1988, the American Bar Association's Commission on the Mentally Disabled (now the Commission on Mental and Physical Disability Law) and the Commission on Legal Problems of the Elderly convened a meeting of national experts at the Johnson Foundation's Wingspread Conference Facilities. These experts (many of whom participated in the June 2 roundtable discussion) reviewed the current operations of the guardianship system and developed an agenda for reform. A part of their agenda is the establishment of a "national guardianship resource center" to provide technical assistance to interested parties and to further reform efforts. Clearly, this is another area where the Federal government and the U.S. Special Committee on Aging, in particular, could be helpful.

Recommended Action by the U.S. Senate Special Committee on Aging. Assuming that you and your colleagues believe that the establishment of a national database on guardianship and/or a clearinghouse and information exchange are ideas worth pursuing, I urge you to consider the central leadership and program capacities of the State Justice Institute (SJI) and the U.S. Department of Health and Human Services (HHS) as possible mechanisms to move the ideas toward reality. As I noted in my written roundtable discussion report to the Committee, the SJI has been particularly responsive to the needs of an ailing guardianship system. The SJI is authorized to award grants, cooperative agreements, and contracts to state and local courts, non-profit organizations, and others for the purpose of improving the administration of justice in the state courts. In previous funding cycles, the SJI has supported several projects to examine, identify and test procedures to improve the monitoring and enforcement of guardianship orders; a project to develop guidelines for judges in considering cases regarding the withdrawal of life-sustaining medical treatment; several projects to develop training materials on guardianship for judges and potential guardians; and a major on-going project to develop national standards for probate courts. The SJI also supported a national conference on the court-related problems of elderly persons and persons with disabilities, and is supporting technical assistance and educational programs to disseminate and help implement the findings and recommendations of that conference.

An interagency agreement between SJI and offices of HSS may be a viable vehicle to implement the idea of a national database and/or a national clearinghouse. I trust that the SJI may have an interest in pursuing this idea with the Committee. The name and address of the Executive Director of the SJI is as follows:

Mr. David Tevelin
Executive Director
State Justice Institute
1650 King Street, Suite 600
Alexandria, VA 22314
Telephone (703) 684-6100

The National Center for State Courts (NCSC) is available to the Committee for helping in bringing together the major organizations representing judges (e.g., the Conference of Chief Justices, the Conference of State Court Administrators, and the National College of Project Judges) and attorneys (e.g., the American Bar Association, the American College of Trust and Estate Counsel) with interests in improving the state guardianship systems.

Although I believe that appropriations of additional monies are necessary to establish a national database and clearinghouse, the sum should be relatively modest. This assumes that new capacities for data collection and clearinghouse functions are established on the bases of existing capacities for reporting state court caseloads and existing clearinghouse functions and information exchanges.

Again, thank you for giving me the opportunity to assist with this important issue. If you or your staff would like further assistance, I am at your disposal.

Sincerely,

Ingo Keilitz

IK:bwj

c: Hon. Field Benton, President, National College of Probate Judges
Dr. Hugh M. Collins, Chair, Court Statistics Committee, Conference of State Court Administrators
Mr. Tom Henderson, Director, Washington Office, National Center for State Courts
Dr. Sally Hillsman, Vice-President, Research, National Center for State Courts
Ms. Ruth Luckasson, Esq., Chair, Commission on Mental and Physical Disability Law, American Bar Association
Hon. Ellen Ash Peters, Chief Justice, Connecticut, and Chair, Committee on Guardianship and Conservatorship, Conference of Chief Justices
Mr. John Pickering, Esq., Chair, Commission on Legal Problems of the Elderly, American Bar Association
Mr. David Tevelin, Executive Director, State Justice Institute
Court Standards

STATE GUARDIANSHIP LEGISLATION: DIRECTIONS OF REFORM

January - April 1992

Commission on Legal Problems of the Elderly
American Bar Association

During the first four months of 1992, thirteen states passed seventeen guardianship bills, out of a total of 59 introduced or considered during that period. One state (Tennessee) made major revisions in its guardianship code; and another (Pennsylvania) modified key portions. Two states (Arizona, Virginia) targeted procedural due process; three states (Colorado, Maine, Arizona) addressed issues of abuse; three states (Maryland, Minnesota, Pennsylvania) amended public guardianship provisions; and two (Nebraska, Rhode Island) initiated or continued guardianship study committees. In addition, a major revision of guardianship law in New York (S.B. 4498 and A.B. 7343) is still pending.

1. Revising State Code. Tennessee S.B. 1325 and H.B. 1119 significantly revise the Tennessee Guardian and Conservator law. (The term "guardian" applies to protection of a minor, and "conservator" to protection of an incapacitated person.) The revisions are the result of extensive legislative committee hearings, as well as work by the Tennessee Probate Study Committee.

The new provisions move toward strengthening several of the procedural due process rights of proposed wards. They specify information to be included in the petition (Sec. 44 of S.B. 1325); and mandate personal service of notice on the proposed ward, as well as notice by certified mail to the person's closest relatives (Sec. 7). A notice form is included within the statute (Sec. 9(c)). The court must appoint a guardian ad litem "to determine what is best for the respondent's welfare" as detailed in the duties listed in the new law (Sec. 8). Respondent has a right to counsel appointed by the court ("attorney ad litem") if he/she wants to contest any portion of the proceedings (Sec. 8(f)), he/she requests counsel, the guardian ad litem recommends counsel, or the court finds it necessary to protect respondent's rights (Sec. 26). Respondent's presence at the hearing is not emphasized.

The new Tennessee initiative does not follow the lead of several other recent state laws in aiming toward a more functional approach to incapacity, but rather continues to define "disabled person" primarily in terms of mental status labels, including "advanced age"

(Sec. 27). The new law does, however, strengthen provisions for limited guardianship, stating that the court must enumerate powers vested in the conservator, and that respondent retains all powers not specifically removed (Sec. 47).

Finally, the new measures reinforce monitoring and accountability, requiring that a conservator of the property file a detailed inventory (Sec. 11), a detailed annual accounting (Section 12), and a property management plan (Sec. 16); as well as clarifying practice concerning bonds (Sec. 6).

2. Making Long-Sought Changes. In 1988, Pennsylvania held hearings and in 1989 completed an extensive report on guardianship reform. This session, the state passed a significant bill making important changes in several key areas (see 20 Pa. Stat. Ann. §§5501-5537). Due process: The current definition of "incompetent" is changed to "incapacitated person," and now requires a review of the functional limitations of the alleged incapacitated person. Notice must now be in large type, simple language, and must clearly delineate the purpose of the proceeding. Presence of respondent at the hearing also is strengthened.

Limited guardianship: The new law prefers limited to plenary guardianship, clearly specifying that the guardian has authority only in those areas enumerated by the court. Monitoring: The new meaure authorizes the court to hold a review hearing at any time, and mandates such a hearing in certain instances. It requires guardians of the estate and of the person to file annual reports. Guardianship agencies: Corporate entities and county agencies may serve as guardian or "guardianship support agencies" in providing less restrictive alternatives.

3. Bolstering Procedural Due Process. In addition to Tennessee, two other states enhanced procedural due process rights for respondents. Virginia amendments specify individuals (in addition to the proposed ward) who must receive notice of the hearing, provide for the notice to be more readily understandable to the proposed ward (Va. Code Ann. § 37.1 - 128.02, 128.1 and 132), and require the guardian ad litem to advise the proposed ward of his/her hearing rights (§37.1 - 133.1).

Arizona tightened up its emergency temporary guardianship statute, possibly in the wake of Grant v. Johnson, 757 F. Supp. 1127

(D. Or. 1991) which declared the Oregon temporary guardianship provisions unconstitutional for lack of minimum due process protections. Arizona limits the duration of the temporary appointment, requires specific court findings regarding the emergency; and provides for notice to respondent "consistent with the nature of the emergency and the circumstances of the proposed ward," and at least within 72 hours of the temporary appointment (Ariz. Rev. Stat. §14 - 5310).

4. Addressing Guardianship Abuse. Three states enacted measures protecting wards from abuse by guardians. Colorado authorizes the court to issue temporary or permanent restraining orders in a guardianship or conservatorship "which results in unreasonable confinement or restriction of the liberty of an elderly person" (Colo. Rev. Stat. §13-6-107(2)(e)). Maine strengthens the role of the Department of Human Services in protecting wards against abuse, neglect or exploitation, and indicates that staff may represent the Department in Probate Court in specified guardianship matters. (22 Me. Stat. Ann. §3473). Arizona seeks to prevent abuse and conflict of interest by listing requirements for guardians and conservators to disclose detailed information to the court (whether he/she has been convicted of a felony, has previously served as guardian or agent under a power of attorney, has been removed as a guardian, etc.), Ariz. Rev. Stat. § 14-5106.

5. Providing for Public Guardianship. In addition to Pennsylvania, two other states legislated changes in the public guardianship arena. Minnesota mandates a study including recommendations on establishment of an independent public guardianship office. It also allows staff providing case management services to perform public guardianship services as well, unless new state funding is appropriated to cover the cost of additional staff (Sec. 2 of S.B. 2247). In Maryland area agencies on aging serve as public guardian of the person, but a new law prohibits the AAA's from serving as guardian of the estate. (Md. Code Ann. § 13-207 (e)).

6. Studying Guardianship. In addition to the Minnesota Public guardianship study, two other state enactments concern guardianship studies. Nebraska L.L.406 mandates a study of guardianship duties, guardian training, and procedure for temporary guardianship. Rhode Island H.B. 7378 for the second time extends an ongoing special legislative commission to study guardianship.

Guardianship Legislation Passed January 1 Through April 30, 1992

Arizona S.B. 1033	Requires that proposed guardians and conservators disclose to the court specified information before appointment.
Arizona S.B. 1249	Strengthens due process procedures for appointment of a temporary guardian.
Colorado H.B. 1087	Concerns emotional abuse of the elderly; and provides that a court may issue a restraining order to a guardian who unreasonably restricts ward's liberty.
Hawaii H.B. 2410	Deletes requirements for a hearing upon termination of guardianship, making it discretionary with the court.
Kentucky S.B. 233	Makes a number of changes in guardianship procedure; and direct court to give due consideration in selection of a guardian to respondent's agent under a power of attorney.
Maine S.B. 859	Strengthens role of Dept. of Human Services in protecting wards against abuse, neglect or exploitation.
Maryland S.B. 109	Prohibits court from naming employee with an area agency on aging as guardian of the estate.
Maryland S.B. 110	Authorizes guardian of the person to change abode of ward within same classification of abode; and to consent to admission or transfer to a medical facility.
Minnesota S.B. 2247	Concerns county staff performing public guardianship duties; and mandates a report on establishment of a public guardianship office.
Nebraska L.R. 406	Mandates a study of guardianship duties, guardian training, and procedure for temporary guardianship.
Oklahoma H.B. 2020	Exempts small estates from guardianship reporting requirements if guardian is a relative.
Pennsylvania S.B. 3	Makes a number of key changes in guardianship code, including due process provisions, limited guardianship, reporting requirements, and guardianship support agencies.
Rhode Island H.B. 7378	Extends reporting date of special legislative commission to study guardianship.
Tennessee S.B. 1325 & H.B. 1119	Revises state guardianship code.
Virginia S.B. 149 & H.B. 407	Revises notice provisions and specifies that guardian ad litem must advise respondent of hearing rights.

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1991 STATE GUARDIANSHIP LEGISLATION: DIRECTIONS OF REFORM

While the year 1991 saw a steady stream of guardianship reform activity, it brought no major, comprehensive new law in any state. During the year, a total of 92 guardianship bills were introduced. Of these 92 bills, 26 bills in 21 states passed -- as compared with 19 bills in 14 states in 1990, 27 bills in 19 states in 1989, and 23 bills in 18 states in 1988.

While guardianship reform efforts within the past four years have been marked by four outstanding trends (stronger procedural due process, a more functional determination of incapacity, greater emphasis on the least restrictive alternative and limited guardianship, and stronger monitoring and accountability), analysis of the new provisions reveals a more scattered pattern. Many of the 1991 changes were fairly minor. Eleven amendments clarified the guardian's authority; five amendments addressed procedural due process; two changed the definition of incapacity; one established a public guardianship system; and four initiatives concerned guardianship study committees.

A New York bill (S.B. 4498 and A.B. 7343) proposing sweeping changes in the state's old conservatorship system was the subject of joint public hearings in June. At year's end, the bill had not passed either house, and was in the Senate Mental Hygiene Committee and Assembly Judiciary Committee, when where it underwent several amendments.

(For continuing analysis of this and other 1992 bills, see the Spring and Fall Updates by the American Bar Association Commission on Legal Problems of the Elderly.)

1. Guardian's Authority and Duties. Numerous 1991 amendments sought to delineate more precisely the authority of the guardian of the property, the person, or both -- and to distinguish actions the court must take, and rights the ward retains.

Four initiatives focus on the guardian's authority concerning the ward's finances. Maryland provides that a guardian of the person may ask the guardian of the estate for estate funds to pay for care and services for the ward, and must maintain records documenting expenditures. Md. Code Ann. §13-708(d). Washington specifies procedures for the guardian to gain access and control over the ward's assets in banks and other financial institutions. R.C.W.

11.92. Minnesota provides that the guardian or conservator may petition the court to set aside a financial transaction, gift or contract of the ward during the two-year period before appointment, if the court finds the ward was incapacitated or subject to duress, coercion or undue influence. Minn Stat. Ann. §525.56.

Other amendments relate to the title or transfer of real property. Connecticut requires that if the sale of the ward's real property is to the guardian or conservator, the ward must be represented by a guardian ad litem. Conn. Gen. Stat. Ann. §45a-164(d). South Dakota clarifies that guardians holding title to the ward's real property hold it in a fiduciary capacity. S.D. Cod. Laws Ann. § 43-4-2 .

Several minor amendments address issues relating to guardians of veterans. Maryland allows guardians of a Veterans Administration beneficiary to invest in certain mutual funds under certain circumstances, without court authorization. Md. Code Ann. ET §13-805. Oklahoma permits the guardian to disclose confidential information to a representative of the U.S. Department of Veterans Affairs and requires bond in cases subject to the Uniform Veterans Guardianship Act. 30 O.S.A. §1-122(b). Georgia addresses compensation for guardians of beneficiaries of the U.S. Dept. of Veterans Affairs. Ga. Code Ann. §29-6-15.

Finally, a few amendments concern the fundamental personal rights of the ward. Oregon states that the ward retains the right to contact and retain counsel, and to have access to personal records; and that the guardian may not prevent the ward from exercising these rights. O.R.S. §126.098(2) and §126.137(6). North Carolina prohibits the court from entering a decree of absolute divorce in an action filed by a guardian on behalf of an incapacitated spouse, NC Gen. Stat. §50-22; while Iowa addresses findings by the court regarding the ward's capacity to marry. Iowa Code Ann. §595.3, §598.29 and §633.635.

2. Procedural Due Process. Key to meaningful procedural due process is legal representation for the proposed ward, yet it traditionally has been rare in guardianship proceedings. A Vermont initiative ensures that "counsel shall be appointed for the respondent" in each case. Counsel is to be compensated from the estate. For indigent respondents, "the court shall maintain a list of pro bono counsel from the private bar to be used before appointing nonprofit legal services organizations." 14 V.S.A. § 3065(a) and (c).

Two measures address petitioning in emergencies -- one strengthening respondent's rights and the other risking a loss of rights. In February 1991, the U.S. District Court for the District of Oregon declared the Oregon temporary guardianship statute unconstitutional in that it did not provide minimum due process protections. Grant v. Johnson, 757 F. Supp. 1127 (D. Or. 1991). In response, an Oregon amendment provides that: the finding of an emergency must be based on clear and convincing evidence; the temporary guardianship may not exceed 30 days; notice must be given two days before appointment, or if necessary within two days after; a visitor must be appointed to investigate; and if a hearing is requested, it must be within two days of appointment. O.R.S. 126.133.

However, a Georgia provision focusing on emergencies could be problematic for the ward. It allows a petition for a temporary emergency guardianship to include at the same time a petition for a permanent guardianship following the termination of the temporary guardianship. The court may authorize both at once. While the purpose of the amendment apparently was to ease the burden of paperwork for families of persons in a coma or persistent vegetative state, it appears overbroad. The assessment of capacity would be only in the context of the emergency hearing, without the full panoply of due process inherent in a regular hearing; and the burden is on the ward to request a full hearing concerning the permanent guardianship. Ga. Code. Ann §29-5-6, 8,10 & 11.

Two 1991 measures concern service of the notice. Florida provides extensive requirements for special process servers appointed by the sheriff. Fla. Stat. Ann. §48.021. Oregon specifies that a court-appointed visitor may not serve the notice except in a temporary guardianship proceeding. O.R.S. 126.103(4)

3. Determination of Incapacity. During the past five years, many states have sought to change the statutory definition of incapacity away from labels focusing primarily on mental status toward a more functional approach (measuring ability to function in society). Maryland's removal of the terms "senility" and "mental weakness," Md. Code Ann. ET §13-705(b), and Montana's removal of the term "advanced age," Mont. Code Ann. §72-5-101, clearly are in accord with this trend.

4. Selection of a Guardian. A new Wyoming law creates an office of the state public guardian under the governor's planning council on developmental disabilities. W.S. §3-7-104 and 105. An Alabama act provides for court appointment of private non-profit corporations to serve as

guardian or conservator for persons who are developmentally disabled, and establishes qualifications for such corporate guardians. H.B. 319.

Oregon places limits on who may serve as guardian. No owner, administrator or employee of a residential facility may be guardian for a resident of the facility, unless the resident is a relative. O.R.S. §441.710, 441.485 and 443.790. In addition, the petition must state whether the proposed guardian is a public or private agency or employee thereof that provides services to the proposed ward. O.R.S. §126.103 (1)(b). Finally, a proposed guardian convicted of a felony, class A misdemeanor, or who has filed for bankruptcy must so inform the court. O.R.S. §126.050(1).

5. Guardianship Studies. Four 1991 initiatives concern guardianship study committees. The most extensive effort is the creation of a twelve-member "guardianship oversight board in Florida. Fla. S.B. 1554. The board is to study the implementation of the 1989 Florida guardianship law, alternatives to guardianship, and public guardianship. The board "shall obtain, through public hearings or other means, the views of the public and of professional and other groups affected by state guardianship and alternatives to guardianship laws." The board is to submit a final report by June 30, 1993.

In addition, Nebraska L.R. 141 initiates a study of state guardianship law by the legislature's Judiciary Committee, to focus on: counsel for proposed wards; standards of proof of incapacity; court review of least restrictive alternatives available to the proposed ward; extent of duties and powers of guardians; and potential reform in the appellate process. Rhode Island H.B. 6263 extends an ongoing study; and North Dakota Resolution 4031 provides for an examination of public guardianship by the Legislative Council.

state .wp

1991 STATE GUARDIANSHIP LEGISLATION

STATE	CODE	BILL	AMENDMENT
Alabama	—	H.B. 319	Provides for the appoinment of a private non-profit corporation as guardian or conservator for persons with developmental disabilities
Connecticut	Conn. Gen. Stat. Ann. §45a-164(d)	S.B. 672	Concerns guardian ad litem in sale of real property of persons with disabilities; and voluntary conservatorship
Florida	Fla. Stat. Ann. §48.021	S.B. 1554	Creates Guardianship Oversight Board; and concerns appointment and qualifications of special process servers
Georgia	Ga. Code Ann. §29-5-6, 8, 10 & 11	H.B. 417	Permits petitioning for limited or permanent guardian with petition for emergency guardian
Georgia	Ga. Code Ann. §29-6-15	H.B. 760	Concerns compensation for guardians of veterans
Idaho	—	H.B. 41	Continues guardian ad litem program
Iowa	Iowa Code Ann. §595.3, 598.29 & 633.635	S.B. 495	Concerns findings by the court in guardianship proceedings concerning capacity to marry
Maryland	Md. Code Ann. ET §13-705(b)	S.B. 25	Removes term "senility" from definition of disabled individual, and terms "senility" and "mental weakness" from causal factors in appointment of guardian
Maryland	Md. Code Ann. ET §13-708(d)	H.B. 280	Provides for payment by guardian of the estate to guardian of the person for care and maintenance services for the ward
Maryland	Md. Code Ann. ET §13-805	S.B. 256	Authorizes guardian of a Veterans Administration beneficiary to invest certain funds without prior court authorization in certain mutual funds under certain circumstances
Minnesota	Minn. Stat. Ann. §525.56	S.B. 691	Authorizes the court to set aside transactions made prior to guardianship if it finds ward lacked capacity or was subject to duress or undue influence
Montana	Mont. Code Ann. §72-5-101	S.B. 308	Removes term "advanced age" from definition of "incapacitated person"
Nebraska	—	L.R. 141	Initiates a study of guardianship law in Nebraska

STATE	CODE	BILL	AMENDMENT
Nevada	N.R.S. §179A.100	A.B. 53	Requires dissemination of records of criminal history at request of public guardian
North Carolina	N.C. Gen. Stat. §50-22	H.B. 417	Prohibits court from entering decree of absolute divorce in action filed by guardian on behalf of incompetent spouse
North Dakota	N.D. Cent. Code §30.1-28-14	S.B. 2399	Concerns guardianships established before the 1989 law amending the Code
North Dakota	—	Res. 4031	Mandates study of public guardianship
Oklahoma	30 O.S.A. §1-122(b) & 4-201(B)(3)	H.B. 1039	Requires bond in cases subject to Uniform Veterans Guardianship Act; and permits disclosure of confidential guardianship information to representative of U.S. Department of Veterans Affairs
Oregon	O.R.S. §126.133	H.B. 2708	Revises provisions for appointment of temporary guardian
Oregon	O.R.S. §126. 098(2), 126. 137(b), 126. 103 & other sections	H.B. 2709	Strengthens due process protections in guardianship proceedings. Specifies ward's right to contact and retain counsel
Oregon	O.R.S. §441, 443.485 & 443.790	S.B. 682	Prohibits owners, administrators or employees of residential facilities from serving as guardian
Rhode Island	—	H.B. 6263	Extends reporting date of special legislative commission on guardianship
South Dakota	S.D. Code Law Ann. §43-4-2	H.B. 1164	Clarifies that trustees, guardians and personal representatives holding title to property hold it in a fiduciary capacity
Vermont	14 V.S.A. §3065(a) & (c)	H.B. 132	Mandates counsel for respondent in guardianship proceedings
Washington	R.C.W. §11.88, 010 & other sections	H.B. 1510	Amends numerous minor aspects of guardianship law
Wyoming	W.S. §3-7-104 & 105	H.B. 123	Creates office of state public guardian

Ms. KINDERMANN. Thank you.

Our next speaker is Martha Miller. She's a private attorney in Little Rock, Arkansas, specializing in government relations. She served on the Board of Directors of the Arkansas Volunteer for the Elderly Program as well as a Pulaski County Bar Association committee which established the Volunteer Organization for Central Arkansas Legal Services emphasizing the delivery of legal services to the elderly. She will address how far we should go in relying on informal alternatives to guardianship, such as durable powers of attorney, living wills, and the like.

Martha.

MARTHA MILLER, ATTORNEY, LITTLE ROCK, AR

Ms. MILLER. Thank you for this opportunity to be here with you today. I feel somewhat intimidated as perhaps the least expert of all of you in the room on these particular issues. However, I will focus on some of the alternatives. Of course, I can't give you an extensive and complete laundry list of the alternatives to the appointment of a guardian for such persons as they become less able to take care of themselves.

In examining the use of alternatives, it may be helpful to approach each alternative by asking the questions such as: To what degree are these alternatives utilized? What factors bear on the choice of each of the alternative processes? Are they desirable in all circumstances, or are they desirable only in certain types of circumstances? Are safeguards appropriate for adoption by the States or by the Federal Government in the use of each of these alternatives? And finally, is there anything that the Federal Government can do to encourage the use of alternatives to guardianship that hasn't already been done?

I think, of course, to begin the discussion we have to acknowledge that the first alternative to guardianship is the passive alternative of doing nothing. Most of the less restrictive alternatives to guardianship, such as durable powers of attorney or the execution of a living will or a trust agreement, require advance planning and, therefore, a willingness by the potential ward to contemplate and plan for his or her future incapacity. As a result, these other alternatives are not utilized very frequently.

Even if one can get beyond this initial hurdle of coming to terms with the possibility of someday not being able to care for oneself, there are other hurdles to overcome. Utilization of many of these alternatives costs money and requires the advice of professionals, and I suspect that many may simply be unaware of the availability of alternatives to guardianship and the variety of advance planning techniques or the relative advantages or disadvantages of these techniques.

All too often, then, the alternative of doing nothing is a result, I believe, of lack of education and access, and I would at this point reference Professor Regan's comments earlier that access is a key problem in the analysis and further discussion of this area. And I think we would all agree that not only is this alternative not desirable, but in almost every case it is not tolerable.

The second alternative is the reliance on family and friends, and it's probably utilized in a great number of instances and in combination with one or more of the other alternative techniques and with varying degrees of success. As a matter of fact, in rural Arkansas, where I grew up, it was just assumed that your family and friends, your neighbors could always be counted on to care for you as you became more unable to care for yourself. As traditional roles, however, of the individual and society have changed, utilization of this alternative has become less prevalent. More women work outside the home, children and grandchildren often live in cities different from their aging family members, and more adults in the 1990's find themselves burdened with trying to juggle the demands of being care providers or caregivers for not only their children, but also their aging parents or grandparents at the same time.

And if there are family and friends who can help care for their less able loved ones and who will act in their best interest—and that's a very important "if"—reliance on family and friends may be one of the most desirable alternatives that are available. If, however, these family members and friends aren't acting in the best interests of the one who needs the help, obviously this is not a very desirable alternative. Since this assumption is unfortunately not universally deserved that they will act in the best interest of the loved one, and since these types of relationships are characteristically not formalized in any sort of written document and are, therefore, private, some safeguards may be appropriate, and this is a situation where we find that ombudsmen can be particularly helpful or the mandatory reporting of suspected physical abuse by physicians and others who are in a position of becoming aware of these potential abuses and other sorts of opportunities for court review of transactions may be appropriate.

A third alternative is the use of joint bank accounts, and I think we'd all agree that this is very prevalent and used with great frequency in conjunction with reliance on family and friends. A typical arrangement is for the aging parent to designate one of the children as a co-signator on a bank account just in case something happens to the aging parent. It's a fairly simple technique to use, since the execution of a signature card is all that is required. It doesn't cost anything and doesn't require the services of a lawyer, CPA, or other professional outside the banking community. The aging parent usually feels confident that he or she is still in control, and I think this issue of control is one that many people base their choice of alternative techniques on to a great extent.

To the extent that this technique provides a sense of security and flexibility to the aging parent at virtually no cost, it is a desirable tool. The obvious disadvantage, however, is that an untrustworthy cosigner can legally liquidate the account and take advantage of the aging person. Are there safeguards? Not really, and to impose any would require significant revisions to banking laws, which I'm not prepared to recommend and I'm not sure that this group of individuals would recommend, either.

The acquisition of alternative techniques is another broad topic, but I've broken it down into several other specific types—for example, the use of residential care facilities. Many of you may not be aware of what a residential care facility is. It's a group living arrangement which provides access to assistance with activities of daily living—for example, the preparation of meals, laundry services, light housekeeping, transportation to shopping and medical facilities, and so forth. Because these types of living arrangements are more home-like and yet provide essential services, these types of situations are being utilized more frequently as the public becomes more aware of the availability of them. They are not commonplace, I don't believe, at this point, though.

When the decision is made to move into a residential care facility, several factors bear on that decision. Of course, the inability or the lack of desire to maintain a private residence is one factor, the security offered by a supervised group living arrangement is another factor and the availability of those services, and the relative privacy of the living quarters is another factor. Of course, some of those factors vary from facility to facility.

For many people, living in a residential care facility or retirement center is a desirable alternative, since it offers an environment of continued relative independence for persons not able to continue to completely care for themselves and whose family and friends are not available to provide the same level of assistance found in that facility.

Another fairly common technique is the use of a representative payee, and you all are all aware, I'm sure, of the parameters of the use of a representative payee for Social Security benefits. In accepting the appointment, of course, the representative payee acknowledges that the proceeds are to be used for the needs of the beneficiary. Like the use of a joint account, the appointment of a representative payee costs nothing, and the representative payee is not required to make formal reports regarding the use of the funds. Because Social Security supplements and SSI benefits tend to be modest sums of money, utilization of the representative payee may be desirable, since no costs of administration are incurred as are incurred, for example, in the use of a trust agreement or other similar arrangement, which brings me to trust agreements.

A trust agreement, of course, is a private document which authorizes another person, frequently a bank, to use property for the benefit of the grantor or others. Because it can be specifically tailored to the needs of the beneficiary and the resources of the trust, these types of alternatives to guardianship can be very beneficial if it is carefully constructed. I personally believe that this is one of the most advantageous types of arrangements if the circumstances are appropriate. However, because there are many types of trust agreements and because they can be very complex and lengthy and, therefore, expensive, trust agreements are not frequently utilized.

Factors which bear on the choice of a trust agreement as an alternative to guardianship of either the grantor or a disabled dependent of the grantor include the degree of control sought to be retained by the grantor in the use of the trust property, the amount of property to be conveyed into trust, the continuing cost of administering the trust, the lack of public disclosure of the extent of the assets of the grantor, and the availability of a competent and trustworthy trustee all are involved in this choice.

Is a trust agreement desirable as an alternative to guardianship? As I mentioned before, as a practitioner and a former trust administrator for a couple of years, I personally believe that this type of arrangement is highly desirable if it is properly constructed and placed with the appropriate trustee.

Powers of attorney and durable powers of attorney are another mechanism. Typically, however, powers of attorney are stated in very broad, sweeping terms authorizing the designee to do virtually any act necessary to conduct business on behalf of the principal. When such sweeping authority is granted to a trustworthy person, a power of attorney can be very convenient, especially when one expects to be unavailable for extended periods of time. A power of attorney and a durable power of attorney, of course, are essentially the same except for that significant difference of the continued authorization of the attorney-in-fact under a durable power of attorney.

I believe that use of these techniques are fairly common. They are viewed as relatively simple and inexpensive and a convenient way to designate a surrogate decisionmaker. Are they desirable alternatives? Certainly a regular power of attorney is undesirable for this purpose, since the authority of the attorney-in-fact designated in such a document ceases if the principal becomes incapacitated, and although the authority granted by a durable power of attorney survives the later incapacity to the principal, the durable power of attorney may only be marginally desirable, since the execution of this type of document may be the result of inappropriate pressure by the designated attorney-in-fact.

A living will is another alternative. Of course, the broader umbrella of a living will is also known as an advance directive, and it outlines what health care choices the person wants honored if he or she becomes terminally ill or permanently unconscious. Let me just make a side comment at this point. The use of advance directives, health care proxies, and family hierarchies of surrogate decisionmaking are all three statutory concepts that have been incorporated into law in the State of Arkansas, and I'm personally familiar with that piece of legislation, since it was a project of the Arkansas Bar Association in 1987. Although the experience of Nancy Kruzan's family prompted many people to execute living wills, the vast majority of Americans do not have a living will, in my experience. As more people receive information about advance directives as a result of implementation of the Patient Self-Determination Act of 1990, more of them will formalize their wishes about what treatment they do or do not want to receive should they become terminally ill or permanently unconscious.

The principal factor which motivates one to execute an advance directive is the desire to make sure that they aren't kept alive when there is no hope of recovery and to relieve loved ones from having to make a difficult decision to withdraw life support if it is not beneficial anymore. This alternative to guardianship is very desirable if the person has a clear understanding of the choices expressed in the living will and if the document accurately reflects how he would choose to be treated at some future point.

The health care proxy is, however, another alternative. If, after consulting with a health care professional, a person isn't entirely sure about what decision he or she might make at some point in the future for a situation that he or she clearly can't project, the designation of a health care proxy may be more desirable than an advance directive. The naming of a health care proxy is especially appropriate in cases where the person you trust to make the "right" decision is a close friend and not a family member.

The statutory hierarchy is the third of these health care decision issues that I referred to. As I mentioned, in Arkansas the legislature has authorized certain persons to execute a living will for another who is no longer able to make health care decisions for themselves. The Arkansas provision identifies eight people or groups of people in order of priority, beginning with the legal guardian, if one has been appointed, followed by the parents of the patient, if the patient is a minor, or the patient's spouse, and so forth. And I have a copy of that act with me today if any of you would like to review that, or I'll provide copies for you.

The key to the successful use of any of these alternatives is access to information about choices and access to professional assistance in executing those that require formal execution, and so I would echo Professor Regan's emphasis of access being a very key issue once again.

Let me make one other observation on a point that was not covered in my scope of comments or that I was asked to address, and that is the resistance of the States to Federal intervention on this issue. Since 1984 I have represented the Arkansas Bar Association as its legislative liaison before the State legislature in Arkansas, and over the last 8 years the issue of guardianship has been addressed legislatively a number of times, and I agree that States, based on my experience in Arkansas, will continue to resist Federal standards that may be viewed as inappropriate or overly burdensome in terms of cost to the individual and cost to the system. So I think that States can be encouraged with assistance in providing models and information, but Federal mandates will be resisted, in my view.

[The prepared statement of Ms. Miller follows:]

DRAFT

A GUIDE TO UNDERSTANDING GUARDIANSHIP AND THE AVAILABLE ALTERNATIVES IN ARKANSAS

PART I

UNDERSTANDING GUARDIANSHIP

The purpose of this manual is:

(1) to provide you with some general information about the concept and process of guardianship for adults; and

(2) to give you information about alternatives to guardianship.

The concept of guardianship is very old, with a history that can be traced back to both Roman civil law and English common law. There has always been an awareness that some individuals, due to a mental impairment, are simply unable to advocate for their own interests or exercise their legal rights competently. In response, the legal system began developing a method of protecting these individuals; the end result was the legal process of guardianship that we know today.

Guardianship is a formally structured, legal relationship in which one person (the guardian) is appointed to act or advocate on behalf of another person (the ward), who is unable to make competent decisions for him/herself. Guardianship exists for one purpose only--the protection of the individual. When used appropriately guardianship enhances the life experiences of the individual to the fullest extent possible, allowing the individual as much autonomy as possible. It is utilized in planning the future welfare of a person who was never competent or who has become incompetent due to advanced age, a chronic illness or other debilitating condition, such as substance abuse. The 1985 Arkansas Guardianship Act states:

> Guardianship for an incapacitated person shall be used only as necessary to promote and protect the well-being of the person, shall be designed to encourage the development of maximum self-reliance and independence of the person and shall be ordered only to the extent necessitated by the person's actual mental, physical and adaptive limitations. (A. C. A. §28-65-105).

When a court appoints someone to make decisions for the ward it correspondingly takes away the ward's right to make those decisions. For this reason, guardianship is a very restrictive procedure and should be used only as necessary. Therefore, it is critical for those considering guardianship give serious thought to whether some less restrictive alternative might be available which provides the security needed without legally removing rights from the individual.

Impact and Intent of Guardianship

One of the most critical aspects of our uniqueness as human beings is our ability to make choices--to determine what we wear, what food we eat, where we go, where we live and with whom we associate. These choices define who and what we are, they reflect our beliefs, preferences and dreams. Indeed, the choices that we make in our daily lives define our very personhood to ourselves and to society. The dramatic importance of individual choice does not lose its significance merely because mental or physical limitations are present. Choice remains a basic human right and a basic aspect of individuality. When our freedom to make important choices is limited, regardless of the reason, it diminishes our personhood. It diminishes self-respect and self-worth.

> Guardianship is the most restrictive and intrusive form of surrogate decision making; and it has very serious consequences for the individual. . . the ward may lose many of his or her civil rights as an adult citizen and be reduced to the legal status of a child--being deprived of the right to control almost every aspect of life, including the right to manage finances, to write checks, to sue and to be sued, to contract, to travel, to choose what medical treatment to receive, where to live and with whom to associate.

With these words, the U. S. House of Representatives Subcommittee on Housing and Consumer Interests recognized the tremendous impact that guardianship can have in diminishing personhood. While on the one hand guardianship is a vehicle through which a person's rights and interests can be protected, it is a process that must be approached with great caution and never for the convenience of others.

Guardianship is a tool to be considered only when a person cannot because of age or mental limitations, make competent decisions regarding his/her own affairs. When considering guardianship it is important not to fall into a common trap of mistaking the agreeability of a decision with the competence of the decision-maker. In other words, just because a decision is not one you would make, does not mean the person making the decision is incompetent. WE ALL MAKE CHOICES OTHERS WOULD INTERPRET AS POOR SOMETIME IN OUR LIFE!

Furthermore, guardianship should not be used to satisfy one person's desire to control another. Only when control over another is necessary due to the proposed ward's inability to manage on his/her own is that control justified and guardianship appropriate. The House Subcommittee report reflects concern about the rising abuse of the guardianship process by some family members and others who seek to gain control over income or property or to control where a person lives for their own benefit, not for the benefit of the individual.

Alternatives to Guardianship

With appropriate support from family and friends, many people who are elderly or have disabilities, are able to manage their own personal and financial affairs without the legal intervention of a guardian. Therefore, it is very important to explore less restrictive safeguards before considering guardianship. Several alternatives which might be appropriate are discussed below. The list is not meant to include all the alternatives possible and it is important to realize that the various guardianship alternatives can be combined to meet the unique needs of the individual.

Family and Friends

Most people consult with family members and friends before making important decisions or before making decisions in situations with which they are unfamiliar. Persons with disabilities and those who are elderly are no different. Family members and friends can provide much guidance and support to the individual. For instance, family members can help define risks, alternatives and consequences of a decision and explain these in terms the individual can more readily understand. This allows for persons with disabilities or who are elderly to continue to make their own choices.

Citizen Advocacy

Citizen Advocacy is a program in which trained volunteers are matched with individuals who are at risk in the community due to disability or age. A citizen advocate may assume a wide variety of roles depending on the needs of the individual. Citizen advocates can serve as guides and advisors, may assist with budgeting and paying bills, may help make purchases, and may perform any of the supportive activities that might otherwise be done by family and friends.

Trusts

A trust is a legal device which permits a person or institution (like a bank) to manage the property and/or money of another person. If the reason for considering guardianship is primarily financial, a trust can provide a good alternative. The success of a trust depends on how the trust is drawn up and who is chosen as the trustee.

If properly made, a trust allows relatives to place property or money in the trust to be managed and used for the benefit of the individual with disabilities. Since the person no longer has control or access at will to the contents of the trust, the trust may not cause the individual to become ineligible for governmental benefits such as Supplemental Security Income (SSI). Furthermore, the government cannot seize the contents of the trust as repayment for past benefits. On the other hand, interest from the trust can be used by the trustee to purchase goods or services for the ward which are not covered by government benefits. There are many different types of trusts (living trusts, testamentary trusts, revocable trusts, irrevocable trusts, insurance trusts, custodial trusts, etc.) Within each of these types of trusts there is flexibility to accommodate a variety of needs, depending on the terms of the trust.

Although a trust does not give the trustee power to make personal decisions for the individuals the person setting up the trust could specify in the terms of the trust that the trustee will act as an advisor to the beneficiary (the person who is elderly or disabled) in making certain personal decisions regarding the use of the funds. Trusts are complex and it is important to seek the assistance of an attorney, once you have decided what you want the trust to accomplish.

Power of Attorney

Any individual can give someone else the power to make decisions regarding his/her money or property. The person given power of attorney has only the authority to do what is spelled out in the document. A power of attorney is easily abused and should be considered only with great caution. It may ONLY be used if the individual giving up power fully understands what s/he is authorizing the other individual to do.

Representative Payee

If the only income an individual has is SSI, social security or some other federal supplement, then a representative payee may be an appropriate alternative to guardianship. A representative payee is an individual who is given the authority by the Social Security Administration to receive and manage the federal benefits for another person, who is unable to manage his/her own money. Application must be made with the Social Security office for the appointment of a payee. Your local Social Security office can provide information on this process.

Limited Bank Accounts

There are several ways in which access to finances can be voluntarily restricted through specialized bank accounts. (Please note that not all banks are agreeable to establishing these types of accounts so you may wish to seek advice from your bank or saving institution.)

Cosigners

Some banks will set up accounts in which two or more persons must sign to approve the withdrawal of funds. Neither person can withdraw funds without the knowledge and approval of the other. The account could be checking or savings.

Ceiling Limit Accounts

Another alternative might be a ceiling limit account established in the name of the person who has a disability or is elderly. Using this method, the individual would be able to withdraw only a limited amount of funds at any given time. In other words, checks or withdrawals over a specified amount would be invalid.

Pour-Over Account

The pour-over account is an account which automatically transfers money to the limited account after a withdrawal is made.

Conservatorship

The Conservators for Aged and Disabled Law enables an individual to consent to allowing a conservator or a representative to handle his/her estate without being declared incompetent. (A. C. A. §28-67-101 et seq.) As in a power of attorney, the individual who is elderly or disabled must fully understand the process and its ramifications in order to approve this method.

Living Will

Adult patients of sound mind have the right to accept or refuse any medical or surgical treatment. This includes the right to accept or refuse treatment through a living will. A Living Will is a legal document in which you tell others of your wish to refuse treatment that you feel is excessive or inappropriate - if you should become unable to express your wishes in the future. The Living Will tells medical professionals and members of your family to what extent special means should or should not be used to keep your body alive if you are incurably ill. The Living Will allows you to refuse certain medical procedures that may only prolong dying, or maintain the body in an unconscious state. The Living Will is to be used only if you become terminally ill or permanently unconscious.

Health Care Consent Law

Under certain conditions, certain persons may make health care decisions and give consent to medical treatment on behalf of a person who is unable to make such decision for him/her -self. The law provides a list of persons who can consent to treatment on behalf of another in the order in which consent will be accepted. For example, a parent's consent to treatment for his/her child is given greater weight than a decision made by the sick child's brother or sister.

When Guardianship is Necessary

Guardianship is necessary ONLY if:

(1) A court finds someone incapacitated or incompetent and s/he has not already given anyone the authority to make decisions on his or her behalf.

(2) A person has never had the capacity or competence to:

—make decisions,
—handle his/her affairs, and/or
—designate someone else to act on his/her behalf.

Although every individual has different needs, there are areas in which a person may need assistance-in making decisions:

* * finances and/or property;
* * medical treatment; and/or
* * specialized programs and services.

Types of Guardianships

Since the capabilities and needs of individuals vary greatly, the Arkansas Legislature provided for flexibility in the guardianship statute. There are two basic types of guardianship duties:

(1) those pertaining to the person, like medical treatment received and where the person lives; and

(2) those pertaining to the estate, or financial decisions.

Some individuals may need only one type of guardian; others may require a guardian both for the person and the estate.

Most importantly, the statute allows for different degrees of guardianship. Guardianship may be limited, giving only specifically described powers to the guardian, or the guardianship may be total (or plenary). This means a person could have a limited or plenary guardian of the person and/or a limited or plenary guardian of the estate. These guardianships may be temporary when there is an emergency situation and the person would be in danger if the guardianship were delayed until the typical legal process were accomplished.

Guardianship of the Person

A guardian with power over the person refers to the individual appointed by the probate court to have legal rights and powers of personal decision-making over the ward. A probate court may authorize a guardian to assume some or all of the following responsibilities of the ward:

(1) to supervise the ward's personal needs by seeing to it that the individual is properly cared for, housed, and educated. This does not mean the guardian must take the ward into his/her home, merely that the guardian must ensure that the ward's needs are met.

(2) to make provision from the ward's estate or other sources, for the ward's care and comfort, and maintenance. Simply stated, the guardian is NOT responsible for providing all of,these essentials to the ward, only to ensure that they are being received by the ward. The guardian has the responsibility to make application for any financial benefits for which the ward may be eligible, such as Social Security, Supplemental Security Income, etc.

(3) to make a reasonable effort to secure for the ward training, education, medical and psychological services and social and vocational opportunities as are appropriate and as will assist the ward in the development of maximum self-reliance and independence. This does not mean the guardian must purchase services for the ward. It does mean the guardian must apply for services and benefits for which the ward is likely to be eligible.

A guardian of the person will be asked to post a bond, of not more than $100, by the court unless the court is asked to dispense with the bond. The request to dispense with the bond can be written into the guardianship order. (A. C. A. §28-65-215)

Guardianship of the Estate

A guardian with power over the estate refers to the individual authorized by a probate court to assume responsibility for the management of all or part of the individual ward's property. The property may include personal income, stocks and bonds, certificates of deposit, real estate or other assets. Funds belonging to the ward should always be kept in a separate bank account. The court requires an accurate and detailed accounting of any financial transactions made on behalf of the ward.

A guardian of the estate will also be asked to post a bond in an amount commensurate with the size of the estate. The bond can be dispensed with if the testator of a will expresses the wish that there be no bond or the ward's estate is all in cash that is to be deposited for interest in an Arkansas FDIC insured bank or an Arkansas credit union with an agreement not to allow withdrawal without a probate court order. (A. C. A. §28-65-201)

Limited Guardianship

With a limited guardianship, the decision-making power is limited to a specific area of an individual's life, with all other rights being retained. The ward keeps the right to act in areas not specifically given to the guardian, keeping as much freedom of choice, responsibility, and independent decision-making as s/he can manage. This type of guardianship was created because full guardianship can actually be harmful to the ward. An individual's legal rights and privileges should not be restricted without a specific finding that s/he is incapable of appropriate action in that area.

The following are some of the possible powers of a limited guardian:

- ** to manage the ward's real estate and/or property,
- ** to give consent for non-emergency medical treatment that might otherwise be denied by the hospital,
- ** to apply for, consent to, and enroll the ward in necessary programs,
- ** to apply for, consent to, and enroll the individual in public or private residential care facilities,
- ** to assist an individual in obtaining appropriate education,
- ** to assist an individual in obtaining employment,
- ** to file suit and to collect on debts, rentals, wages and other claims due an individual,
- ** to apply for and to receive funds from governmental sources for the incapacitated person for example: Supplemental Security Income (SSI), Medicaid, Food Stamps, Aid to Families with Dependent Children (AFDC), Housing and Urban Development (HUD), Section 8 Rent Subsidies, and
- ** to investigate transfers of property by the ward.

Plenary (Full) Guardianship

Historically, all guardians were appointed as plenary guardians of the estate, of the person, or both. A plenary guardian (sometimes referred to as a full guardian) is a guardian of either all the estate, or all the personal choice issues, or both. The appointment of a plenary guardian may be made jointly if it is clearly established to the satisfaction of the probate judge that the individual is totally without capacity to care for him/herself (plenary guardian of the person), his/her property (plenary guardian of the estate), or both.

An order establishing a plenary guardianship over an individual has far-reaching effect. It keeps the ward from being able to make any important decisions for him/herself without the consent of the guardian. Decisions restricted include, but are not limited to, the following:

- ** signing a contract,
- ** obtaining insurance,
- ** consenting to or preventing any surgical intervention,
- ** traveling,
- ** spending money,
- ** moving from one home to another,
- ** suing and being sued, and
- ** making changes in educational, residential or vocational programs.

No guardian can make the following decisions:

- ** authorize abortion and/or sterilization or other extraordinary medical procedures,
- ** consent to marry,
- ** vote, and
- ** donate organs after death.

Temporary Guardianship

A temporary guardian is used for emergencies ONLY. The court must find that "there is imminent danger to the life or health of the incapacitated person or of loss damage, or waste to the property of an incapacitated person" that requires immediate appointment of a guardian in order to grant a request for temporary guardianship.

The appointment can be made without notice, but is time limited. It cannot exceed 90 days. If the appointment is made without notice, the guardian must tell the incapacitated person immediately what has been done. The temporary guardian will report to the Court as specified by the Court. (A. C. A. §28-65-218)

A Guardian's Liability

A matter of concern for many guardians is personal liability for the results decisions they make on behalf of the ward. Generally, a guardian would probably not be held liable for civil damages for decisions made for the ward as long as those decisions were made in good faith and within the limits established by the court, and if the guardian acted reasonably and without negligence. In Arkansas, this principle is referred to as the prudent man standard. This means if the decision made is deemed to be prudent--ie. taking into consideration alternatives and consequences--then it is likely a decision without liability.

In essence, the law states that the plenary, limited, or temporary guardian shall not be liable for civil damages because s/he authorized routine or emergency medical treatment IF the guardian has:

(1) acted in good faith;
(2) acted after medical consultation with the ward's physician;
(3) was not negligent; and
(4) acted within the limits established for the guardian by the court.

Likewise, the guardian shall not be held liable for consent to extraordinary medical procedures if the Court has previously ordered such treatment for the ward and above requirements are met. Finally, the guardian shall not be held liable for injury to the ward resulting from negligence or actions of a third person, ie. a doctor, nurse, etc.

Financial Liability

The law states that one duty of a guardian may be to ". . . make provision for the ward's estate or other sources, for the ward's care, comfort, and maintenance." This duty does not obligate the guardian to assume financial responsibility for the care of the ward. However, one implication which may be drawn is that the guardian has a responsibility to seek financial resources if the ward has none, i.e. make application for SSI, social security, veteran's benefits general assistance or other federal or state financial maintenance benefits. If you have a question regarding your personal liability, please call your attorney.

Another issue of concern is a guardian's financial liability for expenses incurred through performance of his/her duties. Historically, courts have authorized some guardians to be reimbursed from the ward's estate for expenses and/or for the cost of services. For instance, if the ward lives in the home of a guardian, the court may approve an allowance for the ward's care. To protect against liability for such expenditures, the guardian should seek prior court approval. Check with your attorney to determine if the expenses were approved at the time of appointment.

Other expenses may also be charged to the ward's estate, such as the cost of an attorney for the ward, or court fees. If you question any charges made against the ward's estate, check with your attorney to determine their validity.

There are specific requirements for what a guardian can and cannot do in relation to financial investments under (A. C. A. §28-65-311). The guardian's liability in relation to financial investments would likely not be a factor, unless decisions were made outside of those guidelines presented.

A final question with regard to the financial liability of a guardian is the liability for damages, ie. a broken window caused by the ward. At first glance, it would appear that the guardian would not be liable for such damage, solely by reason of the guardianship relationship. However, if it can be determined that the guardian was negligent in his/her duties and that this negligence contributed to the resulting damage, the guardian might be found to be at least partially liable for damages

Protection from Liability

Although none of us is completely protected from liability unless law specifies such protection, there are some important guidelines to follow to protect yourself.

(1) Know the limits of your authority and your duties.

(2) Clarify any questions with your attorney or the probate court clerk.

(3) Document your activities on behalf of the ward so that you have a record in case your actions are ever questioned.

Keep the ward's estate separate from your assets. Never borrow money from the ward's estate. Consult with the appropriate people regarding important decisions, such as seeking a second opinion in elective surgery decisions. Use your common sense in making decisions.

Discharge or Modification of a Guardianship

One of the advantages of Arkansas law is its flexibility. A guardianship may be modified or terminated at any time after the appointment. The ward, or any interested party, may request the modification or discharge. The ward's request may be verbal or in writing; all other parties must request the consideration of change in writing.

The Guardian's Annual Report to the Court

Every guardian must make a report to the court at least annually detailing the condition of the ward. The guardian must be given access to information, reports and records from facilities, a community mental health board or agency, court staff or public or private entity or agency, or a suitable person that are necessary for the guardian to perform his/her duty of filing the report.

The guardian's report is a very important document. Not only does it keep the court informed concerning the ward's condition and progress and the guardian's activities on behalf of the ward, but it also provides an opportunity for the guardian to reassess his/her role and the continuing need for guardianship.

With appropriate services, a ward may increase his/her capacity to effectively manage his/her affairs. If the ward does become able to manage one or more of the areas previously limited, the guardian should indicate this in the report. The probate court may then decide to modify the guardianship to reflect the progress made by the ward.

Conclusion
(Part I)

Following is a summary the major points about guardianship:

(1) Most people are able to effectively manage their own affairs without a guardian. Therefore, alternatives less restrictive than guardianship should be explored before guardianship is considered.

(2) Guardianship is a legally recognized relationship between a competent adult (the guardian) and a person who the court has deemed incompetent to make some or all personal and/or financial decisions (the ward). In this relationship, the guardian is given the duty and right to act on behalf of the ward in making certain decisions affecting the ward's life.

(3) Guardianship is to be used ONLY when a person is determined by a court to be incapable of managing some or all of his/her affairs.

(4) A guardian having the power over the person may be given responsibility for making a reasonable effort to secure the services appropriate for the ward and which will assist the ward in development of maximum self-reliance and independence.

(5) A guardian having power over the estate is authorized by a court to assume responsibility for the management of all or some of the individual ward's property.

(6) A plenary guardian is appointed only when the court determines that an individual is totally without the capacity to care for him/herself.

(7) A limited guardian is appointed when a person can care for some, but not all aspects of his/her person or property. The limited guardian may act only in those areas specified by the court.

Powers and duties of a guardian that may be restricted include, but are not limited to:

** giving consent for extraordinary medical procedures,
** authorizing abortion and/or sterilization,
** voting,
** donating organs after death, and
** consenting to marriage.

A guardian should not be held liable for decisions made on behalf of the ward if those decisions are made in good faith, within limits established for the guardian by the court and without negligence. Every guardian must make a report to the court on the condition of the ward at least annually. This report is usually due no later than the anniversary of the date of the appointment.

PART II

The Guardianship Process

In some situations guardianship is necessary. The Arkansas Guardianship Statute outlines the process for establishing guardianships for people who have disabilities or who are elderly.

Petition for a Guardianship

In asking the court to make you guardian of another, you must file what is called a "petition." A petition for the appointment of a guardian for a disabled or elderly citizen may be filed by any interested person or entity (i.e. organization, agency, etc.) in probate court. Throughout this process, the person who files the petition is called the "petitioner." The person that the petition claims is "incapacitated" is called the "respondent."

The petition must be filed with the probate court in the respondent's county of residence, or in the county where s/he is living at the time the petition is filed if legal residency cannot be established. A sample petition form is provided as Exhibit "1" on the next page.

The Evaluation

Before the hearing can be held a physician, psychologist or certified social worker with experience appropriate to the proposed ward's condition must evaluate the ward. This professional reports to the court about the proposed ward's medical and physical condition, adaptive behavior and intellectual functioning. The evaluator must recommend areas in which the proposed ward needs assistance and options that place less of a limitation on the proposed ward than guardianship. The evaluation must have been done recently, so if no professional evaluation was done in the last six months, the Court will order an evaluation. If the petition is granted, the proposed ward pays for the evaluation. If the petition is denied, the cost of the evaluation is the responsibility of the petitioner. (A. C. A. § 28-65-212) No evaluation is necessary to issue a temporary guardianship. A sample evaluation form is provided as exhibit 2.

Notice of Hearing

After a petition is filed, the court must set a date and a place for the hearing to be held. The notice tells the proposed ward of the hearing date and his rights to be represented by counsel present evidence, examine witnesses, attend and not testify if he does not want to say anything. (A. C. A. §28-65-13)

The law requires the petitioner to give notice of the hearing to all interested parties, such as:

1. the petitioner,
2. the respondent,
3. the respondent's legal heirs,
4. the person who performed the evaluation,
5. the director of a facility in which the person may reside,
6. the respondent's attorney.

The petitioner will probably be required to provide the court with proof that notice was given through submission of an affidavit or signed receipts from interested parties.

The Rights of the Respondent (Proposed Ward)

The appointment of a guardian limits the civil and legal rights of the proposed ward. To ensure those rights are not limited unjustly, Arkansas law provides safeguards. These safeguards or due process protections are:

* to be notifed of the time and place of the hearing.
* to be represented by an attorney, and if the respondent cannot afford an attorney, s/he can ask the judge to appoint an attorney.
* to be present at all proceedings. The respondent does not have to attend if the court excuses him/her. In order to be excused the physician or psychologist who has recently examined the respondent must claim by affidavit that the person's attendance at the proceedings will subject him/her to serious risk of physical or emotional harm.
* to present evidence at the hearing.
* to confront and cross examine all witnesses, including the evaluator at the hearing.
* to secure an independent evaluation.

The Hearing

Before appointing a guardian, the probate judge must find that the person is INCAPACITATED. Persons are incapacitated if they are impaired by: (1) mental illness; (2) mental deficiency; (3) physical illness, or (4) chronic substance abuse problems so that they lack a sufficient understanding or capacity to make or communicate decisions about their health or safety, or manage their property (A. C. A. §28-65-101(1)).

Based on the evidence presented at the hearing, the judge then determines if a guardian is necessary. If alternatives to guardianship are, feasible, the judge may dismiss the petition. If the ward is substantially unable care for himself or his property, the judge can appoint a guardian. In the guardianship order the judge may limit the powers and duties delegated to the guardian. (A. C. A. §28-65-214). In appointing a guardian, the court will give preference to a person nominated by the proposed ward or the ward's spouse, and persons related by bood or marriage. (A. C. A. §28-65-204). A corporation chartered to be a guardian, a bank or trust company can be appointed guardians of the estate.

The Arkansas law gives the judge some degree of flexibility in creating the terms and conditions of the guardianship. For example, the judge can give the guardian power over just personal matters and not over financial matters (or vice versa), and also the judge can determine what rights or powers the ward retains that the guardian cannot control (A. C. A. §28-65-214) The statute requires that the guardianship be used only as necessary to promote and protect the person's well-being and property and only to the "extent necessitated by the person's actual mental physical and adaptive limitations." (A. C. A. §28-65-107).

A guardian of the person, who can control where the ward lives, is required to care for and maintain the ward, using the ward's resources.

Who May Be Appointed As Guardian

Anyone over the age of 18 who is of sound mind, is an Arkansas resident and is not a convicted felon can become guardian for another person. Additionally, the Court should make a reasonable effort to question the person who is disabled concerning his/her preference regarding the person to be appointed guardian. Any preference should be given due consideration by the court but the court is not bound to abide by any expressed preference.

The Order of Appointment

The court order establishing limited guardianship shall:

1. contain findings of fact,
2. define the powers and duties of the limited guardian so as to permit the disabled person to care for his/her person and estate to the extent s/he is able to do so. (A. C. A. §28-65-214)

Remember a disabled person for whom a limited guardian is appointed retains all legal and civil rights except those specifically designated as legal disabilities on the court order or those specifically granted by court order to the limited guardian. The court order appointing a limited guardian does NOT constitute a declaration of legal incompetence except in those areas specified by the court.

Although no specifications are noted for the court order appointing a plenary guardian, one is usually provided and delineates any limitations on authority or other special provisions.

Some courts may also issue a "letter of guardianship or letter of authority." This document, too, may serve as official proof of your authority as guardian.

It is extremely important for you to keep these original documents in a safe place. Additional copies may be obtained for a nominal fee. Anytime you take action on behalf of your ward, you may be required to show one or both of these documents as proof of your authority. You should never give away the original document. Copies should be sufficient proof.

The guardian must file an acceptance of appointment in order for the letters of guardianship to be issued to him or her. The letters and the order are your proof of guardianship should you need to show papers to obtain treatment for the ward.

Modification or Dismissal of the Guardianship

A guardian's duties may be modified whenever the individual's capacity to care for his/her person and/or estate have changed so as to warrant modification or discharge. A petition for modification may be filed by the person who is disabled, the person's guardian or any interested person on his/her behalf.

The individual with a disability may make a request to the court for modification or discharge by any means, including oral communication or informal letter.

Once a petition has been filed, the court shall conduct a hearing on the matter. All of the rights afforded to the person who has a disability in the hearing for initial guardianship shall be provided in a hearing for modification or dismissal of guardianship.
At the conclusion of the hearing, the court shall issue a written order setting forth the factual basis for finding any modification in the guardianship deemed appropriate. The court may do any of the following:

1. dismiss the petition,
2. remove the guardian and dissolve the guardianship order;
3. remove the guardian and appoint a successor:
4. modify the original guardianship order; or
5. make any other order which the court considers appropriate

and in the interests of the ward.

A guardianship ends if the ward dies or the court terminates it because the ward has moved out of the state, or because the guardianship is no longer necessary. (A. C. A. §28-65-401)

The Guardian's Annual Report to the Court

Beginning one year from the date of the appointment, the plenary or limited guardian must file a "report on the condition of the ward" at least annually. The "order appointing guardian" and "letters of guardianship" should state if you must report more frequently than once a year.

If the report is not filed at the appropriate time, the probate court may suspend the authority of the guardian until the report is filed. The probate court may also hold the guardian in contempt of court. Your report to the court must include the following:

** The ward's current mental, physical and social condition.

** The report should contain a description of how the ward
is functioning mentally, physically and socially. However, it
is important to note any significant details, such as
required surgery; recommended services, such as
counseling; improvements or problems in functioning
(such as obtaining competitive employment).

** An assessment of the adequacy and appropriateness for the ward of treatment and residental programs in the ward's current residence.

** In determining appropriateness there are several
questions you might ask:

1. Does the ward enjoy the living arrangement?
2. Does this arrangement allow maximum independence appropriate to the ward's abilities?
3. Does the living enviromnent afford a clean, attractive, healthy, atmosphere? A quality lifestyle?
4. Does the ward receive appropriate services in this living arrangement?
5. Could the ward function as well or better in a less restrictive living arrangement?
6. Would you like to live in such an enviromnent?

** Also--be sure to indicate if the ward has changed residences
and why, and the ward's current address.

** A recommendation of the need for continuing
guardianship. This will be a judgement call. Try to
assess the skills of the ward objectively.

** An accounting of all financial transactions made by the guardian involving the ward's estate. It is important to keep a ledger including all deposits, withdrawals, major purchases, etc.

** Any other information requested by the court or useful in the opinion of the guardian. This is your opportunity for any further comments regarding the ward, your responsibilities or your relationship with your ward.

The Accounting

An accounting must be submitted by the individual acting as guardian of the estate, as often as the court designates. Required at least annually, an accounting may be requested at any time by the court. Included in the accounting should be at least the following.

A summary of major transactions such as the purchase or sale of stocks, bond, property or other assets.

A summary of major expenditures made during the reporting period.

Additionally, it is a good idea to include a brief breakdown of any expenses, such as medical treatment, dental services or the guardian's expenses on behalf of the ward. Remember funds and assets from the Ward's estate should ALWAYS be kept completely separate from any funds or assets of the guardian.

Conclusion
(Part II)

Remember the documents which must be filed with the court and those the guardian receives from the court are extremely important. In order of attachment, those documents include:

1. petition,
2. evaluation,
3. report,
4. notice of hearing,
5. proof of notice,
6. notice of right to request dismissal of guardian or modification of guardianship Order
7. letters of guardianship,
8. order of appointment,
9. petition of modification or dismissal, and
10. accounting.

Questions About Guardianship

The county probate court clerk can answer some general questions and can provide necessary forms. However, probate court staff MAY NOT provide any legal advice concerning any particular situation. Further, probate court staff are prohibited from assisting any individual in completing any court forms. **Any question regarding a particular guardianship should be directed to your attorney.**

You may also contact:

Guardianship, Inc.
519 E. 5th Street
Little Rock, AR 72202
(501) 376-2420

Arkansas Volunteer Lawyers for the Elderly
615 West Markham, Suite 200
Little Rock, AR 72201
(501) 376-8015

Ms. KINDERMANN. Thank you.

Our final speaker will be Mr. Patrick Murphy. He is the Cook County Public Guardian in Illinois. He was named by the Governor of Illinois in 1979 to that position and reconfirmed in 1981 by the Chief Judge of the Cook County Circuit Court. Under his leadership, the office has been cited by the Associated Press for its excellence in guardianship services. He will also address how far we should go in relying on informal alternatives to guardianship.

PATRICK MURPHY, COOK COUNTY, IL, PUBLIC GUARDIAN

Mr. MURPHY. I find that there's almost nothing to add to what I've heard from the other four speakers, and I'm a bit humbled in coming after four people who have such broad knowledge.

Our knowledge in Cook County or my own personal knowledge is based upon a nonacademic approach. I'm just a trial lawyer. I've seen what goes on in the guardianship area from the trial courts of Cook County to the Federal courts and up to and including the U.S. Supreme Court. We've litigated cases involving these issues.

Our office is an office of about 85 lawyers and 35 social workers. We have three divisions. One division represents abused and neglected children, and one division, the one that's appropriate here, is the guardian for people who are incompetent or disabled primarily because of Alzheimer's or organic brain disease. We have a few DD and a few MI. We take care of their estates. We have about $15 million in money and another $15 million in assets.

Part of the problem in coming here and talking about what we do is that we see the narrow aspect. We're like Plato's man—person, if you will—chained to the cave wall. We don't see the real world. We don't see caring families who take care of their aged parents on the children's side, and we don't see parents who take care of their kids in the proper way. We see abused children, we see elderly people who have been left alone because of the transient nature of our society, because of the demise of nuclear families or what have you, we see people with thousands of dollars, millions of dollars in assets who live in filth and poverty, who freeze to death, as in one case a woman who had over $1 million in assets, and we see people who are ripped off by others using durable powers of attorney and just sleazy tactics. And we also see a county of 6 million people not in a rural setting or in a small-town setting. So our viewpoint is jaundiced, it's parochial, it may not be entirely appropriate and certainly isn't for everything that goes on around the United States.

I know there was some comment made about public guardianship from one of the prior speakers. We've seen, I think, in Cook County the best and worst of it. When I took over in 1979, my predecessor had 200 or 300 wards. All of them but one lived in nursing homes when we took over, despite the fact that they had considerable assets or they could apply for benefits to keep them out of nursing homes.

Parenthetically, the one woman who lived outside of a nursing home was always my favorite ward, because she would come down to the office to pick up money, and she'd announce in a very loud voice, "God bless Patrick T. Murphy." [Laughter.]

I came first and the deity came second.

And also my predecessor had no assets. According to my predecessor, none of our wards had any assets other than money, they didn't have any personal property, and in fact she owned an antique shop on the side where she got quite a bit of money from, and we never could figure out where she got her antiques, but I have a pretty good idea.

We have litigated—since I took over, we're able to at any one time keep between 35 and 40 percent of our wards out of nursing homes. To do that we had to sue the State. We sued the Department of Aging and the Department of Public Aid to get money which otherwise would go to a nursing home operator, and we used—I'm going to go off on a tangent here, because I think some of these things are important for purposes of Federal legislation.

When I went to the Department of Public Aid and the Department of Aging and I said, "If you give me two-thirds of what you give a nursing home operator, I can keep these people out of nursing homes and keep them in the community," I was told, "We can't do it," and I said, "We're going to sue you," and they said, "Federal legislation, State legislation, you have no theory." I gave them a theory, it was as weak as prisoners' gruel, they knew it, they challenged me to sue them, and I did. But I waited until about a week before Christmas, I notified the media, and I walked in with three old ladies in walkers and wheelchairs, and of course, they settled the case within a week. [Laughter.]

But the point is that you shouldn't have to go through all of that in order to get something which should come naturally, and that is the one thing that is required federally, the recognition that people can live outside of nursing homes and some of those assets should be used to keep people out of nursing homes.

With respect to Federal legislation, as a veteran of the New Frontier and Great Society programs between 1966 and 1974—I was either in the Peace Corps or in the Legal Services for the Poor Program—I remember how we were going to resolve poverty and problems around the world in those programs, and we see the results today. I realize that Federal legislation sometimes creates more problems than it resolves. Frequently we make great promises which we can never live up to.

Also, just in the juvenile area we have what's called the Adoption Assistance Act, which is supposed to provide on a Federal level for problems involving juveniles, and I've seen that act completely destroy much of the juvenile justice system. We used to have what were I guess pejoratively called orphanages, and they were done away with in great part because of the push in Federal legislation to keep kids at home and to keep them in two-parent foster homes, and we've seen a lot of good child care facilities go down the tubes, and we see kids being returned home to horribly abusive parents, to people who aren't parents, and we see them placed in foster homes which are just absolutely terrible. The demise in the foster home has occurred because of the demise of—well, for a lot of reasons. So that when we're thinking about Federal legislation, we have to really think through all the problems.

Getting to the specific area that I was asked to talk about, again, Ms. Miller really hit upon most of those areas, and I think I would just be repetitive of what she had to say. One of the problems we've seen, though, with durable powers of attorney is that they are very, very frequently used to take advantage of somebody. Either, one, you get the person who is, in the words of a cop friend of mine, "soft as a grape but not quite incompetent," and they sign them, and basically these are the people that you could say, "Well, John, would you please walk off the side of a cliff?," and they would, although they're not really disabled yet, but they're in the Twilight Zone, or like we had a case recently of a former Congressman who got a durable power of attorney and ultimately used it to—and he's a lawyer—ultimately used it to take $900,000 from his client. The guy was competent probably when he signed the durable power of attorney but certainly incompetent by the time he was ripped off by this ex-Congressman. I'm not trying to suggest that former Congressmen are all dishonest, by the way.

And we've seen cases where the person is incompetent, disabled already, and people get durable powers of attorney. For instance, we had one case where a man showed up who had been the son of a former co-employee, hadn't seen this woman in 40 years, hadn't seen her since he was a teenager and now he was in his early sixties, had her sign a durable power of attorney and will granting him the ability to do everything, and the neighbors across the street about a month later got the same thing signed, so we had dueling durable powers of attorney. Both of them were done for the worst possible reasons, to rip the old lady off, and then we got involved and got guardianship, and we had to go after and sue everybody.

The point is that a durable power of attorney is an appropriate vehicle, but it's an exclusive vehicle, that guardianship is something else, and frequently you require guardianship in order to go after someone who has used a durable power of attorney to rip someone off.

Again, I just wanted to leave you with some impressions of some of the problems we've seen in Cook County. With respect to the ultimate question of Federal legislation, I don't think we're in a position to give advice one way or the other. We can tell you the problems we see. We know there has to be reform. We know there has to be reform in Illinois, for instance. Whether it takes Federal legislation to create reform in Illinois, I don't know. Another problem, of course, is the problems we see in Cook County are not going to be the same problems you see in Arkansas, because in a smaller State, in a smaller jurisdiction, everyone's going to know Aunt Tillie and Grandma Smith, whereas in Chicago you can live right next-door to somebody and not talk to them for your entire life. So there are really competing problems, and if there is Federal legislation, you're going to have to somehow resolve those competing problems.

[The prepared statement of Mr. Murphy follows:]

OFFICE OF THE PUBLIC GUARDIAN
COOK COUNTY, ILLINOIS

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Public Guardian of Cook County

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May 29, 1992

The Honorable David Pryor, Chairman
United States Senate
Special Committee on Aging
Washington, D.C. 20510-6400

Dear Senator Pryor:

This letter will flow as logically as I would have liked. I have been on trial for the past week and am dictating this on the run. While it may not be the best organized response to your questions, I believe it does contain much of my thinking.

The Cook County Public Guardian's Office has 85 lawyers and about 35 social workers in three divisions. One division acts as lawyer and guardian and litem for abused and neglected children in Cook County, the second acts as attorney and guardian ad litem for some children in divorce cases where child custody is a question, the third, and the one that is germane to your questions, acts as guardian for a disabled population of mostly elderly citizens and their estates. At any one time we may have 400 wards and about $15,000,000 of their assets. Most of our wards in this division suffer from Alzheimer's or organic brain disease.

Through the years we have encountered countless tragedies of elderly individuals who have survived, worked hard and helped this country through the great depression, the second World War, the boredom of the fifties, the arrogance of the sixties and the political scandals of the seventies, to be exploited in their twilight years. We have seen grandmas locked in vermin infested basements while the grandchildren take over the home and collect social security and pension checks. We have seen elderly men beaten by their children when the parent refuses to cough up money for drugs or booze. And we have seen too many individuals financially exploited.

One of the very first cases I encountered as Public Guardian was a woman who went to her tenants to tell them there was a strange man sleeping in her bed. The strange man turned out to be her husband dead for about three days. The tenants then had the old woman sign a power of attorney and a will and quickly relieved her of her life savings of $90,000.

And there was the son of a former acquaintance of an 85 year old woman who showed up and had the woman sign a power of attorney and will. He then used the power of attorney to sell the elderly woman's valuable real estate in an inside deal for a fraction of its actual worth. In yet another situation, two realtors had an elderly man lying on a nursing home floor mostly naked, sign a contract deeding away his unmortgaged property to them. The contract said he would receive $80,000 with set offs for work they had done. After the set offs, the old man received $9,000.00.

And then there are the cases that do not involve financial exploitation, merely tragedy. For instance, two sisters lived together in a mansion. They had over a million dollars in liquid assets. Yet, because they failed to pay their bills they lived without heat and electricity. One of them froze to death and the second was found sitting by her body.

There are a whole class of other individuals who do not require guardianship services but who require some kind of protection. A street wise cop once remarked about an old man we were trying to help "he's as soft as a grape. Give me about two hours with the guy and I could have him sign over to me his entire estate." A few months later, a lawyer did just that. These men and women perhaps bother me the most. They do not require and should not have guardianships placed over them. Yet, I have seen them victimized repeatedly by, among others, door-to-door salesmen, lawyers, librarians, beauticians and nursing home operators.

In all but one of these rip-off cases we sued and prevailed. (That case is in the Appellate Court). But I know that for every case we have discovered, there are hundreds of others where, because the elderly person cannot defend herself, she lives and dies being exploited by others without the knowledge or help of the public. And from my own experience I know there are countless others where a guardian is appointed or someone obtains a power of attorney and they use their guardianship and/or the power of attorney to take advantage of the elderly individual.

When I took over the Public Guardian's Office in 1979, all but one of our wards lived in nursing homes. I am proud of the fact that today at any one time between 1/3 and forty percent of our wards live in the community. In order to accomplish this we had to sue the state government to obtain funds which otherwise would flow to nursing homes. Our office has also prevailed on the first right to die case won in Illinois and had legislation declared unconstitutional which made it easier for tax scavengers to take property away from the elderly incompetent.

With respect to the various questions raised by your letter, I am not sure that our office in general or myself specifically can give intelligent responses. We can parochially reply based on our experiences as the Public Guardian for the past thirteen years in a county of six million souls.

A. THE NEED FOR DATA

This is a question obviously for congress. However, the problems in guardianship have been documented by the Associated Press' study in 1987, Dade County, Florida and Marin County, California grand jury investigations, an Illinois study in 1989 and a 1990 report from Missouri. The main problems with the guardianship laws is presently that there is a lack of meaningful notice and opportunity to respond to a hearing and, most damning, a lack of judicial post-adjudication inquiry. Under normal circumstances once an individual becomes guardian of another, the courts ignore what happens. In Illinois, for instance, the act previously called for automatic annual reports on the well-being of the ward. This was done away with entirely. Mandatory annual accountings were reduced to once every three years after the first account.

A year ago, we conducted a survey of fifty random Cook County, Illinois guardianship cases where a guardian of the estate was appointed prior to 1988. Under our statute, two accountings should have been due. In 17 of these 50 cases, no accounting at all had ever been filed. In 9 cases not even an inventory of the assets which is due in 60 days after appointment had been filed. In fact, in only two of the cases all reports due were filed. This does not indicate reasonable judicial monitoring.

B. THE NEED FOR BETTER LEGISLATION

The obvious argument against federal legislation is that it would usurp a traditional state interest in controlling guardianship procedures. I favor federal standards for at least two reasons. Many states, including Illinois, are not taking the steps necessary to revise and implement guardianship reform. Second, national minimal standards will assist some of the problems we see in the transient nature of today's society. Families frequently are divided between several states. Each state's guardianship laws differ drastically.

C. RELIANCE UPON INFORMAL ALTERNATIVES TO GUARDIANSHIP

Alternative mechanisms of surrogate decision-making such as durable power of attorneys offer considerable promise. However, we must make certain that informal mechanisms accomplish more than simply placing outside the realm of public scrutiny potential abuses of vulnerable persons. Total reliance on these informal means of assistance is dangerous. They are inexpensive and potentially less intrusive than traditional intervention such as guardianship. Traditional common law theories of agency assume that there is an inherent safeguard in giving an agent a power of attorney because if the agent acts in a manner not to the benefit of the principal, the principal can revoke the agency and ultimately sue the agent under a variety of common law theories.

In the case of durable powers of attorney, this logic falls apart because the principal may have lost the ability to monitor what the agent does and the capacity to revoke that instrument. Further, many elderly individuals who sign powers of attorney may not have the capacity initially to sign such power. Most of the cases that are presently referred to the Cook County Public Guardian's Office involving the misuse of durable powers of attorney are victims who not only do not know or understand what has happened to them but probably never understood the durable power of attorney in the beginning. Between forty and fifty percent of all referrals to our office for financial exploitation involve durable powers of attorney.

For instance, within the past month, the case of an elderly man living in a nursing home was referred to us because the nursing home had not been paid in a year. The man's nephew holds a durable power of attorney. A year ago, the elderly man had $55,000. Today he has $5,000.00. The nephew admitted that he loaned the $50,000 to a family member whom he would not name. We are now suing for return of the money.

Another phenomenon we frequently encounter is the "dueling document syndrome." A friend, neighbor and/or relative gets a power of attorney and a will and within a week or two, another friend, neighbor or relative gets another power of attorney and will.

A summary of the alternative mechanisms of surrogate decision-making include:

1. **Living Will.** Generally, a document that can be executed to give instructions as to medical decisions in the event of disability. The major problem with a living will is that it takes formalities to execute it validly of which the general public may not be aware.

2. **Durable Power of Attorney for Health Care.** A useful document of which the ABA and AMA have very good models. These are submitted to those who have contractual capacity to execute it.

3. **Health Care Surrogate Decision-Making Statutes.** A good and compassionate vehicle for alternative decision-making.

4. **Adult Protective Services.** Case management services may address some needs outside guardianship. The major problem with these is that they usually do not include an outreach/investigative component. They can only serve clients who are brought to their attention and who "volunteer" for services. There are scores of elderly individuals who desperately need services but who because of their condition do not reach out and seek them. There are others whose cognitive functions are greatly impaired and who are living more or less prisoners to those who are exploiting them.

D. FINANCIAL INTERVENTIONS

1. **Durable Power of Attorney.** This is the single most fertile area for referral to our office. Problems with this range from a mistake of the meaning of the law, for example, people becoming joint tenants on property over which they hold power of attorney, to blatant financial and physical abuse. Many who sign powers of attorney are not competent to do so.

2. **Money Management/Trust Services.** Professional or corporate trust services are expensive and normally only work for people with significant accumulation of assets or money, which would not include those of us who work for the government.

3. **Limited Guardianship.** Although many jurisdictions, such as Illinois, have limited guardianships they are at the present time under utilized.

4. **Representative Payee.** Social security has programs to recruit and monitor people to act as representative payee for those who cannot handle their social security income. The parameters of this outreach are narrowly drawn and very few agencies qualify to perform this service. In addition, it is costly to run a representative payee program and there are little financial incentives to do so because of existing regulations.

CONCLUSION

We cannot excuse further involvement in guardianship or other protective services by reliance on these informal mechanisms. Instead standards must be mandated for guardianship and protective service programs that include alternatives to guardianship and the monitoring of less formal arrangements such as the durable power of attorney. In other words, we cannot allow durable powers of attorney to relieve or abate problems in guardianship. They are mutually exclusive remedies when both are used appropriately.

Sincerely,

Patrick T. Murphy amt

PATRICK T. MURPHY

PTM:amt

Ms. KINDERMANN. Thank you.

I want to take this opportunity to thank all our presenters for their insightful comments. We can now open it up for discussion, with the one request that before you speak, just say your name so the court reporter can get that on the record.

Would anyone like to start with comments or questions for the presenters?

REBECCA KOLLENG

Ms. KOLLENG. Rebecca Kolleng, and I have a question actually for the first three presenters. Maybe you could give us some insight on this. Depending on the study you read, 31 States after 1988 have reformed their guardianship statutes significantly, maybe 33 States. Given the fact there are 50 States, is that enough reform for you, and how do you compel the other 19 States to address the issue? The second part of that is, do you feel that the guardianship reform movement in the individual States is gaining momentum or losing momentum?

Mr. REGAN. Well, everyone's looking at everyone else. [Laughter.]

I'm John Regan responding. I'm happy to hear the statistics. I'm not necessarily on top of every last piece of reform on a year-to-year basis. I guess one response is that maybe the other 19 or 20 jurisdictions have already done some good work in this area and didn't need reform post-1988. But more to the point, I think the issue is rather whether a Federal mandate for reform is the way to go. It seems to me pretty impressive to have 31 out of 51 jurisdictions doing it in that short a period of time, with others still in the pipeline. I know we in New York are agonizing over a very comprehensive piece of reform legislation.

So it seems to me that the movement is still perking along very nicely to the extent that it's needed, and if you look at the alternatives—that is, Federal imposition or lawsuits or something of that sort—I think it's a pretty impressive record, and I wouldn't tamper with the way it's going right now.

Mr. KEILITZ. There's significant movement in the States. When people call me, especially reporters, they ask, "How many States have done this?" The answer is always—once I get frustrated—"27." They say, "Thank you very much. Goodbye." [Laughter.]

Seriously, the answer is always, "What do you mean?" and "It depends." States are constantly changing. Next week there will be a State that's going to change its guardianship laws or protective services laws or involuntary civil commitment laws. Some of the changes are minor, others might be major.

I sense a reform is on the way because the issue has been brought to the attention of the public, and this meeting continues it, but most of it is not statutory. In Phoenix, AZ, the court is working with the Sun City community, to create a council made up of people who are retired physicians or retired lawyers, and they, on a pro bono basis, review and monitor guardianships for the court.

In terms of whether the reform is reflected in recent legislation, probably yes, but again, we have no data on that, nor is anybody that interested in collecting any information on that.

Mr. JOHNS. Frank Johns responding. I think the data that's gathered, for example, in the addenda to Sally Hurme's research is really impressive when you look at the statute citation and, under it, look at the year in which that statute was amended, and then go across the columns to see what is changing, language procedurally or substantively in terms of due process or even after-the-fact ethics or standards or monitoring impact. I think Professor Regan hits it on the head, though, when he asserts we don't really know how that's being implemented, and we don't have the data yet to understand what the revisions mean.

And I think all of us have asserted the proposition that all the States are receptive to the idea of reform. I think all States anguish over the proposition of how that reform may mandate an expense to them or change their own form of bureaucracy, and I think that's the key that Congress can help us with, and that is take the data or assert new research grants that have a lot of money behind them and spread it out into the field, possibly from the ground up, in order to find out just how is it working.

Ms. KINDERMANN. I want everybody to feel free to participate without having to raise their hand in order to get a discussion going.

JOHN PICKERING, CHAIRMAN, ABA COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY

Mr. PICKERING. I'd like to break in at this point. I'm John Pickering, chair of the ABA Commission on Legal Problems of the Elderly. With our sponsorship and that of our sister commission called the Commission on Mental and Physical Disability Law, and also with the assistance of the real property probate and trust section of the American Bar Association, we have conducted two national conferences on guardianship problems, which are now ABA policy—the first was in 1986, the second in 1988—calling for substantial reforms in the State guardianship process. You have had handed out to you this morning from our staff reports on legislation in 1991 and so far in 1992. We have studies going back to 1988. Following those two ABA conferences and resulting recommendations, there has been considerable impetus for reform in the States. We're looking at how that goes along.

I agree that the problem is not only the reform of the statutes, but the implementation, and this ABA publication, which Sally Hurme had much to do with, on guardianship monitoring shows how we fall so far short in what we actually do with implementation of the statutes. The ABA recommendations which are broad in various areas, particularly in due process requirements for counsel, notice, opportunity to be present, and so on, are expensive, and the problem in many States, of course, is money. This has always been my own personal feeling where some Federal assistance could be of help.

In the 1991 meeting of the Conference of Chief Justices, I presented the ABA recommendations to the conference and suggested the need for reform, absent which there might be the possibility of Federal legislation. You heard Mr. Keilitz give the resolution of the Conference of Chief Justices. The American Bar Association has no policy on whether there should or should not be Federal legislation in this field. With my friend, Jack Lombard, we have in effect said we ought to wait and see what is developing out there before we go forward on this.

I think I've stated that fairly, haven't I, Jack?

JACK LOMBARD, REAL PROPERTY AND TRUST LAW SECTION, ABA

Mr. LOMBARD. I think you have, John.

Mr. PICKERING. So I don't want the staff or the committee to be under any impression that there is an ABA position on this matter at the moment. We have recommended a number of reforms which we're working to see get adopted.

Judge GRANT. I'd like to make a comment, being sort of in the front line on this being a probate judge, and sort of the concept of what you want the courts to do is change a great deal, because monitoring guardianships requires a lot of time. Fortunately in California we have a staff who looks at the accountings and we set a date for people to file the accountings. A few years ago we didn't do that, and we just never saw any of them, or if we did, it was because somebody wanted to come to court and get an approval of something they had done. But now we set—and we sort of developed this ourselves—we set a date for the accounting to be on file. If it's not on file, they have to come in and tell us why.

We also—and we developed this, and you would be amazed at how much we've flushed out of this—we have required people to file with us the original bank statement showing that their accounting does have the amount that is in it, and a number of people have been—well, in fact, unfortunately, that was the cause of a very good organization going down the tubes because one of their wonderful workers was taking all the money and filing accountings that were not correct.

I just want to also comment on the alternatives, which I'm very interested in what Mr. Regan says about the alternatives as sort of a mix of guardianships and the alternatives, because I think that's something we have to really look into, because attorneys will tell me a guardianship costs $3,000; a power of attorney costs $300. We've got to come to some area where we can have it not be so expensive but still have the safeguards that you get with a guardianship. And I have had some horrendous stories with powers of attorney. A woman who had $12 million went down to about $4 million before somebody came in and got a temporary guardian who was able to look into it.

The other problem that I have and I think that maybe the Federal Government could help is with education for guardians.

That's one of our big problems, getting people who will act. It's almost as bad, though, with trustees. It's hard to get good trustees.

JOANNE LYNN, M.D.

Ms. LYNN. I would like to jump in just a moment. I'm Joanne Lynn. I suppose I'm the closest that we come around the table to someone who's a direct provider, a front line in a different way, to large numbers of persons who are in fact incompetent, almost none of whom have had their incompetence adjudicated in court. I recognize and greatly honor the efforts to improve guardianship, that the abuses are, of course, outrageous, and the extent of them is a national scandal. However, we run the risk of spending a great deal of effort in fixing up guardianship without having noticed what it is that is the true prevalence of the at-risk population and what the impact is of guardianship reform upon the services in fact made available to that at-risk population.

It is interesting that in talking about data that we need, no one has pointed out the need to simply know how many people there are who can't make their own decisions, who in fact it's not their responsibility for their own choices, for the kinds of choices that routinely come at people. In this era in which we grow old and accumulate chronic illnesses and do not die in general rather suddenly but instead after a rather long period of decline, as you look around the table you have got to come to terms with the fact that probably about half of us will have a substantial period of true incapacity. Now, in the current system, most of us will never see a judge. Most of us will never have any of our issues adjudicated. Most of these will all be decided by informal processes. But guardianship reform itself is making that practice much less likely.

There are now whole States in which, in the last 6 months, all nursing homes are moving to establish guardianships for all persons who cannot sign for themselves, even if they have a loving spouse. So the number of potential clients coming your way is enormous and unmeasured. In Washington we did a very flimsy study scientifically but nevertheless reached the estimate that at the minimum, 20,000 people a year come into hospitals and nursing homes—that's only into hospitals and nursing homes; that's not the ones who don't come in—and are factually incompetent. Of that number, in the same year 1 percent of that number ever came to guardianship.

When we talk about reforming guardianship, we may as well be rearranging deck chairs on the Titanic, because the real iceberg is out there in the 99 percent that you never see.

And what you do about reforming guardianship profoundly affects their lives and what will happen with them. If everybody who has a substantial period of incapacity has to come to guardianship proceedings and those guardianship proceedings take 8 months and cost $3,000, I can tell you there are going to be a whole lot more untreated cancers, there are going to be a whole lot more people who ought to have had treatment and who have it delayed, a whole lot more people whose money gets frittered away.

I take care of patients who have $60 a month to spend on everything beyond food, board, and medical care; $60 a month that has, in some cases, been allocated to their court-appointed guardian to pay the $3,000 of upfront costs. It takes the rest of their life before they can again buy a toothbrush. You know, the disproportion here is enormous.

We have to come to some terms with what we're going to do about the fact that many of us are going to face incapacity and that we do not have systems in place that enjoy public approval and some appropriate degree of constitutional protection, and we have to develop a system of making decisions for incapacitated adults of which guardianship is only one piece and of which guardianship somehow manages to capture those cases in which substantial estate matters or substantial personal care matters are at stake and doesn't manage to capture the rather routine medical care treatment decisions of a person who is dying in the loving care of their family. Because I'll tell you, if you want to get review of all those cases, not only are all of us going to have our matters reviewed publicly, but we can't bear the cost. We're talking about a civil rights reform the cost of which we have never seen.

So we have to take account of all of these other people who we aren't looking at when we talk about fixing up guardianship as this narrow issue. We're going to have to have data on how often people become incapacitated, what kinds of causes, what sort of rate of reversibility, how many of them face serious issues. We're going to have to come to some consensus about what counts as serious and then figure out what piece of this appropriately comes into guardianship and how that should be dealt with and how the rest of the system should be dealt with. Because otherwise, we're just reforming this one little piece, making it all pristine, and ignoring the fact that almost all of us will find our abuses completely outside of the guardianship system.

Now, what is the Federal role in this includes a dramatic effect in the last 4 or 5 years of statutes being written entirely unthinkingly that require consent—sounds perfectly correct—consent of the patient or someone authorized under State law to consent on behalf of the patient. That's the usual formulation. It's found in the hospice consent statute, it's found in the recent regulations reforming a use of psychotropics and restraints in nursing homes, it's found in the regulations implementing the Patient Self-Determination Act, that same formulation.

There are only a handful of States in which a spouse is authorized clearly under State law. In all the rest of the States, God knows who's authorized under State law, and the only person, as John Regan was saying earlier, who is clearly authorized under State law is a guardian or a person who has a valid durable power of attorney. Now, for the other 90 percent of people or more, we have no one clearly authorized under State law. Therefore, the current practice of huge numbers of guardianships being initiated by those of us who take care of long-term care patients who feel all of a sudden that we cannot do the care that's required because of this Federal statute, in unthinking language—no one thought of its impact. Everyone thinks there's someone authorized under State law, and there isn't. The first thing is we've got to stop that until we figure out what we're going to do with all these people, and then we need some real data. We need to know what the impact is of alternative modes of approaching the problem of seriously incapacitated adults. What is it we're willing to afford? What are the real costs? Where are the real abuses?

You know, the people who have spoken thus far and the people mostly around this table see the abuses. I'm very humbled by their experience. It also is the case that the vast majority of the 99 percent who never come to court must not be being greatly abused either because they had no money to spend or because there are no serious issues perhaps, but maybe, just maybe, because there are a fair number of people who still care about their family, who still care about people in the community, and maybe there's a way to acknowledge that, at least in systems where there are other professionals who you can nail with abuse-reporting requirements, like in all of health care, where you can have another person involved who must report.

Maybe that's enough protection, but that's the kind of data we need, and if all we do is go out and start tallying noses of those who end up being jettisoned into the guardianship system, one way or another we're going to be counting people who got there for bizarre reasons, rather ectopic reasons not necessarily intrinsically related to anything, and ignoring the huge number of people—I feel like we're, you know, perfecting our game of archery while standing on a battlefield and ignoring the fact that there's a battle going on around us. And you can perfect the archery game all you want. If you ignore the battlefield, you've missed the whole point, which is that many of us—most of us perhaps—are going to have a period of incapacity, and for most of us there is not a clearly delineated, publicly approved system that allows decisions to be made in a proper way, and that's what it seems we have to come to terms with, that the Federal Government could take a lead on at least the data collection and could stop messing it up by pretending there's a system out there when there isn't.

Mr. REGAN. Could I respond just briefly? John Regan.

Centuries ago the common law developed a system post-mortem, after death, for taking care of people who executed an advance directive, known as a will, and for those who didn't, known as the laws of intestacy, and it provided that one way or another, whether you planned or didn't plan, decisions would be made, heirs would be taken care of, et cetera. The more we've gotten into, at least on the health care decisionmaking front, pre-mortem anticipated surrogate decisionmaking, I think we're moving as a society in the same direction.

Joanne mentioned a few States that have laws which allow spouses, and others to make decisions for people. We in New York have been drafting a surrogate decisionmaking statute to undo our horrendous State law that permits no one to make decisions without an advance directive, and the parallels between the post-mortem and pre-mortem decisionmaking are startling when one begins to analyze them. I wonder whether we shouldn't be thinking in terms of expanding that approach to the 99 percent of families that really do try to do right by their kin and expanding it into property decisionmaking, at least to a certain amount, and over certain kinds of property, and leave the large estates and the large businesses and holdings and complex situations to the more formal mechanisms of the law. At least this is a direction, it seems to me, to develop these extensive pre-mortem parallels that some creative thinkers around the room might want to undertake and perhaps try to unravel some of the problems that we have now.

Mr. LOMBARD. John, Jack Lombard. In response to Joanne's concern, the uniform commissioners are at the moment dealing with a uniform Health Care Consent Act that will pick up what now almost 20 States have in identifying a priority of persons who can make health care decisions. The other thing is that all of the States that I'm familiar with have emergency procedures with respect to health care decisionmaking. The major problem is when you have, as we did in Philadelphia—we developed a very elaborate program of volunteers to act as guardian ad litem, and those decisions in the health care emergency area would be made within 48 to 72 hours. The problem is that we don't have people to serve as the guardian to then make the decision. You can have a guardian ad litem as a lawyer volunteer, but often times what happens is the administrator of the hospital is appointed.

I think we're moving in the direction of solving that problem, but clearly one of the things that I did in preparation for coming here today was to talk to Judge Poalik, who I believe our judge friends here know. Judge Poalik is the administrative judge of the Philadelphia Court, and he's authorized me to mention these few points that are coming from his concern about overregulation in the guardianship area, and these are practical, actual, factual things that are occurring. Maybe it's only in Philadelphia, but I think we'd find the experience is happening throughout the country.

One, corporate trust companies are refusing to accept guardianships because they don't want to comply with the new regulations. Bonding companies are increasingly refusing to write bonds in the States particularly of young incompetents, and I've been through this experience myself in a Michigan guardianship. That bond expense will be an increasing burden on the guardianship if the corporate trust companies are out of the market. If individual guardians are the only candidates and you can't secure a bond, then the only option is a blocked account, as we call it in Pennsylvania, where you can just put it in an interest-bearing savings account or a certificate of deposit at today's low rates. You can only get money with court approval, so you have to go in and petition the court to get it out of the blocked account.

His concern is the presumption for limited guardianships is based on the disabled, retarded model, and that represents the smallest number of persons who are in the guardianship system. Most guardianships involve persons who are at the end stage of chronic brain disease and will not benefit from any system that's designed for persons of limited but not complete capacity. In his view, abuses happen with rare frequency, and a system should not be modeled on the assumption that everyone needs to be protected from the abuse of the few, because, I think as we've heard in Chicago, if a person wants to abuse someone, they'll abuse them no matter what the system is.

The more complex the system is, the more expensive it will be—the increasing bond premium is just one example of that—and fewer people will be willing to serve as guardians, and that is the serious point in the whole problem.

As far as I'm concerned, it's the most serious thing we've discussed today—John mentioned it—and that is the need for guardians, because the system only works if you have people who are willing to serve. Unfortunately, you know, the Associated Press report gets a lot of indictment of the system, but really if you read it, it says the system for the most part works well. It works, people are honest, and they're discharging their responsibility, and that really is the message we should be getting to people. It is something that is worthy to do, and what the Federal Government might help us do in this partnership is to encourage the training of guardians. There have been a lot of good models. The San Francisco training model for guardianship is an excellent resource, and all of that has happened over the last 5 years.

We're making strides, but for goodness sake, don't overregulate a system and make it break when that is the possibility. If in fact bonding companies aren't writing bonds, that could cause the breakdown in the system itself, and maybe that's something that the Federal Government could find out about.

Mr. MURPHY. Patrick Murphy. I just want to make one point. I didn't make it when I was talking before, and I guess it's because in the parochial nature of where I'm coming from, I just see things in Chicago, and I realize there are different forms of guardianship around the country.

When we took over the Public Guardian's office, it was a public guardian, but my predecessor supported her office entirely from the funds of the people over whom she was the guardian, and as a result, I think, there was a lot of not only outright thievery, which obviously can be avoided, but there was a lot of slippage. We work on a deficit. The taxpayers support our office about two and a half to one over what we pull in from our wards, and I think to be an effective public guardian, it's going to be taxpayer-supported. The taxpayers of the county cough up several times what we pull in.

So we have people on our payroll who will go out and assist in taking care of a home which may be in disrepair. They'll clean out the home. You'll go in some homes which will be obviously a foot high in dead cats and rats and so on and so forth. Obviously, if you're going to use the ward's assets to clean that out, it could be quite expensive. We actually have an account where we loan the ward money. Sometimes the ward has assets that are tied up, and we'd have to keep the ward in a nursing home in the meantime while we got rid of some of the assets. The county will actually loan the ward money while we're trying to peddle off the assets. It might be a home we're trying to sell, and then we'll keep the ward in an apartment with the assets we get from the home, but in the meantime we have to support that ward.

So I think that any real viable guardianship program will have to be taxpayer-supported to one degree or another, even if you're dealing with wards who have assets.

VICKI GOTTLICH, NATIONAL SENIOR CITIZEN LAW CENTER

Ms. GOTTLICH. This is Vicki Gottlich. I'd like to make a few points and respond to a few things that people have said.

First, Jack, I think a lot of us around the table would disagree that limited guardianships are not good for older people, and I think that's really a very ageist comment to say that people with organic brain syndrome and especially in the end stages cannot have some control over their lives. In fact, at some points, they're already in a nursing home, they may have a representative payee, they're on Medicaid, and they don't really need a guardian. There's nothing left to be done for them, and yet I've seen whole guardianships imposed over such people when really there are other alternatives in place.

The second thing I want to say is to Joanne concerning some of the Federal legislation, and I want to address specifically the Patient Self-Determination Act, because I want to use that for my main point. I'm very concerned with that statute as well, because I've seen nursing homes throughout the country trying to use that statute to say that people need guardians when clearly that's not what the statute says. But quite frankly, in my years of representing older people, nursing homes have used whatever hook they can to try and say that people need guardians. And it might be Medicaid law. They always come up with something. This is the latest hook, and I can't argue against using Federal legislation, because somebody's going to misinterpret it.

Quite frankly, nursing homes are always going to misinterpret everything, and our organization will always say that. But I think there is a role for Federal legislation, and I think that the role is in some of the education efforts that we need and some of the access efforts that we need. For example, under the Older Americans Act under the new title, there is room to indicate that people should be looking at guardianships, people should be looking at alternatives to guardianships, and maybe there would be no money to fund it, but if you keep throwing in the language "alternatives to guardianship," the people who receive money under that statute are going to start considering those issues.

The Patient Self-Determination Act is far from perfect, yet it's getting people to start thinking about advance directives, and by requiring facilities that receive Medicaid and Medicare money to distribute information, it may actually be hitting people who would not ordinarily learn about advance directives. For example, a lot of low-income individuals and minority individuals are less likely to execute an advance directive, but if they go to a hospital emergency room where they receive their primary medical care and they're given a piece of paper explaining what an advance directive is, they may learn about something that they might not have known about beforehand.

There are other reforms that—Senator Pryor, for example, was very instrumental in getting the representative payee legislation passed. That reformed the statute, and we worked very closely with him and the Aging Committee on that.

There are more reforms that could be made to the representative payee statute in Social Security and definitely in VA to make those kinds of alternatives to conservatorships and guardianships more viable for low-income clients, and that's a role that this committee can play in further pursuing some of the reforms that are necessary. I think the legislation, as John Regan has said, that's currently existing in the Glenn bill and the Pepper bill are no longer necessary, but there are other ways that we can look at a role for Federal Government that may not exactly require additional money but may help with access and with information.

JOAN O'SULLIVAN, MANAGING ATTORNEY, SENIOR CITIZEN LAW PROJECT, ANNAPOLIS, MD

Ms. O'SULLIVAN. I'd like to comment on a few things Vicki just said as another front-line practitioner. I do have rather a limited role, but I'll tell you a couple of really big gaps that I've seen in Maryland.

Vicki talked about education, and I think one group that needs to be educated are the attorneys who are appointed to represent alleged disabled people. We have a good statute in Maryland, in part thanks to Professor Regan, that does require mandatory representation, but the attitude of the judges, and it trickles down to the attitude of the attorneys all too often, is that it is an administrative procedure, it is not an adversary procedure. We've done some education there, and there's just a lot of resistance to the advocacy model.

Another point I'd like to make regarding Joanne Lynn's comments is the surrogate decisionmaking procedure that's in place in New York as a project, I think, in which panels of medical personnel make decisions on routine medical care.

Maybe Professor Regan could comment on that project. It's a pilot project in which panels of three people make decisions on the medical care for institutionalized persons.

Mr. REGAN. It's called the Commission for the Quality of Care. It's Article 80 of the New York mental hygiene law. These are volunteer panels of people from various who meet sometimes once a week to be the surrogate decisionmakers for institutionalized mentally disabled persons. It's in place only in a couple of areas in New York—New York City and, I think, Albany. It's been authorized statewide.

The funding isn't there, and there are some questions as to whether it really can work statewide, since it depends on volunteers. While it's generally very well thought of, I'm not sure that it can be replicated on a wide scale without some changes in the personnel who would serve on these panels.

Ms. O'SULLIVAN. We've been trying to come up with a similar model in Maryland, just to address the question that you were talking about. What we see all too often are nursing homes or institutions treating people without any authorization whatsoever. So we kind of saw that as a way that actually probably better decisionmakers than judges could decide on routine care, such as a biopsy, so that it doesn't take 8 months for someone to get one. Unfortunately, we've bogged down where everybody else has bogged down, in the question of money, because the State doesn't want to pay lawyers to represent these people. We're saying that the same due process protection should be in place for these people as in a regular guardianship, but the State thinks that a representative or a lay person could advocate at this level rather than a lawyer, so we're bogged down at that point. The city doesn't have the money. But it's an idea, a way to get faster decisionmaking for mentally disabled people.

LARRY FROLIK, PROFESSOR OF LAW, UNIVERSITY OF PITTSBURGH SCHOOL OF LAW

Mr. FROLIK. I'm Larry Frolik. I think that we could go back to the point that John made originally and that Frank Johns also made, which is that legislation is, I think, inappropriate at this point, because we're talking about a culture, a practice, rather than a statutory problem, and culture is very resistant to legislative attempts to solve or change. You change culture not by fiat, but by education and example, and what we really need is to inculcate the courts—some already have it, but many don't—with the concept of the least restrictive alternative in the guardianship area. We need to take that right out of the mental health area, which has been very successful, and plug it right into the guardianship area so that when a judge thinks about guardianship, his or her first question is, what can we do that's going to be the minimum intrusion on the person's life and yet still meet the need, whatever that need may be, for decisionmaking?

And certainly I think that's going to become more imperative, if we take Joanne's point, that we have this concept of informed consent, which, of course, doesn't grow out of Federal law but out of common law, and that the need for substitute decisionmaking in health care is going to drive the system to more quick and efficient solutions, and I think it is in fact silly to act as if that should be an adversarial situation with all the costs attendant. We're going to have to find a culture to have quick substitute decisionmakers for health care needs.

I would focus on the need for the Government to help promote training of judges and court officials and court investigators and whoever else is involved, depending on the system, through model projects. We need to show these local—and incidentally, speaking to Jack's point about what happens in Philadelphia, PA, is quite different than Pittsburgh. Same State, same statute. We have public guardianship in Pittsburgh. We actually have a set of nuns who run around who are the public guardians, funded under AAA money. So even within the States, the right hand doesn't know what the left hand is doing, and maybe the right hand isn't doing the right thing after all.

We need to train and locate guardians. This is going to be a big issue in the future, training of guardians, but there are lots of good—we don't have to invent the wheel. I know in Colorado they do an excellent job of training guardians, at least from what I understand. So we need to take those best models and bring them out to the various courts, orphans courts, probate courts, and show them what can be done. Similarly monitoring guardians. I'm certain someone out there has figured out how to do this in an efficient and effective way, and it's just a question of showing others how to do it, and we just need to get that information out.

Finally, I think we should recognize—I think we're heading for a two-tier system of decisionmaking for people. The well-to-do will have durable powers of attorney and advance directives and living trusts. A few will not get around to signing these, but most will. It's really the lower income groups who are going to end up caught in the guardianship system, because they will not have the lawyers who will tell them when they walk in to sign a will that they also need to sign a living will or advance directive, and I think statistically if you checked, as John suggested, the probate system, intestacy applies overwhelmingly to the lower income, lower asset groups disproportionately.

Now, if you're talking about a group who has fewer assets and less sophistication perhaps in legal matters, or at least has less access to sophisticated assistance, then we better have a system that works efficiently for these people and not throw up all sorts of procedural and administrative mazes that discourages them from using the system or makes it so costly that they cannot afford to use it.

JUDGE FIELD BENTON, DENVER, CO

Judge BENTON. Judge Benton from Denver. I want to supplement what was said in real-life practice.

Joanne, most of the guardianships I create, temporary guardianships, are petitions by social services for the kind of impoverished patients you're talking about: the neglected, the forgotten, and so forth. Those in a sense are free. They can be done very quickly in a quasi-adversary situation. You go to the nursing home, if necessary, for a real crisis. What we need is the opposite of what we're getting, and that is because of State fund cutbacks, social services are cutting back. In Colorado Springs they're down to one intake worker for Adult Protective Services. In Denver they've cut back to five, and they're cutting back on the kinds of cases they'll take. I think we could use some help in Federal money for petitioners in the form of social services to cover the nursing home kind of issues you're raising.

SUSAN MILER, LEGAL COUNSEL, AARP

Ms. MILER. I'm Susan Miler from Legal Counsel for the Elderly Department of the American Association of Retired Persons, and I work with a project which is, as Ingo said, where the rubber hits the road. We have trained volunteers to monitor guardianships in three cities—Denver, Houston, Atlanta—and now in Portland. I guess I want to speak in support of innovation and encouraging innovation and also in the dissemination of information about that innovation.

On the most basic level when we started our projects, the critical problem turned out to be that if we were looking at cases that were 8 or 10 years old, we simply could not find the wards and the guardians, because there was no requirement that an updated address be kept with the court each year necessarily in all the jurisdictions. In some there was, in some there wasn't. I think that's the level of detail we're talking about when we talk about changing the systems and making them work better, and there are lots of innovations going on there outside of what we're doing, obviously. The problem is that each of those tends to take place in its own small locality, and so a mechanism to share that information—not just to create the innovation, but to share it—I think is particularly critical in this area.

MARSHALL KAPP, WRIGHT STATE UNIVERSITY, DAYTON, OH

Mr. KAPP. I'm Marshall Kapp. It's interesting that we're always anxious to jump into mechanisms and very reluctant to look at first principles, and to some extent John and Joanne began to try to get us into first principles. I suspect that if we went around the room and asked everybody to define guardianship reform, everyone would have a different definition of reform, because I don't think there's a consensus on what the problem is. What are we trying to protect people from? Are we trying to protect people from too much guardianship, laws and systems that permit guardianship to be imposed willy-nilly without adequate protections, without adequate monitoring? Is the problem people who are at risk who don't have guardianship or other satisfactory means of surrogate decisionmaking? As Joanne was saying, what's the denominator?

It seems to me until we have some consensus on what the problem is, what are we protecting people from, we're not going to have very much consensus on what the reform ought to be. It seems to me the mechanisms are probably the easier part of the equation. The more difficult challenge is defining what the problem is and what our social goals are that we're trying to devise mechanisms to meet, and perhaps federally sponsored research can help us in reaching some consensus on what the problem is, what the evils are that we're trying to protect people from.

RALPH LUKENS, PROBATE COURT ADMINISTRATOR, CONNECTICUT

Mr. LUKENS. My name is Ralph Lukens. I'm the probate court administrator in Connecticut. As I sit around and listen to everybody talk, I've served on panels—I served on a panel with John Pickering—and I've been to seminars, and I've written task force books, and I've seen hundreds of them, and my biggest concern is that we're going to walk away from here today and nothing else is going to resolved again. And I think if the Special Committee could do anything, it isn't pass legislation, it's to somehow or other funnel the activities. I listened to Susan Miler saying that she's got a volunteer program. I've listened to everybody say we have a program. There seems to be no central place where we could all submit our ideas and have something come out.

Attorney Johns, Professor Regan, Mr. Keilitz all mentioned the fact that we don't have data. We have data in Connecticut. No one's ever asked for it. We're using it. We're using it, we hope, very successfully. We have also, through Justice Peters, who is one of the co-authors of the resolution that Mr. Keilitz read—because she is the Chief Justice in the State of Connecticut, we have proposed to her a task force that we propose to be used nationwide. I have a copy of that, which I will certainly submit to the Committee.

I just have this terrible feeling that before anything gets done, I'm going to be under a guardian, because too much time is passing, and if nothing comes out of this roundtable discussion, it would be to get something really off the ground in a very practical sense and let's move forward, collect the data, find out what the problems are, let everybody help everyone else in what we can do for each other. We have a visitors program. San Francisco has a visitors program. Everyone has something different. Let's put it all together and find one that really works.

Ms. KINDERMANN. Let me just comment, since you've brought up a good point. The Special Committee does intend on having this be the first in a series of sessions on guardianship, and we had hoped to have this initial roundtable discussion to bring out ideas on whether future workshops might be appropriate or hearings, if necessary. So keep in mind that this is just the first in a series and we hope that you all will join us for future sessions.

Mr. JOHNS. Frank Johns. I'd like to respond to the counsel from Connecticut. The preface of my opening comments was that as I looked at all the information that I did have, it stretched back for 30 years, and it seems that the identification of the problem in terms of this mechanism, Mr. Kapp, is the point that's being addressed here today.

We have a concern, Ms. Lynn, with the idea that guardianship is a vehicle that's among a number of tools available for intervention in life planning and for quality of life assistance, wherever it's needed. The tool has been there for a long time. The problem is the mechanism has been utilized inappropriately and abusively. I think the point of the Special Committee's call to all of us is to ask so much to the point, where do we stand today? What do you see from where your perspective is in terms of this tool, the tool of guardianship, and how do you focus on this tool in terms of its utilization?

And as a final comment, I think about what Professor Frolik was saying, and I think about the struggle that the State of Florida had, and I don't know that anybody is here from—somebody is here from Florida. They went through a monumental effort to design a significant, beautifully well-written piece of legislation, and what we hear from so many practitioners in Florida is how burdensome it is, how paper-ridden it is, how monetarily cumbersome and expensive it is, and yet it seemed to be the model of all models going into the process.

I think that if we focus, as Larry Frolik says, on concepts of basic application that aren't so expensive, that we can all agree is the format that we want to try to impart in terms of practicality, I think our job would then be to gather the data and to see how that practicality can be applied with the State, going to the State and saying, "How does your system work? Do you have a task force? Can we meet with your task force? How can we work with you to make it practical?"

Mr. KEILITZ. I'm hearing two things. One is a clearinghouse. The States individually do not have the capacity to do this, and as Mr. Lukens said, there are people who are collecting good information, but no one knows about it. And the second is a data collection mechanism. We have a massive organization in the National Institute of Mental Health, for example, that collects data, but we don't have that kind of organization in this area.

When the two systems—the judicial system and the social service system—interact, people assume, "Well, I thought you were doing that," and "I thought you were doing that." We need to figure out how to collect and transfer valuable information that already exists. The mechanisms are already set up—for example, through the court system—to collect case load statistics.

I may not know what's good or bad, but I know what nothing is, and we can't afford to do nothing. When my friend Joanne Lynn painted her picture, she painted the problem in such a large, large size that it overwhelmed my capacity to do anything about it. We can't afford to be incapacitated by size of the problem. Even though guardianship is only a small step and a small thing in the larger picture, I'm willing to take that first step, and I would encourage everyone to do the same.

JUDY McCUE, AMERICAN COLLEGE OF TRUST AND ESTATE COUNSEL

Ms. McCue. Judy McCue from American College of Trust and Estate Counsel. I would like to add to what Ingo just said about what I'm hearing. I would like to emphasize that one of the things I am hearing as well is that there is no need for federally mandated standards in the guardianship area. The American College of Trust and Estate Counsel has taken a position opposing federally mandated standards. I think we did that based upon our perception that this is a role best left to the States, and that was based in part as well upon our concept that the States were acting to reform their own guardianship legislation.

I'm heartened to hear that our informal studies are being confirmed by virtually everybody sitting at this table. There are plenty of statutes on the books. What we have to do is figure out a way to make them work, and I think certainly focusing on dissemination of information, what is working, what's not, both in the guardianship area and I think in the area that Joanne addressed, which I agree with her is just an essential area that we shouldn't be ignoring, although we need to take these things, one step at a time and deal with issues that perhaps we can more quickly make better. I would certainly thank the Committee for inviting all of us, because I think this has been a real helpful kind of activity.

Thanks.

DaCOSTA MASON, AARP

Mr. Mason. I'm DaCosta Mason with AARP, who represents 30 million members, and I guess I've sat here and I've listened to what's been said and so forth and have been working on these issues for a number of years, and from a consumer perspective, it seems to me that all of us are generally in agreement that the guardianship system is being reformed.

I think one of the problems that we have here is that we're not all confident that at the State level they're all being implemented, that you can go and talk to someone, one judge in one county or another judge in another county, and see that the reform is in fact taking place, and that there needs to be some mechanism to ensure people, even people here, that no matter where you go or who you talk to, there may be some agreement as to what we mean when we talk about least restrictive alternative, when we talk about limited guardianship. I mean, we have a debate here about limited guardianships, and it seems to me if we can't agree here, people who are experts in the field, then what can we expect at the local level for a judge who's looking at a case that's being presented to him or her and making the determination of whether or not there should be a plenary guardianship or a limited guardianship?

I think that there needs to be some means, maybe through the Administration on Aging through RFPs or whatever, to provide a mechanism to spread the word about what's happening with regard to programs, monitoring programs and so forth, but also on the idea of if we have statutes that talk about limited guardians and maximizing the autonomy and self-determination of individuals, that has some meaning to everyone and not just to the person who wrote the statute, but it has meaning to the attorney who's representing a petitioner, to the petitioner, to the visitors who are going to do the investigation, to the attorney who's representing the ward, as well as to the judge, that they all understand what that means and what they will be looking at in a particular case, and everyone is not there looking at it differently.

It seems to me that even if we go around the table, even though there may be some disagreement on issues like least restrictive alternative and when it's appropriate and so forth, I think there's probably some consensus here with regard to what we're talking about in general, and if we can get that to the local level, that may be a role that the Federal Government can play in making it possible for that to happen but not necessarily trying to tell States exactly what to do. Because they know the statutes tell them what to do, it's how they go about doing that, and it's a role that perhaps can be made, like I said, through the Administration on Aging through grants for legal assistance, technical assistance to States and so forth, or to bar associations or to whatever, to provide appropriate training, education programs, disseminating information that will assist in that process.

PENNY HOMMEL, CENTER FOR SOCIAL GERONTOLOGY, ANN ARBOR, MI

Ms. HOMMEL. I'm Penny Hommel from the Center for Social Gerontology in Ann Arbor, MI, and I just wanted to make two points. One is to mention some research that we're doing and indicate how it shows the importance of what so many people have been saying, which is that we need to focus on implementation and not simply whether the words of the laws have been reformed, and then I just secondly would like to underscore the need for some kind of clearinghouse.

The research that we're doing, although in the grand scheme of things is quite minor, in the area of guardianship is probably some of the most significant research that's being done, and we've been looking at guardianship in 10 States in a limited number of courts in each of those 10 States and have been looking at three things. One is just what's in the files in the guardianship cases; two, observing the court hearings that are happening; and three, and probably most exciting and important in terms of implication for what we need to be doing, is we've been interviewing the petitioners for guardianship.

The point I wanted to make on what we're finding in looking at the court files and observing the court hearings is that there really seems to be very little relationship between the written law and what happens. The 10 States that we're looking at include States that have very good reformed laws and some that are not considered such model legislation. Some of the ones that are considered the better laws—just thinking of Michigan, which now has a law that has some very strict requirements with respect to presence of the potential ward at the hearing, very strict requirements with respect to showing findings of incapacity in particular areas in order to allow full guardianship. Michigan is one of the States that comes out least good of the 10 in terms of is the ward actually present at the hearing, is limited guardianship actually used. So I think we need to worry much less about what the written law says and much more about what actually happens in practice.

The other piece, however, and I think this is where the real excitement comes, is in that petitioner interview, because what we're trying to look at is not what the law says, not what the process of imposing guardianship is like, but rather what are the needs of the people at issue here. So that we're trying to begin—and as I say, it's just a very first step—we're trying to begin to get some ideas of whether there are certain things that trigger petitions for guardianship. We know, for example, in the nursing home area that incontinence is something that usually drives a family that's capable of caring for an older person to seek nursing home care. We're asking questions about other similar kinds of things that really trigger a petition for guardianship. But then we're also just asking about what are the needs of the individual who is having the petition filed against them. What can and can't they do for themselves and what kinds of services might be available that really would help in the situation and that might prevent or at least prolong the need for petitioning for guardianship? Those are all the open-ended questions, so we don't have any of the final analysis done, but shortly we'll begin to have some answers about those sorts of things.

But then I also just wanted to underscore how important in the various kinds of things that we've been doing in the area of guardianship this notion is of having some kind of clearinghouse, because no matter what we get into, whether it's trying to come up with standards for guardianship service organizations or doing this research or whatever, the minute we start looking, we find that incredible things are being done across the country and we just haven't known about them. So that I think one of the most important things that the Federal Government can be doing is to really make sure that what we do know and the success stories that are out there are being shared and that others around the country have a chance to implement them.

LLOYD LEVA PLAINE, REAL PROPERTY PROBATE AND TRUST LAW SECTION, ABA

Ms. PLAINE. Lloyd Plaine. One thing just again from listening to what other people are saying. I agree from what we have said that the clearinghouse, I think, is really so fundamental to this, and also, from what Martha Miller was saying and Joanne Lynn, I think we don't want to lose focus of we're talking about implementation, we're talking about training of the attorneys, we're talking about training the judges. We also want to focus on that larger group and on the smaller group in terms of the guardianship perspective and have a way of educating the lay people to know what these options are and what's available.

I know the ABA Commission on Legal Problems of the Elderly put out, using services of Helen Hayes, an excellent tape about 5 years ago on durable powers of attorney, health care decisionmaking, things of that sort, but that's just another level of this that we're looking at the judges, we're looking at the attorneys, and we're also looking at the community itself, because they're the people that have to start. We don't want to wait for the nursing home to push someone into a guardianship. We want to be able to take advantage of the things that Martha is saying, and that is a broad-based dissemination of information.

SUSAN McMAHON, RAY GRAHAM ASSOCIATION FOR PERSONS WITH DISABILITIES

Ms. McMahon. Susan McMahon from the Ray Graham Association for Persons With Disabilities, and I represent developmentally disabled and mentally ill individuals. I realize that our primary attention today is on the aged population and how guardianship impacts them. I think it's very important, however, to keep in mind when we talk about guardianship that it is frequently used by the developmentally disabled populations and the mentally ill populations and that as we're talking about research that needs to be done and reform that needs to occur, we need to keep in mind those populations as well and include them in the process of modification of this system.

I'd also like to address the fact that there have been numerous comments about the reform that's occurring in guardianship, and the assumption undefined here has been any change in a statute is a positive reform, and reform has been, by consensus, considered a good thing here. I want to point out that in Illinois we've recently reformed our guardianship statute, and we have arranged for our annual report of the person to occur every 2 years. From what we've said here, yes, we've reformed our guardianship, and it's not a positive thing. It does not provide any additional protection to the individuals we want to protect. I would caution that when we talk about the fact that changes are occurring in the statutes that exist, we want to carefully look at what those changes are and whether or not in fact they are improving the system.

Judge Benton. Well, I'm Field Benton, and I may be very thickheaded, Susan. I don't understand us to be talking today about primarily the needs of the aging population. Wards come in all ages, shapes, and sizes. I resent it, from my own viewpoint, not speaking for the National College of Probate Judges, when people say judges look at plenary guardianships first. A plenary guardianship is the last thing I look at. I don't know where your data comes from on what judges think and do, but I believe some of it is mistaken.

Ms. Gottlich. I'd just like to respond. This is Vicki Gottlich. I think you're right, and having sat in meetings with you, I wish you were the judge that I could be with, but in my own experience in doing guardianships before a judge who's considered a very good judge, he treated the cases in which I was representing the ward and my colleagues at the Legal Aid Bureau were representing the ward very differently from other cases. So there was a lot more due process in the proceedings that I handled, because I insisted upon them, and yet in other proceedings they would just walk straight through or there would be a lot of problems. So not only do we have different judges in different parts of the State, as Larry Frolik and Jack Lombard said, but the same judge treating different petitioners differently, depending upon whom they were representing, and for once I could say that poor people probably, in some cases, got better representation than people who had a little more money.

JOHN HALL, SENIOR CITIZENS LAW PROJECT, VERMONT

Mr. HALL. I'd like to respond to a couple comments that actually bring a couple of thoughts that I had together. One is that in Vermont, which is probably the smallest State that's represented around the table here today, we have done a fair amount of empirical study of the guardianship system. We reviewed in great detail over 1,000 involuntary guardianship files that were filed in the State between 1979 and 1989, and we started in 1979 because that was the date that Vermont adopted the ABA model code and so had, starting out, one of the better statutes that you would want to look at. And what we found when we looked at those cases, and I think it bore out our experience out in the field, was that the strong statutory emphasis on utilizing limited guardianships was not in fact being carried out in practice in the courts, that we saw that in the petitions that were being filed by primarily family members, petitioners asked for total guardianship about 80 percent of the time. The psychiatric evaluations supported total guardianship about 64 percent of the time and in the remaining situations recommended limited guardianship of some kind, and the probate courts proceeded to order total guardianship 94 percent of the time, almost 30 percent higher than the rate at which the psychiatrists were recommending it.

Another thing that we found—one of the problems in the Vermont statute—and when we talk about reform in the States, I guess I feel that in large part—not universally, but in large part—the reform that has taken place since 1979 and then again in the second wave since 1988 has been largely positive. But one of the things that has not been happening as States have been engaging in introspection and looking at their guardianship statutes is the question of the right to be represented by counsel in guardianship cases.

To date, to use the statistic that Ingo was referring to, I believe only about 27 States mandate that counsel be appointed in involuntary guardianship cases, and even in the vast majority of States, the language is not that a person has a right to be represented by counsel in this proceeding which involves probably the largest invasion of civil liberties of any intervention that the Government takes against an individual. In most States the language and the language which occurred in Vermont before we changed our statute last year was that the individual had the right to retain counsel, and I submit to you that the right to retain counsel in an involuntary guardianship proceeding is essentially a meaningless protection, and that our data showed that the right to retain counsel translated into individuals being represented by counsel in only 32 percent of the involuntary guardianship cases that we surveyed over that decade.

Even among the 27 States, the role of counsel, as Joan O'Sullivan referred before, is not clearly the role of an individual who will assist the respondent in preparing a defense to the case. It's often a sort of mixed role where the counsel is required to serve in the dual role of a GAL. While I think in many respects the States have sort of flipped this concept on its head, the States have moved in the direction of occupying the area of reforming problems in the guardianship system, but I continue to be concerned about the extent to which thousands of wards every year in this country continue to be pushed into this system without the representation of counsel, and I think that that's an important part of when we talk about accountability, when we talk about monitoring the system, when we talk about looking at the issues that John Regan raised about whether or not wards are brought to the hearing, whether or not, in our case, proof of service is in the file. Our survey showed that proof of service was missing from the file in 50 percent of the 1,000 cases that we reviewed.

When you talk about questions about whether the evaluation has been performed by a qualified mental health professional, when you talk about whether or not the hearing is held in a timely fashion, when you talk about whether or not the accountings are being filed or whether the States are sending out the annual notification of the right to petition for a termination or a modification, which we found occurs in only 15 percent of the cases in the State of Vermont, the counsel is a fundamental aspect of assuring that that happens, and our studies have shown, and I think that other States that have this experience will bear it out, that while the correlation is not perfect, there is definitely a positive correlation between the presence of counsel and the vindication of the due process rights of wards in these cases. And I think if the Federal Government has anything to say about the direction that States should be moving in dealing with the problems in the guardianship system, I would suggest that that's one of the biggest areas where reform could be made.

Mr. REGAN. I'd like to follow up on those comments as to the role of counsel very briefly, since I understand time has run out, and this is for the ABA to think about. The ABA's rules of ethics concerning the role of counsel in the office for dealing with a disabled person are very unclear, the conflicts of interest that can develop in office practice between a disabled person and the well-meaning family have not been sorted out very well in the rules. It seems to me as well the role of counsel in mental health proceedings in court is also very unclear, if addressed at all. Perhaps we should extend all this into the law schools and the dearth of training in wills and trusts and estates courses on the representation of disabled persons. But it seems to me while it's not a role for the Federal Government, it's part of the menu of issues that I think we're setting before us today.

Mr. Lombard. John, there is a task force under way examining that issue.

Ms. O'Sullivan. But I would point out that—I mean, a friend of mine says it's a good thing mankind has a large brain so we can hold two very diverse ideas at the same time.

I would very much agree with the kinds of things that Mr. Hall would like to see reformed. My civil liberties part of me would very much like to have those protections carefully protected. I think the biggest deficiency in our local statute here is that there's no requirement of notice to the proposed incompetent under the Health Care Decisions Act, under the nonstatutory provisions, so that I can declare a person incompetent without ever having had to have told them that they're being declared incompetent. I find that outrageous.

On the other hand, the provisions that we would require under this sort of careful due process and careful attention to due process do make it less likely that guardianship will be pursued for a person with marginal indications for guardianship, and that is a very real negative impact upon persons who otherwise would come under the protection that is afforded by even less careful guardianship provisions.

There's an unfortunate see-saw here that to the extent one pushes down on the possibility of abuse and lack of protection, one raises costs and increases inflexibility. It may be that we need to abandon that playground and develop a different toy so that we can have both some flexibility, some responsiveness, some reduced costs, and at least reasonable minimal due process protection.

Ms. Kindermann. Unfortunately, our time has run out. We've actually gone a little over. I wish we could stay here longer. I want to thank you all again for what has been a very, very informative session, and I hope to be working with you soon on our next in the series of sessions on guardianship. I look forward to working with you to develop that.

[Whereupon, at 12:45 p.m., the meeting was adjourned.]

APPENDIX

East Arkansas
Area Agency on Aging
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May 14, 1992

Anna Kinderman
U.S. Senate Special Committee on Aging
Majority Staff
G-31 Dirksen Senate Office Building
Washington, D.C. 20510-6400

Anna:

In response to Issue #1:

Yes, there is a need for Federal Legislation to address the appointing and monitoring of guardians. The weakest area is the monitoring. A vast majority of the abuse could be eliminated if just the accountings were done.

In response to Issue #2:

One obvious "hook" would be to put more requirements as far as compliance goes on the Federal Funds that do flow to the courts.

Another approach might be to increase the funding so the courts might be better able to monitor their own handiwork.

In response to Issue #3:

I do not really think that the states will resist as much as the individual judges themselves. We have many judges who run their courts as they choose and see fit regardless of the laws.

In response to Issue #4:

I am not sure if we should rely on informal alternatives to guardianship at all.

If a person is incompetent and things are out of control, a guardian is actually your only choice. Other things, such as Power of Attorneys, are not really alternatives.

We see a tremendous amount of abuse when a person needs a guardian but only has a Power of Attorney.

This is why I think it so important to put into place laws that will insure that a ward of guardianship will be monitored and protected by the courts.

If I can be of further assistance, please feel free to contact me.

Respectfully,

David Martin
Ombudsman

CIRCUIT COURT
SIXTH JUDICIAL CIRCUIT
STATE OF FLORIDA

THOMAS E. PENICK, JR.
CIRCUIT JUDGE

PINELLAS COUNTY COURTHOUSE
315 COURT STREET
CLEARWATER, FLORIDA 34616
(813) 462-3231

May 27, 1992

Ms. Anna Kinderman
United States Senate Special
Committee on Aging, Majority Staff
G-31 Dirksen Senate Office Building
Washington, D. C. 20510-6400

Dear Ms. Kinderman:

I sincerely thank you for inviting me to participate on the 2nd day of June, 1992 in the United States Senate Special Committee on Aging Guardianship Roundtable Discussions. Unfortunately, due to my judicial calendar and prior commitments, I will be unable to participate in these discussions.

I would like to have been able to attend because we, here in the Sixth Judicial Circuit of the State of Florida, have devoted hundreds of hours and thousands of dollars to developing what we believe to be one of the very best guardianship programs in this country. I do not mean for this to sound self-serving but inasmuch as we here in the St. Petersburg, Florida area are affectionately referred to as the "retirement capital of the United States", we take our responsibility to all of the citizens very seriously.

If there is any way that I can answer questions that may arise during or after the conference, please feel free to call me immediately or write me.

I would like to be considered by you and the United States Senate Special Committee on Aging for participation in any future hearings or discussions on the important issues of guardianships, probate matters and mental health issues.

With kindest regards.

Very truly yours,

Thomas E Penick

Thomas E. Penick, Jr.
Circuit Court Judge

TEP/bg
cc: Lori Stiegel, Staff Attorney, ABA

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Chairperson, Emeritus

May 29, 1992

Ms. Anna Kindermann
U.S. Senate Special Committee on Aging
G-31 Dirksen Senate Office Building
Washington, DC 20510-6400

Dear Ms. Kindermann:

Thank you very much for the invitation to participate in the Special Committee on Aging Guardianship Roundtable scheduled for June 2. As we discussed, I regret being unable to attend nor to respond adequately to the excellent discussion issues that will be considered by the roundtable.

To respond generally, however, it does not appear to me that federal legislation is needed at this time. Over the past 10 years, many of the states have made very significant changes in their guardianship statutes with regard to limited guardianships, guardianship monitoring, etc.

These statutes, however, are not self-executing and unlike many of the activities conducted by courts, there must be a commitment on the part of the judges and other court personnel to make the system work. That is basically because these proceedings are non-adversarial in the usual sense and therefore the courts must take a more active role in seeing that things happen as provided by the statutes.

In addition, judges under these laws retain a great deal of discretion in choosing, for example, to impose a limited rather than plenary guardianship. Frankly, it is probably easier to impose the latter and busy courts and judges sometimes succumb to what is easiest. In addition, judges have no particular insights into the physical and psychological changes that may come with aging because it is not generally part of their formal training.

While many other activities maybe helpful, and while my views may sound self-serving, I think of nothing more important than to have judges in our state courts learn more about the aging process and to consider the policy recommendations that have been made by several national conferences of judges involved with these issues. It is a matter of educating and sensitizing judges to the value of these progressive statutes that will make the difference.

The National Judicial College has conducted several conferences dealing with guardianship issues and continues to offer courses for judges on these matters. If funds were available, many more judges would be able to attend such courses, but restricted state finances have reduced judicial education in all areas to a bare minimum. As a non-profit educational institution, The National Judicial College must seek funds either through grants or tuition to conduct its programs.

If the premise is correct that better trained judges will make better decisions concerning guardianship issues, I would urge that consideration be given to finding some source of funding to permit institutions like NJC provide more training for more judges involved with these decisions.

I trust that the roundtable discussion will be a great success and I look forward to hearing about future activities.

Yours very truly,

V. Robert Payant
Dean

VRP/kn

Comments to the Guardianship Roundtable Discussion
June 2, 1992
Joanne Lynn, M.D.

Many, perhaps most, adults will have a substantial period of being incompetent before the end of life. Very few will come under formal guardianship under current practices. Those who do will often be served poorly by the experience. Improving that experience is the focus of most guardianship reform and, indeed, of most of this discussion. While I support guardianship reform, it will not be the focus of my comments. Instead, my focus lies in concern for the prudent development of a <u>system</u> to provide decision-making for adults who cannot be responsible for making their own choices. Guardianship is only a part --- a small part --- of such a system. And, who is subject to guardianship is profoundly affected by the workings of the rest of the system.

Unfortunately, there is a direct and perverse relationship between the degree to which guardianship is protective of the ward's rights and welfare, on the one hand, and the degree to which guardianship is costly, time-consuming, and inflexible on the other. Requiring comprehensive investigation and review and careful notice and appeal entails delay, costs, public scrutiny, and rigidity. However, encouraging more informal procedures engenders both the appearance and the risk of practices that can profoundly disadvantage the incapacitated person.

Thus, guardianship reform simply cannot proceed without examining the prevalence of incapacity, the rate of entry into guardianship proceedings, and the determinants of guardianship being utilized. Though data are imprecise, once one examines this arena, an almost incredible situation becomes apparent: Virtually none of the at-risk persons actually came into guardianship! Most of us, under current practices, will enter a period of incapacity, often near the end of life, and will have our affairs handled and decisions made by an array of informal and unarticulated procedures, never supervised by a court or even formalized in a written durable power of attorney. In a very preliminary survey five years ago, we found that at least twenty thousand adults annually in Washington, D.C., are probably incompetent to make their own treatment choices and are in a hospital or nursing home, but only about one percent of this number were brought to guardianship each year. In looking at what little data exists, this seems to approximate the national rates: probably five percent of adults are actually incompetent in any year and almost none come to guardianship.

Thus, addressing these issues must <u>start with</u> the system for decision-making for incompetent adults. Focussing on guardianship reform is such a tiny tip of the iceberg that the endeavor is overwhelmed by the population that does <u>not</u> come to guardianship.

Serious reform requires these elements:

(1) Delineating those issues where little is at stake and informal procedures can be made to be adequate;

(2) Defining the border zone of capacity so that incapacity can be decided without court procedures, but with adequate care and due process;

(3) Protecting substantial assets of potentially incompetent adults;

(4) Protecting substantial personal or health status interests of potentially incapacitated adults.

Doing this will require very real trade-offs among legitimate interests and rights. It will require thinking systematically and evaluating policy is a comprehensive way. This can be done only with better baseline data, evaluation of innovative programs, and fostering of a genuine multi-disciplinary and public debate on the wisest course.

What could the Federal role be? First and foremost, Federal statutes and regulations must immediately be more cognizant of the problem of incompetent adult decision-making. Federal statutes often require the formal consent of a person "authorized under state law." Examples include the statute governing consent to the hospice benefit under Medicare, the one requiring consent for certain treatments (psychoactive drugs and restraints) in long-term care facilities, and the regulations effectuating the required notice under the Patient Self-Determination Act. Except in a handful of states (with broad family consent statutes), <u>no one</u> is clearly "authorized to consent" on behalf of a patient who is probably incompetent, except a guardian or a proxy appointed by a durable power of attorney. Contrary to popular perception, the loving spouse, in most states, has no clear authority -- only the inertia of practice. The recent Federal statutes and regulations are being interpreted in many quarters to require court adjudication of incompetence and designation of guardianship. In most cases, this "fixes something that is not broken." It imposes costs, publicity, and paperwork burdens without any discernable or expected improvement in the decision-making on behalf of incompetent persons.

Secondly, the Federal government needs to engender national data --- not just on guardianship numbers and abuses, but on the prevalence and characterization of adult incapacity, the merits of alternative procedures, the evaluation of innovative programs, and the preferences of the nation regarding the trade-offs at stake. The Administration on Aging, the Agency for Health Care Policy and Research, the National Institute on Mental Health, the Social Security Administration, the Department of Veterans Affairs, and the Department of Health and Human Services all have interest in these areas and should engender the relevant research the American College of Physicians, the American Bar Association, and the American Association of Retired Persons have been collaborating in a long-term project to address these issues. Perhaps, that group could anchor an ongoing review of the progress and priorities. Alternatively, a different permanent national multidisciplinary group could serve this function, but it would have to be engendered anew. Perhaps, such a "center" or "clearinghouse" function could be contracted to a concerned academic center (e.g., a Geriatric Research and Education Center or a "Pepper" Center of Excellence, the VA's National Medical Ethics Center, or a permanent social gerontology or mental disability center).

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May 28, 1992

The Honorable David Pryor
Special Committee on Aging
United States Senate
Washington, DC 20510-6400

Dear Senator Pryor:

Thank you for your letter of May 19, 1992 inviting me to participate in the roundtable discussion of the Senate Special Committee on Aging and the various issues involving guardianship. As a former Chair of the Real Property, Probate & Trust Law Section of the American Bar Association, I have been interested in this issue for many years. Shortly after the release of the Associated Press articles I gave the keynote speech at the Wingspread Conference on Guardianship. For your information I am enclosing a copy of that speech.

In my view, significant strides have been made since the Wingspread Conference in reforming and improving the guardianship system in most of our states. For reasons which I am prepared to discuss on Tuesday, I do not believe that this is an area requiring federal intervention at this time.

I look forward to seing you on Tuesday.

Respectfully,

John J. Lombard, Jr.

JJL,Jr:pat

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GUARDIANSHIP CONFERENCE
WINGSPREAD, WI

Introductory Remarks of
JOHN J. LOMBARD, JR.
Morgan, Lewis & Bockius
Philadelphia, Pennsylvania

We all realize that we live in a less than perfect world. The events of just these last few weeks, like most other weeks in history, make that all too evident.

So, too, in the area of legal incompetence and the guardianship system we know that we have less than a perfect system. Our own studies, the studies of the academic community and more recently the Associated Press study have dramatically demonstrated that the system is in need of improvement. In part, because of this need for improvement, wherever possible the objective of many planners has been to keep the disabled person out of the system entirely.

At the same time, in my opinion, we must recognize the need for the system itself and further recognize that, despite the misuse of the system by a few unscrupulous persons, including in some cases, greedy relatives, there are thousands of guardians who are discharging their responsibilities faithfully and in the best interests of their wards. The fact that a relative who may inherit on the death of the incompetent is named as guardian for an incompetent should not be presumptively suspect. Serving as a guardian for an incompetent is no easy task and often close relatives are the only persons willing to serve. Without them the system would not function.

Disability is a fact of life. Our aging population, impairment at birth and disability of younger persons through accidents, will result in the need to call upon the judicial system for the appointment of a guardian. We must, therefore, be careful in our deliberations that, while the protection of individual liberties is important, so also is the need to protect and provide appropriate care to a person who is no longer able, for whatever reason, to care for himself or herself.

Actuaries have told us that one in two of us in this room is likely to be disabled in our lifetime requiring some form of care and protection. Ironically, the younger you are the higher the liklihood. Fortunately, we now have the ability to plan for our own possible disability through the use of the durable power of attorney, which in most instances will avoid the necessity of a formally appointed guardian. Yet how many of us have done so? [A show of hands, please]

The ABA Commissions on the Elderly and Mentally Disabled have recently completed a project to encourage the use of life services planning. The prize winning Helen Hayes video and supporting speakers' material are deserving of widespread dissemination. Other organizations, such as the National Association of Retired Persons, are also stressing the need to plan for possible disability.

The preparation of durable powers of attorney should be part of every estate plan if the person has an agent who is willing to act on their behalf. Hopefully our friends from the press will encourage the use of durable powers in the same manner as Ann Landers has promoted the use of living wills.

Unfortunately, we know that, even with the advent of the durable power as a means of planning for disability, human nature is such that many people will still require a formally appointed guardian. Therefore, while encouraging the use of alternative means of care for the disabled, we must also devote our attention to the improvement that the system requires.

I have lived with the system a long time, as a practicing attorney, a police officer, a guardian, a trustee for the disabled children of now deceased clients, and as an estate planner for parents with handicapped children. I have also lived with the system for over forty years as the son of a father who, unfortunately, is a manic depressive. A brilliant businessman and a loving father, he nevertheless suffers from what we now know is an incurable but sometimes controllable illness.

One of the most difficult cases I have ever tried was a commitment hearing for my own father where the court required, at least initially, a full public hearing with my mother as the principal witness, until it became apparent that the need for immediate hospitalization was clear. I know all too well how slow the system can be when the need for immediate treatment is obvious. Fortunately I know how to function within the system. Pity those people who do not. We must be careful in the development of procedural protections not to make access to the system more difficult when the need is clear. I can recall vividly an experience as a police officer where a patient recently released from a state institution was arrested for assault on a bus driver and other passengers. He pleaded to be returned to the state institution from which he had been released only days before since, in his words, he was not ready to function outside the confines of the hospital.

The courts have been criticized in the press for holding hearings that are no more than perfunctory. In many instances of permanent coma, or profound retardation, the outcome of the proceeding is a foregone conclusion. Clearly, as in all cases, the medical evidence should be presented by qualified testimony. Beyond that, what should be required before the court acts? I would hope that we will discuss and reach a conclusion on how adversarily we should require the clear case to be.

The deinstitutionalization of our mental hospitals over the past twenty years has, for the most part, been a positive development. We have learned that, with appropriate support, many handicapped persons can live and function in the community. Unfortunately, in many instances the community support programs have not been developed as quickly as persons have been released from these institutions. In our cities, this has, in part, contributed to people living on the streets. This has become an acute problem in northern cities in the winter when petitions for emergency medical guardianship increase dramatically.

In Philadelphia, our firm, in conjunction with the Probate Section of the Philadelphia Bar Association, is working with Judge Edmund Pawelec, the Administrative Judge of the Orphans Court, to develop a program which will provide persons willing to act as guardians ad litem in these medical emergency cases. Oftentimes in these cases a hospital is requesting permission to amputate because of severe frostbite. By having a program with trained volunteers, the judicial system will be able to respond more quickly when the court is faced with a medical emergency petition of this type, where time is of the essence.

I am told that the Probate Court in Denver has been successfully using volunteer professionals, such as nurses and social workers, to interview the proposed incompetent and prepare a report to the court, which provides the court with an independent evaluation of the need for a guardian and the condition of the alleged incompetent.

I believe that the improvements we seek will require more volunteer programs on the part of the organized bar and other social agencies in the community. This represents another area where this Conference can be helpful in identifying programs that have succeeded in other communities, which are deserving of wide support in our effort to improve the system as a whole.

TURNING NOW TO THE SYSTEM ITSELF. HOW CAN WE IMPROVE IT?

I. First, no person should be committed or declared incompetent unless there is "clear and convincing" evidence of the need for immediate care or asset management. The courts should insist that the medical evidence be submitted if at all possible by the direct testimony of qualified physicians who have conducted a comprehensive examination of the alleged incompetent. Age or eccentricities alone should never be a basis for a finding of incompetency. To the extent statutory definitions would permit such a finding, they must be changed to provide a more suitable definition, such as that contained in the proposed Model Statute:

> ""Disabled persons" means adults whose ability to receive and evaluate information effectively and/or to communicate decisions is impaired to such an extent that they lack the capacity to manage their financial resources and/or to meet essential requirements for their physical health or safety even with court-ordered assistance or the appointment of a limited personal guardian or limited conservator."

In this way, only the person who truly needs the assistance of the system will be embraced by its protection.

II. The presence of the proposed incompetent in the court room should be required unless there is clear and convincing testimony by the medical professionals that his/her presence would be detrimental to their well being. This is not to say that the hearing should always be in open court, unless the alleged incompetent insists on it. Nothing concerns me more than the humiliation to the proposed incompetent when incompetency cases are heard by courts mixed in with a long list of other cases, with their parties and counsel in the court room.

Wherever possible, in my view, the court should have a separate list for incompetency proceedings. What I am suggesting is a sensitive way of balancing the privacy issue while assuring that the proceeding meets the necessary due process requirements. I don't expect that you will all agree with me on this point but it's a point worth discussing.

III. The all or nothing approach to guardianship must be regarded as an anachronism which is no longer deserving of support. I have been amazed, as I'm sure you have, at the improvement that often occurs when a disabled person responds positively to increased personal responsibility. Therefore, courts must be willing to customize the restrictions which come with guardianship so that only those vital to the protection of the ward are in fact imposed.

George Alexander suggested this in 1972 and it is only now receiving the attention it deserves. Unfortunately, this will require more judicial involvement in the process, but there should be opportunity for limited guardianships.

IV. There must be increased accountability by the guardian. In Pennsylvania, individual guardians are required to post bond, usually well in excess of the value of the assets, so that the ward or his heirs are protected against the possible misappropriation of funds in situations such as those described by the AP story. I would be interested in knowing whether or not bonding is commonplace in other jurisdictions as I believe the trend has been against their requirement.

It might also be interesting to know how many claims have been paid by the bonding companies. I believe it is very few. Perhaps a study of bonding requirements in all jurisdictions and their cost should be considered to protect against those few unscrupulous persons who would abuse the system and steal from the person they have been approved to protect.

More importantly, however, is what is the guardian doing to assure appropriate care of the incompetent. A form of annual or bi-annual report listing the current living arrangements, medical condition, annual financial requirement and current available assets should not be a too burdensome requirement. The mere requirement of filing reports will be of no value unless it is also combined with a system of review and monitoring to be certain that the information is accurate and the guardian is actually meeting the needs of his ward. Here we face a question of cost which may present obstacles to the implementation of such a review system. The overall question of cost in any program for improvement must be recognized in our deliberations.

V. Petitions for the restoration of competency deserve special attention and in appropriate cases should be expedited by the court. If a person who has previously been declared incompetent is now living independently outside of either an institution or health care facility, should there be a presumption that he is competent unless the guardian submits the same type of clear and convincing evidence that was submitted at the original hearing?

If there was one abuse that the AP study made clear, it is the difficulty to be restored to competency when reasonable grounds appear to be present that the basis for the original appointment is no longer present. This is clearly a problem deserving of our special attention.

VI. Additionally, we must expect more from the guardians who are appointed. Greater inquiry should be addressed to their qualifications at the outset of the proceeding. The first volunteer in a family may not be the most suited. An affidavit on their business experience should be required at a minimum. Have they declared bankruptcy? Are they delinquent in their debts? These are just a few facts which a court should know in advance of appointment.

At the same time, the courts must develop programs which will acquaint the newly appointed guardians with the responsibility they are expected to assume and what they can do independently and what will require further court approval. The video tape programs in Dade and Broward Counties, Florida, are examples of what can be done in this regard and may represent models which should be recommended in all jurisdictions. This might be the type of program which could attract foundation support if a video of universal application could be developed.

I have an inherent faith in human nature. I believe most people will do the right thing if they only know what is expected of them. There is no question that, in many jurisdictions, there is inadequate training of newly appointed guardians. Despite this lack of training, I still believe that most guardians do what is in the best interest of their wards. However, we should place a high priority on the qualification and training issue in our deliberations.

Finally, we must recognize that alternatives exist and have been expanded with the use of such relatively new devices as the durable power of attorney. Many persons who are otherwise disabled function outside the system through some form of alternate system like family trusts. Shouldn't these alternate systems be encouraged so long as they provide the necessary protection the individual needs, particularly if it is the result of advanced planning by the individual himself?

Should the system seek to catch those who haven't requested its assistance because an alternate system is a bit unorthodox? I don't happen to think so provided it is meeting the needs of the person being served. How do you feel?

No system we devise will be perfect. We know we do not live in a perfect world. Unfortunately, the disabled will continue to need a guardianship system. That being the case, our objective must be to have the best system available which recognizes the protection they need while at the same time assuring the dignity they deserve.

State of Connecticut

OFFICE OF THE
PROBATE COURT ADMINISTRATOR

186 NEWINGTON ROAD
WEST HARTFORD CONNECTICUT 06110-2320
(203) 566-7897

June 27, 1989

Honorable Ellen A. Peters, Chief Justice
Supreme Court, State of Connecticut
Supreme Court Building
231 Capitol Avenue
Drawer N, Station A
Hartford, CT 06106

Dear Chief Justice Peters:

Please find enclosed our recommendation with respect to the basic design of a model task force to study conservatorship protection and associated due process considerations. This basic design could easily be refined or enhanced in each state, as necessary, to reflect its own structural situation. For example: we have called this a "Conservatorship Study Task Force." In many states, the proper appellation would be "Guardianship Study Task Force."

The remainder of this letter is by way of commentary, either editorial or to elaborate on various elements of the model attached.

1. The task force make-up we suggest should be able successfully to conduct and document the results of a full spectrum study of conservatorship. It occurs to us that official sponsorship or leadership by the judicial branch in a study of conservatorship of a full spectrum scope might appear to extend judicial branch interest beyond the traditional horizons of that magistracy. Yet, given the projections for the aging of the nation, the subject assumes importance of a magnitude that might justify judicial branch interest. Furthermore, given that an incapacitated person under conservatorship becomes a ward of the court, the ultimate responsibility for seeing to the ward's protective needs being met is the court's and would seem to require an awareness of extralegal aspects of conservatorship that might pose impediments to providing the protection the court is responsible for providing. An interest in a broad scope study might therefore be justified even by traditional views of the judiciary's area of responsibility.

2. Regarding blue ribbon status for the task force, we would note by way of passing observation that such stature impressed on a committee or task force often limits its freedom to find, even though such might indeed be the case, that there is nothing, or nothing much, wrong with the process being studied. The perception becomes, even among its members, that blue ribbon committees do not review processes that are functioning properly, or essentially so, and therefore wrongs must be there that must be found. The study starts with a bias in derogation of the scientific method of study. Nevertheless, on balance, blue ribbon status would be desirable.

3. The needs study survey, we would expect, would answer such questions as:

- -Who are the people who need conservators?
- -In respect of what functions are they disabled?
- -Do their disabilities, once matured, thereafter remain essentially static or stable, or do they change; and if they change, is it in predictable respects or random and varying respects?
- -What are common characteristics, if any, other than the fact of being incapacitated, of the ward population, or of any significant classes of that population that can be identified, e.g., their age, ethnic, socio-cultural, educational and financial backgrounds, their health and their retained capacities and their marital and family situation?
- -What do wards need by way of protective services?

Too, the needs study, done in each state and preferably asking the same questions in each state, will enable comparative analysis of each state's ward population and needs and assessment of the feasibility and wisdom of establishing national standards for conservatorship.

4. The legal study should, among other specifics, cover due process notice requirements, appointment and role of counsel, standard of proof, effect of finding of incapacity, definition of incapacity, reviews, hearing procedures and format, temporary and emergency orders and continuing court oversight.

5. The resources study, as well as producing an inventory of available resources, might also consider new methods of accommodating protective needs and compare the merits of various sources of protection presently available. For example, in respect of housing protective needs, the subcommittee might consider the possibility of private for-profit "mom and pop" owned and operated small scale congregate living arrangements, boarding homes if you will, rationally regulated for the health and safety of wards, and hopefully thereby, for their peace and contentment as much as, in context, there can be such. Such facilities used to be widely available in cities and generally provided quite decent living arrangements in a kindly and understanding social environment. As to why such arrangements disappeared, I am not certain. Whether or not encouraging their reappearance would be productive might be studied. Also in the resource study, attention might be directed to the seeming differences in protective care arrangements between commercial ventures and non-profit religious, fraternal and ethnic arrangements, the latter three seeming more credibly to be characterized as gentle, kind and solicitous. Perhaps this perception of difference is a flawed perception -- perhaps not. It should be looked at for information as to how to render necessary imposed protection less onerous to wards and coincidentally, less worrisome to their families.

6. The task force in each state might commence with development of a comprehensive questionnaire that might be sent to all agencies and organizations having to do with conservatorships. Identification of such agencies and organizations would have to be done in the local context and would presumably be within the knowledge and experience of the task force members and their staff. The purpose of such a questionnaire would be to develop empirical data, statistical and otherwise, from which the nature and parameters of the conservatorship universe and its strengths and problems, state by state, would be disclosed and could be understood and appreciated. For example, as noted above in describing the functions of the needs study subcommittee, data could be collected as to all or a statistically significant sample of wards in the state as to marital status, family (children or other relatives), age, education, financial resources, health status, ethnic and racial background, socio/cultural background, and so on, and as to reasons for conservatorship and relationship of appointed conservator to the ward (e.g., relative, friend, state or municipal official, attorney, bank, private agency). The data can then be reviewed to determine correlation between the need for conservatorship and the various characteristics, both separately and in various combinations, of a ward's background and develop "typical" ward profiles. Identification of likely future respondent groups may be enabled thereby, permitting advance planning for meeting their future protective needs.

7. Data development methodology employed, whether questionnaires or questions asked at interviews, or questions to which answers are extracted from research into statutes or court or other records reviewed, should be the same for the study in each state in order to allow for credible comparative analysis and report of results, and in order to enable computer assistance in analysis, including seeking correlation of various data elements and disclosure of patterns. Design of the questionnaire will be critical to the success of the project. We expect there probably exists a theory and technology of questionnaire development which when applied produces data that can more readily be processed and analyzed. We, however, are not familiar with such theory and technology, and maybe, but only maybe, expert review of any questionnaire developed might be considered before its use. On the other hand, a questionnaire developed by the task force employing the familiarity of its members with the subject might, substantively at least if not from the computer processing perspective, be confidently adopted without prior expert review. Indeed, perhaps the task force might include a computer processing person from one of the governmental agency members on the task force as a member. Questionnaire development will likely be a time-consuming task and is one which will have to be addressed first in the project. A model questionnaire for all states to use would, in addition to enabling uniform and correlated analysis, be of considerable assistance to each state's task force.

At your call, we would be pleased to try to develop a possible model questionnaire for your committee's consideration and presentation through your conference to the states. We presently have some good background material to assist you or us in the preparation of such a questionnaire.

8. We might note that if a study of uniform scope and development of like data is to occur in each state, then a national co-ordinating committee will likely have to be included in the project to guide the state task forces along similar or compatible study routes. The national co-ordinating committee might mirror, in its makeup, the disciplines represented on the model task force, by drawing from various state task forces, members of different disciplines from each to constitute a broad spectrum national co-ordinating committee. Ideally, from the political perspective, one representative from each state's task force would sit on the national co-ordinating committee. This would, however, make an unwieldy committee. Whether or not any regional coalitions of state governments exist from which to draw one representative per region and enable a smaller co-ordinating committee, I do not know.

It may indeed be that if sponsorship of the project were by the Conference of Chief Justices, co-ordination might be by a subcommittee of the Conference, and accomplished by working through the states' Chief Justices.

The object of national co-ordination would only be to assure a study methodology that would enable analysis of state needs, laws, and resources, as they correlate to various fundamental characteristics of the state, and comparative analysis between states in absolute terms. Each state could be expected to effect any changes in its conservatorship process that the study in the state disclosed as being needed. The object of this study would not be to establish or measure a state's system against any national or majority guidelines. That would be another issue if serious need for such were disclosed. The national co-ordinating committee would presumably also see to a national analysis of the collective task forces results being done, the documentation of the national analysis being prepared for present or later use, or for the academic record, as indicated, and the central archival preservation of the collective and correlated results.

After you have had an opportunity to review this material, I would be pleased to discuss it further with you.

Sincerely,

Ralph D. Lukens
Probate Court Administrator

RDL:nm
Enclosure

A TASK FORCE TO STUDY CONSERVATORSHIP

I. MEMBERSHIP

A. State Executive Authorities:

1. Welfare Commissioner
2. Mental Health Commissioner
3. Mental Retardation Commissioner
4. Aging Commissioner
5. Protection and Advocacy Commissioner

or their high-level designees.

B. Judicial and Legal Authorities:

1. Chief Justice
2. Probate or Surrogate Court Administrator or Chief Judge
3. Attorney General
4. Chair of the appropriate section of the State Bar Association

or their high-level designees.

C. Professional Representatives:

1. Private non-profit social service agency
2. Private for profit social service agency
3. Convalescent home and nursing home social service personnel
4. Hospital association social service personnel
5. A physician specializing in Gerontology

[Representation in category C should be both from commercial and from non-profit religious, fraternal and ethnic homes.]

D. Senior Citizen Lay Representatives

1. AARP
2. Gray Panthers
3. Senior Citizen Groups
4. Veteran's Association

II. ORGANIZATION

A. A chair designated by the task force sponsor

B. A steering committee, consisting of the chair and a representative from each of the four divisions of representation on the task force, i.e., State Executive Authorities, Judicial and Legal Authorities, Professional representatives, and Senior Citizens Lay Representatives

C. Needs study subcommittee

D. Legal study subcommittee

E. Resources study subcommittee, to study:
   1. private sector resources
   2. public sector resources
   3. fraternal, religious, ethnic societies resources

III. CHARGE

A. Philosophical Study -- society and government's duty to protect the incapacitated; the incapacitated's right to expect and receive protection from society and government. This study should also examine the extent to which a person's right to be free of unwelcomed government intervention should be honored. In doing so, ascertain prevailing public perceptions as to conservatorship and the public's position on the key philosophical questions.

B. Operational Study.
   1. <u>A needs study</u>, from a demographic perspective, to determine protection needed both as to present population under conservatorship and projected population. This study would develop data as to who needs conservators, the nature of their disabilities, and what protective services are needed. The needs study would also seek to determine if there were characteristics especially relevant to only particular classes of the population of persons under conservatorship to enable classification of such population into categories by such characteristics. This

would permit identification of areas of greater or lesser need and enable more rational resource allocation and development. It would also identify future classes at risk and allow early thinking both as to ways to abate that risk and ways to accommodate such of it as cannot be abated.

Data developed in this study might also enable determination of whether conservatorship is being overused, or perhaps underused, albeit in both cases with good intentions.

2. A legal study, to include a comprehensive review of the enacted and administrative substantive and procedural law of the state relating to conservatorships, and its application and implementation in practice. This would include an assessment as to compliance of the law, both as it is stated and as it is applied and implemented, to constitutionally applicable due process requirements, and a report of findings of non-compliance with recommendations of specific changes to effect compliance.

3. A resources study to produce an inventory of both public and private resources for furnishing necessary protection to persons under conservatorship. Public sector resources should include resources available from federal, state and municipal government, and private sector resources, those from religious and fraternal organizations and ethnic societies, and private profit and non-profit agencies. Also studied, for its impact on planning for future development and expansion of agency-provided resources, should be the extent of the person's own resources brought to the conservatorship -- both financial resources and resources represented by family and other personal relationships available to serve the ward.

STATE OF CONNECTICUT
SUPREME COURT

CHAMBERS OF
ELLEN A. PETERS
CHIEF JUSTICE

DRAWER N, STATION A
HARTFORD, CT 06106

February 3, 1989

RECEIVED
FEB 6 1989

Hon. Ralph D. Lukens
Probate Court Administrator
186 Newington Road
West Hartford, CT 06110

Dear Judge Lukens:

At a recent meeting of the Conference of Chief Justices, I was appointed to chair a committee to consider proposed national standards for guardianships and conservatorships. I urgently solicit your advice and comments.

Two questions occur to me:

(1) Is the subject one that is better addressed locally or nationally?

(2) Are the proposed standards, in whole or in part, appropriate for local adoption even if Congressional intervention is undesirable?

I understand that the impetus for Congressional action comes from testimony that elderly citizens have been victimized by improper competency proceedings that deprive them of control over their property. You probably are fully aware of the complaints that have been voiced. I assume that the underlying issues resemble the ongoing debate within the juvenile justice system, i.e. the conflict between benign informality and minimal due process.

My committee will not meet until August, but I would like to send out an informed agenda well before that time. When can you enlighten me about how to proceed?

Sincerely yours,

Ellen Peters

Ellen A. Peters
Chief Justice

EAP:ld

State of Connecticut
Probate Administration

OFFICE OF THE
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(203) 566-7897

March 9, 1989

Hon. Ellen A. Peters, Chief Justice
Supreme Court of Connecticut
Drawer N, Station A
Hartford, CT 06106

RE: Proposed National Standards for Guardianships and Conservatorships

Dear Chief Justice Peters:

This is our reply to your letter of February 3, 1989. It has been set out in three separate sections. First we attempt to answer your specific questions and make recommendations. Second we have given you our summary comparison of the present Connecticut law with the National Standards, along with our opinion as to the merits of each. Third we have included a copy of the final report of the Task Force on the Appointment of Conservators together with a list of the persons who made up this Task Force and a list of the persons to whom copies were sent.

After you have had an opportunity to evaluate this material, we would be pleased to meet with you to answer any additional questions you may have and to expand or explain the material enclosed with this letter. Protecting the elderly is of vital importance in our society today. It is also one of the most important areas with which we deal in the probate courts. We should certainly consider any constructive modifications in our methods of carrying out our duties.

I hope that we have been of assistance to you and can be of further assistance in the future.

Sincerely,

Ralph D. Lukens
Probate Court Administrator

RDL:nm
Enclosure

SECTION I

REPLY TO QUESTIONS AND RECOMMENDATIONS

You might find the following helpful in developing an agenda for your August committee meeting:

1. Replying to your question (1): We suggest that guardianship and conservatorship are subjects that are both more appropriately and better addressed on a state level than on a national level. It is the state's responsibility to care for its incapacitated citizens. Federal law on the subject would of necessity, given its wide area of application, be unable to be finely tuned to accommodate the diversities of the various states in respect of their state court systems, cultural and social characteristics, incapacitated populations, extent of resources available to deliver necessary protections, and so on. A nationwide system would not be characterized by flexibility, and would be unable to quickly respond to changing needs in any given state.

2. Replying to question (2): The proposed federal standards, while they would in large measure be appropriate in any state, and are in large measure in effect in Connecticut, would also, in significant respects, be inappropriate in Connecticut. For example, jury trial cannot be provided under present Connecticut law. Conservatorships are within the jurisdiction of the Connecticut Probate Courts. The probate courts are statutory courts of limited jurisdiction, and are not empowered to empanel juries. Based on recent past experience, Connecticut can expect to hear something on the order of 1,700 to 1,900 conservatorships and 400 to 500 guardianships of the mentally retarded per year. To comply with a jury trial requirement, our statutes would have to be changed to include these cases among the classes of cases eligible for jury trials. This would have complex ramifications in our system. It is important to note we have no indication whatever that the lack of a jury trial has caused concern to any citizen of this state involved in conservatorship proceedings. If there are problems in other states, it would only serve to support our feeling that each state has different problems.

It is also important to note as inappropriate that the proposed federal standards give final authority to an evaluation team to decide whether or not one is incapacitated, and requires dismissal of the matter before the court if it decides he is not. Such a procedure denies independent judicial evaluation, makes the court a "rubber stamp", the appointment of counsel unnecessary and indeed itself appears to deny due process protections.

Other examples of inappropriate standards are discussed in Section II.

3. <u>As for recommendations:</u>

a) We recommend a careful survey of all state laws to see if the laws satisfy due process requirements. We are concerned that the premises offered in the proposed standards as necessitating the proposals may be more of anecdotal derivation than the result of formal study methodology. There is, of course, existing remedy wherever a state's law as written does not accord due process -- the U.S. Attorney may act against the state under existing law. To be sure, this is an extraordinary remedy to be avoided if compliance can be brought about less confrontationally.

b) We recommend a task force study in each state on implementation of the state laws on the subject -- a study perhaps along the lines of that recently completed in Connecticut by a task force organized by the Probate Administrator's office. That task force report constitutes Section III of this report.

To the extent that the law of a state is proper, but its implementation violates due process, both civil and criminal actions would be available under present federal and, likely, state law in that state, to address the resulting violation of civil rights.

We would like to mention, in passing, our feeling of concern that efforts to enhance the protection afforded to incapacitated persons are going in the wrong direction with national standards. The overstructuring of protection that is proposed tends to institutionalize and depersonalize the entire process.

Section II

BY WAY OF BACKGROUND AND DETAILED DISCUSSION:

The following discussion, unless otherwise indicated, is with reference specifically to conservatorhips. Connecticut law with respect to guardianship of the <u>person</u> of a mentally retarded adult individual is separate law with separate standards and we comment on it later in this report. Conservatorship is, however, the route to protection of the <u>estate</u> of such an individual.

Overall, Connecticut law affords effective due process protections in establishment and continuing judicial maintenance of conservatorships. Indeed, our law presently provides, conceptually in virtually the same terms as the House proposals, for:

(1) the right to effective meaningful notice,

(2) personal service of notice on respondent (alleged incapacitated individual), and, seriatim, on spouse, children, parents, or other kin of respondent;

(3) contents of the notice in terms of informative value, i.e. time and place of hearing, and explanation of the legal effects of conservatorship;

(4) prohibition of waiver of notice;

(5) right to convenient forum;

(6) right to be present at the hearing;

(7) provision for relocation of hearing when necessary to facilitate attendance by a physically incapacitated respondent; and

(8) right to counsel -- court-provided counsel if respondent is unable to request or obtain counsel for any reason, and public funds payment of counsel if respondent is unable to pay.

It also provides for annual reports to the court by conservators of the person, mandated periodic accounting to the court by conservators of estate, annual notice by the court to respondents and their attorneys of their right to a rehearing, mandated rehearing every five years, and the right to a request for restoration at any time.

Some of the details of the above provisions differ in H.R. 5266 and H.R. 5275 from the corresponding provisions of Connecticut law. For example, in H.R. 5266 the minimum notice period of 30 working days in Sec. 3(a)(1), and the requirement in Sec. 3(d)(2) that counsel be provided not less than 20 working days before the hearing, are longer periods than our law provides. Frankly, we think the lengthy advance notice period required unduly delays adjudication of the issue and, if the respondent is incapacitated, leaves the respondent too long unprotected. We have never experienced any difficulties with our notice period. On that rare occasion when more time is needed, a request for continuance is quite in order.

Connecticut's explanation on its notice form of the legal effects of conservatorship is not quite so finely broken down in respect of specific "can do's" and "cannot do's" as in H.R. 5266 Sec. 3(a)(2)(C). We are not persuaded, however, that such detailed specificity is necessary to due process, and we are concerned that it ties the hands of court and conservator in addressing legitimate needs of the ward that become evident after the conservatorship becomes operative, but that could not reasonably have been anticipated during the proceedings and therefore were not included in the list of specific effects.

As for areas in which present Connecticut law does not square with the federal proposals:

1) Present Connecticut law does not provide for an independent professional evaluation team in conservatorship cases as in Sec. 3(e) of H.R. 5266, and we question the necessity for such a team. Under the federal proposal, evaluation by the team will only be available on request of the respondent or his counsel. Counsel in Connecticut may always secure an evaluation by practitioners of counsel's choice and present the findings

as evidence for the court's consideration. Our law already provides in General Statutes §45-70d that the medical report or testimony "contain specific information regarding the disability and the extent of its incapacitating effect". That is essentially what an evaluation team's report would cover. As for furnishing the court with views from practitioners in other disciplines, e.g., social workers, psychologists, co-ordinating assessment and monitoring agencies, and the like, §45-70d already provides for the court to consider such input as is available. Indeed, one would think the court might request either or both sides to present such views, if the court felt it would be helpful in a given case.

Of serious concern is the provision in Sec. 3(e)(6) that assigns to the evaluation team, the determination that the court should be making -- i.e., the sufficiency and the credibility of all of the evidence on the issue, including the team's evaluation, and the ultimate disposition of the application for conservatorship. Giving the dispositive decision to the evaluation team is to deny the respondent the protection of the judicial art. It does a further disservice to society and to governance in general to reduce the judicial role and involvement in the protection of the citizenry.

Indeed, by way of parenthetical comment, too much and too detailed instructive legislation as to how to practice the judicial art and how to document that practice trivializes the judicial role in any area of the law.

2) Present Connecticut law, which commits jurisdiction of conservatorship proceedings to the probate court, does not enable jury trial on request, as called for by H.R. 5266. Probate courts may not empanel juries. I do not know that Connecticut law would allow a jury trial on this issue in Superior Court. General Statutes §52-215 does not seem to allow it, if it gets to Superior Court by appeal from probate court; and present law does not, except perhaps by extraordinary process of some sort, get the matter into superior court except by appeal.

A change in Connecticut law could provide for jury trial in superior court and for an automatic transfer of contested conservatorship proceedings to Superior Court upon timely request of the respondent before the first hearing on the merits of the matter for jury trial there -- a provision along the lines of that which now permits transfer of contested termination of parental rights matters [General Statutes §45-61c(f)], albeit without being eligible for jury trial.

It should be noted that we have absolutely no evidence whatsoever that the lack of a jury trial has ever caused a judicial problem in the State of Connecticut. It does not seem that jury trial is a needed protection.

3) Also, Connecticut law does not provide, as such, for limited conservatorships -- i.e., conservatorships in which the conservator's authority is tailored and limited to only those areas of function in which the ward has incapacitating deficits, e.g., the inability to secure a suitable place to live. Limitations on the scope of the conservatorship are permitted in temporary conservatorships under General Statutes §45-72(a), but temporary conservatorships are generally to address an emergency situation, and in any case are of limited duration, up to a maximum of thirty days -- contemplating, usually, the concurrent processing of a so-called regular or non-emergency application. Also able, in a sense, to be considered as limited conservatorship, albeit not as finely limited as could be had under H.R. 5266, are the Connecticut law's provision for separate conservatorships for person and estate, permitting the conservatorship of either alone, or both concurrently. It is possible that a limited conservatorship should be given some consideration in Connecticut to see if it is workable. We have not, however, experienced such a need.

4) H.R. 5266 requires conservators to receive training, initially and ongoing. It does not say whose role it is to provide that training. H.R. 5275 has a similar provision in Sec. 2(h) which provides for "...court-supervised training, based upon standards developed by the governor of the state or his designee ...". Connecticut conservatorship laws do not presently provide for such training. In the case of public agencies acting as conservators, training programs are likely already required, if not explicitly then implicitly, by the law and regulations establishing the agencies and authorizing their functioning as conservators. Provision and supervision of these programs would be by the agencies. Private agencies, too, likely have training provisions for the personnel through whom they will act as conservators, as a necessary part of their being in business, whether they be profit or non-profit agencies. Most conservators however, are private individuals -- spouses, children, siblings, parents or perhaps other relatives of the ward, or sometimes a friend. Any stringent requirements for formalized academic type or "technical school type" training before one can qualify to serve as conservator might well result in elimination as conservators of those persons closest to the respondent and/or the inability to get volunteer conservators. Clearly, such requirements might also foreclose availability of service by individual professional persons, e.g., attorneys in the community, who might otherwise be willing to devote reasonably needed, albeit not optimum, time to serving as conservator on a pro bono or disproportionately modest fee basis.

Understanding the needs and sensitivities of the ward are most important to affording quality and compassionate protection to the ward, and, doubtless, formal training in this area cannot help but enhance a caretaker's performance of his duties. A measure of this understanding and sensitivity can be present naturally, without formalized training, in one who is willing to serve but is unable to devote the additional time required to formally train for the role. Requiring formal training can exacerbate the shortage of conservator candidates.

It would seem that it could be left to the court to determine the qualifications of the proposed conservator in the context of each particular case, and that the standard for selection of a conservator could be that provided in present Connecticut law. Present Connecticut law provides for the court to appoint a "nominee" offered by a respondent who has sufficient capacity to form an intelligent preference; otherwise "any qualified person", authorized public official or a private profit or non-profit corporation except a hospital or nursing home. In both instances, the court is required by the statute to be guided in making its appointment "by the best interests of the respondent" [General Statutes §45-70d(d)].

<u>By way of other comment or question</u>:

I am not comfortable regarding the credibility of the premises underlying H.R. 5266, set forth as findings in Sec. 2. We do not know where the data came from, nor how scholarly the process of analysis and crafting of the findings was. Frankly, I do not believe there are 33 states in which advanced age alone is sufficient to impose conservatorship. Indeed, we would venture the doubt that there is even one state in which the legislature's intent is that advanced age, alone and as such, is sufficient ground for imposing conservatorship. Adjudicated incapacity, caused by advanced age or otherwise, yes -- but age per se, we doubt it. Other of the findings, too, leave us uncertain regarding the credibility of their professed import as being unquestionable evidence of violation of constitutional right.

We suggest a survey of all state laws on conservatorship or guardianship of adult persons be undertaken via a questionnaire carefully drawn to address the essential elements of due process, such as notice, right to counsel, a public hearing, and right to call and cross-examine witnesses. Still other elements of the practice in each state, which may not be essential to due process but may nevertheless be of interest as enhancing the protection of persons for whom conservatorship is sought, may be the subject of inquiry on the questionnaire. The questionnaire can be directed to the Chief Justice or to the Attorney General of each state. Survey results can be collated and we can see whether there are any constitutional problems in design of the law on the subject, or whether problems, if any, are in improper enforcement or application of properly designed law. Much of what may appear to be denial of due process, in practice, may be instead a manifestation of lack of resources to deliver the conservatorship services properly adjudicated to be needed. Query, for example, how does one decline to appoint an untrained but willing proposed conservator when there is a shortage of persons willing to serve as conservators in the first place?

As suggested in Section I, to evaluate the precise nature and extent of implementation problems in the conservatorship field, whether in available resources, training, or whatever other aspects, we recommend the undertaking of a task force study in each state, along the lines of the recently completed Connecticut study. A copy of the Connecticut study report is enclosed as Section III.

Collation and interpretation of the data thus developed in each state can be done, as to the data from the law questionnaire, by a national judicial agency, perhaps the Center for State Courts, or by a governmental agency such as the U.S. Attorney's office -- perhaps the Civil Rights Division, since the essential questions and the concerns of the Congress are due process concerns. As to the data developed from the task force implementation study in each state, collation and interpretation may be by the United States Health and Human Services Department.

Time should be taken to do a credible study. If there are due process violations, the Justice Department can act now, without new federal legislation, against any state whose laws or practices reflect calculated denial of due process. We suggest, however, that if a careful survey and analysis of state laws were done, we would not find denial of due process in the law as written. We might find civil rights violations in the law as being incorrectly applied -- and that is another story.

Generally, conservatorship law should be constitutionally acceptable local law. The only national test of the propriety of these laws should be constitutionality. State standards, state by state, will accommodate local needs and situations. When there are so-called uniform laws enacted, states frequently modify them to accommodate their own needs, resources, and local characteristics.

We believe the concerns regarding this legislation expressed in Attorney James R. Wade's December 30, 1988 letter to President Edward B. McConnell of the National Center for State Courts, are well founded. Concerning the October 30, 1988 Resolution of the American Bar Association Real Property, Probate and Trust Law Section, and our interpretation of what it says, we concur (1) that a full adversary model is not a necessary or a preferable model for determining, at the threshhold, the existence and degree of incapacity (Resolution 1); (2) that state action rather than federal legislation is the preferable way to improve the guardianship system (Resolution 2); (3)

that there should be concern, albeit in the context of and tempered by the importance of necessary guardianship reform, for cost ramifications of changes, including where those costs fall (Resolution 3); and (4) that flexible approaches are preferable in dealing with incapacitated persons, permitting recognition and accomodation of relevant differences in the manifestations of incapacity and the protective needs of the mentally ill, the developmentally disabled, and the elderly (Resolution 4).

Many of the proposed federal standards are already in force in Connecticut. Details differ some, and where they differ, we believe our standards proper and appropriate, and some of the proposed federal standards inappropriate.

By way of summary of the proposed standards which do not square with present Connecticut law, such as the right in conservatorship cases to evaluation by an independent professional guardianship evaluation team; right to a jury proceeding; limitation of conservatorship to specifically detailed and delineated matter within established areas of incapacity; prior and ongoing training as a requirement for appointment and continued service as conservator; prohibition on appointment of convicted felons; and the requirement for the court to at least annually "conduct investigations" of the conservatorships in the court [H.R. 5266 Sec. 6(c)(4)]; our experience has shown that such features are not necessary in the law to accord due process or to provide proper protective conservatorship care.

The requirement of H.R. 5266 for counsel and transcripts to be furnished to indigent appellants for their appeals are inappropriate under the present Connecticut system since appeal in Connecticut is by trial de novo in Superior Court, and the Superior Court would address the question of providing counsel.

The provisions of H.R. 5266 for filing report of the ward's absence from the jurisdiction and for transfer of supervision of the conservatorship to a court of another state in which the ward takes up residence of 6 months or more during any 12 month period may be troublesome or unworkable; although some sort of notification to a social services agency in the other state might be established to bring the presence of the incapable to the attention of state authorities there for their decision on seeking oversight. The authority of a Connecticut conservator as to determining the place of abode of his ward, is limited to a place of abode in Connecticut. If the conservator seeks to move his ward out of Connecticut, he should seek permission of the court, and the court can then lay down conditions for establishing supervision elsewhere before it grants permission.

Regarding emergency conservatorships, which can be established ex parte and quickly, H.R. 5266 permits the same only for purposes of providing emergency medical treatment or shelter for the individual, and permits a duration of only 72 hours with one 72 hour renewal available. An emergency of longer than 144 hours duration cannot then be accommodated, inasmuch as regular conservatorship, so-called, cannot be put into effect before at least 30 working days of notice of hearing is given. Furthermore, emergency conservatorship is not available to address financial emergencies -- for example, to prevent a respondent from being defrauded or from irrationally disposing of his money or other property, or otherwise to act on behalf of the ward in a business emergency. Present Connecticut law allows up to 30 days of temporary conservatorship in emergencies, in respect either of the ward's person or the ward's estate, or both, as the case may be.

Regarding distinctions between protective appointments for mentally retarded adult individuals, and incapable persons who are not mentally retarded:

Protection of incapable non-retarded adults is provided through conservatorships, either of the person of the incapable or of the incapable's estate, or both if both are needed. General Statutes Ch. 779.

Protection of incapable mentally retarded adults, as to protection of the person of the incapable, may be provided either through conservatorship of the person under Ch 779, or through guardianship of the person under General Statutes Ch. 799. Ch 779 is specifically dedicated to protection of the person of an adult who is incapable by reason of mental retardation.

Protection of the estate of a mentally retarded adult is effected through conservatorship, just as is the estate of an adult who is incapable otherwise than by reason of mental retardation.

In respect of guardianship of the person of a mentally retarded adult, our Ch. 799 laws are essentially in compliance with H.R. 5266 and H.R. 5275 in like manner as are our conservatorship laws. Beyond that, the guardianship law also provides for an evaluation team approach by mandating assessment by an assessment team established by the Department of Mental Retardation. Unlike the proposed standards, this assessment team evaluation is a part of the evidence considered by the court, but is not the sole determinative factor.

Limited guardianship too is specifically provided for in Connecticut. The notice to the mentally retarded respondent of proceedings for appointment of a guardian expresses the legal effect of the guardianship with specificity in respect of the availability of limited guardianship and also details the various limitations.

Additionally, in Connecticut, court review of the guardianship through rehearing of the matter is mandated at least every three years.

SECTION III

REPORT OF TASK FORCE TO DEVELOP RESOURCES FOR APPOINTMENT OF CONSERVATORS

This section consists of a copy of the report of the Task Force to Develop Resources for Appointment of Conservators, organized by the Probate Administrator's Office in March, 1988, to assess current and project future need for conservators, to explore issues of concern, and to formulate specific recommendations which might be implemented. The study was completed and the report issued in December, 1988.

Copies of this report were sent to Governor William A. O'Neill; State Senators Anthony V. Avallone and Kenneth L. Przybysz, respectively Co-Chair of the Judiciary and of the Human Services Committees; State Representatives Joseph D. Courtney and Richard D. Tulisano, respectively Co-Chair of the Human Services and of the Judiciary Committees; Anthony V. Milano, Secretary, Office of Policy and Management; and Commissioners Lorraine Aronson, Department of Income Maintenance, Elliot Ginsberg, Department of Human Resources, and Mary Ellen Klinck, Department on Aging.

STATE OF CONNECTICUT
SUPREME COURT

CHAMBERS OF
ELLEN A. PETERS
CHIEF JUSTICE

DRAWER N. STATION A
HARTFORD, CT 06106

TO: Justice Robert L. Clifford, NJ
Chief Justice Thomas F. Fay, RI
Chief Justice Sonny Hornby, AL

FROM: Chief Justice Ellen A. Peters

RE: Committee to Study Proposed National Standards for Conservatorships and Guardianships

DATE: April 28, 1989

As we begin to plan for the Annual CCJ meeting in Lake Tahoe, Nevada, I thought it might be useful to sketch out some preliminary ideas about the forthcoming agenda of this committee. You will recall that we were appointed in order to allow the conference to make a principled response to the proposals for reform of guardianships and conservatorships contained in proposed federal legislation (e.g. HR 5266 and S.2765) on that subject.

There are two independent issues that this committee might address:

(1) To what extent is there solid, rather than anecdotal, evidence to support the need for uniform federal standards that would, inter alia,

(a) impose nationwide due process standards derived from a full adversarial model rather than more flexible standards arguably more responsive to the particular needs of the potential ward;

(b) impose procedural conditions such as mandatory access to a jury trial;

(c) impose formal notice requirements for initial guardianship proceedings and for subsequent reappraisals of a ward's condition;

(d) impose a professional evaluation team that might limit independent judicial evaluation of a ward's needs;

(e) impose formal training requirements upon private conservators without regard to the nature of the personal relationship between the conservator and the ward.

(2) To what extent should the Conference of Chief Justices undertake a program to establish minimum standards for adoption in the various states?

(a) should we ourselves undertake a critical study of the substantive proposals contained in the federal statute or should we solicit expert advice (e.g. through a presentation at a future CCJ meeting) to ascertain what appropriate state standards might encompass?

(b) should we ask the National Center to ascertain the extent to which state practices now conform to the practices proposed in the federal statute?

(c) should we adopt a resolution recommending the creation of local task forces to study ways and means of assuring that local guardianship and conservatorship proceedings fully protect the rights of their wards?

Background

Approximately one year ago the Office of Probate Administration conducted a survey of the probate courts which addressed the human services matters that came before the courts. The survey identified conservatorship as the area of greatest concern to the courts. The primary reason listed was the difficulty experienced in locating a qualified person or agency to be appointed as conservator of estate or conservator of person for an individual found to be incapable. This difficulty arises when the incapable has modest assets available. Only in instances when the person has ample assets to pay for conservatorship services is it easy to locate qualified appointees. Persons who need a conservator do not always have family or other closely tied individuals available and willing to serve. This is particularly true for those groups for whom we might expect the greatest need, such as the frail elderly and persons impaired by long term substance abuse or mental illness.

Over one third of the courts responding indicated they had had difficulty locating a qualified party. Barriers identified as contributing factors were:

1) Time involved for little or no compensation. 2) Lack of resources to support the appointee, 3) Fear of responsibility and liability and 4) Bureaucratic practices and lack of training.

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Other concerns identified in the survey of the courts included the following:

1) The State's Conservator program within the Department on Aging had essentially reached its limit. The program initiated in 1984 was intended to fill the need described above. However, the statute provided for the Commissioner to accept appointments "within available appropriations". When the caseloads of the conservator designees reached what the department deemed to be a maximum number, the Commissioner was forced to close intake and to accept only temporary appointments of an urgent nature. This occurred on a number of occasions.

2) Caseloads were felt to be too high for this type of intensive service. Some courts expressed concern that despite the best efforts of the conservator designees, wards were not being provided the desired level of service under non-urgent situations.

3) Reports required to be filed with the courts were falling behind, despite the good intentions and efforts of the conservator designees.

4) Individuals in need of a conservator do not always meet the eligibility criteria for the state's program. That is, they are either under age (60) or over asset ($1500 in liquid assets excluding a burial fund).

For all of these reasons the Office of Probate Administration decided in March of 1988 to create a Task Force to study the issues and make some recommendations. The purpose of the Task Force was to assess current and project future need for conservators, to explore issues of concern, and to formulate specific recommendations which might be implemented.

It was a coordinated interagency effort which brought together representatives from State agencies, the probate courts, the CT Bar Association, nursing home administrators, the CT Hospital Association, the CT Coalition on Aging, the CT Assoc. of Local Administrators of General Assistance and others identified as having an interest in the issues. (Please refer to attachment A for full list of membership.)

ORGANIZATION OF TASK FORCE

The Task Force endeavored to evaluate what we have and what alternatives there might be. To accomplish this three subcommittees were formed. The Task Force had information on a successfully operated municipal conservator program in the town of Manchester. Therefore, one committee was established to look at: What are the desirable qualities of a local program? How receptive are local government agencies? What would training and funding needs be?

Another subcommittee was organized to look at private sector involvement. Specifically, what roles can the private sector play? How might interest be generated and developed in an integrated and coordinated manner? Clearly issues of legal liability and insurance are viewed as prohibitive factors by private agencies. Could recommendations be developed which might overcome these prohibitive factors?

Finally, a subcommittee was formed to take a look at enhancement of state agency programs. Are there benefits to keeping existing programs? What are issues which need to be addressed? What staffing would be adequate, based on acceptable practice (both casework, and supervisory). Can service provision be improved?

Data Collection

To ascertain current and project future need, the Task Force conducted a number of surveys and interviews and reviewed surveys done earlier by the Office of Probate Administration.

Surveys of the probate courts were conducted in September of 1987 and January of 1988. The first survey examined the human services areas in which the courts act. It identified the lack of qualified persons or agencies to serve as conservators as the greatest need facing the courts, and identified additional concerns regarding the ability of the state's conservatorship program to meet growing needs (See Attachment B). The second survey was conducted at the request of the Office of Legislative Research. It provided some first encounter data with respect to where petitions for the state's conservator programs are initiated and the age and residence of conserved individuals at the time of petitioning (See Attachment C).

Members of the Task Force conducted interviews with representatives from state agencies which might have a direct or peripheral interest in current programs. Agencies interviewed included: the Dept. of Income Maintenance, Dept. of Health Services, Office of Protection and Advocacy, Dept. of Mental Health, Department of Veteran's Affairs, and Office of the Attorney General. The result of these interviews are included in the section of the report dealing with recommendations of the Subcommittee on Enhancement of State Programs. In addition, agencies serving populations which might include individuals who are mentally or physically incapacitated were asked to complete a survey regarding current need and projections regarding future need (Please see Appendix D).

Representatives from state agencies which have a conservator program were interviewed by members of the Task Force concerning the programs which they administer. These included the Department on Aging, Department of Human Resources and Department of Administrative Services. (The results of these interviews are included in the section of the report dealing with enhancement of the state conservator programs.)

Members of the Municipal Model Subcommittee conducted interviews of local agencies (social service, elderly services, and welfare) in a sample of municipalities. The results of these interviews are included in the section of the report dealing with recommendations of that subcommittee.

Surveys were conducted of the largest group of petitioners for conservatorship as identified by the survey of the probate courts. These included acute and chronic care hospitals and medical facilities in the state (other than children's facilities), licensed nursing and convalescent homes and homes for the aged, and state psychiatric hospitals.

The surveys solicited data regarding current need for qualified appointees to serve as conservator of estate and conservator of person, and projections regarding need in one year and in five years. Officials at these facilities were asked to state an opinion as to whether availability of alternatives to conservatorship would significantly reduce the number of conservatorship appointments. They were also asked if they have seen abuses when alternatives to conservatorships lacking court supervision were used. (See Attachment D.)

In addition to the above, data was compiled regarding location and bed capacity of all hospitals and health care facilities by town and probate district. Data was also compiled by town on per capita income figures and projections of population increase. (Please refer to Attachments F through M).

Alternatives to Conservatorship

Trusts, powers of attorney, living wills, joint bank accounts and financial management services are alternatives which, if used properly, may be utilized to avoid appointment of a conservator. Alternatives should be carefully designed to avoid conflicts with Medicaid requirements. Although there are advantages to each, if carefully designed, there are also disadvantages. The major disadvantage is the lack of court supervision. Of hospitals and health care facilities which were surveyed, a fair number indicated that abuses were seen where alternatives such as those listed above were used. (See Attachment C). Most often these abuses involved mismanagement or misappropriation of the incapable's monetary resources. Frequently it involved avoidance or delay of decisions and actions related to treatment or placement.

In addition to the alternatives referred to above, voluntary conservatorship and predesignation of a conservator prior to a determination of incapacity are alternatives which may be utilized. These alternatives allow for an individual to be involved in the selection of a substitute decision maker. This form of conservatorship is preferable to involuntary conservatorship in which proceedings are initiated after the individual has become incapable.

Over fifty per cent of officials responding to the surveys of hospital and health care facilities indicated they felt increased availability of alternatives would reduce the need for conservatorship appointments. It is the sense of task force members that there is a need to provide increased information to the public regarding alternatives. In addition, educational materials which include samples of alternative documents should be made available. Vehicles for providing this information could include the senior center network and municipal agents.

However, it must also be mentioned that many of the officials who predicted a reduction in need also felt that reduction would be relatively small because persons who need state conservators are not likely to avail themselves of alternatives. Also, several officials commented that many hospitals and nursing homes prefer appointment of conservators, particularly when they anticipate the need for granting of medical consent to treatment.

Interpretation of Data:

Officials at accute and chronic care hospitals are predicting a dramatic increase in need for conservatorship over the next five years, particularly in the area of conservator of person. Officials at State psychiatric facilities are also predicting an increase in need. There is growing concern that authoritative substitute decisions be sought for medical treatment and procedures when patients are incapable of granting informed consent. This concern is heightened when decisions focus on removal from life support systems and other decisions that come at the end of the dying process.

Officials in nursing and convalescent homes are also predicting a dramatic increase in need over the next five years, particularly with regard to conservator of estate. Frequently applications for appointment of a conservator are received when an incapable person's resources are spent down to the asset limitation which enables the individual to be eligible for medicaid payments. Several facilities surveyed reported that this is the time at which difficulties and abuses often occur. Relatives may endeavor to conserve funds for survivors. They may postpone application because of lack of information and understanding concerning eligibility for medicaid payments and because of the complicated application process. In addition, the Nursing Home Reform Provisions of the Omnibus Budget Reconciliation Act, P.L. 100-203, Title IV, Subtitle C, enacted in December of 1987, provide that if a resident is not adjudged incompetent any "legal surrogate" may exercise patient's rights. Where families have not executed a power of attorney, nursing homes may imply the need to petition for appointment of a conservator. Such an interpretation by health care facilities may impact on the demand for conservator appointees.

The survey referred to in Attachment C demonstrated the fact that half the total number of appointments of state conservators were made in a dozen towns. Of these, the majority were made in large city courts where per capita income is lowest, there is the largest concentration of hospitals and health care facilities, and a larger population exists of those most likely to need a substitute decision maker, such as individuals incapacitated due to mental illness and long term substance abuse. When thinking of approaches to increase the numbers of resources for appointments, we must take these factors into consideration.

Proposed Organization

A rapid increase in the need for appointment of conservators has been predicted by recognized experts in the field (One such expert is Professor Winsor C. Schmidt who has written extensively on the topic of conservatorship). This increase is largely predicated on an anticipated explosion in the elderly population and on trends in the fields of medicine and mental health. It has been confirmed by the results of the surveys completed by the task force. As the increase is predicted to be large, we must begin now to look at possible means of meeting that need while controlling cost. The Task Force feels that the proposed scheme of reorganization represents the most cost effective use of resources and the best means of controlling sky rocketing costs while meeting the needs of Connecticut's citizens.

Building upon the experience of other states and looking at what appears most practical for the State of Connecticut at this time, the Task Force recommends development and delivery of an array of services at the state, local and private sector levels. This array of services should be encouraged and developed through a systematic approach to a comprehensive long range plan.

It is vital that the state play a leadership role in development and implementation of a comprehensive long range plan. The state must assume responsibility for encouraging creation and implementation of conservatorship programs and developing educational tools at the local community level and within the private sector. However, the development of programs should be a shared responsibility, shared by state and local government and private institutions and organizations.

To encourage and integrate development of programs, one state agency should be given responsibility for channeling state and federal funding into appropriate programs by providing grants to assist local government and private sector institutions and organizations in establishing programs. The same state agency should be given responsibility for ongoing coordination and evaluation of programs which are developed.

As conservators often face weighty decisions, it is essential that conservator appointees be qualified. The state agency which has responsibility for coordination and evaluation of programs should be given responsibility for establishing qualifications and standards of conduct. The agency should also have responsibility for providing training in an integrated systematic manner. Training and support should be tied in with development of supportive services which are community based. Family members should be encouraged to accept appointment as conservators when practical. To foster this, better training and support for family members should be included in any plan for training.

The legislature should provide a mandate to the state agency which has been given responsibility for development of programs to create an "Office of Conservatorship Programs". The office should be funded, and would have responsibility for overseeing grants for start up of local programs, development of standards for programs, and assistance with training needs. It would also be responsible for community outreach, to provide information to communities regarding development of programs, and to encourage involvement of agencies and organizations from the private sector. Development of local programs will necessarily be on a gradually implemented basis.

Underlying Philosophy

The members of the Task Force feel strongly that certain principles should be embodied in any programs which are developed or enhanced in accordance with recommendations made by the Task Force. These principles are as follows: Each individual case deserves individual quality attention. The focus of the conservator should be on the whole person, not just on any single aspect of a person's functioning or needs. A primary responsibility of a conservator is to preserve or enhance individual autonomy and minimize unnecessary institutional care. Any system of conservatorship should be adopted to best serve the needs of the incapable individual. Finally, services should be provided in a responsible and timely fashion.

Enhancement of Existing State Programs

At this time, cities such as Hartford, New Haven, Bridgeport and Waterbury, which have the greatest need for expanded resources for conservatorship appointments, have budgets which are already strained. Other population centers will no doubt experience similar difficulties. Therefore, it is likely that the state will need to continue to play a significant role in conservatorship in such areas. In view of the fact that the state is likely to play a continuing role in provision of conservator services, at least for the near future, it is extremely important that we take a careful look at how they are currently provided and where there may be a need for improvement.

Surveys and interviews of state agencies provided information about the conservatorship programs as they currently exist within the Department on Aging, the Department of Human Resources and Department of Administrative Services (16 cases). The purpose of these surveys was to gather information which could be used as the basis for deriving recommendations for enhancement of existing programs with the goal of optimal service delivery to incapable individuals determined to be in need of court appointed substitute decision makers. Information gathered from these surveys is the basis for the following recommendations:

The Task Force recommends the commissioner of the designated state agency for a conservatorship program develop a plan to limit caseloads, and develop standards to insure the intensive supervision of persons conserved by the agency. Conservator designees should be provided the benefit of direct supervision which is accessible. Adequate provision should be made for coverage of caseloads in case of temporary unavailability of the conservator designee due to illness or absence.

The commissioner should promulgate standardized forms for record keeping and a system of quality assurance to ensure that individual records are adequately maintained. Records should include documentation of all contacts, including face to face contacts. Regulations adopted by the agency should specify a minimum requirement for frequency of face to face contacts for individuals maintained in the community and for individuals placed in institutional settings, recognizing that individuals who remain in community settings would require more intensive supervision.

The commissioner should promulgate standardized forms for development of a "conservatorship plan" for each conserved individual which would outline individual needs and specify needed services. The agency's policy should require an internal review of the "conservatorship plan" which would include review of the continued need for conservatorship and specified services on at least a yearly basis.

When the Dept. on Aging's conservator program came into effect in 1984, the enabling legislation established an asset limitation of $1500 in liquid assets as part of the eligibility criteria. This asset limitation was tied to DIM regulations regarding eligibility for Title XIX. However, new regulations which came into effect in October of 1988 allow for the following: a prepaid irrevocable burial contract of up to $3600, a $1600 personal account and a life insurance policy with cash value totaling no more than $1500.

In view of the language contained in Public Act 88-206, many individuals eligible for Title XIX remain ineligible for the appointment of a state conservator. Therefore, the Task Force recommends the General Assembly raise the asset limitation for the state's conservator programs to bring eligibility criteria into compliance with the DIM regulations.

When the conservator program was first implemented the Connecticut General Assembly appropriated enabling funding to the Department on Aging for the purpose of creating a program as defined by the statute. In fiscal year 1987-88 the Department on Aging's approved budget for conservator of person and conservator of estate included the following appropriations: personnel: $155,183.00 and estimated additional costs for items for office supplies, vehicle leasing, telephone, etc., in the amount of $29,951.00, totaling $185,134.00.

Public Act 88-206 transferred a major portion of the program, the responsibility for conservator of person, to the Department of Human Resources, with no additional funding, no additional personnel. The program was added to the already busy Adult Services Program. The Task Force strongly recommends the legislature appropriate sufficient funds to the Department of Human Resources At a minimum, this appropriation should be sufficient to staff and administer the program. The Task Force also recommends that additional funding be appropriated to staff a position of "Office of Conservatorship Programs", if the recommendations contained herein are accepted.

Separation of the state's conservator program into two separate programs housed within the Department on Aging and the Department of Human Resources creates inherent problems. Although the two departments are pledged to work closely in a spirit of cooperation, the concern is that the definition of roles and responsibilities becomes less clear and may impact negatively on provision of services to the whole client.

The Task Force has concerns about the division of person and estate due to the distance this puts between identification of needed services and placement and payment for such. This may result in delays in provision of services, duplication of effort, and increased administrative costs.

Another concern is the staffing of the Department on Aging's conservator program. On several occasions the Commissioner has found it necessary to close intake and to accept only temporary appointments of an urgent nature when caseloads reached what was deemed to be a maximum level. If staffing for the program remains unchanged, there is concern that extended illness or absence of one staff person could lead to temporary shut down of the program again.

The Task Force acknowledges the fact that representatives of Aging and Human Resources have worked diligently and responsibly to ensure coordination of effort. However, for the reasons enumerated above, there remains concern that division of conservatorship of person and conservatorship of estate into two separate programs located in two state agencies may lead to delays in provision of needed services and delays in placements. Therefore, it is recommended that in long range planning, consideration should be given to locating both programs within one state agency.

Development of Municipal Conservator Programs

There are many benefits to the development of local conservator programs. For example, many incapable individuals do not qualify for the state conservator program because they do not meet age or income requirements.

These individuals may not have family members who are willing or able to serve as conservators. Local programs can establish their own eligibility criteria to allow for service to individuals who now fall through the cracks. In addition, incapable individuals may have problems which require the appointment of a town conservator with social work or other special skills.

Other benefits for wards are: 1) town conservators are able to develop expertise in dealing with problems due to familiarity with local resources; and 2) conservators are accessible should a ward develop problems which need immediate attention.

Through the efforts of town conservators, wards may be maintained in the community, thus avoiding or postponing institutionalization. If and when it becomes necessary for a ward to enter a nursing home, a town conservator could provide continuity in the relationship and continue to act as a substitute decision-maker, especially for medical treatment.

Some financial incentives are available to cities and towns in the state for establishment of local conservator programs. The Town of Manchester, for example, receives federal block grant funds from the Department of Human Resources for counseling services and for protective services. The town uses the grant to fund a conservator program within its Department of Social Services.

Other financial benefits are realized when an individual can be maintained in a less restrictive and presumably less expensive environment through the efforts of a trained conservator. Similarly, money can be saved by the early appointment of a town conservator to facilitate transfer of an individual from a hospital to a nursing or convalescent home. The conservator can apply for benefits or manage the resources of the ward. Fees allowed under state law can be collected for the local program from estates of individuals who have sufficient income. In addition, close supervision of certain individuals can lower costly use of such services as ambulance and Emergency rooms.

One issue of great importance to conservators of the person is potential exposure to lawsuits for alleged negligent performance of duties. Liability insurance, however, is costly. The Town of Manchester has resolved this issue by appointing the Dir. of Social Services. The town's liability coverage extends to this position and the position is bonded in the manner in which other town officials are bonded. It is worth noting that in the seven years of Manchester's program there have been no complaints filed, nor have there been any lawsuits or threats of lawsuits in connection with the conservatorship program.

To encourage towns, or groups of smaller towns, to establish local programs, the Task Force recommends the General Assembly create and fund an "Office of Conservator Programs" within the Department of Human Resources. The "Office" would request proposals for grants from the towns and would have authority to approve the grants. Standards for local programs would be set through the joint efforts of the "Office" and local communities. While ongoing programs would require little outside supervision, the "Office" would assist with statewide training programs for town conservators and would be available for consultation.

Since there are local communities which are unable or choose not to establish local programs, the State must maintain a strong statewide conservatorship program.

Encouragement of Private Sector Involvement

A number of agencies and organizations within the private sector have expressed interest in developing conservatorship services. One agency spent two years exploring the feasibility of developing a program only to conclude that the agency could not afford to provide conservatorship services.

Private non-profit agencies interested in offering conservatorship services face several major barriers to program development. These obstacles include securing funds, hiring and retaining staff, obtaining insurance coverage and dealing with legal implications. Insurance coverage and legal issues are typically the most difficult areas to resolve.

Specifically, agencies have major concerns regarding the risk of malpractice claims such as irresponsibility, mismanagement and not acting in the best interest of a ward. Adequate insurance coverage is therefore critical to protect assets should a liability claim arise. A 1987 survey of non-profit organizations throughout the United States offering conservatorship services indicated that most programs already had very adequate liability insurance prior to starting a conservatorship program and did not face the problem of initially securing coverage. For such agencies, policy renewal was often difficult and extremely expensive. A standard insurance package for a conservatorship program should include: comprehensive professional and general liability, Directors and Officers Liability, Improper Administration/Errors and Omissions, Employee Dishonesty, and Probate Bonds (when acting as conservator of the estate).

In the Connecticut area, many insurance carriers are not interested in offering the needed insurance, at any price. Within the industry, a conservatorship program is viewed as a high risk operation with long term exposure. Most insurance companies will not consider insuring these programs. Agencies must look to excess line markets, such as Lloyds of London, instead. In most cases, excess lines will consider providing coverage to individuals, with extensive experience acting as conservators rather than to an agency. Carriers also prefer to issue bonds to individuals rather than to an agency. If available, annual premiums can average $15,000 - $30,000. This is cost prohibitive for many non-profit agencies.

In terms of legal protection, the state of Connecticut enacted a Tort Reform Statute on October 1, 1986 (Public Act 86-338 §10) which offers directors, officers, and trustees of non-profit organizations, (who are not financially compensated) immunity from civil liability for any act or omission resulting in damage or injury, provided the person was acting in good faith, and within the scope of official duties. However, this statute does not provide insulation from law suit. In practice, a Board of Directors would still be liable and would need Directors and Officers liability insurance coverage.

Recommendations

Funds should be set aside by the agency which has been given responsibility for development of municipal programs, to encourage development of programs within the private sector.

In view of prohibitive insurance costs and legal risks, it appears that the state must offer incentives to encourage private agencies to become involved in conservatorship programs. The following incentives should be considered:

1. The Task Force favors adoption of language similar to that in C.G.S. 45-335 to provide immunity to court appointed conservators in certain circumstances. Conservators of the person should be immune from civil liability except in cases of gross negligence. However, conservators of the estate should be held to an ordinary negligence standard (due to the many publicized incidents of fund mismanagement). Conservators of the estate should be afforded the traditional forms of protection, including surety bonds. The cost of the bond should be provided as part of the cost of the program.
2. The state should offer assistance with insurance protection. The state should consider extending its liability coverage to include private agencies with which the state may subcontract. Another alternative would be for the state to make funding available for insurance protection.
3. Separate from the insurance and immunity issues, other enhancements may be used to attract private agencies to assume conservatorship roles:

   State and local governments might explore use of organizations such as AARP and RSVP to locate persons willing to act as appointees or volunteers (visitors). A successful model for this is the VIE (Volunteers Intervening for Equity) Program in Omaha, Nebraska. VIE utilizes volunteers to act as conservators. To deal with the liability concern, volunteers have been able to place a rider on existing insurance policies. VIE accepts only voluntary conservatorships (person agrees to having a conservator). The volunteers adhere to strict procedures and are monitored carefully. It must be noted that this level of volunteer commitment would be difficult to find and retain.
4. The state must also be willing to explore creative funding options (e.g. federal programs and private foundations), including grants which may be available from other sources. The State should consider channeling funds to private agencies to establish programs. Funding is critical since a conservatorship program should ideally assure continuity of services on a lifetime basis. Agencies must have stable sources of income, especially if they are offering

services to the indigent. The best model would be a combination of private endowments, client fees, state grants/contracts and private philanthropy.

In summary, the ability of government agencies to contract with private agencies and to extend liability coverage would be the most feasible means of attracting more involvement from the private sector. If this option were combined with changes in immunity standards and greater availability of alternate sources (use of volunteers, etc.), private agencies would be more willing to manage the risk factors inherent in a conservatorship program and to offer the needed services.

SUMMARY AND RECOMMENDATIONS

The probate courts of Connecticut have become increasingly aware of a dilemma facing the state's health care institutions, ie. the lack of adequate resources of qualified persons to serve as conservators for incapable individuals who cannot afford to pay fees customarily charged. Increasingly, petitions are being filed in which the petitioner is unable to identify a proposed designee to serve as conservator. Although the majority of these petitions fall within the eligibility criteria for the state's conservator programs, there are a significant number in which the respondent does not meet the criteria for the state's programs.

The need for additional resources exists now and will increase dramatically over the next five years and into the forseeable future. Data collected by the Task Force support this prediction. Increased availability of alternatives to conservatorship will not significantly reduce the need for conservatorships.

To address the predicted increase in need, the state must begin now to look at the most cost effective utilization of resources and the most practical means of providing the best services to Connecticut's citizens. To satisfy the anticipated increase in need an array of services should be encouraged. Development of expanded resources for conservator services should be a shared responsibility, shared by state and local government and organizations and agencies within the private sector. The state should provide a leadership role in developing expanded resources with an eye toward the most cost effective use of resources.

As conservators often face weighty decisions, it is vitally important that conservator appointees be qualified. The state should also play a role in establishing qualifications and standards of conduct and ethical behavior for conservators of person and estate, and in coordinating training for appointees.

A primary responsibility of a conservator is to preserve or enhance individual autonomy and minimize unnecessary institutional care. Each individual deserves individual quality attention from his/her conservator.

The matter of providing adequate numbers of qualified individuals to serve as conservators is an important one which deserves careful consideration by elected officials of the executive and legislative branches of government.

Therefore, members of the Task Force on Appointment of Conservators ask for consideration of the following recommendations:

1. To encourage and integrate development of programs, one state agency should be given responsibility for:
    a. Exploring expanded resources. Due to the potential benefits, priority should be given to establishing local programs.
    b. Establishing qualifications, and coordinating training for appointees.
    c. Channelling of funding (including grants) into local programs, established by local government and private agencies.
    d. Providing better training and support to family members to encourage participation where appropriate.
2. An "Office of Conservator Programs" should be established within the state agency given the responsibilities enumerated in recommendation #1. This "Office" should be staffed with a funded position. Responsibilities would include:
    a. Research and planning
    b. Encouraging development and implementation of conservatorship services at the local community level within municipal government agencies and within the private sector.
    c. Provide standards for programs.
    d. On-going coordination and evaluation of programs which are developed.
3. Adequate insurance coverage is critical to encouraging participation within the private sector. The Task Force recommends:
    a. Adoption of language similar to that found in C.G.S. §45-335 to provide court appointed conservators of the person immunity from civil liability.
    b. The state should offer assistance with insurance protection. The state should consider extending its liability coverage to include private agencies with which the state may subcontract.
    c. The state should explore use of organizations such as R.S.V.P., A.A.R.P. to act as appointees or volunteers.
4. To encourage the best provision of services within state agencies in which conservator programs are located, the Task Force recommends that such agencies:
    a. Develop standards to ensure intensive supervision of conserved persons.
    b. Develop standardized forms for record keeping and a system of quality assurance to ensure that individual records are adequately maintained.

c. Require documentation of all face to face contacts and adopt regulations which specify a minimum frequency of face to face contacts, recognizing that individuals who remain in the community would require more intensive supervision.

d. Require a "conservatorship plan" be developed and recorded for each conserved individual.

e. Develop a plan to limit caseloads while ensuring adequate staffing to cover caseloads.

5. Eligibility criteria for the state's conservator programs should be brought into compliance with D.I.M. regulations.

6. Further, it is recommended that adequate funding be provided to the Dept. of Human Resources to staff and administer the conservator of person program which was located within the department as a consequence of Public Act 88-206.

7. The Task Force acknowledges the fact that representatives of the Department on Aging and the Department of Human Resources have worked diligently and responsibly to ensure coordination of effort on behalf of conserved persons. However, there remains concern that division of conservatorship of estate and conservatorship of person into two separate programs located in two state agencies may lead to delays in provision of services and delays in placements. The Task Force recommends these concerns be further examined in any comprehensive long range planning.

Appendix

Development of a Long-Range Plan for Conservator Services at the Local Level in Connecticut

In considering how to plan and develop locally administered conservator programs in Connecticut, the assumption has been made that there will be three major factors influencing the need for these services, i.e:

1. Per capita income.
2. Population size.
3. Location of concentrations of people who may require conservator services. (e.g. hospitals and nursing homes.) Mandates for nursing homes.

Statewide data was collected from the Comprehensive Planning Division of the Connecticut Office of Policy and Management and from the Connecticut Department of Health Services. The income, population, and health care institution data was organized by individual municipality for the purpose of developing a priority ranking of municipalities for the development of conservator programs.

It is recognized that such a priority ranking of need will not be used as a statistical "strait-jacket" absolutely necessitating that the development of local programs follow this pattern. Rather, it is suggested that this ranking be used as a general guideline which will identify the probable areas of greater and lesser need for conservator services. Interest of local public officials in developing programs, and a variety of local political factors, will undoubtedly have an influence on the "acceptability" or "non-acceptability" of local conservator programs.

Furthermore, experience with the locally administered conservator programs over a period of years will indicate more precisely which one of the factors indicated above will be more determinative of future conservator service need. It seems probable that certain types of health care institutions will, in the long run, produce more patients with need for conservator services than others.

The absence of a centralized universal coding and information system make it extremely difficult at this stage to obtain objective data. Therefore, the ranking method employed has taken all categories of hospitals and nursing homes serving adult patients into consideration. In planning for conservator services in municipalities it would be extremely valuable to have a universally recognized coding system for the collection of "First Encounter" data. Such a coding system would indicate the actual physical location of the client for whom conservator services are being requested. Categories of hospitals and nursing homes would be identified by code numbers. By another code number, an individual would be identified as residing at home. It would also be valuable to know how the referral was made. For example, was the need for conservator services identified through the municipal Department of Public Assistance or Department of Social Welfare?

We have information which leads us to believe a number of towns may be interested in developing programs. However, the ability to test the waters requires staff with expertise in community program development and the ability to commit a major portion of time to this task.

Index to Attachments

ATTACHMENT A

TASK FORCE ON APPOINTMENT OF CONSERVATORS

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ATTACHMENT B

SURVEY RESULTS - CONSERVATOR
(with 61 courts reporting)

Part I

1. Answers to the question, "Have you had difficulty locating a qualified person or agency to be appointed as conservator of the estate or conservator of the person who has been found incapable?" were as follows:

   34% answered yes
   60% answered no
   6% reported no experience

2. Of those answering yes, barriers identified as most significantly contributing were: (in order of most frequently identified)

   (1) Time involved for no compensation (19 courts)
   (2) Lack of resources to support the appointee (16 courts)
   (3) Fear of legal responsibility and liability (13 courts)
   (4) Beaureaucratic practices and lack of training (2 courts)

3. When an appointeee is not named, most often the courts go to a list of attorneys. Other sources listed included:

   Courts' approved list
   Bank
   Town conservator
   Municipal agent
   Minister
   A mutually agreed upon party

4. Courts have appointed agencies as conservator as follows:

   Department on Aging - 22
   Department of Human Resources - 18
   Connecticut Community Care, Inc. - 2
   Municipal Social Service Dept. - 7

   Of the courts responding, 21% indicated they feel their local Department of Human (or Social) Services might be receptive to establishing a conservator program.

5. Of the courts which have appointed any of the agencies in question 4, specific problems regarding their meeting their duties and responsibilities were enumerated as follows:

   A. Department of Human Resources - (1) Did not visit incapable often enough nor take care of personal needs. (2) Appointee was some distance from incapable, was not too available. (3) Agreed to appointment as co-conservator, but after appointment refused to serve unless sole conservator.

   B. Department on Aging - (1) Caseloads are too high. Do not provide desired level of service. (2) Reports are not filed on a regular basis. (3) Lax in filing annual report on condition of the ward. (4) Have refused appointment.

Part II - Investigations

1. In answer to the question, "Do you feel you receive sufficient information to evaluate the need for conservators?":

   82% answered yes
   18% answered no

2. Responses to the question, "Do you feel you receive a 'summary of the physical and social function level or ability of the respondent..' under CGS 45-70d(a)?" were:

   67% answered yes
   24% answered no
   9% answered N/A or did not answer

   a. Of the courts which reported they receive a summary (above)

      50% reported receipt of a summary 100% of the time
      17% reported receipt of a summary 90-99% of the time
      10% receipt 70-75% of the time
      5% receipt 50-60% of the time
      2% receipt 40% of the time
      5% receipt 5% of the time
      11% did not answer the question

b. To the question, "Should such information be mandatory?":

70% answered yes
16% answered no
13% answered N/A or did not answer.

3. Do reports received from agencies appointed as conservator of the person contains sufficient information to determine the condition of the respondent?

	90-100%	75-90%	50-75%
Department on Aging	10 courts	3	2
Department of Human Resources	11 courts	4	-
Conn. Comm. Care, Inc.	1 court	1	-
Local Social Service	-	1	-

4. The question, "What information should be included in the annual reports that you do not presently receive?" elicited the following comments:

a. A statement regarding frequency of visits to the respondent and date of last visit prior to completing the report.

b. Information regarding social level of functioning (or addressing daily living skills) as well as physical level of functioning.

c. A list of medications, their purpose and side effects, if any.

d. Doctor's report regarding any changes in the respondent (mental and physical).

e. The condition of life of the respondent.

f. Voluntary reports should be more specific.

Part III - Monitoring

1. Does the Department on Aging, when appointed conservator of the estate, file the inventory within two months? (Estimate percentage of cases filed on time).

90-100%	75-90%	50-75%	Under 50%	N/A or no Answer
5	4	4	3	45

2. Are the agencies appointed as conservator of the person reporting annually to the court concerning the condition of the ward? (Estimate percentage of cases on which reports are received on time).

	90-100%	75-90%	50-75%	Under 50%	N/A or no Answer
Dept. on Aging	10	1	6	4	Remainder
Dept. Human Res.	7	1	2	2	"
CCC, Inc.	1	1	-	1	"
Town Social Svc.	2	1	-	1	"
Other Appointees	4	2	2	1	"

Part IV - Additional Comments, Criticisms, Suggestions Obtained from Questionnaire, and Interviews of Courts

1. Conservators are the area of greatest human service need for the probate courts. The elderly population is increasing, and the need for qualified appointees is a necessity as is the need for some type of guaranteed arrangement.

2. The inner city courts are the courts in which the need appears greatest and the potential for future increase in need appears greatest. Many of those needing appointment are those who are the most difficult with which to deal. Frequently, they are alcoholics, mentally ill, or homeless persons.

3. The elderly population is also increasing. The need for qualified appointees is a necessity as is the need for some type of a guaranteed arrangement.

4. Although most courts acknowledged that the Department on Aging is doing an adequate job, they also expressed the opinion that the Department on Aging has reached its limit under current staffing, and cannot meet the needs of some of those for whom court seeks appointment. Frequently, potential respondents do not meet the Department on Aging criteria for eligibility.

5. Several courts reported having difficulty getting attorneys to accept appointment because they are not paid (or paid enough) for their time and effort.

6. One court suggested a way be found of paying people at least a minimum fee.

7. One court suggested the creation of a "Board of Conservators".

8. One court stated it would like some means of assuring that the attorney for the respondent or conservator of the person had contacted the respondent regarding the annual report, and that the respondent has received the notice of the right to request reinstatement.

9. A court suggested that courts should be given the authority to order a physical examination (and other examinations as deemed necessary) in order to determine the respondent's level of functioning, if the proposed incapable refuses examination.

10. Courts should be given more discretion in setting of bonds.

11. Courts could benefit from a better system of follow-up on annual reports. It would be helpful if the computer could generate a list monthly.

12. There should be, in writing, concrete guidelines for conservators, in addition to the booklet provided by probate administration which provides general information. (The West Hartford court has developed a handout sheet of written guidelines, court expectations, and a "fact sheet" for identifying information for the court's use.)

ATTACHMENT C

SURVEY OF COURTS REGARDING APPOINTMENT OF COMMISSIONER OF STATE DEPARTMENT ON AGING AS CONSERVATOR: PRELIMINARY REPORT ON SURVEY CONDUCTED FEBRUARY 1988

A computer print-out generated at Probate Administration identified twenty-nine courts as having appointments of the Commissioner of the Department on Aging as conservator of the person, estate or both for the period from January 1, 1987 through December 31, 1987. This included appointments made within the calendar year 1987 and appointments made prior to 1987 for which the Department on Aging remained as conservator in 1987.

Surveys were sent to the twenty-nine courts with a copy of the computer print-out for each individual court. Names of persons for whom it appeared the Commissioner of the Department on Aging may have been appointed were highlighted. Courts were asked to check each highlighted file and to check internal controls for any appropriate files which may not have been reflected in the print-out. They were asked to complete the survey for all appropriate files. Twenty-six courts completed and returned the survey.

In addition, surveys were sent to all courts of probate which had no appointments of the Department on Aging as determined by the print-out. They were asked to check their internal controls and to complete the survey for any appointments identified within the calendar year 1987. As a result, additional data was received from three courts.

The attached report includes data from twenty-nine of thirty-two courts identified as having appointments of the Department on Aging as conservator during the survey period. The survey responses reported 128 appointments plus 11 appointments as temporary conservator (not included in attached statistics). Discrepancies in numbers may be accounted for by the fact that some courts did not complete that portion of the survey.

SURVEY RESULTS:

The applicants for conservatorship were as follows:

Nursing and convalescent homes		41
Hospitals		38
Department of Human Resources (P.S.E.)		23
Self (voluntary application)		7
Other:		17
Relative	2	
Spouse	1	
Friend	2	
City Welfare	1	
CCI	3	

Care at Home	1
Doctor	2
Judge	1
Conservator appointed by court	3
Department of Income Maintenance	1

Residence of respondent as listed at time of application:

Nursing or convalescent home	47
Hospital:	
General	26
State	7
Own home/apartment, alone	41
Own home/apartment with spouse or other	4
Street person	1
Housing Elderly (formerly in car)	1

Age of respondent at time of application

Age 85 years and over	25
Age 80 to 85	25
Age 75 to 80	19
Age 70 to 75	17
Age 65 to 70	18
Age 60 to 65	15
Age unknown	2

When S.D.A. was appointed as conservator of the person:

57 cases were reported as having a conservator of the person open for at least one year. 36 reports on the condition of the ward were reported as received.

When S.D.A. was appointed as conservator of the estate:

12 courts reported they require filing of a periodic accounting on the estate annually. The remainder require it every 3 years.

Estimates of the percentage of time in which accounts are filed within the required time-frame are as follows: (28 responding courts)

Under 50%	4 courts
50-75%	8 courts
75-90%	3 courts
90-100%	5 courts

Not applicable (no accounting has yet been due, or SDA not appointed as conservator of estate) - 9 courts

Cases in which S.D.A. has been appointed conservator of the estate and DHR has accepted appointment as conservator of the person for the same respondent:

18 cases were reported in the survey. All indicated this was of benefit to the ward.

Number times Commissioner Klinck petitioned to withdraw and requested court appoint a successor conservator:

No courts reported Commissioner Klinck being replaced by a successor.

No courts reported refusal to allow Commissioner Klinck (or her designee) to withdraw as conservator.

Restoration to capacity:

Within the calendar year 1987, in cases where S.D.A. was appointed conservator, 5 wards were restored to capacity.

Appointment of legal counsel to represent respondent at time of application:

Courts reported appointing counsel in 117 of the 128 cases reported.

None of the respondents were reported as having their own legal counsel.

Reasons given for not appointing:

Voluntary conservatorship (7 cases reported). Case appeared clear-cut.

Prepared 04-Jan-89

ATTACHMENT D

CONSERVATORSHIP SURVEY

	Health Care Facilities	Percent Change*	Hospitals	Percent Change*
NO.FACILITIES RPTG	54		23	
Current-Consv Estate	387		515	
1989 - Consv Estate	533	37.7	529	2.6
5 Yrs-Consv Estate	878	126.9	1734	236.7
Totals/Avg Change	1798	82.3	2778	119.7
Current-Consv Person	608		525	
1989 -Consv Person	701	15.3	561	6.9
5 Yrs-Consv Person	1092	79.6	1886	259.2
Totals/Avg Change	2401	47.5	2972	133.0

OTHER MISC INFORMATION

		% OF TOTAL		% OF TOTAL
Would increased Alternatives-Reduce Consv Appts (Y)	30	55.6	14	60.9
Where Altntives used-Seen abuses? (Y)	20	37.0	9	39.1

	State Agencies	Percent Change*	Psych Facilities	Percent Change*
NO.FACILITIES RPTG	2		3	
Current-Consv Estate	95		140	
1989 - Consv Estate	102	6.9	95	-47.4
5 Yrs-Consv Estate	235	147.4	257	83.6
Totals/Avg Change	432	77.1	492	18.1
Current-Consv Person	10		170	
1989 -Consv Person	15	50.0	97	-42.9
5 Yrs-Consv Person	100	900.0	327	92.4
Totals/Avg Change	125	475.0	594	24.7

OTHER MISC INFORMATION

		% OF TOTAL		% OF TOTAL
Would increased Alternatives-Reduce Consv Appts (Y)	1	50.0	3	100.0
Where Altntives used-Seen abuses? (Y)	2	100.0	3	100.0

*From Current

ATTACHMENT E

Pertinent Comments Received in Survey of

Hospitals and Health Care Facilities:

Feel some difficulties will arise after October 1, 1988 because the Commission on Aging will appoint the conservator of the estate and the Department of Human Services will appoint the conservator of the person. We will then have to deal with two individuals rather than one.

The lack of qualified persons to serve as conservators for the indigent person is alarming! Even when a local attorney finally agrees (reluctantly) to serve, the lack of interest and investment in settling the affairs of the conserved person is outrageous. Weeks will go by with no response to calls from the hospital, nursing homes etc, yet there is no one else to take over. This State badly needs a pool of people to serve as conservators.

The scope of the problem may be difficult to define, in part because of the understanding of the caregiving community (both family and professional) of the assessment of need for, the criteria for appointment of, alternatives to and scope of authority of a conservator of estate and/or person. Further, as the number of people with conservators increase, it is of concern that those appointed have adequate information about the need for and availability of various options for care in the community. The caregiving ability of the system can be heightened by cooperative effort.

As stated above, Most of our pts that Are in need of conservators are those with no other avenue open to them. Most are without resources and oftentimes it is very difficult to find some one willing to serve, even <u>with</u> Court involvement.

We need a pool of people to serve as conservator of person and estate for elderly patients who have no relatives & whose funds do not warrant appointment of attorneys or bankers – Social workers who know the long term care scene make the best conservators – We need funds to pay such persons. I have had difficulty finding someone to serve from time to time.

1) Question V. & VI

Patients have a right to a less restrictive environment as soon as they no longer need inpatient services. Discharge plans for our geriatric patients often include the need for Medicaid funding for convalescent home placement. Difficulties have occurred in establishing eligibility and filing of forms for Medicaid funding which result in unneeded days in the hospital.

A) Trusts - The Department of Income Maintenance wants these disolved and used to pay existing medical bills. Many are irrevocable. One patient waited over six months for DIM to accept simply the income from such a trust.

B) Powers of Attorney - Our POAs are usually relatives especially spouses, who either try to "save" the assets from going "to the State" or (in the case of spouses especially wives) postpone application for funding because it means loss o the patients income.

C) Joint Bank Accounts - For spouses in this age group, seeing lifetime savings depleted is understandably traumatic. This trauma sometimes results in stonewalling DIM's request for splitting assets.

D) Private Individuals or Agencies - Experience is limited to three patients who had case managers. These estates were handled well. Restriction here seems to be degree of patients cooperation with this arrangement.

E) Conservators of Estate - Relatives who are appointed may present the same difficulties as above but on the whole act responsibly. Experience shows many attornies appointed don't view these clients with any priority and delays of several months can occur. Experience with Commissioner on Aging was positive.

F) Medical Permission - Phone calls to area hospitals has revealed hesitation on their part to accept POA signatures on consent forms

This is a very important service for some of our low functioning psychiatric clients. They need help with entitlements and someone to help them when their judgment is too impaired to enable them to make decisions in their own best interest (eg need to be in nursing home or supervised psychiatric facility.)

I believe that our present system of conservatorship is burdensome and lenghty especially in light of Health Care Needs and financial implications relating to necessary length of stay secondary to the court process.

Once appointed thru the probate process, Lawyers have caused serious delays in discharge planning from acute care facilities as they often do not follow thru promptly with necessary information to facilitate a discharge plan. This often results in extensive and unnecessary stays in the hospital with great cost to the patient, hospital and state welfare systems.

If this process could be facilitated by other means it would be beneficial to the patient, the health care institution, families and others involved. However, caution must be given to implement some safeguards with regard to insuring that an incompetent persons needs are met. Therefore, I believe that decisions and actions of substitute decisions makers must be monitored to insure that

There is a problem with Conservatorship for hospital support systems where Probate Judges will no longer grant temporary conservatorship except for life threatening circumstances. This delays placement in extended care facilities; also impedes getting T19's because intended conservator cannot access pert. documents required for the application process.

Family members frequently make suitable arrangements to handle money, but overlook health and personal care issues. The relatives or friends who remain do not want the responsibility or liability of making medical decisions--such as DO NOT RESUSITATE Orders.

More publicity and public education is needed to inform people of the choices available and the reasons why the options are needed.

Attorneys acting as trust officers not responsive.

RE. QUESTION #5

REDUCTION WOULD BE MODERATE RATHER THAN SIGNIFICANT SINCE MOST OF THE ALTERNATIVES LISTED (WITH THE EXCEPTION OF LIVING WILLS) MIGHT NOT PROVE ADEQUATE FOR MANY SERIOUS DECISIONS.

The other alternatives would be helpful, but the need for Conservators remains Critical.

In cases of the elderly I have found that if a conservator of estate is not appointed there are other people who will take advantage.

It is in the best interest of the Resident to have a conservator of estate and conservator of person. I have had to make application for a Number of residents. and in *all* cases the conservators have been very pleasant.

More abuses are seen in P.O.A. situations due to lack of accountability.

IN One instance, as an example, son used P.O.A. to buy himself a new car, left town, & stuck facility for $20,000 medicaid disallowance

Re: Power of Attorney. Little or no accountability. Misuse of funds.

HIDDEN AGENDAS IE: CONSERVE patient FUNDS FOR SURVIVORS, manipulation OR POWER STRUGGLES WITHIN families. REFUSAL for PERMISSION FOR SERVICES. DELAYED RESPONSE FOR PERMISSION OR SERVICES OR PAYMENT.

Both financial abuse of funds & unwillingness to assume caretakers role re. DNR orders - providing for personal needs - inability to cope with TXIX applications.

There have been questions regarding the management of money with family members taking on power of attorney responsibilities. However, the major problem has been the limits of the role of power of attorney to make decisions after the patient becomes incompetent or a medical question comes up, rather than financial.

Trustees, or alternate responsible parties can be very competent especially with private patients until funds are exhausted and its necessary to initiate Title XIX then they do not always perform their function

ATTACHMENT F

TASK FORCE ON APPOINTMENT OF CONSERVATORS

POPULATION GROWTH IN CONNECTICUT

1980-2000

The following information has been taken from a report entitled "Revised Age and Sex Distributions of Population Projections for Connecticut Municipalities and Regions to the Year 2000" published in December 1984 by the Comprehensive Planning Division of the Connecticut Office of Policy and Management. This report contains revisions to the age and sex distributions promulgated in June 1983. These population projections with age and sex distributions are forwarded for use in plans and activities involving all state and statewide programs.

In developing the original projections, two important assumptions having a possible indirect relation to the need for conservators were made:

1. Mortality, and therefore survival, will remain constant at rates for 1980 for each municipality over the 20 year period.
2. Certain predetermined census tracts containing institutional populations within municipalities throughout the state will maintain relatively constant unique age and sex distributions of the population over the twenty year projection period.

Total Population

The total population of the state will increase over the twenty year period with a slow and steady growth of about 2.2% every five years. The net growth of 8.8% statewide will not be evenly distributed across the states. It will tend to be concentrated in the suburbs of our major cities and regionally in the Housatonic Valley and Midstate Planning Regions.

The Housatonic Valley Region includes Bethel, Bridgewater, Brookfield, Danbury, New Fairfield, New Milford, Newtown, Redding, Ridgefield and Sherman. The Midstate Planning Region includes Cromwell, Durham, East Haddam, East Hampton, Haddam, Middlefield, Middletown and Portland.

Mature Population

The combined cohorts aged 20-64 years may be termed the mature population and broadly described as the employed or supporting population. This is the largest population age group in the state, numbering 2,171,964 persons in 1980. This age group will show only slight proportional increases over the entire pojection period, growing from 58.2% of the population in 1980 to 61.5% in the year 2000. This minor growth represents approximately 270,000 persons.

Elderly Population

Overall the elderly population, aged 65 years and older, continues to show the most pronounced proportional growth over the twenty year projection period. From 364,864 persons in 1980, or 11.7% of the population, this group grows steadily to 516,002 or 15.3% of the population in the year 2000, an increase of 151,138 persons.

ATTACHMENT F-1

POPULATION TRENDS AND PER CAPITA INCOME ESTIMATES BY PROBATE DISTRICT AND MUNICIPALITY IN CONNECTICUT

Probate Districts	Municipalities	1986 DHS(a) Estimated Population	2000 OPM(b) Population Projections	Rank by(c) Population Size of Municipality For Year 2000	1985 BOC(d) Est. Per Capita Inc. Income	Rank by(e) Per Capita Income of Municipality
Hartford County						
Avon	Avon	12,940	14,201	72	$22,841	8
Berlin	Berlin	15,900	15,840	69	$13,928	74
	New Britain	74,240	70,809	7	$10,945	150
		90,140	86,649			
Bristol	Bristol	60,250	61,470	10	$12,361	115
Burlington	Burlington	6,430	6,542	114	$14,070	69
Canton	Canton	7,960	8,647	99	$15,631	45
East Granby	East Granby	4,330	4,868	127	$15,205	51
East Hartford	East Hartford	52,180	57,063	13	$12,544	110
East Windsor	East Windsor	9,270	9,680	93	$12,464	112
	South Windsor	20,850	20,578	51	15,299	48
		30,120	30,258			
Enfield	Enfield	44,290	50,198	20	$12,094	123
Farmington	Farmington	18,430	17,611	61	$18,717	19
Glastonbury	Glastonbury	27,210	31,831	31	$18,999	17
Granby	Granby	8,920	9,757	92	$17,010	30
Hartford	Hartford	135,080	143,385	2	$ 8,677	169
Hartland	Hartland	1,540	1,669	162	$13,945	73
Manchester	Manchester	51,100	52,763	15	$13,664	83
Marlborough	Marlborough	5,150	6,870	110	$14,487	62
Newington	Newington	29,350	32,142	29	$14,490	61
	Rocky Hill	15,550	21,555	48	$15,254	50
	Wethersfield	27,410	27,010	35	$15,612	47
		72,310	80,707			
Plainville	Plainville	17,450	17,500	63	$12,176	120
Simsbury	Simsbury	23,030	26,159	37	$19,044	16
Southington	Southington	38,590	41,577	24	$13,083	101
Suffield	Suffield	10,520	9,862	90	$16,059	40
West Hartford	West Hartford	61,180	60,079	11	$19,864	15
	Bloomfield	20,140	22,110	46	$15,615	46
		81,320	82,189			
Windsor	Windsor	27,040	29,701	32	$14,159	68
Windsor Locks	Windsor Locks	12,330	12,321	81	$12,720	106

ATTACHMENT F-2

Probate Districts	Municipalities	1986 DHS(a) Estimated Population	2000 OPM(b) Population Projections	Rank by(c) Population Size of Municipality For Year 2000	1985 BOC(d) Est. Per Capita Inc. Income	Rank by(e) Per Capita Income of Municipality
New Haven County						
Bethany	Bethany	4,550	4,901	126	$15,176	53
Branford	Branford	25,720	24,940	39	$15,723	43
Cheshire	Cheshire	24,560	26,789	36	$15,183	52
	Prospect	7,300	6,630	112	$12,030	125
		31,860	33,419			
Derby	Derby	12,350	13,110	77	$12,311	116
	Ansonia	19,030	19,220	55	$10,981	149
	Seymour	13,870	17,637	60	$12,379	114
		45,250	49,967			
East Haven	East Haven	25,570	25,730	38	$11,217	143
Guilford	Guilford	19,190	20,726	49	$16,426	35
Hamden	Hamden	51,590	51,975	18	$13,720	82
Madison	Madison	15,080	17,029	66	$17,229	28
Meriden	Meriden	59,160	58,870	12	$11,952	126
Milford	Milford	51,980	52,648	16	$13,534	87
Naugatuck	Naugatuck	29,070	29,639	33	$11,418	140
	Beacon Falls	4,370	4,398	130	$11,489	138
		33,440	34,037			
New Haven	New Haven	126,490	131,100	3	$ 9,378	165
North Branford	North Branford	12,600	12,699	80	$13,035	102
North Haven	North Haven	22,360	23,268	42	$14,970	58
Orange	Orange	13,440	14,042	74	$17,862	25
Oxford	Oxford	7,410	8,537	102	$13,621	85
Southbury	Southbury	14,690	17,263	64	$16,214	38
Wallingford	Wallingford	39,660	41,767	23	$13,013	103
Waterbury	Waterbury	106,160	105,410	4	$10,187	157
	Middlebury	6,250	6,380	115	$16,419	36
	Wolcott	13,840	13,990	75	$11,211	144
		126,250	125,780			
West Haven	West Haven	54,050	55,330	14	$11,556	133
Woodbridge	Woodbridge	8,170	8,112	103	$25,606	7

ATTACHMENT F-3

Probate Districts	Municipalities	1986 DHS(a) Estimated Population	2000 OPM(b) Population Projections	Rank by(c) Population Size of Municipality For Year 2000	1985 BOC(d) Est. Per Capita Inc. Income	Rank by(e) Per Capita Income of Municipality
New London County						
Bozrah	Bozrah	2,270	2,098	154	$11,671	130
Colchester	Colchester	8,880	9,508	96	$12,298	117
East Lyme	East Lyme	14,830	15,303	70	$14,651	60
Griswold	Griswold	9,630	9,971	89	$ 9,890	161
Groton	Groton	43,280	42,769	22	$11,343	141
Lebanon	Lebanon	5,280	5,458	121	$11,522	136
Ledyard	Ledyard	14,700	17,058	65	$13,397	93
Lyme	Lyme	1,910	2,318	150	$21,052	13
Montville	Montville	17,000	19,170	56	$11,316	142
New London	New London	28,720	28,575	34	$10,629	155
	Waterford	18,700	18,200	59	$14,005	72
		47,420	46,775			
North Stonington	North Stonington	4,370	4,020	134	$12,810	105
Norwich	Norwich	38,480	40,948	25	$10,870	151
	Franklin	1,740	1,680	161	$12,425	113
	Lisbon	3,500	3,830	137	$10,809	152
	Preston	4,830	5,279	124	$10,773	153
	Sprague	3,070	2,863	147	$11,514	137
	Voluntown	1,760	1,940	158	$11,576	132
		53,380	56,540			
Old Lyme	Old Lyme	6,430	8,061	104	$18,951	18
Salem	Salem	2,800	3,238	143	$13,338	94
Stonington	Stonington	17,610	18,360	58	$13,910	77

ATTACHMENT F-4

Probate Districts	Municipalities	1986 DHS[a] Estimated Population	2000 OPM[b] Population Projections	Rank by[c] Population Size of Municipality For Year 2000	1985 BOC[d] Est. Per Capita Inc. Income	Rank by[e] Per Capita Income of Municipality
Fairfield County						
Bethel	Bethel	17,250	20,042	53	$14,459	63
Bridgeport	Bridgeport	143,500	143,769	1	$ 9,427	163
Brookfield	Brookfield	14,330	16,970	67	$17,038	29
Danbury	Danbury	67,230	67,569	8	$13,337	95
Darien	Darien	19,000	19,844	54	$33,448	2
Fairfield	Fairfield	55,720	51,850	19	$18,107	23
Greenwich	Greenwich	60,370	61,784	9	$29,764	5
New Canaan	New Canaan	18,580	20,554	52	$36,250	1
New Fairfield	New Fairfield	12,170	14,051	73	$15,718	44
Newtown	Newtown	20,370	24,613	40	$15,963	41
Norwalk	Norwalk	80,000	80,251	6	$15,907	42
	Wilton	16,950	19,052	57	$27,925	6
		96,950	99,303			
Redding	Redding	7,820	9,517	95	$22,607	9
Ridgefield	Ridgefield	21,710	23,119	45	$21,539	11
Shelton	Shelton	34,720	36,296	26	$13,833	79
Sherman	Sherman	2,520	3,081	145	$18,181	21
Stamford	Stamford	107,560	104,307	5	$18,246	20
Stratford	Stratford	50,860	52,383	17	$13,784	81
Trumbull	Trumbull	33,830	34,530	27	$16,647	33
	Easton	6,290	7,407	106	$21,633	10
	Monroe	16,280	17,607	62	$15,023	56
		56,400	59,544			
Westport	Westport	26,570	24,573	41	$30,072	4
	Weston	8,940	9,983	88	$32,007	3
		35,510	34,556			

ATTACHMENT F-5

Probate Districts	Municipalities	1986 DHS[(a)] Estimated Population	2000 OPM[(b)] Population Projections	Rank by[(c)] Population Size of Municipality For Year 2000	1985 BOC[(d)] Est. Per Capita Inc. Income	Rank by[(e)] Per Capita Income of Municipality
Windham County						
Ashford	Ashford	3,400	3,819	138	$11,892	127
Brooklyn	Brooklyn	6,280	7,087	109	$11,877	128
Canterbury	Canterbury	3,790	4,429	129	$11,002	147
Chaplin	Chaplin	1,880	2,010	155	$ 9,961	159
Eastford	Eastford	1,040	1,269	166	$11,823	129
Hampton	Hampton	1,450	1,921	159	$12,511	111
Killingly	Killingly	15,200	16,699	68	$ 9,944	160
Plainfield	Plainfield	13,170	14,646	71	$ 9,422	164
Pomfret	Pomfret	2,920	3,532	140	$11,173	146
Putnam	Putnam	8,900	8,628	100	$ 9,185	167
Sterling	Sterling	1,920	2,099	153	$ 8,710	168
Thompson	Thompson	8,450	8,889	98	$10,726	154
Windham	Windham	21,340	23,137	43	$ 9,714	162
Tolland County						
Andover	Andover	2,400	2,742	148	$13,444	91
	Bolton	4,260	4,443	128	$16,221	37
	Columbia	3,750	3,971	135	$13,600	86
		10,410	11,156			
Coventry	Coventry	9,240	10,406	86	$12,245	119
Ellington	Ellington	10,830	11,712	83	$13,275	96
	Vernon	29,390	32,530	28	$12,714	107
		40,220	44,242			
Hebron	Hebron	6,520	7,399	107	$13,916	76
Mansfield	Mansfield	20,810	21,622	47	$ 9,297	166
Somers	Somers	9,270	9,028	97	$13,212	97
Stafford	Stafford	10,210	10,172	87	$11,174	145
	Union	550	850	169	$12,124	122
		10,760	11,022			
Tolland	Tolland	10,670	13,189	76	$13,454	90
	Willington	5,000	5,540	120	$11,461	139
		15,670	18,729			

ATTACHMENT F-6

Probate Districts	Municipalities	186 DHS[a] Estimated Population	2000 OPM[b] Population Projections	Rank by[c] Population Size of Municipality For Year 2000	1985 BOC[d] Est. Per Capita Inc. Income	Rank by[e] Per Capita Income of Municipality
Litchfield County						
Barkhamsted	Barkhamsted	3,030	3,489	141	$13,163	98
Canaan	Canaan	1,030	1,047	168	$12,658	109
	North Canaan	3,320	3,243	142	$10,113	158
		4,350	4,290			
Cornwall	Cornwall	1,370	1,331	164	$18,146	22
Harwinton	Harwinton	5,130	5,920	119	$13,111	100
Kent	Kent	2,700	2,960	146	$16,559	34
Litchfield	Litchfield	8,080	8,041	105	$15,167	54
	Morris	1,960	1,998	156	$15,010	57
	Warren	1,110	1,121	167	$16,831	32
		11,150	11,160			
New Hartford	New Hartford	5,210	5,352	123	$14,057	71
New Milford	New Milford	21,200	23,121	44	$13,515	88
	Bridgewater	1,560	1,811	160	$21,071	12
		22,760	24,932			
Norfolk	Norfolk	2,210	2,231	151	$16,206	39
Plymouth	Plymouth	11,160	11,732	82	$11,538	134
Roxbury	Roxbury	1,680	1,970	157	$20,042	14
Salisbury	Salisbury	4,040	4,039	133	$16,937	31
Sharon	Sharon	2,750	2,721	149	$14,251	65
Thomaston	Thomaston	6,460	6,777	111	$12,085	124
Torrington	Torrington	32,260	31,991	30	$11,646	131
	Goshen	2,080	2,209	152	$15,263	49
		34,340	34,200			
Washington	Washington	3,870	3,862	136	$17,339	27
Watertown	Watertown	20,060	20,689	50	$12,279	118
Winchester	Winchester	11,060	11,169	84	$10,982	148
	Colebrook	1,290	1,349	163	$13,873	78
		12,350	12,518			
Woodbury	Woodbury	7,490	7,261	108	$17,982	24
	Bethlehem	2,780	3,120	144	$13,923	75
		10,270	10,381			

ATTACHMENT F-7

Probate Districts	Municipalities	1986 DHS[a] Estimated Population	2000 OPM[b] Population Projections	Rank by[c] Population Size of Municipality For Year 2000	1985 BOC[d] Est. Per Capita Inc. Income	Rank by[e] Per Capita Income of Municipality
Middlesex County						
Clinton	Clinton	12,200	12,741	79	$12,826	104
Deep River	Deep River	4,180	4,299	132	$14,223	66
East Haddam	East Haddam	6,270	6,617	113	$12,157	121
East Hampton	East Hampton	9,350	10,572	85	$12,664	108
Essex	Essex	5,410	5,429	122	$17,593	26
Haddam	Haddam	6,740	8,578	101	$14,065	70
Killingworth	Killingworth	4,350	5,178	125	$14,717	59
Middletown	Middletown	41,220	44,539	21	$11,530	135
	Cromwell	11,390	12,772	78	$14,208	67
	Durham	5,530	6,292	116	$14,410	64
	Middlefield	3,900	4,321	131	$13,116	99
		62,040	67,924			
Old Saybrook	Old Saybrook	9,880	9,762	91	$15,099	55
Portland	Portland	8,610	9,540	94	$13,437	92
Saybrook	Chester	3,220	3,799	139	$13,785	80
Westbrook	Westbrook	5,470	6,000	118	$13,482	89

(a) These 1986 estimate figures were derived by the Connecticut Department of Health Services. They were based on records of births and deaths and resulting population changes during the 1985 calendar year.

(b) These 2000 population projection figures were developed by the Connecticut Census Data Center of the Office of Policy and Management.

(c) This ranking of population is by decreasing size (from 1 to 169).

(d) These 1985 per capita income figures were developed by the U.S. Bureau of the Census.

(e) This ranking of per capita income is by decreasing size (from 1 to 169).

ATTACHMENT F-8

Most Elderly Population

In making the projection of December 1984 representing a revision of the 1983 projection, a revised methodology was employed taking into consideration increased probabilities for survival. These probabilities were concentrated in the tails of the population age distributions, and thus they shifted the gain in life expectancy towards the most elderly, or 85+, cohorts. Therefore, the greatest change in the revisions in the proportional size of the 85+ cohort now almost doubles between the years 1980 and 2000 from 35,729 to 60,291 persons. This represents an increase from 1.1% to 1.8% of the total population.

Comment

Although increasing age is not by any means the only factor influencing the growing number of persons who may become incompetent and need the services of a conservator, the greatest number of petitions for such services may be expected to come from the elderly population. Throughout the state, this population group continues to show the most pronounced proportional growth, but there are significant variations in the municipalities that may have an influence on the number of requests for conservator appointments made to district courts.

ATTACHMENT G

NUMBER OF PROBATE DISTRICTS AND MUNICIPALITIES IN CONNECTICUT

Number of Municipalities Per District	Number of Probate Districts
1	107
2	17
3	6
4	1
5	0
6	1
	132

NUMBER OF PROBATE DISTRICTS IN POPULATION RANGES IN CONNECTICUT

Population Ranges	Number of Probate Districts	
0-1,000	0	
1,000-2,000	8	
2,000-3,000	7	
3,000-4,000	5	
4,000-5,000	7	
5,000-6,000	7	
6,000-7,000	7	
7,000-8,000	3	
8,000-9,000	6	
9,000-10,000	5	
		55
10,000-11,000	4	
11,000-12,000	2	
12,000-13,000	6	
13,000-14,000	2	
14,000-15,000	4	
15,000-16,000	3	
16,000-17,000	0	
17,000-18,000	4	
18,000-19,000	2	
19,000-20,000	2	
		29
20,000-30,000	12	
30,000-40,000	8	
40,000-50,000	5	
50,000-60,000	10	
60,000-70,000	4	
70,000-80,000	1	
80,000-90,000	1	
90,000-100,000	2	
100,000-110,000	1	
110,000-120,000	0	
120,000-130,000	2	
130,000-140,000	1	
140,000-150,000	1	
		48
		132

ATTACHMENT H

NURSING HOME LICENSURE CATEGORIES

The state of Connecticut Public Health Code Section 19-13-d1(b) defines three distinct nursing home licensure categories as follows:

- CHRONIC AND CONVALESCENT NURSING HOME

  A long-term institution having facilities and all necessary personnel to provide skilled nursing care under medical supervision and direction to carry out simple, non-surgical treatment and dietary procedures for chronic disease or convalescent stages or acute diseases or injuries.

- REST HOMES WITH NURSING SUPERVISION

  An institution having facilities and all necessary personnel to provide, in addition to personal care required in a home for the aged, nursing supervision under medical direction twenty-four hours per day.

- HOME FOR THE AGED

  An institution having facilities and all necessary personnel to furnish food, shelter and laundry for two or more persons unrelated to the proprietor and in addition providing services of a personal nature which do not require the training or skills of a licensed nurse. Additional services of a personal nature may include assistance with bathing, help with dressing, preparation of special diets and supervision over medications which are self-administered.

ATTACHMENT I-1

MUNICIPALITIES RANKED IN ORDER OF PER CAPITA INCOME WITH CORRESPONDING POPULATION SIZE RANK AND NUMBERS OF ACUTE CARE AND LONG-TERM CARE HOSPITAL AND NURSING HOME BEDS IN CONNECTICUT

Municipality	1. Per Capita(a) Income Rank	2. Population(b) Size Rank	3. No. of(c) Short-term Hospital Beds	4. No. of(c) Long-term Hospital Beds	5. No. of(d) Chronic & Convalescent Nursing Home Beds	6. No. of(d) Rest Home With Nursing Supervision Beds	7. No. of(d) Home For the Aged Beds	Total Priority Score (Columns 1-7)
Hartford	169	168	2,105	830	1,162	65	215	4,714
Sterling	168	17						185
Putnam	167	70	158		60	59		514
Mansfield	166	123		60				349
New Haven	165	167	1,357	105	929	255	137	3,115
Plainfield	164	99			112	60		435
Bridgeport	163	169	1,206		982	236	128	2,884
Windham	162	127	175		60			524
Griswold	161	81			90			332
Killingly	160	102			270		10	542
Chaplin	159	15						174
North Canaan	158	28					12	198
Waterbury	157	166	852		1,159	267	115	2,716
Scotland	156	5						161
New London	155	136	383		245		72	991
Thompson	154	72					24	250
Preston	153	46						199
Lisbon	152	33						185
Norwich	151	145	260	693	464	30	100	1,843
New Britain	150	163	432	200	515	240	95	1,795
Ansonia	149	115						264
Winchester	148	86	73		45	30		382
Canterbury	147	41						188
Pomfret	146	30					16	192
Stafford	145	83	71					299
Wolcott	144	95			60	59	20	378
East Haven	143	132			30	30	72	407
Montville	142	114					34	290
Groton	141	88	81		179	119	90	698
Naugatuck	140	137						277
Willington	139	50			120		60	369
Beacon Falls	138	40						178
Sprague	137	23						160

ATTACHMENT I-2

Municipality	Per Capita Income Rank [(a)]	Population Size Rank [(b)]	3. No. of Short-term Hospital Beds [(c)]	4. No. of Long-term Hospital Beds [(c)]	5. No. of Chronic & Convalescent Nursing Home Beds [(d)]	6. No. of Rest Home With Nursing Supervision Beds [(d)]	7. No. of Home For the Aged Beds [(d)]	Total Priority Score (Columns 1-7)
Lebanon	136	49						185
Middletown	135	149	380	658	373	255	34	1,984
Plymouth	134	88			30			252
West Haven	133	156	1,372		317	199	23	2,200
Voluntown	132	12						144
Torrington	131	140	188		390	150		999
Bozrah	130	16					25	171
Eastford	129	4						133
Brooklyn	128	61			30	105	10	334
Ashford	127	32					30	189
Meriden	126	158	322		465	254	211	1,536
Prospect	125	58			180			363
Thomaston	124	59						183
Enfield	123	150			312	42	10	637
Union	122	1						123
East Haddam	121	57			53	13		244
Plainville	120	107			120	60		407
Coventry	119	84						203
Watertown	118	120			96		44	378
Colchester	117	74			120	120		431
Derby	116	93	261		121	120		711
Bristol	115	160	250		412	59	40	1,036
Seymour	114	110						224
Franklin	113	9						122
East Windsor	112	77			120	150		459
Hampton	111	11						122
East Hartford	110	157			630			897
Canaan	109	2			120			231
East Hampton	108	85			60		41	294
Vernon	107	142			120			369
Windsor Locks	106	89			48	11		254
North Stonington	105	36						141
Clinton	104	91				40		235
Wallingford	103	147		702	518	264	86	1,820
North Branford	102	90						192
Southington	101	146	98		158	30	18	551
Harwinton	100	51						151

ATTACHMENT I-3

Municipality	Per Capita[a] Income Rank	Population[b] Size Rank	No. of[c] Short-term Hospital Beds	4. No. of[c] Long-term Hospital Beds	5. No. of[d] Chronic & Convalescent Nursing Home Beds	6. No. of[d] Rest Home With Nursing Supervision Beds	7. No. of[d] Home For the Aged Beds	Total Priority Score (Columns 1-7)
Middlefield	99	39						138
Barkhamsted	98	29						127
Somers	97	73	60					230
Ellington	96	87	102					285
Danbury	95	162	450		508	182	65	1,462
Salem	94	27						121
Ledyard	93	105						198
Portland	92	76		105	89		50	412
Andover	91	22						113
Tolland	90	94						184
Westbrook	89	52					18	159
New Milford	88	126	85		159	44	69	571
Milford	87	154	149		382		20	792
Columbia	86	35						121
Oxford	85	68						153
Woodstock	84	53						137
Manchester	83	155	303		816	251	91	1,699
Hamden	82	152			659	30	69	992
Stratford	81	153			180	60		474
Chester	80	31			60	60	44	275
Shelton	79	144			418	150	50	841
Colebrook	78	7						85
Stonington	77	112			110		25	324
Hebron	76	63						139
Bethlehem	75	26						101
Berlin	74	101			60		42	277
Hartland	73	8						81
Waterford	72	111			360			543
New Hartford	71	47						118
Haddam	70	69					29	168
Burlington	69	56						125
Windsor	68	138			450	170		826
Cromwell	67	92			120	180	51	510
Deep River	66	38			30		31	165
Sharon	65	21	92					178
Durham	64	54				73		191
Bethel	63	117						180

ATTACHMENT I-4

Municipality	1. Per Capita[a] Income Rank	2. Population[b] Size Rank	3. No. of[c] Short-term Hospital Beds	4. No. of[c] Long-term Hospital Beds	5. No. of[d] Chronic & Convalescent Nursing Home Beds	6. No. of[d] Rest Home With Nursing Supervision Beds	7. No. of[d] Home For the Aged Beds	Total Priority Score (Columns 1-7)
Marlborough	62	60				120		242
Newington	61	141	186	228	180	161		957
East Lyme	60	100						160
Killingworth	59	45						104
North Haven	58	128			60	120		366
Morris	57	14						71
Monroe	56	108						164
Old Saybrook	55	79			150	60		344
Litchfield	54	65			25		93	237
Bethany	53	44						97
Cheshire	52	134			350	70	77	683
East Granby	51	43						94
Rocky Hill	50	122		350	360	30		912
Goshen	49	18						67
South Windsor	48	119			120			287
Wethersfield	47	135			180	60	31	453
Bloomfield	46	124			390	173		733
Canton	45	71						116
New Fairfield	44	97						141
Branford	43	131			120			294
Norwalk	42	164	427		390	120	29	1,172
Newtown	41	130		743	156			1,070
Suffield	40	80						120
Norfolk	39	19					18	76
Southbury	38	106			142	120	48	454
Bolton	37	42						79
Middlebury	36	55			58			149
Guilford	35	121			150		20	326
Kent	34	24					24	82
Trumbull	33	143		41	201	72	21	511
Warren	32	3						35
Salisbury	31	37			30	30	25	153
Granby	30	78						108
Brookfield	29	103					10	142
Madison	28	104			45			177
Washington	27	34					17	78

Municipality	1. Per Capita Income Rank[(a)]	2. Population Size Rank[(b)]	3. No. of[(c)] Short-term Hospital Beds	4. No. of[(c)] Long-term Hospital Beds	5. No. of[(d)] Chronic & Convalescent Nursing Home Beds	6. No. of[(d)] Rest Home With Nursing Supervision Beds	7. No. of[(d)] Home For the Aged Beds	Total Priority Score (Columns 1-7)
Essex	26	48				49	100	223
Orange	25	96				87		208
Woodbury	24	62					15	101
Fairfield	23	151			591	120		885
Cornwall	22	6						28
Sherman	21	25						46
Stamford	20	165	565		475	40	66	1,331
Farmington	19	109	232		190	60		610
Old Lyme	18	66						84
Glastonbury	17	139			186		22	364
Simsbury	16	133			118	37	25	329
West Hartford	15	159			603	130	212	1,119
Roxbury	14	13						27
Lyme	13	20						33
Bridgewater	12	10						22
Ridgefield	11	125					6	142
Easton	10	64						74
Redding	9	75						84
Avon	8	98			176			282
Woodbridge	7	67						74
Wilton	6	113			60	60		239
Greenwich	5	161	296		335	60		857
Westport	4	129		78	90	30		331
Weston	3	82						85
Darien	2	116			90	30		238
New Canaan	1	118		77	67			263

(a) Municipalities have been ranked by increasing per capita income (from 169 to 1).

(b) Municipalities have been ranked by decreasing population size (from 169 to 1).

(c) The data in these columns were obtained from "The Connecticut Health Data Booklet" published in 1987 by the Connecticut Department of Health Services, and "The American Hospital Association Guide to the Health Care Field".

(d) The data in these columns were obtained from "Nursing Home Facilities Licensed by the State of Connecticut 1988-1989" published by the Connecticut Department of Health Services.

DEFINITIONS OF LENGTH OF STAY IN CONNECTICUT HOSPITALS

Short-term - The average length of stay for all patients is less than 30 days; or over 50 percent of all patients are admitted to units where the average length of stay is less than 30 days.

Excluding newborn infants, the average stay in short-term general non-government not-for-profit hospitals in Connecticut is now 7.2 days.

Long-term - The average length of stay for all patients is 30 days or more; or over 50 percent of all patients are admitted to units where the average length of stay is 30 days or more.

SHORT-TERM HOSPITAL BEDS AND LONG-TERM HOSPITAL BEDS BY SERVICE CLASSIFICATION BY PROBATE DISTRICT IN CONNECTICUT

Probate Districts	Number of Short-Term Beds in General Medical Surg., Childrens and Oncological Hospitals	Number of Beds in Long-term Hospitals			Total Number of Long-term Beds
		Geriatric and Chronic Disease Hospitals	Psychiatric and Alcohol & Drug Abuse Hospitals	Rehab. Hospitals	
Hartford County					
Berlin (incl. New Britain)	432	200			200
Bristol	250				
Farmington	232 (JDH)				
Hartford	2,105	45	417 368 (BHH)		830
Manchester	303				
Newington	186 (USVA) 98	350 (VHH)	130 (CRH)		480
Southington	98				
New Haven County					
Derby	261				
Meriden	230 92 (WWIIMH)		57 (CYC)		57
Milford	149				
New Haven	1,395 45 (CMHC)		60		60
Southbury					
Wallingford	15	100		121	221
Waterbury	852				
West Haven	641 (USVA)				
Fairfield County					
Bridgeport	1,206				
Danbury	450				
Greenwich	296				
New Canaan			77		77
Newtown			35 (HAH) 743 (FHH)		778
Norwalk	427				
Stamford	565				
Trumbull		41			41
Westport			78		78

Probate Districts	Number of Short Term Beds in General Medical Surg., Childrens and Oncological Hospitals	Number of Beds in Long-term Hospitals: Geriatric and Chronic Disease Hospitals	Psychiatric and Alcohol & Drug Abuse Hospitals	Rehab. Hospitals	Total Number of Long-term Beds
New London County					
Groton	81 (USN)				
New London	350				
	33 (USCG)				
Norwich	260				
	44 (UOTH)		649 (NH)		649
Windham County					
Putnam	158				
Windham	175				
Litchfield County					
New Milford	85				
Sharon	92				
Torrington	188				
Winsted	73				
Middlesex County					
Middletown	380		64 (RHC)		
			658 (CVH)		722
Portland			105		105
Tolland County					
Ellington (incl. Rockville)	102				
Mansfield	60				
Somers	60 (CDC)				
Stafford (incl. (Stafford Spgs.)	71				

ATTACHMENT K-1

HOSPITALS, INSTITUTIONS FOR THE MENTALLY ILL, AND INSTITUTIONS FOR THE MENTALLY RETARDED IN CONNECTICUT

Probate District	Towns and Cities	General Medical and Surgical Hospitals (Name & #Beds)	Geriatric and Chronic Disease Hospitals (Name & #Beds)	Rehabilitation Hospitals (Name & #Beds)	Children's Hospitals (Name & #Beds)	Psychiatric Hospitals (Name & #Beds)	Alcohol & Drug Abuse Hospitals (Name & #Beds)	Institutions for Mentally Retard. (Name & #Beds)
Hartford County								
Berlin	New Britain	New Britain General Hospital - 432	New Britain Mem. Hospital - 200					
Bristol	Bristol	Bristol Hosp. - 250						
Farmington	Farmington	John Dempsey Hospital - 232						
Hartford	Hartford	Hartford Hospital - 1,025	Hebrew Home & Hospital - 45			Institute of Living - 417	Blue Hills Hospital - 368	
		Mount Sinai - 379						
		St. Francis - 701						
Manchester	Manchester	Manchester Memorial Hospital - 303						
Newington	Newington	V.A. Medical Center - 186			Newington Chil. Hospital - 98	Cedarcrest Reg. Hospital - 130		
	Rocky Hill		Veterans Home & Hospital - 350					
Southington	Southington	Bradley Memorial Hospital - 98						

ATTACHMENT K-2

HOSPITALS, INSTITUTIONS FOR THE MENTALLY ILL, AND INSTITUTIONS FOR THE MENTALLY RETARDED IN CONNECTICUT

Probate District	Towns and Cities	General Medical and Surgical Hospitals (Name & #Beds)	Geriatric and Chronic Disease Hospitals (Name & #Beds)	Rehabilitation Hospitals (Name & #Beds)	Children's Hospitals (Name & #Beds)	Psychiatric Hospitals (Name & #Beds)	Alcohol & Drug Abuse Hospitals (Name & #Beds)	Institutions for Mentally Retard. (Name & #Beds)
New Haven County								
Derby	Derby	Griffin Hospital - 261						
Meriden	Meriden	W.W. II - Memorial Hospital - 92 Meriden-Wallingford Hospital - 230			Altobello Chil. & Youth Cntr. - 57			
Milford	Milford	Milford Hospital - 149						
New Haven	New Haven	Hospital of St. Raphael - 482 Yale-New Haven Hospital - 875 Yale University Health Services Ctr. - 38				Conn. Mental Health Center - 45 Yale Psychiatric Institute - 60		
Southbury	Southbury							Southbury Training School - 1,107
Wallingford	Wallingford	Archbold Hospital, Choate Rosemary Hall - 15	Masonic Hospital - 581	Gaylord Hospital - 121				
Waterbury	Waterbury	St. Mary's Hosp.-347 Waterbury Hosp.- 505						
West Haven	West Haven	V.A. Medical Center - 1,372						

ATTACHMENT K-3

HOSPITALS, INSTITUTIONS FOR THE MENTALLY ILL, AND INSTITUTIONS FOR THE MENTALLY RETARDED IN CONNECTICUT

Probate District	Towns and Cities	General Medical and Surgical Hospitals (Name & #Beds)	Geriatric and Chronic Disease Hospitals (Name & #Beds)	Rehabilitation Hospitals (Name & #Beds)	Children's Hospitals (Name & #Beds)	Psychiatric Hospitals (Name & #Beds)	Alcohol & Drug Abuse Hospitals (Name & #Beds)	Institutions for Mentally Retard. (Name & #Beds)
Litchfield County								
New Milford	New Milford	New Milford Hosp. - 85						
Sharon	Sharon	Sharon Hospital - 92						
Torrington	Torrington	Charlotte Hungerford Hospital - 188						
Winsted	Winsted	Winsted Memorial Hospital - 73						
Middlesex County								
Middletown	Middletown	Middlesex Memorial Hospital - 380			Riverview Hosp. for Children (psychiatric)- 64	Conn. Valley Hospital - 658		
Portland						Elmcrest Psych. Institute - 105		
New London County								
Groton	Groton	Naval Hospital - 81						
New London	New London	Lawrence & Memorial Hospitals - 350 U.S. Coast Guard Academy Hosp. - 33						
Norwich	Norwich	William W. Backus Hospital - 260	Uncas on Thames Hospital - 44			Norwich Hosp. - 649		

HOSPITALS, INSTITUTIONS FOR THE MENTALLY ILL, AND INSTITUTIONS FOR THE MENTALLY RETARDED IN CONNECTICUT

Probate District	Towns and Cities	General Medical and Surgical Hospitals (Name & #Beds)	Geriatric and Chronic Disease Hospitals (Name & #Beds)	Rehabilitation Hospitals (Name & #Beds)	Children's Hospitals (Name & #Beds)	Psychiatric Hospitals (Name & #Beds)	Alcohol & Drug Abuse Hospitals (Name & #Beds)	Institutions for Mentally Retard. (Name & #Beds)
Tolland County								
Ellington	Rockville	Rockville General Hospital - 102						
Mansfield	Mansfield					Natchaug Hospital - 60		Mansfield Training School - 576
Somers	Somers	Conn. Dept. of Corrections Hospital - 60						
Stafford	Stafford Springs	Johnson Memorial Hospital - 71						
Windham County								
Putnam	Putnam	Day-Kimball Hospital - 158						
Windham	Willimantic	Windham Community Hospital - 175						

ATTACHMENT K-5

HOSPITALS, INSTITUTIONS FOR THE MENTALLY ILL, AND INSTITUTIONS FOR THE MENTALLY RETARDED IN CONNECTICUT

Probate District	Towns and Cities	General Medical and Surgical Hospitals (Name & #Beds)	Geriatric and Chronic Disease Hospitals (Name & #Beds)	Rehabilitation Hospitals (Name & #Beds)	Children's Hospitals (Name & #Beds)	Psychiatric Hospitals (Name & #Beds)	Alcohol & Drug Abuse Hospitals (Name & #Beds)	Institutions for Mentally Retard. (Name & #Beds)
Fairfield County								
Bridgeport	Bridgeport	Bridgeport Hospital - 614 Park City Hospital - 201 St. Vincents Med. Center - 391						
Danbury	Danbury	Danbury Hosp. - 450						
Greenwich	Greenwich	Greenwich Hospital - 296						
New Canaan	New Canaan					Silver Hill Foundation Hospital - 77		
Newtown	Newtown				Housatonic Adolescent Hospital - 35 (psychiatric)	Fairfield Hills Hospital - 743		
Norwalk	Norwalk	Norwalk Hosp. - 427						
Stamford	Stamford	St. Joseph Hosp. - 260 Stamford Hosp. - 305						
Trumbull	Trumbull		St. Joseph's Manor - 41					
Westport	Westport					Hall-Brooke Hospital - 78		

ATTACHMENT L

For Each Probate District and for Each Municipality in the State of Connecticut, Obtain Information On:

Elderly population size and population trends (subtract from total population)

+

Per capita income and trends

Total number of beds in short-term and long-term hospitals that may be in area

+

Total number of beds in each type of nursing home that may be in area:
Chronic and convalescent nursing homes.
Rest homes with nursing supervision homes for the aged.

Identify probable levels of need for conservator services in probate districts and in municipalities in Connecticut and rank in order:

Highest Level	75th-100th Percentile
Upper Medium Level	50th-74th Percentile
Lower Medium Level	25th-49th Percentile
Lowest Level	1st-24th Percentile

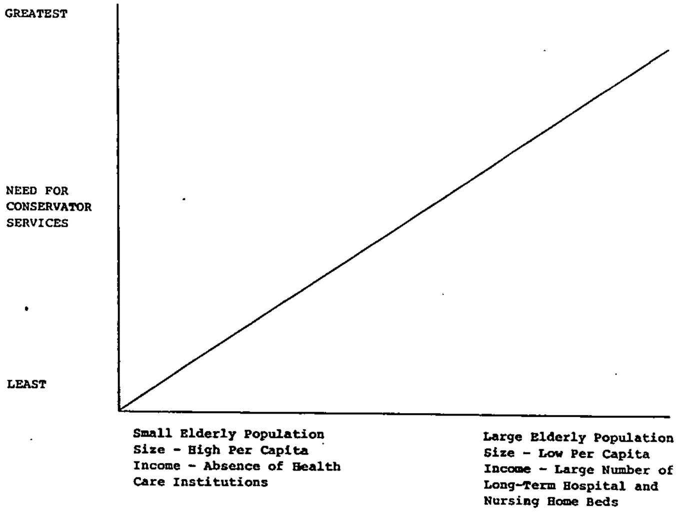
If possible, relate these levels of "risk" to the actual experience of conservator need in each probate district and municipality by obtaining first encounter data from those agencies (both public and private and at both the municipal and the statewide levels) which have been offering conservator services.

Surveys of hospitals and nursing homes are likely to also provide information, but will be of limited use if they are based on conjecture and speculation only.

Probate court records indicating the number of appeals for the services of a conservator of the estate and for conservator of the person over specified 1-year periods would give us an idea about trends in the need for each type of conservator. It would be ideal to have this for three 1-year periods and to be able to identify the location and reason for each first encounter.

ATTACHMENT L-1

FACTORS INFLUENCING NEED FOR CONSERVATOR SERVICES



ATTACHMENT M

Analysis of Data

There are 169 municipalities in Connecticut. It was decided to develop a priority ranking system by:

(a) assigning the value of 169 to the municipality having the lowest per capita income and the value of 1 to the municipality having the highest per capital income, all others being ranked in between;

(b) assigning the value of 169 to the municipality having the largest population and the value of 1 to the municipality having the smallest population, all others being ranked in between;

(c) for each municipality adding together the total number of hospital and nursing home beds, including all categories; and

(d) adding together the income, population and hospital-nursing home figures for each municipality to reach a total priority score.

The total priority scores were then arranged in order of priority.

In studying the recorded figures, it should be noted that many Connecticut nursing homes contain both chronic and convalescent beds and rest homes with nursing supervision beds. In such cases the two figures for a nursing home were separated and added to the appropriate columns (6 and 7).

ATTACHMENT M-1

MUNICIPALLY BASED CONSERVATOR PROGRAMS DEVELOPMENT PRIORITY RANKING DERIVED FROM TOTAL PRIORITY SCORE

Priority	Municipality	Score	Priority	Municipality	Score
1	Hartford	4,714	51	East Haven	407
2	New Haven	3,115	52	Plainville	407
3	Bridgeport	2,884	53	Winchester	382
4	Waterbury	2,716	54	Watertown	378
5	West Haven	2,200	55	Wolcott	378
6	Middletown	1,984	56	Vernon	369
7	Norwich	1,843	57	Willington	369
8	Wallingford	1,820	58	North Haven	366
9	New Britain	1,795	59	Glastonbury	364
10	Manchester	1,699	60	Prospect	363
11	Southbury	1,561	61	Old Saybrook	344
12	Meriden	1,536	62	Brooklyn	334
13	Danbury	1,462	63	Griswold	332
14	Stamford	1,331	64	Westport	331
15	Norwalk	1,172	65	Simsbury	329
16	West Hartford	1,119	66	Guilford	326
17	Newtown	1,070	67	Stonington	324
18	Bristol	1,036	68	Stafford	299
19	Torrington	999	69	Branford	294
20	Hamden	992	70	East Hampton	294
21	New London	991	71	Montville	290
22	Newington	957	72	South Windsor	287
23	Mansfield	925	73	Ellington	285
24	Rocky Hill	912	74	Avon	282
25	East Hartford	897	75	Berlin	277
26	Fairfield	885	76	Naugatuck	277
27	Greenwich	857	77	Chester	275
28	Shelton	841	78	Ansonia	264
29	Windsor	826	79	New Canaan	263
30	Milford	792	80	Windsor Locks	254
31	Bloomfield	733	81	Plymouth	252
32	Derby	711	82	Thompson	250
33	Groton	698	83	East Haddam	244
34	Cheshire	683	84	Marlborough	242
35	Enfield	637	85	Wilton	239
36	Farmington	610	86	Darien	238
37	New Milford	571	87	Litchfield	237
38	Southington	551	88	Clinton	235
39	Waterford	543	89	Canaan	231
40	Killingly	542	90	Somers	230
41	Windham	524	91	Seymour	224
42	Putnam	514	92	Essex	223
43	Trumbull	511	93	Orange	208
44	Cromwell	510	94	Coventry	203
45	Stratford	474	95	Preston	199
46	East Windsor	459	96	Ledyard	198
47	Wethersfield	453	97	North Canaan	198
48	Plainfield	435	98	North Branford	192
49	Colchester	431	99	Pomfret	192
50	Portland	412	100	Durham	191

ATTACHMENT M-2

Priority	Municipality	Score
101	Ashford	189
102	Canterbury	188
103	Lebanon	185
104	Lisbon	185
105	Sterling	185
106	Tolland	184
107	Thomaston	183
108	Bethel	180
109	Beacon Falls	178
110	Sharon	178
111	Madison	177
112	Chaplin	174
113	Bozrah	171
114	Haddam	168
115	Deep River	165
116	Monroe	164
117	Scotland	161
118	East Lyme	160
119	Sprague	160
120	Westbrook	159
121	Oxford	153
122	Salisbury	153
123	Harwinton	151
124	Middlebury	149
125	Voluntown	144
126	Brookfield	142
127	Ridgefield	142
128	New Fairfield	141
129	North Stonington	141
130	Hebron	139
131	Middlefield	138
132	Woodstock	137
133	Eastford	133
134	Barkhamsted	127
135	Burlington	125
136	Union	123
137	Franklin	122
138	Hampton	122
139	Columbia	121
140	Salem	121
141	Suffield	120
142	New Hartford	118
143	Canton	116
144	Andover	113
145	Granby	108
146	Killingworth	104
147	Bethlehem	101
148	Woodbury	101
149	Bethany	97
150	East Granby	94
151	Colebrook	85
152	Weston	85
153	Old Lyme	84
154	Redding	84
155	Kent	82
156	Hartland	81
157	Bolton	79
158	Washington	78
159	Norfolk	76
160	Easton	74
161	Woodbridge	74
162	Morris	71
163	Goshen	67
164	Sherman	46
165	Warren	35
166	Lyme	33
167	Cornwall	28
168	Roxbury	27
169	Bridgewater	22

REMARKS BY THE HON. ELLEN A. PETERS
PROBATE COURT ASSEMBLY
APRIL 17, 1991

Judge Lukens, Judge Lyddy, Judge Powers, Judge Kierman, ladies and gentlemen:

It gives me great pleasure, for my seventh time as chief justice, to welcome you to the Supreme Court today for your annual meeting. I especially want to greet the 32 new probate judges for whom this is the first probate assembly. I am confident that each of you will find yourself enriched by the special educational programs that Judge Lukens and his staff are providing. If I may offer brief advice about the profession of judging, it is: We can never afford to stop learning!

Offering educational programs for new probate judges continues the long tradition of administrative excellence that Connecticut's probate system enjoys. This excellence is also manifested in your legislative vigilance, in your diligent pursuit of legislation submitted to the General Assembly by the Office of the Probate Court Administrator.

Among the pending legislative initiatives in which the Probate Administrator has had a hand is a proposed statute that, if enacted, would improve the procedure and shorten the frequency of periodic reviews of conservatorships and guardianships for the mentally retarded. Another proposed act would further clarify right-to-die issues addressed in our Supreme Court's decision in McConnell v. Beverly Enterprises - Connecticut, and the United States Supreme Court's decision in Cruzan v. Director, Missouri Department of Health. Building on his participation in a national seminar of the Conference of Chief Justices, to which I will return shortly, Judge Lukens is helping the State Justice Institute to define the proper sphere of the state role for conservatorships for the elderly and the infirm.

Each of these initiatives - education, legislation, consultation - together with your perseverance in the pursuit of technological efficiency, of social services improvements and of legal research and other administrative initiatives - bears witness to the proud record of achievement that enhances Connecticut's reputation as a problem solver in probate administration. Whatever may be the case in other jurisdictions, Connecticut's probate system manifests a reflective but proactive approach to the daunting issues that confront probate courts today.

I was forcefully reminded of how intractable these issues can be when, as a member of the national Conference of Chief Justices, I was appointed to head a committee to study proposed federal standards for guardianship and conservatorship matters. The task of my committee is twofold: to make recommendations to the Conference about the desirability of having state rather than national hegemony over guardianships and conservatorships, and to make recommendations, if the state course is the preferred route, for guaranteeing that state systems are prepared to address these matters seriously and in depth.

As is often the case, my responsibilities to the Conference rapidly became intertwined with my local responsibilities for oversight of our own probate rules and regulations for guardians and conservatorships. I turned for advice on where we stood in Connecticut to Judge Lukens, and was delighted to learn from him that the practices that Connecticut already has in place put you as probate judges in the forefront of the national movement to address the problems and protect the rights of those requiring surrogate decision making. As chief justice, I proudly applaud your foresight and initiative in making Connecticut a model of effective, compassionate, constructive probate administration. Your experience should prove an important resource for courts in other states.

It is not surprising that national attention has come to focus on procedures for constitutionally appropriate and personally sensitive guardianship procedures. We are all aware of: the aging of our population; the effect of this sociological phenomenon on probate dockets; and the growing national clamor for greater recognition of the rights of the elderly. Of course, nothing is more effective for getting these concerns on the agenda of state judicial groups than the likelihood that, if we do not put our house into order, the Congress will act.

Consider the following as an overview:

- Currently, approximately 3.9 million people in the United States have developmental disabilities.
- Approximately 130,000 patients reside in state mental hospitals and another 344,000 are admitted to those hospitals in any one year.
- Some 25 to 40 percent of the so-called "street population" in our nation is probably suffering from chronic mental illness.
- Of the approximately 1.5 million individuals who carry the AIDS virus, a sizable percentage are likely in time to experience sufficient mental impairment to require access to appropriately defined surrogate decision making.

Aggravating this bleak picture of acute mental problems is the inescapable fact that all of our population is aging. The good news is that dramatic improvements in medicine, health care and nutrition, permit us collectively to live longer. The bad news is that age itself, without more, often requires care: many of our friends and neighbors, themselves in their 60s, now find themselves charged with looking after their parents in their 80s.

These demographic changes have particular significance for the post-World War II "baby boom" generation, which someone has aptly described as "a watermelon passing through a snake." The influx of this generation swamped our grammar school classrooms in the 60s, arrived in great numbers on college campuses in the '70s and strained the availability of affordable housing in the 80s. We can now anticipate that the aging of this population bulge will have profound implications for our programs and policies for the elderly, for our social security system and for our health care industry. For you in the probate court, equally grave consequences loom as your system's capacity to appoint and monitor well-trained and caring conservators and guardians will be put to the test.

We may already be seeing the first waves of the coming storm. Last year, applications for the appointments of conservators rose sharply throughout your dockets. Those for temporary conservators increased 47 percent over the previous year. Applications for involuntary appointment of conservators of the person increased 31.7 percent. Those for voluntary appointment of the conservator of an estate increased 18.8 percent. Applications for a five-year hearing review jumped 276 percent.

These numbers have only one way to go: they will get worse! The United States Senate Special Committee on Aging estimates that by the year 2035, our country will include nearly 71 million elderly persons - approximately 1/4 of the total population! We must undertake now the reforms that will enable probate systems throughout this land to meet the increased demands for probate services.

In recent years, some reports have raised fears that certain states or local jurisdictions are already failing in their constitutional responsibility fully to protect the rights of the elderly and the incapacitated. While the origin ~~for~~ of some of these fears may be more anecdotal than statistical, we cannot ignore the possibility that they may have some basis in fact.

We need, therefore, to take a critical look at prevailing practices to be sure that individual rights are procedurally and substantively protected. We need to search for ways and means to assure the availability of sufficient numbers of well-trained and caring guardians and conservators. We need to provide clear guidelines about what constitutes incapacity in order to enable courts and guardians to discharge their responsibilities. We need to develop and to strengthen alternatives that minimize intrusion into personal autonomy whenever possible. There are many questions and few answers.

How best, in a free society, to manage the transfer of the decision-making responsibility from a person declared to be incapable of handling his or her own affairs to another person, is a matter of utmost seriousness, for the individual and the judicial system. The urgency of our aging population is what has put these questions on the potential agenda of the Congress and the present agenda of the Conference of Chief Justices. I consider the possibility of national intervention a second-best solution. National standards inevitably override local diversity in court systems, in the size of the incapacitated population and in the resources available to deliver required services. National regulation is, however, well-nigh inevitable unless responsible state and local mechanisms are rapidly, visibly, put into place.

As I said earlier, I believe that well-established probate practices in Connecticut, and the improvements that are now on the drawing board, can serve as a model for effective state management of this urgent social concern. Our law in Connecticut already provides, as does the proposed federal legislation, for the right to effective meaningful notice, the right to counsel, and the right to be present at the hearing at an appropriate site. Our law also insists that those appointed as conservators report and account periodically to the probate court, and that those who have become wards of the court be periodically reevaluated, optionally after one year, mandatorily after five, to determine their continuing need for surrogate decision-making.

These safeguards guarantee that our elderly and incapacitated citizens do not get lost in the shuffle either in the processing of an initial application for conservatorship or thereafter, once guardianship has been granted. They are at the very heart of Connecticut's effective system of full protection for the rights of the elderly and the incapacitated.

To help me to discharge my national responsibilities for these urgent matters, Judge Lukens and Judge Francis X. Hennessy, our deputy chief court administrator, have been a reassuring source of invaluable information and wise counsel. They joined me in Arizona earlier this year to present an informative conference on these very questions for the midyear meeting of the states' chief justices.

Our presentation reminded the assembled jurists of their role as a guiding force in assuring that the probate structure throughout the United States will be ready and able to meet the demands that accompany the aging of our population. As we make progress on this daunting agenda nationally, you can take pride in your yeoman's work in preparing the way. Future generations look to us to work together to safeguard their rights and liberties in an ever more just and caring society.

Thank you for your patient attention.

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Office of Geriatric Medicine
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June 3, 1992

Anna Kindermann, Counsel
Special Committee on Aging
United States Senate
Washington, DC 20510-6400

Dear Anna:

Thanks for the opportunity to participate in the interesting discussion on guardianship yesterday.

You suggested that we each submit items for possible inclusion in the formal record. Accordingly, I enclose a few things that I have written on this subject that might be appropriate for this purpose. Please let me know how I may contribute further to your important work in this field.

Sincerely,

Marshall B. Kapp

Marshall B. Kapp, J.D., M.P.H.
Professor, Community Health
Director, Office of Geriatric Medicine
and Gerontology

MBK:10667S

Enclosures

Hastings Center Report July/August 1989

Medical Empowerment of the Elderly

by Marshall B. Kapp

Empowering the elderly to make their own decisions regarding medical care is a noble social, political, and ethical cause; but society must guard against excesses that might, ironically, deny the elderly their autonomy by forcing it upon them.

"Empowerment" of the elderly has become a popular gerontological buzz-phrase of the 1980s.[1] It refers to the movement among advocates for older individuals to encourage activism among the capable elderly regarding their own rights and interests whenever possible, within a society in which rights are respected and acted upon only if one claims those rights personally or through a proxy.[2] There is widespread philosophical agreement among professionals concerned with the well-being of the elderly that political, legal, social, economic, and health-related services that support the capacity of older persons to speak for themselves—that is, that empower older persons—greatly enhance the autonomy, independence, and dignity of the older self-advocate.

Additionally, recent research underscores the relationship between a sense of control over one's decisions and life goals and positive outcomes in aging.[3] Many interpret such data to show that the extent to which individuals are encouraged to take more control over their lives and health may be a major determinant of satisfaction and well-being (that is, quality of life) in their later years.

The chief legal mechanism of empowerment in the health area is the doctrine of informed consent, the requirement that medical interventions be administered to a patient only if preceded by the voluntary, adequately informed agreement of a capable patient or that patient's legally authorized substitute decision-maker. The depth of commitment to the notion of empowerment of the elderly in health care is manifested in the growing use of legal planning devices, such as the living will and the durable power of attorney, on a prospective basis to effectuate informed consent later in life.[4] Through these legal mechanisms as well as other means, professional advocates, family members, friends, physicians, and other health care providers all play an important role in helping the elderly to make and exercise their own life choices.

Limits of Empowerment

The enthusiasm for empowerment must be tempered with caution, however. There are important limits and nuances to this concept that must be thoroughly considered.

First, power over one's life entails more than mere control over particular choices. In a real sense, it is knowledge that creates power. Hence, the older individual's purported right to make choices about matters affecting him or her acquires meaning only if those choices are accompanied by adequate information, both about the personal rights involved and the factual ramifications of one's decision, as well as the range of reasonable alternatives among which to choose. As our early experience with "Medigap" insurance policies teaches, the older person's right to choose should not be confused with the "right to be ripped off." Thus, insistence on adequate information is essential to meaningful (as opposed to apparent) empowerment.

Second, decision-making power must be accepted voluntarily (if at all) by the older person. We rightly start with a legal and ethical presumption that most elderly people wish to make their own decisions regarding health care. However, this presumption is rebuttable, not conclusive. There are a significant number of adults, including but by no means limited to a substantial percentage of the elderly, who would not voluntarily accept responsibility for making some or all of their own difficult decisions.[5]

This paradox—older individuals who would rather not make their own decisions—compels us to confront a fundamental policy issue of whether we should permit capable, informed older adults voluntarily to waive empowerment if they so wish, or instead force empowerment on them. Put more starkly, should we recognize a right of the elderly to be dependent on others? This dilemma invokes basic philosophical premises about the nature of personal choice and responsibility, and their interaction and tension. In the context of elderly empowerment, is the relationship of rights and duties one of polarity or correlativity?

Forced Empowerment

There are several plausible arguments for forcing capable, informed older individuals to be empowered, that is, to advocate for themselves and participate maximally in their own significant decisions. Some would argue that there is a fundamental duty incumbent on all of us to be autonomous, to accept personal responsibility as masters of our own ship. This view sees that decisions concerning one's own health are of such a deeply personal character that they cannot ethically be delegated to anyone else. The decision—and its consequences—belong to the patient alone. Jay

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Katz has claimed, for example, that as a matter of universal ethical and social policy, he would never permit any capable patient to abdicate or waive his or her right to make final medical decisions.[6]

Moreover, under this philosophical view, older persons who are *capable* of being empowered to fend for themselves in medical decisionmaking have a duty to *assume* responsibility for decisionmaking as a matter of justice. Otherwise they will unnecessarily consume increasingly scarce resources that should instead be directed toward the growing number of involuntarily dependent elders who have no choice but to rely on others for basic advocacy and proxy decision-making services. The establishment, administration, and monitoring of a proxy decision-making apparatus requires substantial financial costs.

Further, Katz and others have suggested that forcing consumers of medical services, including the able elderly, to accept decision-making power is the only effective way to safeguard against health care professionals acting paternalistically and condescendingly toward the consumer.[7] This position suggests a skeptical, even cynical, perspective toward the helping professions, particularly toward physicians, but one that is not convincingly disproved by historical analyses of communication within the professional-patient relationship and failures in implementing the spirit of the doctrine of informed consent.

Forgoing Empowerment

Nevertheless, persuasive arguments can be asserted in favor of allowing capable, informed older persons the choice to forgo, to a greater or lesser extent, personal empowerment and thereby waive or abdicate responsibility for some of the decisions they are ethically and legally entitled to make. On this position, choosing dependence on others rather than independence would be a respected alternative for the capable elder.

It can, first of all, be argued that honoring the older person's autonomy logically encompasses that person's right to delegate to others his or her decision-making duties, just as much as does honoring his or her right to consent to or refuse offered medical services. There is no logical mistake in permitting a capable person knowingly and voluntarily to transfer some decision-making power to another of his or her choosing. As Arthur Dyck reminds us, autonomy is not synonymous with self-determination; rather, autonomy is the capacity for self-determination, a capacity that the individual may or may not choose to exercise.[8] Both ethically and legally, society clearly permits informed individuals voluntarily to choose not to exercise their fundamental rights in other areas of life. For instance, few of us would object to an older person turning over to an attorney substantial power relating to management of his or her financial affairs. Since the attorney stands in a fiduciary relationship with the client, he or she is ethically and legally obligated to act in the client's best interests. Similarly, the fiduciary nature of the physician-patient relationship mandates a commitment to the patient's best interests; hence, appointing a physician as an agent for choosing the appropriate course of medical care to follow is neither unwise nor an unwarranted burden upon the physician.[9]

Perils of Independence

Nevertheless, placing too much reliance on empowerment of the elderly can lead, if we are not careful, to the implicit condoning of neglect of the elderly if they do not exercise their power sufficiently. Individualism and independence, if too rugged, may turn into health care nihilism. When our expectations about responsibility are shifted too radically from institutions and agencies to the older individual, we run the risk of letting those institutions and agencies escape their proper duties too easily. We may provide them with too ready a defense, in the face of neglect, harm, and deterioration of older patients, that the power belonged to the older person (that is, the victim), and that the institution or agency was merely carrying out the elder's explicit or implied orders.[10] To blend autonomy with beneficence effectively, empowerment ideally should entail a negotiated sharing, as opposed to a sequential transfer of authority.[11]

For instance, an older hospital patient may insist on being discharged to a home environment where he or she lives alone and refuses assistance from home care staff. The hospital and its staff who facilitate the discharge without giving sufficient attention to alternatives may be compromising their commitment to beneficence under the guise of respecting autonomy. The institution and its staff should instead make every reasonable effort to negotiate terms of home care that are palatable to the patient but that provide at least minimally adequate assistance and assurance of protection. The proper degree of cajoling, persuasion and—if necessary—legal intervention will vary from case to case.

Lastly, it frequently is difficult to ascertain and interpret older individuals' actual preferences regarding specific questions about their medical care or other services. Many may wish to receive certain services, or conversely may desire to reject those services, but are too embarrassed or afraid to announce their preferences. Even after barriers to effective communication and informed consent have been vigorously addressed, some persons still simply would rather be led by others than assert themselves. This phenomenon should not surprise us, considering how many young and middle-aged persons in our society in effect elect to forfeit their own empowerment in important matters in favor of passively relying on the presumed expertise, experience, charisma, or caring of professionals, family members, or friends.

We cannot reasonably expect people who have a long-standing personal history of attempting to "escape from freedom"[12] suddenly to embrace an ethic of individual empowerment upon reaching a certain chronological age. If anything, the physical and social infirmities of age tend to compel movement in the opposite direction. Several recently completed empirical studies regarding the process of geriatric decisionmaking, as well as a body of published research concerning do-not-resuscitate decisionmaking, strongly suggest that many elders both want and expect others, such as their physicians, family members, and friends, to take primary responsibility for making medical decisions. Frequently these surrogate decisionmakers are provided with little or no direction by the older person to aid them in fulfilling this responsibility.[13]

Of course, the empirical fact that some elderly persons refuse their own empowerment does not definitively settle the normative question of whether such dependency is acceptable, let alone desirable. Still, such data are a meaningful part of health policy formulation and cannot be merely dismissed; instead, the relevance of moral principles for the question of empowerment of the elderly must be tested against this empirical basis. Ethical questions are not resolved by popular plebiscite, but actual opinions and actions are relevant factors in the health policymaking calculus.

Resolving the Tension

How, then, may we begin to resolve the tension created between the emphasis on empowerment of the elderly and the persisting desire by certain capable, informed older adults voluntarily to delegate their decision-making rights and responsibilities? No solutions are hazarded here, but a few guidelines may prove helpful.

The common law regarding the doctrine of patient waiver as an exception to the ordinary medical informed consent requirement is generally sensible and instructive. Such allowances recognize that society has a duty to strive for and facilitate empowerment of the elderly without forcing it on unwilling persons. Physicians and others in positions of authority ought to presume that most older persons would desire to make, or at least extensively participate in, medical and other decisions having an impact on their own lives, reserving reliance on a waiver of decision-making rights to a special, extraordinary occurrence.

By the same token, physicians should also recognize that exceptions to this presumption are displayed in the lives of a sizable number of older patients. Some capable elderly individuals will voluntarily and authentically choose, based on adequate information, to refrain from exercising their decision-making rights and responsibilities and to delegate those rights and responsibilities to the physician, family, or friends. Respect for persons necessarily entails respect for such conscious decisions not to decide personally.

The key ethical and legal concern lies in achieving the delicate balance of recognizing and respecting the older person's right to transfer empowerment, but not doing so too quickly or facilely. Physicians and other health care professionals should ensure that any purported delegation of decision-making authority by an older patient is indeed intentional and voluntary, made in the context of adequate information conveyed (or at least a bona fide attempt to convey) to the patient about the decision itself, its likely ramifications, and the patient's right to make that decision.[14] Before accepting and acting on the older patient's transfer of decision-making power, the physician or other professional should insist that the patient's wishes be indicated expressly and unambiguously. As an element of risk management, all professional-patient interactions concerning empowerment or its delegation should be thoroughly documented in the patient's medical record. In these circumstances, the physician or other health care professional ought to openly acknowledge reliance on the waiver exception, rather than hollowly pretend to follow the standard informed consent ritual.[15]

Empowerment of the elderly in medical decisionmaking is a noble social, political, and ethical cause. Like other noble causes, however, excesses and intolerances can occur unless we are on guard against them. It would be ironic indeed if we were to deny the elderly their autonomy by forcing it upon them. Yet another exquisite challenge for health professionals lies in recognizing and respecting the older patient's right to forgo and thereby delegate choice, as well as the right to choose his or her own medical destiny.

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Shared decision making about placement and medical interventions can be empowering to the older person involved, relieve burdens on the older person and family members, and facilitate better surrogate decision making later. Potential dangers of the shared process include coercion, conflicts of interest, and disagreements between family members. New legal concepts, similar to those governing property, could help our legal system better accommodate the realities of shared decision making.

Key Words: Law, Ethics, Interdependency, Autonomy, Family burden

Health Care Decision Making by the Elderly: I Get by with a Little Help from My Family[1]

Marshall B. Kapp, JD, MPH[2]

The concept of informed consent is a bedrock ethical and legal doctrine within the American health care system (President's Commission, 1982). In order for consent to, or refusal of, a medical intervention to be considered ethically and legally valid, three elements must be present: voluntariness, mental capacity, and adequate information (Rozovsky, 1990). There is a parallel between the right to control medical decisions and the right to control information about those decisions; the person who is deemed to have the ethical and legal authority to act as decision maker concerning specific medical interventions is also deemed to be the appropriate recipient of facts and recommendations concerning treatment and to be the one who is authorized to claim or waive confidentiality rights regarding the release of patient-specific information to third parties.

Where elderly patients are involved, the element of decision making that has received the lion's share of attention in the ethical and legal literature is mental capacity (although voluntariness, especially in institutional environments, and information disclosure certainly are pertinent). Where the older person is decisionally incapacitated, either in law (de jure) or in fact (de facto), a great deal of energy has been devoted to the topic of surrogate decision making on the patient's behalf (Hastings Center, 1987), including significant research on pátient expectations and desires (High, 1988). Legal doctrines and mechanisms of surrogate decision making have been developed to implement the ethical principles of autonomy and beneficence; these include advance planning devices, principally living wills (Martyn & Jacobs, 1984) and durable powers of attorney (Kapp, 1990), family consent statutes (Fentiman, 1989), substituted judgment (Superintendent of Belchertown State School v. Saikewicz, 1977), and the best interests standard (In re Conroy, 1985).

We need to devote much more attention, though, both theoretical and practical, to the ethical and legal issues that are implicated not when decisional power transfers from the mentally incapacitated patient to a proxy, but rather when mentally capable older persons work together with their families (taking the term in a very broad sense) (Brown, 1990) at shared health care decision making. Decisional capacity refers to a minimal level of current functional ability and many older persons who meet the minimal criteria, and therefore are not candidates for surrogate decision makers, nonetheless want and can benefit from some family assistance in making difficult health care choices.

Indeed, a substantial body of empirical data (Pratt et al., 1989) clearly establishes that, in the real world, older mentally capable patients do not behave as lone, isolated, atomistic agents (Collopy, 1988), but rather rely heavily on family members, particularly daughters and daughters-in-law, for assistance in medical decision making. The process of health care decision making for many older people is an excellent paradigm of the interdependence between generations.

As we think about this paradigm and its application to the health care decision-making process, we ought to consider that the autonomy model of a lone individual defending his or her choices against adversarial intervenors armed with high technology medical weapons stems chiefly from experience in acute care settings from which the patient can walk or be carried away. Different models of autonomy that are more balanced and empirically predicated, such as the concept of 'negotiated consent' (Moody, 1988), have begun to emerge recently from long-term care experience (Hofland, 1988; Hofland, 1990). These newer models for accommodating to indetermi-

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[1] This paper is based on a presentation made at the Annual Scientific Meeting of the Gerontological Society of America, Boston, November 19, 1990.

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nately ongoing situations (Agree et al., 1989) may contribute to our understanding of shared decision making regardless of specific care environment.

This article briefly explores some of the most salient ethical and legal considerations in shared health care decision making involving older persons. The subject matter is defined to include acute and long-term medical interventions — that is, interventions ordinarily carried out by health care professionals and regulated and reimbursed as health services — as well as placement decisions where those decisions are related to health care facilities and the patient's health care needs.

Ethical Considerations in Shared Decision Making

Persons live their lives embedded within various relationships, among which the family for most people is paramount. Since these relationships tend to grow stronger over time, they take on added significance for most older persons. Many have argued that these relationships have an empowering quality (Clark, 1987), contributing to the older person's potential for positive, affirmative autonomy to think and act, as opposed to the simple, negative autonomy to be left alone (Collopy, 1988). Thomasma (1984) refers to this as the freedom to do something, rather than the freedom from something. Power in the medical decision-making realm is not a zero-sum game, in which there is a finite amount that has to be divided among the participants and one party's gain or domination is another party's corresponding loss or disenfranchisement. Instead, sharing power multiplies it through a collaborative, supportive exercise in which the participants and their sense of control grow individually and collectively.

Proponents of "communal" or "care-centered" moral reasoning (Bellah et al., 1985) posit that moral identity is expressed by how one lives within a complex, interdependent web of relationships rather than by individuation or pretending to wall oneself off from the rest of the world. Communal moral reasoning entails a continuous dialogue with others whose views and interests are a dialectical part of one's own values. An individual formulates values, at least in part, through the experience of being a member of a distinct family, since families are a basic social unit. Values are honed by trying ideas out on family members and getting their feedback as part of what is essentially a moral conversation (Jecker, 1990).

Another point in support of shared decision making for older patients is the growing amount of empirical data suggesting that many patients of advanced years possess less desire for information about, and control over, health care decision making than do their younger counterparts (Smith et al., 1988). Many older persons welcome the opportunity to share what they perceive as the burden, not just the right, of health care decision making. Contrary to the pure autonomy model that Americans cherish in theory, some persons do not want to be empowered exclusively. The desire of many older persons to enhance their autonomy by sharing it should be respected; we shouldn't attempt to force exclusive autonomy on the reluctant. By encouraging and facilitating assisted or shared consent, we may help to delay or prevent total delegation of consent, in which the older patient abandons further personal autonomy by giving away complete decision-making authority to someone else.

Another legitimate reason why an older individual may share authority with family members is to minimize family burden. By sharing decisions, the individual may attempt to reduce feelings of tension or guilt that otherwise might bother a family that felt it must override the patient's wishes.

Even where the older person is decisionally capable, he or she may still have serious communication problems with the health care providers for a variety of reasons ranging from linguistic or ethnic differences to sensory impairments. In such circumstances, the involvement of adult children in the provider/patient/family triad can facilitate the necessary communication or translation of information between provider and patient, and thereby enhance the patient's autonomy.

When unassisted independence is no longer a feasible alternative for an older person, interdependence between generations helps to stave off a stark choice between total dependency, with its emasculation of all power, on the one hand, and an unsupported, meaningless, nihilistic facade of autonomy on the other. Partial control through a fluid relationship between dependency and interdependency is preferable to no control for the older patient (Thomasma, 1984).

Another argument in support of shared decision making is that, since the quality of the patient/family interaction is likely to strongly influence, if not determine, the outcome of various health care interventions, getting the family involved as thoroughly and early as possible in the patient's care is therapeutic. Hence, this form of helping the patient is consistent with the ethical principle of beneficence.

Furthermore, family members bear potential burdens — emotional, financial, and sometimes even physical — as a result of health care decisions affecting the patient, such as those relating to institutional discharge or avoidance and the initiation or continuation of home care. Fairness to family members thus at risk of incurring adverse consequences strongly suggests their right to participation in the decision-making process.

The process of sharing power through frank and concrete discussions between the older patient and family, taking place while the patient is still decisionally capable, should lead to better, more accurate proxy decision making later on when it becomes necessary due to the patient's mental deterioration. Shared decision making in a timely manner affords an opportunity for ongoing dialogue that informs future surrogates more fully about the patient's values and preferences regarding future decision making. Thus, sharing authority today is one way for a person to help fulfill the moral responsibility to plan for tomorrow.

Ethical Caveats

While the ethical foundations for the concept of shared health care decision making by older persons and their families are strong, several caveats or questions must be considered in the course of applying the concept in practice. First, older persons need to be protected against family coercion (i.e., infringement of voluntariness) masquerading in the guise of shared decision making, even if the decisions in effect being coerced are intended, paternalistically, to serve the patient's best interests. Because many older persons are less interested in personal involvement in information receipt and control over health care decision making, they are particularly vulnerable to being ignored, bypassed, or pressured into involvement that is merely *pro forma*. Health care providers must be sensitive to the possibility of undue influence and work to assure that the older patient enjoys as much personal involvement in making decisions as he or she wants and is functionally capable of handling.

Second, older patients also must be protected against families effectively coercing decisions, again in the guise of shared decision making, that serve the interests of the family better than those of the patient. A potential conflict of interest between patient and family must always be considered and providers must remain alert to it. Nonetheless, a rebuttable presumption in favor of families supporting rather than overpowering a capable patient's decision making seems appropriate and preferable to an alternative of presumed distrust of families and routine outside intervention.

In a recent article, Hardwig (1990) raises interesting questions about the proper place of families in health care decision making. Does the health care provider have a duty, or indeed even the right, to involve the family when the outcome of a decision for their older relative may affect other family members (which is very often)? As noted earlier, placement and treatment decisions concerning the older patient may impose substantial emotional, financial, and even physical burdens on family members, and those possible costs entitle family members to be involved in decision making. The provider thus is ethically compelled to facilitate such family participation. However, in the face of patient resistance to family involvement, the provider's primary loyalty must rest with the patient; the provider should offer to assist with, but not forcibly intrude upon, apparent breakdowns in family dynamics.

The substantive interests of the family in the outcome of a decision should be accounted for in the decision-making process, ordinarily even to the point of influencing the result. In extreme cases, though, the provider has an obligation to intervene to protect the patient from the family, where the interests of the latter appear to predominate disproportionately over those of the former.

At some point in certain individual cases, the presumption that families act in the best interests of their loved ones is rebutted, and — at least at the threshhold stage — that judgment is one for the health care provider most intimately connected to the patient and family to make. For example, the family that insists on continued aggressive, burdensome medical intervention solely to continue collecting government benefit checks is acting in a morally suspect way. On the other hand, the family that refuses consent for routine, clearly beneficial care in order to save money and conserve their future estate is not acting in the patient's best interests. Where an ethically troublesome conflict of interest has come to the surface, the provider's professional integrity compels allegiance to the patient's autonomous choices, even in the face of family displeasure. If that displeasure is severe and unmalleable to the provider's best interpersonal efforts at communication and negotiation, formal legal protection for the patient may need to be invoked as a last resort.

Additionally, families do not always speak with one voice when expressing preferences about medical decisions pertaining to their older relatives. While the emphasis here has been on intergenerational sharing of decision making among an older patient and his or her children, it must be acknowledged that spouses, siblings, and unrelated lovers and friends may also be included in the patient's definition of family. Various family members may disagree, among themselves as well as with the patient, about what choices are in the patient's best interests. Such disagreements, in the rare instances where they are intractable to informal communication and compromise, may present ethical conundrums so difficult for the provider that resort to the legal system is implicated. For instance, a guardianship petition may need to be initiated to clarify the formal decisional authority of a family member whom the provider believes is demanding futile, burdensome care for a patient or whom, conversely, is denying permission for care that the provider feels is so ordinary as to be morally obligatory.

Legal Considerations

The question of remedies for troublesome dilemmas in patient/family health care decision making brings us to a discussion of pertinent legal considerations. There are several problems associated with expecting law and the legal system to be really useful in dealing with the ethical issues implicated by the concept of shared health care decision making between older persons and their families.

Chief among the law's shortcomings in this regard is its bluntness as an instrument that tends to dissect the world in terms of adversarial disputes with zero-sum, either/or, winner/loser resolutions. This property of the legal system is the very reason that parties bring their problems to the courts — not because litigants want wisdom, but because they desire definitive answers to their disagreements. Health care providers caring for older patients have a legitimate thirst for reasonable legal certainty concerning questions such as who has the legal authority to make valid health care decisions permitting specific interventions and assuming foreseeable risks, to receive medical information about the patient, to claim or waive the right of confidentiality regarding the patient's medical information, and to commit himself or herself to responsibility for paying the bill for services provided. The legal risks entailed in treating older patients in the absence of total clarity on these points about decisional authority are probably greatly exaggerated, since treatment occurs regularly within legal "gray zones," but a desire for some certainty of rights and obligations on the part of health professionals is understandable.

These legal issues and the legal system that we have to address them do not lend themselves easily to the psychosocial, interpersonal dynamics of shared decision making between older patients and their families, with its many delicate nuances and subtleties. As Joel Handler has noted perceptively (1989), the law generally deals poorly with continuing relationships or processes; it ordinarily gets involved either in discrete, contained transactions between parties to a relationship or in repairing the damage when a relationship has broken down. While the law pretends there is a neat, precise distinction between self and others, Jecker (1990) instead finds in the real world a pattern of intimate moral relationships that enables autonomy to flourish.

The American legal system needs to accommodate better the reality of shared decision making by developing for medical decision-making purposes some workable analogue to joint banking accounts, joint tenancy, tenancy in common, and other legal devices (Strauss, Wolf, & Shilling, 1990) that have been in use for hundreds of years in matters pertaining to real and personal property. Perhaps some kind of "joint medical consent account" could be established between patient, designated family member, and health care provider. Under this arrangement, the participants could agree in advance that future health care decisions affecting the patient may be made in a binding manner, while the patient retains mental capacity, only upon joint consent of the patient and the designated family member. Conversely, future decisions could be made upon the permission of either the patient or the designated family member. Our treatment of individual rights lags conceptually and operationally far behind our treatment of property rights in this regard.

Additionally, the expectations and guidelines for each patient/family/professional relationship should be discussed explicitly, defined clearly, and documented in the patient's record by the health care professional at the outset of the relationship, in terms of authority for decision making and information sharing. Patient preferences concerning family involvement should not be taken for granted, in one direction or the other. The patient and family should be consulted about their assumptions and desires. Health care providers must resist the tendency to defer too readily to the family's expressed wishes because of an overblown, free-floating apprehension about the family as a potential plaintiff who will be around to initiate any future legal action against the provider.

This clarifying discussion can be analogous to, or a part of the same process as; the discussion that should be occurring between patient, family, and provider about advance health care planning to prepare for the patient's eventual incapacity and the need for a surrogate decision maker (Schneiderman & Arras, 1985). As with advance planning, provider dialogue with the patient and family about shared decision making should not be a single event, but instead should be an ongoing, dynamic process, especially as the patient becomes more dependent but not yet decisionally incapacitated. As in other areas, the health care provider's best legal-risk management strategy is thorough discussion with all appropriate players and timely, complete, accurate documentation of both the process and outcome of the discussion.

Conclusion

Ideally, and most of the time in practice, older individuals are not islands when it comes to making important health care decisions. The majority of older persons get by in this context not solely by themselves, but with a little help from their families. Nothing in this analysis should be read to undercut the primacy of individual autonomy; instead, the considerations enumerated are intended to help facilitate and effectuate the older patient's self-determination by supporting and buttressing it. Ethical principles that strongly support a process of shared or assisted decision making for older patients have not been artfully articulated, and certain ethical caveats await deeper exploration. New legal concepts need to be developed to accommodate the nuances and subtleties implicated when decisional autonomy concerning personal matters is shared rather than exercised exclusively or delegated completely to an agent.

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Protecting Judgment-Impaired Adults: Issues, Interventions and Policies

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Evaluating Decisionmaking Capacity in the Elderly: A Review of Recent Literature

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SUMMARY. This article critically reviews and analyzes recent contributions to the medical and legal literature dealing with the subject of defining and assessing decisionmaking capacity in older patients/clients. The themes and issues set forth in this burgeoning literature are described and guidelines are commented upon in terms of their usefulness to practitioners and the ethical and social policy implications they raise.

INTRODUCTION

Before a proxy decisionmaker in the form of a guardian or conservator may be appointed by a court to act on behalf of an individual, the court must make a determination that the individual in question (the ward) presently lacks the mental capacity to make decisions on his[1] own behalf. There is widespread acceptance of the concept that, because of primary mental illness or physical maladies with medical or psychological consequences, some people are not able to understand and appreciate the quality of their decisions and to engage in an autonomous, authentic decisionmaking process (Tremblay, 1987). However, the attempt to achieve a precise, easily measurable and applied legal definition of decisional incapacity

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[1] For the sake of simplicity, the masculine pronoun is used throughout this article.

was likened over a decade ago to a "search for the Holy Grail" (Roth, Meisel & Lidz, 1977). Little has happened in the realm of statutory or case law development in the recent past to change that assessment. Although standards differ slightly among the jurisdictions, legislatures and courts continue to define decisional capacity, if at all, only broadly and vaguely. To the consternation of health care, human service, and legal professionals who work with older persons of questionable capacity, the mechanical "competency meter" to which an individual might be connected and a numerical "readout" produced has not yet been invented.

Nonetheless, voluminous literature in the health, human service, and (to a much lesser extent) in legal journals has arisen in the subject area of defining and assessing decisional capacity, particularly for the elderly for whom memory, intelligence, and problem-solving ability may be compromised. Especially in the absence of precise guidelines provided by legal authorities, this literature is significant, for it informs actions by those professionals whose judgments about patient[2] decisional capacity (as will be discussed further below) generally *de facto* determine whether the individual's spoken choice will be followed or formal or informal proxy decisionmaking will occur. This article identifies some common threads or issues discussed in a few recent selections from this burgeoning literature.

COMMON THEMES

Criteria or Tests of Capacity

There is widespread acceptance by now of the concept that decisional capacity is a matter of the patient's functional ability to make decisions, rather than one that is automatically determined by agreement or disagreement with an outcome (that is, whether or not the decision itself is one that a 'reasonable' person would have reached) or the patient's status or membership in a particular 'vulnerable' class based on age or medical diagnosis. "The most important task for the legal standard of competency is to distinguish effectively between foolish, socially deviant, risky, or simply 'crazy' choices made competently, and comparable choices made incompetently. Although incompetent behavior may be restrained, identical competent behavior may not" (Tremblay, 1987).

Under the heading of functional assessment for decisionmaking purposes, four distinct but related standards are mentioned repeatedly (Appelbaum & Grisso, 1988; Stanley, Stanley, Guido & Garvin, 1988). First, is the patient able to evidence and communicate a choice, and one that is stable enough over time to permit its effectuation? Second, can the patient understand relevant information, both in terms of specific facts and the patient's own role in the decisionmaking process? This standard has the virtue of relatively easy testability, but depends heavily on the patient's verbal (rather than reasoning) skills. Third, what is the quality of the patient's thinking process; can the patient manipulate information logically?

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[2] The term "patient" is used in this article to describe the person whose decisional capacity is in doubt, although "client" or "consumer" might also be an appropriate description.

Is the patient able to weigh the decisional factors according to the values that the patient himself has assigned those factors? Is the outcome of the patient's decisionmaking exercise consistent with his starting premises? Fourth, does the patient appreciate the nature of his own situation (e.g., rather than denying a serious medical problem or risk) and the consequences of the decision for himself?

In a pragmatic roadmap to capacity assessment in the context of refusal of antipsychotic medications by a mentally disordered patient, one psychiatrist (Beck, 1987) has broken these criteria down into two elements: (1) capacity to assimilate relevant facts and (2) appreciation or rational understanding of the patient's situation as it relates to the facts. Beck's clinical definition that combines these two elements states that a mentally disordered person has capacity to refuse treatment if he is aware of having a mental disorder, has sufficient factual knowledge about medication and mental disorder, and does not base refusal on delusional beliefs.

Broken down further, Beck's criterion of capacity for assimilating relevant facts requires that the patient be educated about, and aware of, pertinent facts but not that the patient agree with the clinician's interpretation of those facts. Put differently, the patient who says in effect, "I know what you say, but I do not agree," possesses decisional capacity.

Beck reduces the rational understanding criterion to two parts. Under the heading "Acknowledgement versus Denial of Illness," he states that a patient may deny his illness either correctly, because in fact there is no illness, or incorrectly because the patient does not understand his own situation. Only denial of a real illness signals decisional incapacity; consequently, the clinician's first task in this formulation is to verify the existence of an actual illness that the patient is denying. Under the heading "Delusional Basis for Refusal," Beck declares that delusions only produce decisional incapacity if they relate to the treatment refusal. The clinician should probe whether even the delusional patient's choice rests on some other, realistic foundation.

The distinction between comprehension of facts, on one hand, and the quality of reasoning using those facts, on the other, as separate elements of decisional capacity is illustrated in recent research by Stanley et al., (1988). In their study, this team compared the capacity of patients with mild or moderate Alzheimer's disease to that of older persons with major depression, to determine whether these groups encounter special problems with the informed consent process beyond those difficulties that have been identified previously in the general elderly population. Based on individual interviews with the subjects during which quantitative measurements were assigned, these researchers found no differences with respect to quality of reasoning between the cognitively impaired, the depressed, and a control group. Even the cognitively impaired could weigh risks and benefits, at least globally. However, this study found significant differences in the comprehension of consent information, with the Alzheimer's patients experiencing the most difficulty. Stanley et al., posit even greater problems for the more severely cognitively impaired.

Psychiatrists Gutheil and Bursztajn (1986) emphasize that decisional capacity depends not just on cognitive factors, but can also be influenced by psychotic states and affective disorders. They submit that many physicians, attorneys, judges, and guardians *ad litem* are 'taken in' by incapacitated individuals who successfully feign decisional ability through their talent for remembering and reciting information without understanding or appreciating its meaning for them. Typical patient types in this category are the 'glib paranoid,' the pessimistic and severely depressed patient, the denying manic or hypomanic person, or the patient with anorexia nervosa.

Lawrence Hipshman (1987) proposes a new model for assessing decisional capacity: the patient's ability to form a workable 'therapeutic alliance' with the clinician. Under what he calls the 'legal' component of his model, he would inquire whether the patient is able to consult effectively with the clinician regarding treatment (an inquiry intentionally analogous to the Supreme Court's *Dusky* (1960) standard of ability to consult with and assist legal counsel as the determinant of a criminal defendant's competency to stand trial). Taken by itself, Lipshman's therapeutic alliance definition of capacity seems to beg the question; it is precisely the issue of the patient's ability to work 'effectively' with the clinician that is at stake. However, Hipshman's so-called 'ethical' or autonomy component defines 'effective' decisionmaking in a manner that makes his model potentially quite useful: Does the patient, collaborating with the clinician, have the capacity to express his own beliefs and preferences and to make decisions consistent with those personal values? In other words, are the patient's choices authentic for him? Importantly, if the impediment to the formation of an effective therapeutic alliance stems from some factor other than the patient's cognitive or psychological deficits (such as a personality rift between patient and clinician), decisional incapacity should not be inferred.

Limits of Standardized Tests

A number of standardized tests for measuring mental functioning in the elderly have been developed (Grisso, 1986). Silver (1987) and Baker (1989) are among recent authors who have reviewed screening tests of cognitive ability frequently used with the elderly in clinical practice. The former described the Alzheimer's Disease Assessment Scale, Weschler Adult Intelligence Scale, and the Weschler Memory Scale. Psychiatrist Baker compares the Folstein Mini-Mental State Examination, Kahn Mental Status Questionnaire, Cognitive Capacity Screening Examination, Mattis Dementia Rating Scale, and Kokmen Short Test of Mental Status. While Dr. Baker cites standardization and quick administerability by nurses as benefits of these tests, it is admitted that they are preliminary screening instruments only (i.e., first steps), rather than the final word on a patient's capacity, and that the choice of instrument ought to vary depending on what aspect of the patient's mentation is being measured: orientation, memory, cognitive processing, or neurologic functioning.

Other current literature highlights the limitations of bedside mental status examinations and standardized screening devices by themselves to assess decisional capacity (Farnsworth, 1989; Hipshman, 1987). Naugle and Kawczak (1989) note that one of the most commonly employed screening devices, the Mini-Mental State Examination, is intended for use for diagnostic – hence, treatment – purposes. Even so restricted, problems with false positives and false negatives in identifying cognitive impairment abound. Although this instrument was in no way devised for use in assessing decisional capacity, it is frequently misused by clinicians for that purpose.

On the other hand, physician Gerald Goodenough (1988) argues the virtues, in terms of improved objectivity of physician evaluations of mental capacity, of using a standardized functional testing instrument and recording findings on a uniform form. He decries the fact that, in assessing mental capacity in a guardianship context, there are no objective criteria as there are for most other phenomena (such as the existence of a physical disability in the Workers' Compensation context) that the physician is asked to evaluate. He criticizes most physician reports on decisional capacity as conclusory, based on diagnosis (i.e., the patient's status) rather than a determination of how, if at all, that diagnosis affects the patient's ability to function. Among the problems Goodenough refers to in physician evaluations are medical bias against the elderly and toward the family seeking control, a failure to realize that capacity may be a transient state, undue influence of communication problems in the older patient, and a general misunderstanding of the reason for a capacity evaluation.

While favoring the spread of standard functional testing instruments and recording forms to improve objectivity, Goodenough expresses pessimism that the average practicing physician has the financial or professional incentive to learn better techniques for such medicolegal assessments. In addition, he ignores the probability that widespread use of standard devices for assessing decisional capacity would encourage physician overreliance, resulting in a mechanical filling-in-the-blanks thinking process de-emphasizing appropriate professional judgment and flexibility.

Decision-Specific Nature of Capacity: Sliding Scale Standard

It is by now uniformly accepted in the literature (even if not yet universally applied in medical or legal practice) that capacity to make personal choices must be judged on a decision-specific, as opposed to a global or all-or-nothing, basis. A patient's capacity must be judged according to the particular decision with which that patient is confronted, whether medical, legal (e.g., conducting a certain business transaction) (Smith, 1988), or other in nature. A patient may be generally capable of making most decisions but unable emotionally (Gutheil, Bursztajn, Kaplan & Brodsky, 1987) to weigh risks and benefits concerning a specific question, or not able to comprehend information or engage in a rational thought process on most matters but capable of focusing sufficiently on a specific matter of importance to him (Farnsworth, 1989; Mahler & Perry, 1988). In a similar vein, there is broad consensus in the literature that capacity may be partial or compromised rather than entirely absent. Capacity thus may fall or fluctuate along points of a continuum, instead of resting at either end (Kloezen, Fitten & Steinberg, 1988). Likewise, there is little dispute that decisional capacity refers only to a minimal or baseline functional level, rather than an ideal of perfect comprehension and rational thought (Appelbaum & Grisso, 1988).

Since mental capacity is decision-specific and fluctuates along a continuum, some have proposed that it be evaluated according to a sliding scale, where less capacity is required for questions that are simpler or carry less serious consequences than for more complex or consequential decisions (Drane, 1984; Drane, 1985; President's Commission, 1982). Although courts have not explicitly adopted this concept, Appelbaum and Grisso (1988) surmise that judicial findings may be affected implicitly by the potential consequences of the decision facing the patient at the time of inquiry.

Many commentators reject the notion of a sliding scale, arguing that the assessor should not adjust the standard of capacity required but instead ought to apply an unchanging standard of capacity to the particular decision in question. Thus, the standard of capacity remains constant but its application depends on the specific case — both in terms of the unique patient and the unique choice encountered. For example, Kloezen et al., (1988) would replace a sliding scale of decisional capacity approach with the use of a combination of increasingly complex hypothetical clinical vignettes, where the patient's answers are scored against 'normal' responses, and a uniform mental status examination. Mahler and Perry (1988) reject the sliding scale idea in favor of a three-step process: (1) focusing on the capacity to make specific decisions and placing the patient's ability on a spectrum of impairment; (2) using the Hundert (1987) method of identifying and weighing all conflicting values in the case, while recognizing the law's presumption of patient autonomy; and (3) working with the patient and staff to reach a mutual decision, while keeping open the possibility of judicial involvement.

Assisted Decisional Capacity: Information, Treatment, Manipulating the Environment

Consistent with the concept of decisional capacity being of a choice-specific, spectrum nature rather than falling in an all-or-nothing category, commentators universally endorse the notion of 'assisted capacity.' This doctrine holds that many older persons, although perhaps not capable of making entirely autonomous, authentic decisions completely on their own, are nonetheless able to muster 'enough' powers of comprehension and rational thinking when given the proper degree of assistance, encouragement, and support by others. This assistance to render the older person sufficiently able to function as decisionmaker may take the form of providing adequate information, treating underlying medical problems, and manipulating environmental factors.

Family physician Farnsworth (1989) underscores that what appears as incompetent treatment refusal by an elderly patient often is a matter of the patient being inadequately informed about the nature, rationale, and projected benefits of the proposed medical intervention. Appelbaum and Grisso (1988) caution that the capacity evaluator cannot assume that the patient has been informed adequately. Farnsworth suggests that third party mediation occasionally may be worthwhile in this regard. A study by Beck of state mental hospital inpatients and antipsychotic medications (Beck, 1988) concluded that apparent decisional incapacity can be corrected for many patients by providing them with more pertinent information (i.e., improving their factual knowledge), to go along with their rational understanding. Continual education of the patient concerning benefits and risks of treatment, according to Beck, not only improves decisional capacity, but makes rational consent and compliance more likely.

Tymchuk et al., (1988) discovered that the manner in which information is presented to elderly persons substantially affects comprehension. In their study, consent information given to older nursing home patients (all of whom were pre-judged by facility staff to be mentally capable) in simplified and storybook formats was understood better than information presented in a standard format. The study also found that older persons faced with important decisions want, and are able to handle, substantial amounts of information. Results provide some support for the hypothesis that a simplified or storybook presentation of information format improves quality of reasoning as well as factual comprehension. Tymchuk et al., recommend, in addition to simplification of the subject matter for the patient, that the information so simplified ought to be presented in repeated immediate (massed practice) or repeated delayed (distributed practice) fashion to reinforce the message.

Evaluation of decisional incapacity may also be confounded by the presence of a treatable underlying medical pathology. The primary precept of Gutheil and Bursztajn's credo (1986) is to intervene clinically first. Appelbaum and Grisso (1988) urge that the patient be given a chance to exhibit his highest level of mental functioning and that treating medically treatable conditions initially may often improve that functional level and thereby enhance the patient's autonomy. Mahler and Perry (1988) also stress the clinician's early duty to recognize and minister to non-cognitive problems like interpersonal patient/staff barriers, depression, delirium, or denial that may interfere with the patient's capacity and undergird his treatment refusal. For all of these authors, the clinician's duty to explore, rule out, or intervene regarding underlying medical problems precedes any resort to the courts for the involuntary imposition of a substitute decisionmaker. To illustrate the clinician's role in investigating the possible physical bases for a patient's seemingly irrational decision, Kloezen et al., (1988) describe a case where, once the patient's family convinced him to take his blood pressure medicine, the patient's capacity improved markedly.

Besides admonishing clinicians to make certain that the patient has been properly informed and that treatable physical conditions have been addressed, the literature is also clear that clinicians should account for environmental factors in assessing capacity and should manipulate those factors where appropriate. Since capacity often varies over time and according to physical surroundings (Farnsworth, 1989), clinicians are advised to rely on multiple examinations conducted over a period of time and, ideally, in a variety of settings (Appelbaum & Grisso, 1988). An attempt to rehabilitate a seemingly cognitively compromised patient to make the best use of his existing capacity (Kloezen et al., 1988) also entails taking into account, and responding to through education of both patient and evaluator, special ethnic, cultural, and educational factors manifesting themselves as barriers to decisional capacity (Appelbaum & Grisso, 1988).

The value of family, friends, and professional caregivers in assisting the patient to deal more competently with difficult decisions through general support and encouragement is a constant thread in the literature. As Gutheil et al., (1987) explain, a person who is bolstered by supportive relationships (including the therapeutic alliance with a medical professional) may be better able to cope with tough choices than one who feels all alone and consequently is overwhelmed by anxiety. Evaluation of capacity is an ongoing process influenced integrally by patient interactions with others (Mahler & Perry, 1988).

Capacity versus Competence: Clinical Assessment versus Judicial Intervention

The literature in both medicine and law today draws a sharp distinction between the concepts of decisional capacity, on one hand, and competency, on the other. The former term relates to the opinion of a clinical evaluator concerning an individual's functional ability to make autonomous, authentic decisions about his own life. The latter term refers to the judgment of a court of law about the same issue, which generally is the prelude to appointment of a proxy decisionmaker over the objection, or at least without the voluntary consent, of the person deemed to be incompetent. The clinician only opines whether the patient 'appears' to have capacity to make a particular decision within a specific social/medical context, but does not possess the authority to ultimately decide if the patient is legally competent (Mahler & Perry, 1988).

There is strong support for the "least restrictive alternative" position (Kloezen et al., 1988) that most cases involving decisionmaking for persons of questionable functional status are better dealt with through evaluation of capacity rather than competence. That is, resort to the courts to resolve the issue, with the resultant creation of a guardianship or conservatorship, should be avoided wherever possible (Annas & Densberger, 1984).

Commentators agree that it is the treating clinician's role in the first instance to gather data and to decide whether the particular circumstances trigger the need to seek (1) further clinical consultation regarding the patient's capacity and/or (2) a judicial adjudication of incompetence and formal appointment of a surrogate (Appelbaum & Grisso, 1988). There are no clear guidelines on this largely ethical question of when the presumption of competence has been sufficiently rebutted and the circumstances as a whole compel resort to the courts (Hipshman, 1987).

One geriatrician (Stollerman, 1989) asserts that an appraisal of mental capacity should occur at the outset of every encounter with an older patient (or any age patient, for that matter), at least implicitly. Stollerman laments that usually such appraisal is completely omitted from the medical record. His own appraisal guidelines are described by the acronym ROAMS: Reaction, Orientation, Affect, Memory, and Speech.

When the treating clinician is an attorney – that is, when the issue of mental capacity arises in the context of a client of questionable mental capacity relating to an attorney for the purpose of obtaining legal services – that clinician too must make an initial assessment of the patient/client's ability to make autonomous, authentic decisions, in this case regarding the exercise of legal (rather than medical) options. The American Bar Association's 1969 Model Code of Professional Responsibility and 1983 Model Rules of Professional Conduct fail to provide any guidance to the attorney for assessing a person's functional capacity, beyond a permission (not a mandate) to consult an unspecified 'diagnostician.'

Attorney Linda Smith (1988) suggests that consultation with medical diagnosticians may be useful to the attorney in documenting the patient's capacity in case the issue is raised later and in facilitating the attorney's attempt to assist (Smith calls it 'gradual counseling') the somewhat compromised patient in a decisionmaking process that obviates the need for court intervention. At the same time, she suggests caution because invoking a medical diagnostician may upset the patient/client and because many clinicians return assessments concentrating on medical diagnosis rather than functional evaluation and on global rather than decision-specific capacity. For Smith, the attorney's key threshhold concern is determining when, based upon the attorney's own preliminary assessment, further clinical or judicial involvement is unavoidable, as opposed to relying on 'gradual counseling' and collaboration with informal proxy decisionmakers to achieve the patient/client's best interests or substituted judgment.

When cases are brought into the judicial arena, there is consensus that judges' determinations of legal competence are very heavily influenced by clinical opinions concerning capacity (Mahler & Perry, 1988), to the point where courts in large measure have 'turfed' the problem of mental capacity to the clinicians (where the majority of commentators argue that the issue properly belongs) (Hipshman, 1987). Vital in this aspect of forensic medicine – the application of medical expertise and experience to help resolve legal issues – are the clinician's notes in the patient's record (Farnsworth, 1989). Gutheil and Bursztajn (1986) counsel their psychiatric colleagues to anticipate the possibility that a patient's mental capacity may become an issue, and to document thoroughly the clinical determinants (i.e., the facts) supporting the clinician's view regarding capacity or incapacity. Consultations concerning the patient's capacity with family, treatment and forensic specialists, and other professional staff who have contact with the patient also should be documented in the patient's chart.

Leading forensic psychiatrists and psychologists emphasize the value of clinician (especially psychiatrist/attorney collaboration on difficult capacity assessment cases (Appelbaum & Grisso, 1988). For Gutheil et al., (1987), the attorney as an advocate focusing on short-term rights and the clinician as an expert investigator and therapist concentrating on long-term benefits make a powerful and constructive team. Moreover, the clinician has an essential role in educating institutional attorneys and the courts about clinical issues and in employing attorneys in the presentation of clinically probative evidence (Gutheil & Bursztajn, 1986).

CONCLUSION

A legally and clinically usable definition of decisional competence that is both sufficiently specific to avoid false positives and broad enough to avoid false negatives is probably impossible; some clinical and judicial leeway is both inevitable and desirable (Mahler & Perry, 1988). Moreover, a determination of clinical capacity or legal competence does answer the more important question of what particular choice ought to be made by or for the patient. Nonetheless, the assessment of capacity is a vital threshhold issue for those concerned about decisionmaking by and for older persons, the extent of individual autonomy versus protectionism, and the implications of substitute decisionmaker involvement. The type of medical and legal literature reviewed in this article will continue to grow, based on clinical experience, empirical investigation, and philosophical and legal analysis, as commentators continue to identify and flesh out the common threads discussed above.

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Advocacy for The Mentally Impaired Elderly: A Case Study Analysis*

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Marshall B. Kapp***

The authors present a case study to illustrate how a mentally impaired but socially intact nursing home resident, who had no one to act as an advocate for her, was denied appropriate treatment for an acute illness which ultimately resulted in her death. The case raises important questions about advocacy for the mentally-impaired, acutely-ill institutionalized patient. This Article explores the role of the advocate, how advocates are selected, what qualities and talents they should possess, and what responsibilities should be assigned to them. The authors suggest that nursing home residents should be encouraged to engage in self-advocacy to the greatest extent possible. The competent elderly should be urged to name their preferred advocates. Individuals who serve in advocacy roles should be advised to seek information regarding the patient's wishes from those who know the patient well. Furthermore, there is a need for quality education and training of those who serve in advocacy roles on behalf of nursing home residents, and state laws need to specify the responsibilities of persons who serve as advocates.

Advances in biomedical science during the past few decades have increased the ability of physicians to treat illness and to prolong life. In the past, patients who contracted an acute illness were treated as aggressively as possible.[1] As biomedical science has advanced, however, situations that were once a matter of fate have now become a matter of human decision. It has become increasingly apparent that prolonging life may have both positive and negative consequences for health care providers, patients, their families and society. In response to unprecedented technological advances, health care professionals, philosophers,

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[1] D. CRANE, THE SANCTITY OF SOCIAL LIFE: PHYSICIANS TREATMENT OF CRITICALLY ILL PATIENTS (1975).

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ethicists, lawyers and policy makers are endeavoring to develop policies and guidelines to establish whether decisions to treat or not to treat certain patients are legal, ethical, economically feasible and humane.[2]

The use of life-sustaining technology, such as mechanical ventilation, dialysis, nasogastric tube feedings, cardiopulmonary resuscitation and the use of life-sustaining antibiotic therapy affects all age groups. The elderly are most often the focus of discussions regarding life-sustaining technology. As people live longer, often to a very old age, they acquire multiple chronic diseases that may afflict them for decades, resulting in mental and physical disabilities that require ongoing long term care. These disabilities are a burden for the chronically-ill individual, the individual's family and society.

In 1980 there were 25.9 million people over the age of sixty-five, comprising 11.1% of the population. By the year 2000, there will be 36.3 million Americans over the age of sixty-five, comprising 13.2% of the population, and projections indicate that by the year 2040, 67.3 million persons, or 20.5% of the population, will be over the age of sixty-five.[3] Furthermore, there has been a tremendous increase in those who are seventy-five years of age or older. In 1975, 38% of the elderly were seventy-five or older, and it is predicted that by the year 2000, 45% of the elderly population will be over the age of seventy-five.[4] These statistics are significant because the incidence of two of the most prevalent forms of dementia, Alzheimer's disease and multi-infarct dementia, increases with age. It has been estimated that between 10% and 18% of all persons sixty-five years of age and older suffer from some form of dementia, and that between 15% and 20% of those who are eighty years and older will be cognitively impaired.[5]

Cognitive impairment often precipitates institutionalization. It has been estimated that about 50% of nursing home residents have some degree of mental impairment.[6] When many of these patients become ill, they are dependent upon others to make decisions regarding treatment.

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[2] HASTINGS CENTER REP., GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING (1987)[hereinafter GUIDELINES]; U.S. CONG., OFFICE OF TECH. ASSESSMENT, LIFE-SUSTAINING TECHNOLOGIES AND THE ELDERLY (July 1987)[hereinafter LIFE-SUSTAINING TECHNOLOGIES]; PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROB. IN MED. & BIOMED. BEHAVIORAL RES., DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT (1983) [hereinafter PRESIDENT'S COMM'N].

[3] Rice & Feldman, *Living Longer in the United States: Demographic Changes and Health Needs of the Elderly*, 61 MILBANK MEM. FUND Q. HEALTH & SOC'Y, 362 (1983).

[4] NATIONAL INST. ON AGING, OUR FUTURE SELVES: A RESEARCH PLAN TOWARD UNDERSTANDING AGING (1978).

[5] *See* Jarvik, *Diagnosis of Dementia in the Elderly: A 1980 Perspective*, 1 ANNUAL REV. GERONTOLOGY & GERIATRICS 80 (1980).

[6] C. JOHNSON & L. GRANT, THE NURSING HOME IN AMERICAN SOCIETY (1985).

One way for patients to maintain some control over the decision-making process, even after the onset of cognitive impairment, is for them to state clearly in advance what they would want should they become incapacitated. This process, called "advance directives," has been discussed extensively in the medical, legal and ethical literature and in recently published reports.[7] An advance directive is a written document from a mentally competent person regarding decisions about future medical treatment in the event he or she should become incapable of making decisions.

There are two types of advance directives: a treatment directive and a proxy directive. In a treatment directive, such as a living will, people can identify those treatments they wish to receive or forego should they become irreversibly unconscious or severely impaired mentally, and critically ill. In preparing a proxy directive, people identify a surrogate to make decisions on their behalf should they become incapable of doing so themselves.[8] In some settings, such as skilled nursing facilities, one seldom finds advance directives. The wishes of a mentally impaired nursing home patient are rarely known; typically, physicians rely upon the next of kin when a medical crisis occurs. Health care professionals often assume, logically, that family members are the most concerned about the patient and the most knowledgeable about the patient's values, wishes and preferences. In some instances, however, this is not true.

I. THE RESEARCH STUDY

The case study presented here was part of a larger research project that investigated the sociocultural factors and other circumstances most likely to influence the evaluation and treatment of acute illness in nursing homes. The investigators gathered data over a period of eighteen months in three nursing homes in a west coast urban area. They used three research strategies to obtain data: participant observation, in-depth interviews with nursing home residents, their families, nursing staff and physicians (100 in each category), and event analysis. During the course of one year, the investigators followed 215 residents who developed acute illnesses, describing in detail the medical management of each case. The findings disclosed that in most cases patients were treated actively when an acute illness occurred. In some instances, however, factors such as the patient's mental status, the cost of care, the patient-doctor relationship, the presence or absence of families and the

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[7] *See* GUIDELINES, *supra* note 2, at 78-84; LIFE-SUSTAINING TECHNOLOGIES, *supra* note 2; PRESIDENT'S COMMISSION, *supra* note 2, at 136-53, 193, 309-87, 389-437.

[8] For a full discussion of advance directives, see GUIDELINES, *supra* note 2, at 78-84.

attitudes and beliefs of health care providers influenced the decisionmaking process.

The purpose of this Article is to present a case study illustrating how the interaction of these variables influenced the decisionmaking process when a patient developed an acute infection, and to discuss the issue of advocacy for mentally impaired, acutely-ill nursing home residents.

The Case Study

Mrs. S was an eighty-five year old Caucasian woman who had been in a nursing home for four years. She was a widow with one son who lived in a nearby suburb. Mrs. S was admitted to the nursing home with a diagnosis of Alzheimer's disease, arthritis and hypothyroidism. Despite the diagnosis of Alzheimer's disease, she was active socially and functionally independent. Mrs. S regularly participated in the social activities in the nursing home; she enjoyed outings and had developed a close friendship with a male patient with whom she had lunch daily. Mrs. S was able to walk without help, needed minimal assistance with personal grooming, was continent of bowel and bladder, could carry on a conversation with others and was generally alert but confused at times.

On Saturday, September 5, Mrs. S's condition suddenly changed. She complained of a sore throat and demonstrated her discomfort by placing her hand on the right side of her neck. It was difficult for her to talk and swallow, and she could take only a small amount of food and liquids. At 2:00 p.m., the nurse left a message at her personal physician's office notifying him that Mrs. S had a fever of 100 degrees Fahrenheit.[9] The physician ordered that she be given two hundred fifty milligrams of Erythromycin four times a day for six days. By 10:00 p.m., Saturday, Mrs. S was restless; her temperature was 103 degrees. Her attending physician was not available. An on-call physician was therefore notified of the rise in temperature. He ordered that she be given ten grains of Tylenol orally every four hours. On Sunday, September 6, Mrs. S refused breakfast; she took only a few sips of juice, saying she could not swallow because her throat hurt. She was unable to swallow her medication, and her temperature was 102 degrees. At 12:00 p.m. on Monday, September 7, the nurses noted that Mrs. S was short of breath. They tried to encourage her to drink, but again she stated, "I just cannot swallow — my throat." At 1:30 p.m., they informed the doctor of Mrs. S's declining condition. He advised the nurses to encourage her to drink, and said he would be in to see her the following day. Mrs. S refused food throughout the day. At 6:40 p.m.

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[9] For the sake of brevity, all temperatures referred to in this paper will be stated in degrees Fahrenheit. Due to the patient's condition, all temperatures were taken rectally.

the nurses again called the doctor to notify him that Mrs. S had not eaten, that she was restless, and that her chest was congested. At this point, the physician left an order for Mrs. S to be transferred to an acute care hospital. Five minutes later, however, the doctor called back and cancelled the order for transfer, saying the family did not agree to the move. At this time the doctor ordered that she be given four milligrams of morphine sulfate intramuscularly when necessary to ease her pain. He also stated that the nurses were not to perform cardiopulmonary resuscitation, that they were not to transfer Mrs. S to another facility, and that they were to continue administering Erythromycin in liquid rather than tablet form.

On Tuesday, September 8, Mrs. S had a fever of 101 degrees, she refused all meals and was taking fluids poorly. Her personal physician saw her in the morning, and the family was again notified of her condition. On the following day, Mrs. S could take only a few sips of liquids and purulent secretions were draining from her mouth. The nurses again notified the doctor of her condition and asked if he had tried calling the family regarding transfer of Mrs. S to an acute hospital. The doctor reaffirmed the family's wishes, saying they did not want to do anything "heroic" for Mrs. S. He left an order for the nurses to obtain a culture of the secretions that were draining from her mouth on the following morning. Mrs. S had a fever of 101.2 degrees. The nurses attempted to call her son, but were unable to reach him, so they left a message on his telephone answering machine.

On Thursday, September 10, the nurses requested a dental consultation by the on-call dentist. He looked in her mouth and said, "It is not a tooth, but this lady is very sick." Mrs. S could not swallow the liquid Erythromycin. The nurses therefore called the physician to notify him of the situation. The doctor cancelled the order for the liquid Erythromycin and ordered 1,800,000 units of Penicillin G intramuscularly every eight hours for four days. He also ordered the nurses to place warm compresses to the right side of Mrs. S's face every eight hours. Finally, he asked the nurses to call him on the following Monday to inform him of her condition.

The research staff could not be in this particular nursing home every day to collect data. Two research assistants were in each of the three facilities three to four times a week. The project director and the principal investigator, Dr. Kayser-Jones, rotated among the three facilities. It was on the evening of Wednesday, September 9, that members of the research staff first became aware of Mrs. S's condition. A research assistant (R.A.) went to the nursing home and asked if there were any patients who had been ill during the past few days. The social worker at the nursing home told the R.A. about Mrs. S. The social worker was upset because the patient had not been transferred to an acute hospital. When the R.A., a doctoral nursing student, saw Mrs. S, she was in a septic condition. The R.A. asked the charge nurse why they had neither started an intravenous solution in order to hydrate Mrs. S nor administered antibiotics. The nurse replied that the family did not want "heroic measures" taken; they merely wanted Mrs. S to be kept comfortable.

The R.A. noted that Mrs. S was in a semi-comatose condition. She called Dr. Kayser-Jones, who went to see Mrs. S the following morning. Dr. Kayser-Jones was shocked when she saw her. Mrs. S did not respond to verbal stimuli; the right side of her face was greatly swollen and she appeared to be in pain. This situation presented an ethical dilemma for Dr. Kayser-Jones, who is a health care professional as well as a research scientist. As a general rule, the research scientist should not intervene because this changes the "natural situation;" a posture to be avoided.[10] Yet, because of Dr. Kayser-Jones' clinical knowledge, she felt that Mrs. S needed further treatment.

Although she felt some responsibility for the patient, Dr. Kayser-Jones was also aware that if she became too involved and the nursing home staff saw her intention as inappropriate or threatening, they might ask her to leave the setting. This would have had grave consequences on the research project.

Bearing this in mind, Dr. Kayser-Jones decided that because Mrs. S was critically ill with an apparently treatable illness, she would attempt to intervene. She approached the Director of Nursing Service and inquired about the management of Mrs. S's case. She pointed out that Mrs. S was gravely ill. The Director replied that the family did not want Mrs. S transferred to the acute hospital, and that, in fact, the family did not want her to live. Dr. Kayser-Jones then asked, "When the family is not an advocate for the patient, is there anything you can do?" The Director, though somewhat annoyed by these questions, followed Dr. Kayser-Jones' suggestion and agreed to call the Medical Director of the nursing home. The Medical Director was reluctant to intervene. He

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[10] Research investigators who are also health care professionals may experience role conflict and ethical dilemmas for several reasons. First, the role of the investigator is complicated because she brings to the research setting some degree of professional expertise and a set of values and expectations of herself and of other health care providers. The investigator is aware of the clinical problem, can evaluate the care, and has some knowledge of the consequence of taking or not taking action in a given situation. Second, because the investigator is identified as a health care professional as well as a research scientist, other health care workers, patients, and their families may have certain expectations of her. Third, health care professionals are bound by a professional code of ethics. These codes, although unique to each profession, state the fiduciary principle that the professional must act to safeguard the patient at all times.

agreed, however, to call and discuss the case with the attending physician.

On Friday, September 11, six days after the onset of the infection, the staff nurse again called the attending physician and persuaded him to let her start an intravenous solution of 1000 cc. of 5% Dextrose in water at 50 milliliters per hour. By this time, the patient's condition was critical. About two hours after the intravenous solution was administered, she died.

Following the patient's death, the researchers interviewed the nursing staff, the attending physician, and Mrs. S's son in an attempt to obtain more information about the case and the decisionmaking process. When interviewing the nursing staff, the researchers learned that the staff's primary concern was the possibility of litigation. The nursing staff felt confident, however, that in this case they would not have to worry about a lawsuit because Mrs. S's family did not care for her. The attending physician stated that he thought the patient had parotitis, and that initially he felt she should be transferred to an acute care hospital. He spoke with the son, however, who said that his mother no longer recognized him. Further, the son remarked that his mother was "just sort of existing" and that there was "nothing to save." The doctor, therefore, made no attempt to persuade the son to transfer Mrs. S to an acute care hospital for treatment. The nurses reported that the son had not visited his mother during the past two or three years, and he did not visit during the acute illness episode.

When Dr. Kayser-Jones reached the son by telephone, he stated that he was extremely busy and gave brief responses to questions. He said that his mother had a total loss of memory, was not functioning well, and that the family wanted her to be comfortable, but that they did not want anything "elaborate" done. Further, the family did not want Mrs. S to be transferred to an acute care hospital "unless it was absolutely necessary."

In this case, neither the health care providers nor the family advocated on behalf of this mentally impaired, but socially intact, elderly woman. No one took the action necessary to save her life, and she died of an apparently treatable infection. This case raises many important questions about advocacy for those acutely ill institutionalized patients who are mentally disabled and need someone to act on their behalf.

II. ADVOCACY — RAISING THE SUBJECT

Cases like that of Mrs. S have generated a great deal of interest among health care practitioners and scholarly commentators concerning the legal and ethical criteria and procedural requirements for protecting the rights of nursing home residents in the realm of medical treatment.[11] Some commentators have also considered the related question of who should make treatment decisions on behalf of residents based on these substantive criteria and according to these procedures.[12]

Resident rights, whether in the area of medical decisionmaking or elsewhere, do not simply "happen" automatically. We live in what has been termed a "claim-based"[13] society, in which individual rights usually must be asserted affirmatively before they are respected and acted upon. The concepts of self-advocacy and individual empowerment[14] are commendable as far as they go. Nonetheless, many nursing home residents need the assistance of others as advocates on their behalf, particularly those who are mentally or physically debilitated to the point that they cannot carry out or enforce personal decisions.[15]

We have assumed that the individual or entity who is empowered to make substitute decisions on behalf of a resident also functions in the role of resident advocate, almost by definition. The purpose of this discussion is to question this reflex assumption, and to suggest that the separate duties of the substitute decisionmaker, who must balance the resident's rights and preferences against other possibly legitimate competing interests, and the advocate, who must be solely loyal to the resident's wishes, may form a tension that compels that separate individuals or entities occupy these roles.

The nature of advocacy in the context of acute medical treatment decisionmaking in a long term care institution raises a number of questions: (1) Who should advocate on behalf of the nursing home resident who is incapable of unassisted self-advocacy and, specifically, should the advocate be someone different than the substitute decisionmaker? (2) How should the advocate be selected? (3) What special blend of qualities or talents are desirable in the advocate? (4) What training or experience should the ideal advocate possess? (5) What responsibili-

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[11] *See generally* Uhlmann, Clark, Pearlman, Downs, Addison & Haining, *Medical Management Decisions in Nursing Home Patients: Principles and Policy Recommendations*, 106 ANNALS INTERNAL MED. 879 (1987); Rango, *The Nursing Home Resident with Dementia: Clinical Care, Ethics, and Policy Implications*, 102 ANNALS INTERNAL MED. 835 (1985); PRESIDENT'S COMM'N, *supra* note 2, at 108-11.

[12] *See, e.g.*, Alessandroni, *Who Decides for Patients Who Can't?* 8 GENERATIONS 27 (1984).

[13] Cohen, *Nursing Homes and the Least-Restrictive Environment Doctrine*, in LEGAL AND ETHICAL ASPECTS OF HEALTH CARE FOR THE ELDERLY 173, 177-78 (M. Kapp, H. Pies & A. Doudera eds. 1986).

[14] *See, e.g.*, Clark, *Individual Autonomy, Cooperative Empowerment, and Planning for Long-Term Care, Decision Making*, 1 J. AGING STUDIES 65 (1987); Clark, *Autonomy, Personal Empowerment, and Quality of Life in Long-Term Care*, J. APPLIED GERONTOLOGY (In Press).

[15] Hoyt & Davies, *Meeting the Need for Clear Guidelines: Protecting Vulnerable Adults from Improper Limitation of Medical Treatment in Institutions*, in 4 LAW & INEQUALITY 355 (1986); Jost, *The Problem of Consent for Placement Care and Treatment of the Incompetent Nursing Home Resident*, 26 ST. LOUIS U.L.J. 63 (1981).

ties should be assigned to, and powers authorized for, the advocate? (6) What compensation, if any, should be paid to the advocate, and by whom? and (7) What standards of performance and means of accountability should be imposed on the advocate?

A. The Need to Inquire

The notion that these questions are either academic or that they have simple solutions should be dispelled. First, it has been argued that much attention has already been focused on nursing home advocacy. Examples include: 1) the establishment in some states of a patient advocate office by legislative action;[16] 2) the Older Americans Act nursing home ombudsmen program;[17] 3) legal services programs for the elderly funded under the Older Americans Act;[18] and 4) the Legal Services Corporation.[19] This attention, however, has primarily concerned matters other than acute medical decisions. Advocacy involving everyday living issues, such as public benefits, freedom to join and participate in resident councils, the right not to be transferred or discharged involuntarily, decent institutional conditions, access to visitors, and the like, may entail quite different talents and responsibilities than advocacy in the acute medical care arena. Similarly, advocacy efforts targeted specifically at the mentally disabled[20] are limited to what they can teach us about acute medical decisionmaking.

Second, one might surmise that, with the legislative[21] and judicial[22] trend toward the "substituted judgment"[23] rather than the "best

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[16] Opperman, *Michigan's Bill of Rights for Nursing Home Residents*, 27 WAYNE L. REV. 1203 (1981).

[17] 42 U.S.C. § 3030d (a)(10) (1987). For a general description of the nursing home ombudsman program, see A. MONK, L. KAYE & H. LITWIN, RESOLVING GRIEVANCES IN THE NURSING HOME: A STUDY OF THE OMBUDSMAN PROGRAM (1984). *Cf.* Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997 (1982).

[18] 42 U.S.C. § 3030d (a)(6) (1987).

[19] *See generally* Nathanson, *Legal Services for the Elderly*, in ENCYCLOPEDIA OF AGING 381 (G. Maddox ed. 1987).

[20] For a discussion regarding advocacy efforts targeted at the mentally disabled, see generally S. HERR, RIGHTS AND ADVOCACY FOR RETARDED PEOPLE (1983); Luckasson & Ellis, *Representing Institutionalized Mentally Retarded Persons*, 7 MENTAL DISABILITY L. REP. 49 (1983); Mickenberg, *The Silent Clients: Legal and Ethical Considerations in Representing Severely and Profoundly Retarded Individuals*, 31 STAN. L. REV. 625 (1979); Wilson, Beyer & Yudowitz, *Advocacy for the Mentally Disabled*, in NATIONAL INST. OF MENTAL HEALTH, MENTAL HEALTH ADVOCACY: AN EMERGING FORCE IN CONSUMERS RIGHTS (L. Koplow & H. Bloom eds. 1978); *see also* 42 U.S.C. §§ 6012 (protection and advocacy system for the developmentally disabled), 9501 (protection and advocacy system for mentally ill persons)(1982).

[21] *See, e.g.*, Steinbrook & Lo, *Decision Making for Incompetent Patients by Designated Proxy: California's New Law*, 310 NEW ENG. J. MED. 1598 (1984)(discussing California's Durable Power of Attorney for Health Care Act, which explicitly requires the agent to decide as the principal would have decided if capable).

[22] *See, e.g.*, Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 497 N.E.2d 626 (1986).

interests"[24] standard for proxy decisionmaking, the proxy who is deciding on the resident's behalf should naturally occupy the role of advocate. This assumption is questionable on at least two grounds. Substituted judgment does not help resolve what should be done when the resident's earlier wishes are unknown. In such cases, the advocate, whether he or she acknowledges it openly or not, has no alternative but to choose a specific bias.[25] Even where the resident's earlier preferences are known, proxy decisionmakers who choose to ignore those wishes — out of love, greed, spite or guilt — are effectively unaccountable.[26] In either circumstance, an advocate, who may or may not be identical to the proxy decisionmaker, is called for.

Third, some may point to the growing acceptance of Institutional Ethics Committees (IECs)[27] in long term[28] as well as acute health care facilities as creating a forum for discussing and resolving difficult treatment dilemmas, and therefore obviating the need for resident advocacy. Precisely the opposite is true; the proliferation of a new type of forum creates, instead, one more place where, and one more audience before whom, the resident's rights need to be asserted.

Thus, the questions posed above concerning advocacy for nursing home residents are substantial and difficult. The most fundamental of these questions, and the one from which answers to the other will proceed, is addressed next.

B. WHO SHOULD ADVOCATE?

There are several candidates for the role of the nursing home resi-

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[23] Under the "substituted judgment" standard, the proxy decisionmaker is expected to "don the mental mantle" of the incompetent patient, to decide as the patient would have decided if, for one magic moment, the incompetent person were suddenly competent again. Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, 752, 370 N.E.2d 417, 431 (1977).

[24] Under the "best interests" standard, the proxy decisionmaker decides to pursue that course that the proxy believes to serve and protect the best interests of the incompetent patient. *See* PRESIDENT'S COMMISSION, *supra* note 2, at 134. For a critique of the substituted judgment/best interests distinction, see Guthiel & Appelbaum, *Substituted Judgment: Best Interests in Disguise*, 13 HASTING CENTER REP. 8 (1983).

[25] Certainly, some judicial precedent exists for the purported use of substituted judgment even where the patient's own autonomous wishes are not — and could not — be known. For example, the Massachusetts courts have set forth factors to be considered in making such judgments. *See* Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, 735, 370 N.E.2d 417, 422 (1977); *In re* Hier 18 Mass. App. 200, 209, 464 N.E.2d 959, 964 (1984).

[26] *See, e.g.*, Solnick, *Proxy Consent for Incompetent Non-Terminally Ill Adult Patients*, 6 J. LEGAL MED. 1 (1985).

[27] *See generally* B. HOSFORD, BIOETHICS COMMITTEES: THE HEALTH CARE PROVIDER'S GUIDE (1986); INSTITUTIONAL ETHICS COMM. & HEALTH CARE DECISION MAKING (R. Cranford & A. Doudera eds. 1984).

[28] *See* Weisman, *A Nursing Home's Experience with an Ethics Committee*, 29 NURSING HOMES, Sept.-Oct. 1980, at 2; *see also* M. KAPP, PREVENTING MALPRACTICE IN LONG-TERM CARE: STRATEGIES FOR RISK MANAGEMENT 158-61 (1987).

dent's advocate. Different candidates, or combinations of them, may be more or less appropriate for different residents in different circumstances.[29] We move first to identify the characteristics of the "ideal" nursing home resident advocate for medical decisionmaking purposes, so that we may then proceed to compare each option against that standard.

The most cogent statement of the ideal qualities of a medical decisionmaking advocate may be adapted from an article[30] recently cited by the Congressional Office of Technology Assessment in its comprehensive report, *Life-Sustaining Technologies and the Elderly*.[31] This statement originally referred to surrogate decisionmakers and to contexts other than long term care for the elderly. It is also instructive when considering resident advocacy within such a setting. These ideal qualities were identified as follows: (a) the advocate should have no conflict of interest or should be able to overcome any conflict of interest; (b) the advocate should have the capacity to participate in and contribute to the decisionmaking process in an informed and conscientious manner, with the assumption that adequate information is provided to the advocate; and (c) the advocate should have the ability to act on behalf of the resident's interests and preferences throughout the decisionmaking process.[32]

1. Naming a Decisionmaker Ahead of Time

The most obvious and least controversial potential advocate would be a person explicitly named for that purpose ahead of time by the resident while still mentally competent.[33] Such a designation could occur through an advance planning document like a durable power of attorney for health care, which, as noted earlier, is frequently referred to as a proxy directive.[34] A living will, although usually conceived of as an instrument directing specific treatment or non-treatment, may also be

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[29] *See, e.g.*, Veatch, *Limits of Guardian Treatment Refusal: A Reasonableness Standard*, 9 AM. J.L. & MED. 427 (1984)(discussing the proper role of health professionals, hospital ethics committees and courts in the decisionmaking process).

[30] Capron, *Authority of Others to Decide About Biomedical Interventions With Incompetents*, in WHO SPEAKS FOR THE CHILD? THE PROBLEMS OF PROXY CONSENT (W. Gaylin & R. Macklin eds. 1982).

[31] LIFE-SUSTAINING TECHNOLOGIES, *supra* note 2, at 110.

[32] *Id.* at pp. 133-37 (citing Capron, *Authority of Others to Decide About Biomedical Interventions with Incompetents*, in WHO SPEAKS FOR THE CHILD? THE PROBLEM OF PROXY CONSENT (W. Gaylin & R. Macklin eds. 1982)).

[33] For definitions of decisionmaking mental competence, see, e.g., Culver, *The Clinical Determination of Competence*, in LEGAL AND ETHICAL ASPECTS OF HEALTH CARE FOR THE ELDERLY 277 (M. Kapp, H. Pies & A. Doudera eds. 1986).

[34] *See, e.g.*, F. COLLIN, J. LOMBARD & A. MOSES, DRAFTING THE DURABLE POWER OF ATTORNEY: A SYSTEMS APPROACH (1984); Note, *Appointing an Agent to Make Medical Treatment Choices*, 84 COLUM. L. REV. 985 (1984).

used as a proxy directive.[35] Although durable powers of attorney and living wills ordinarily designate persons to act as the substitute decisionmaker, once the resident has become mentally incompetent, there is no reason that they could not simultaneously be utilized to name the resident's advocate. If these documents were specific enough, then the advocate and the substitute decisionmaker might be the same person. The central point is that the resident's autonomous wishes would rule on this matter.

Most nursing home residents, however, have neither the foresight, nor family support, nor professional guidance[36] to plan ahead in this fashion while they are still competent. Furthermore, an increasing number of elderly people do not have family members or friends who are willing and able to undertake the proxy or advocate roles.[37] Additionally, a small but significant percentage of nursing home residents, for example, those who are severely or profoundly mentally retarded, have never possessed sufficient mental capacity to make and express autonomous choices on matters of this importance.[38]

2. Family

In the absence of an available advocate explicitly designated by the resident while still competent, the next natural choice for the advocacy role would be members of the resident's own family. While deference to family wishes has been traditionally more a matter of medical custom than clear legal authority,[39] the law has begun to recognize the family's legitimate proxy decisionmaking power in both statutes and judicial decisions.[40] There is a natural tendency to assume that the family will take on the advocacy role in like fashion.

There are some problems, however, with this assumption. As

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[35] For a listing of state statutes permitting living wills to be used as proxy directives, see SOCIETY FOR THE RIGHT TO DIE, THE PHYSICIAN AND THE HOPELESSLY ILL PATIENT: LEGAL, MEDICAL AND ETHICAL GUIDELINES 25 (1985).

[36] For a discussion of the health care professional's role in helping patients to do advance planning, see generally Schneiderman & Arras, *Counseling Patients to Counsel Physicians on Future Care in the Event of Patient Incompetence*, 102 ANNALS INTERNAL MED. 693 (1985); Uhlmann, Clark, Pearlman, Downs, Addison & Haining, *supra* note 11, at 882-84.

[37] *Cf.* Wingard, Jones & Kaplan, *Institutional Care Utilization by the Elderly: A Critical Review*, 27 GERONTOLOGIST 156, 161 (1987)(availability of caregivers reduces risk of institutionalization).

[38] *See, e.g.*, Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); *see also In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 54 (1981)(involving decisionmaking for a profoundly retarded man in a non-nursing home environment); *In re* Hier, 18 Mass. App. 200, 464 N.E.2d 959 (1984)(nursing home resident with a long history of mental illness).

[39] *See* Areen, *The Legal Status of Consent Obtained from Families of Adult Patients to Withhold or Withdraw Treatment*, 258 J. AM. MED. ASS'N 229 (1987).

[40] *Id.*; Comment, *The Role of the Family in Medical Decisionmaking for Incompetent Adult Patients: A Historical Perspective and Case Analysis*, 48 UNIV. PITT. L. REV. 539 (1987).

noted above, an increasing percentage of nursing home residents lack capable and available family members to act in this capacity. Even where family members are present, however, their financial or emotional interests may conflict — consciously or subconsciously — with the preferences and best interests of the resident.[41] In the case of Mrs. S, for example, for some unknown reason, her son did not act in her best interests. Potential conflicts of interest lead some to question the propriety of designating the family as substitute decisionmaker for an incapacitated resident.[42] It is surely more of a concern in cases in which the family is disposed to act against the best interests of the resident, as in the case of Mrs. S.

3. Ombudsman

Many will suggest that the nursing home ombudsman program created in 1978 under the Older Americans Act[43] is the appropriate apparatus for fulfilling the advocacy role. Under this program, each state Office on Aging is required, as a condition of receipt of federal aging program funds, to administer a nursing home ombudsman program to assist nursing home residents with disputes and daily problems encountered in living within a nursing home.[44] Most states accomplish this indirectly by funding a number of local ombudsman programs.

The ombudsman program has the appeal of relying on an already established apparatus, avoiding the necessity of creating some new bureaucracy. The New Jersey Supreme Court succumbed to this appeal in *In re Conroy*,[45] which involved the removal of artificial feeding tubes from an elderly, mentally incompetent and physically debilitated nursing home resident. The court ordered that the state nursing home ombudsman's office investigate, in advance, every proposed medical treatment removal, including the removal of an artificial feeding tube, from an elderly, mentally incompetent nursing home resident, to determine whether that resident was expected to die, with or without treatment, within a year.[46] Furthermore, the office was to begin each

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[41] For cases explicitly stating that families must act in good faith, see Barber v. Superior Ct., 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983); Foody v. Manchester Mem. Hosp., 40 Conn. Supp. 127, 482 A.2d 713 (1984); John F. Kennedy Mem. Hosp. v. Bludworth, 452 So. 2d 921 (Fla. 1984).

[42] *See* Baron, *The Case for the Courts*, 32 J. AM. GERIATRICS SOC'Y 734 (1984); Marzen, *Medical Decisionmaking for the Incompetent Person: A Comprehensive Approach*, 1 ISSUES L. & MED. 293 (1986).

[43] 42 U.S.C. § 3030d (a)(10) (1987 & Supp. 1988).

[44] *See generally* A. MONK, L. KAYE & H. LITWIN, RESOLVING GRIEVANCES IN THE NURSING HOME: A STUDY OF THE OMBUDSMAN PROGRAM (1984).

[45] 98 N.J. 321, 486 A.2d 1209 (1985).

[46] *Id.* at 382, 486 A.2d at 1242.

investigation with an assumption of possible resident abuse.[47]

Although this same court loosened the rigorous role of the ombudsman in a subsequent decision,[48] the idea of assigning the ombudsman the primary advocacy responsibility in cases requiring acute medical decisionmaking remains troublesome.[49] It was an idea adopted *sua sponte* by the court, without briefing by the parties,[50] and apparently without consultation — or at least public consultation — with the ombudsman's office itself. This approach fails to grapple with several limitations of the ombudsman to perform this function optimally.

First, there may be deficiencies in experience and expertise. Most local ombudsman programs operate with a small paid professional staff and a large number of volunteers, often retirees from work backgrounds far removed from long term health and human services. The nursing home ombudsman program is intended chiefly to assist residents in resolving daily living problems, including disputes with the facility administration, and it is within this realm that these programs and their staffs have developed their greatest experience and expertise. The ombudsman programs were never intended to mediate, and therefore have developed little expertise in mediating questions involving acute medical decisions for residents.[51] Whether existing programs and their staffs can make the transition effectively from one type of

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[47] For persuasive critiques of this aspect of the *Conroy* decision, see Annas, *When Procedures Limit Rights: From Quinlan to Conroy*, 15 HASTINGS CENTER REP. 24 (1985); Curran, *Defining Appropriate Medical Care: Providing Nutrients and Hydration for the Dying*, 313 NEW ENG. J. MED. 940 (1985).

[48] *In re*, Peter, 108 N.J. 365, 529, A.2d 419 (1987)(ombudsman no longer required to refuse permission to discontinue a nursing home resident's artificial feeding just because the resident was likely to survive for more than one year with such feeding). In this case, the New Jersey nursing home ombudsman had investigated and found that all requirements set by the court in *Conroy* for removal of nasogastric feeding tubes had been met, with the exception of the provision that the individual is likely to die in one year. The ombudsman also found that Mrs. Peter and her family would want the tubes removed, but since the one year provision was not met, felt constrained to object to the guardian's request for removal. He stated:

> These findings create a dilemma with which I have to struggle . . . . On the other hand, my role as ombudsman requires me to advocate for and protect the patient's rights and interests. I am convinced in this case that Hilda Peter would not have wanted to continue life in this way, and were she competent, her right to chose would be respected.

Sullivan, *Ombudsman Bars Removal of a Feeding-Tube in Jersey*, N.Y. Times, Mar. 7, 1986, at B2, col. 1.

[49] Broderick, *One-Legged Ombudsman in a Mental Hospital: An Over-the-Shoulder Glance at an Experimental Project*, 22 CATH. U.L. REV. 517 (1973).

[50] *See* Society for the Right to Die, *Brief of Amicus curiae — Brophy v. New England Sinai Hospital, Inc.*, 35 J. AM. GERIATRICS SOC'Y 669 (1987).

[51] *See* 42 U.S.C. § 3030d(a)(10)(stating the original purpose of the nursing home ombudsman was to "receive, investigate, and act on complaints . . . and to advocate for well being of residents).]

problem solving to the role of medical decisionmaking advocacy is questionable. Of course, other potential judicially-assigned advocates would face the same difficulty in adjusting to this role.

Second, assuming that existing ombudsman programs and staffs are adequate for the task in terms of professional experience and expertise, there remains the question of adequate funding. A major additional responsibility of this magnitude will require an infusion of funds to enable necessary expansion, training, and support services to take place. Historical precedent amply demonstrates that assigning new and ambitious responsibilities to public agencies in the absence of adequate financial backing dooms those agencies to an unacceptable level of performance.[52] An additional complication is that the judiciary, which might assign the ombudsmen's office the medical advocacy role,[53] is without power to authorize or appropriate funds to support that role. Developments in analogous areas, such as litigation involving conditions in mental health and retardation facilities demonstrate the difficulty in coaxing funds from state legislatures to fulfill judicial mandates, even those with constitutional basis.[54] One possible way around this separation of powers problem would be to have the legislature or executive branch, rather than the judiciary, assign the ombudsman an advocacy role.

Finally, the orientation of the nursing home ombudsman program must be defined much more precisely if we are to consider seriously assigning it the role of advocacy for medical treatment decisions. Studies show that different programs currently function under quite distinct philosophical and operational orientations, ranging from conciliatory mediation to strident adversarialism.[55] The strong pro-resident bias that is imperative for the medical decision advocate may or may not be the most appropriate bias for a program charged with helping residents, facilities, and other agencies to mediate peacefully and resolve potential disputes among them. In any event, the ombudsman program should be clear both internally and publicly about its biases before taking on responsibilities like medical decisionmaking advocacy.[56]

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[52] *Cf.* Brown, *Public Hospitals on the Brink: Their Problems and Their Options*, 7 J. HEALTH POL., POL'Y & L. 927 (1983).

[53] *See, e.g.*, *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).

[54] Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972).

[55] Litwin, Kaye & Monk, *Conflicting Orientations to Patient Advocacy in Long-Term Care*, 24 GERONTOLOGIST 275 (1984); Monk & Kaye, *The Ombudsman Volunteer in the Nursing Home: Differential Role Perceptions of Patients' Representative for the Institutionalized Aged*, 22 GERONTOLOGIST 194 (1982).

[56] *See* Rengo, *The Double-Edged Sword of Nursing Home Advocacy*, in PUBLIC CONCERNS, COMMUNITY INITIATIVES: THE SUCCESSFUL MANAGEMENT OF NURSING HOME COMMUNITY INFORMATION PROGRAMS 18-20 (C. Ewig & J. Grigg eds. 1985)(discussing the three crucial duties of the

4. Guardians Ad Litem

Should the courts appoint guardians ad litem[57] to carry out the advocacy function on behalf of nursing home residents who cannot speak autonomously for themselves and about whom acute medical treatment decisions must be made? This approach embodies what is perceived by some to be the virtue of judicial involvement in the selection of a relevant actor and continuing judicial oversight over the actor's performance.[58]

Extensive court involvement in these highly personal and emotional decisions, with the concomitant financial expense, time commitment, and physical and psychological strain, is precisely what many practitioners and commentators would find objectionable about routine reliance on formally appointed guardians ad litem.[59] There is also the question of who would serve as guardians ad litem for medical decisionmaking purposes, and what combination of experience and expertise would be desirable for this new class of human service provider. Should we give preference as guardians ad litem to persons who had a previous relationship with the resident, such as family and friends, or should preferences be given to strangers?[60] Neither option is ideal. In fact, many of the problems associated with finding an ideal guardian ad

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nursing home ombudsman as investigation, mediation, and information gathering); *see also* Broderick, *supra* note 47, at 530-32.

[57] BLACK'S LAW DICTIONARY 635 (5th ed. 1979)(defines "guardian ad litem" as "a special guardian appointed by the court to prosecute or defend, in behalf of an infant or incompetent, a suit to which he is a party, and such guardian is considered an officer of the court to represent the interests of the infant or incompetent in the litigation"); Baron, *Assuring 'Detached but Passionate Investigation and Decision': The Role of Guardians Ad Litem in Saikewicz-Type Cases*, 4 Am. J.L. & Med. 111 (1978).

[58] *Cf.* Baron, *supra* note 4, at 736 (arguing in support of this view that: (1) judges must make and explain decisions based on principles; (2) judicial decisions are impartial; (3) the adversary quality of the proceedings assures that all sides are considered; and (4) the public nature of the proceedings protects the patient); Solnick, *Withdrawing and Withholding of Life-Support in Terminally Ill Patients, Part II*, 4 MED. & L. 1 (1985)(arguing that to protect the incompetent patient's interest in the continuation of medically appropriate treatment and to protect the patient's right to refuse or withdraw treatment, an adversary proceeding before a court should be required by statute in order to assure that all sides of the issue are argued fully). The same arguments made in favor of court appointment of the substitute decisionmaker should apply with full force to the selection of a guardian ad litem, who is an officer of the court.

[59] *Cf.* Mariner, *Decision Making in the Care of Terminally Ill Incompetent Persons: Concerns About the Role of the Courts*, 32 J. AM. GERIATRICS SOC'Y 739 (1984)(indicating dismay over judicial involvement in life-sustaining medical treatment decisions for incurably ill patients who cannot express their own preferences, and preferring that the role of the courts be restricted to reviewing the decisionmaking of others, such as family or medical professionals, in order for there to be procedural fairness). Arguments against routine court appointment of proxy decisionmakers should apply with full force to routine appointment of resident advocates, whose very effectiveness in advocacy depends on independence.

[60] *Cf.* Veatch, *supra* note 29, at 442-49 (1984)(expressing a strong preference for the deference toward the decisions of "bonded guardians," such as those with whom the patient

litem are common to all potential advocates and decisionmakers. A previous relationship may not always have been a positive one — as in the case of Mrs. S — and family and friends, who are usually heirs to an older person's estate, may have a conflict of interest. On the other hand, a stranger who is not or has not been emotionally involved with an older person may make decisions that are not in his or her best interests. In either case, ambitious training and supervision efforts would undoubtedly be necessary.[61]

We must also ask what compensation, if any, would be paid to individuals or agencies that serve as medical treatment guardians ad litem, how that compensation would be determined in particular cases, and from what source of funds such compensation would be derived. Furthermore, the issue of continuity in advocacy must be addressed. Will the same guardian ad litem be appointed for each new set of medical decisions for a specific resident? Will the advocate be appointed instead as guardian without time limit, or will we simply dispense with continuity and have a different guardian ad litem appointed for each new set of decisions?

Finally, if we accept guardians ad litem as nursing home resident advocates regarding acute medical decisionmaking, we will need to provide some clear guidance regarding their proper orientation to, and conduct within, the advocacy role. Currently, guidance for guardians ad litem is frequently absent or confused, with disparate legislatures and courts sending mixed and garbled signals, leaving most on their own to determine whether they should be advocating in a manner consistent with the resident's best interests,[62] substituted judgment,[63] spoken choice,[64] or, instead, always in favor of maximal medical

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previously enjoyed a positive relationship, in the area of acute medical decisionmaking for incompetent patients).

[61] *Cf.* Iris, *Guardianship and the Elderly: A Multiperspective View of the Decisionmaking Process*, GERONTOLOGIST (Special Supplement)(In Press); Morrissey, *Guardians Ad Litem: An Educational Program in Virginia*, 22 GERONTOLOGIST 301 (1982). In addition, the Retirement Research Foundation, through the second phase of its initiative in "Autonomy in Long Term Care," currently is funding a project at the University of New Mexico's Institute for Public Law, to identify and train volunteers to act as guardians ad litem to fulfill the substitute medical decisionmaking role on behalf of elderly hospital patients who have no family or friends to act in the proxy capacity. *See* Retirement Res. Found., Personal Autonomy in Long Term Care Initiative Newsletter Issue 1, at 3 (Nov. 1987).

[62] On the guardian's role to advocate for the ward's best interests, see, Veatch, *supra* note 29, at 440-41; Tyson v. Richardson, 103 Wis. 397, 399, 79 N.W. 439, 441 (1899)(best interests of infant); Kingsbury v. Buckner, 134 U.S. 650, 678-81 (1890)(best interests of infant).

[63] On the guardian's role to advocate consistently with the ward's substituted judgment, see, Veatch, *supra* note 29, at 439-40. *See generally* Baron, *supra* note 42.

[64] For development of the concept of "spoken choice," see Zuckerman, *An Attorney's View*, 11 GENERATIONS 60 (1987); Zuckerman, *Conclusions and Guidelines for Practice*, 11 GENERATIONS 67 (1987).

intervention.[65]

5. Public Guardianship

A variation of this strategy might be public guardianship,[66] the utilization of a governmental agency or private agency under contract to the government to provide advocacy services to nursing home residents. A number of states have created public guardianship programs in the past decade[67] to deal with the increasingly prevalent situation of persons for whom decisions need to be made and for whom there is no suitable family member or friend available to act as a private guardian. This strategy offers the same advantages as the guardian ad litem approach, extending those advantages to residents who are without the benefit of willing and able family members and friends.

Public guardianship has the same shortcomings as the guardian ad litem approach, especially in the areas of financing and extensive court involvement. An additional problem would be the creation and maintenance of a permanent governmental bureaucracy to oversee the public guardianship function. The track record of public guardianship programs is rather mixed thus far, with the most severe criticism directed toward programs with excessive caseloads and inadequate budget appropriations.[68]

6. Resident Representative Programs

Individual nursing homes might attack the challenge of assuring appropriate advocacy for residents by creating and maintaining internal resident representative programs similar to those presently in place in many acute care hospitals.[69] Such programs offer the advantage of a permanent institutional structure, financed through the long term care

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[65] *Contra In re* Jobes, 210 N.J. Super. 543, 510 A.2d 133 (1986)(court refused to appoint a "life advocate"); Matter of Spring, 380 Mass. 629, 405 N.E.2d 115 (1980)(probate court appropriately decided that treatment should be withheld); Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977)(court applied substituted judgment standard to determine that incompetent patient, if competent, would have elected not to accept chemotherapy). For an analysis sympathetic to appointment of a mandatory pro-life guardian ad litem, see Note, *Can a 'Life Advocate' Impair the Constitutional Right to Reject Life-Prolonging Medical Treatment?*, 17 CUMBERLAND L. REV. 553 (1986-87).

[66] *See* W. SCHMIDT, K. MILLER, W. BELL & E. NEW, PUBLIC GUARDIANSHIP AND THE ELDERLY (1981); Schmidt, *The Evolution of a Public Guardianship Program*, 12 J. PSYCHIATRY & L. 349 (1984).

[67] *See, e.g.*, Cal. Prob. Code §§ 2353-2357 (West 1979 & Supp. 1989); Ill. Ann. Stat. c. 110 1/2, ¶¶ 11-3, 11-5, 11-10.1, 11-13, 13-1 - 13-5 (Smith-Hurd Supp. 1988); Me. Rev. Stat. Ann. tit. 18A, §§ 5-301 - 5-313 (West 1979 & Supp. 1988).

[68] *See* Schmidt, *supra* note 66, at 355-59.

[69] The National Society of Patient Representatives is an affiliate of the American Hospital Association. Its regular publication is *Patient Representative*. *See* NATIONAL SOC'Y PATIENT REPRESENTATIVES, PATIENT REPRESENTATION IN CONTEMPORARY HEALTH CARE (1985)(National Soc'y Patient Representatives is an affiliate of the American Hospital Association).

institution and supported by its governance, administration and professional staff. In-house resident advocates would enjoy ready access to residents and to practitioners and administrators within the nursing home. The representative could become involved in advocating for a resident on an ongoing basis, or at least very early in the medical decisionmaking process.

Many of the arguable weaknesses of hospital patient representative programs could encumber the acceptance and effectiveness of this approach in the nursing home setting. An obvious conflict of interest would exist in cases in which the representative charged with advocating on behalf of the resident is a paid employee of, and thus subject to hiring, promotion, and firing by the health care institution.[70] Resolving this issue would entail a delicate balancing of the representative's responsibilities and personal interests, and even where an acceptable accommodation could be made, skepticism about the representative's independence may persist.

Another potential problem with the internal resident representative approach revolves around the issue of expertise and experience. Patient representative programs have existed in hospitals for a long enough period of time that many people occupying that role have a high degree of relevant experience and expertise.[71] The pool of educated and knowledgeable representatives available for advocacy service within nursing homes, however, is likely to take some time to grow. Candidates for these positions will need to be trained not only in advocacy skills, but in the unique characteristics and needs of residents who reside and are treated within the long term care milieu.

Further, attention must be paid to assure that nursing homes do not budget for institutional resident representative programs out of funds that would otherwise be available for resident care. If resident representative programs are desirable enhancements to resident dignity and well-being, then the reasonable cost of such programs should be calculated into reimbursement rates paid to nursing homes by Medicare,[72] Medicaid,[73] and other third-party payers,[74] as well as into rates

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[70] On the conflict of interest tension experienced by a hospital patient representative, see S. Terkel, Working 646-47, 650 (1974).

[71] Sarah Lawrence College in Riverdale, New York offers a degree program in patient advocacy.

[72] Medicare Part A currently pays for skilled nursing facility care if it is needed on a daily basis following a hospital stay of at least three days, up to one hundred lifetime days of care. 42 U.S.C. § 1395d (a)(2)(A) (1987). Waivers of the three-day hospitalization requirement are permitted, *id.* at §§ 1395d (a)(2)(B) & (f). In 1985, Medicare paid for approximately two percent of this nation's total nursing home bill. *See* Burda, *The Nation Looks for New Ways to Finance Care for the Aged*, 61 Hosp., Sept. 20, 1987, at 48.

[73] Medicaid, the federal and state combined health care financing program for the indigent, pays for skilled nursing and intermediate care. 42 U.S.C. §§ 1396d (c), (d) & (f) (1987).

paid privately by or on behalf of residents.[75]

Finally, this approach to the advocacy challenge may be seen as the creation of a new profession, and hence a new interest group fighting for recognition, benefits and territory. This would add a further element of bureaucracy to an already overburdened — some would claim unmanageable — health care delivery system. Holders of this perspective would submit that the very virtues of this idea, a permanent, institutional cadre of professionals trained for and dedicated to a specific function, are also its most significant weakness.

7. Volunteers

Resident advocacy services could conceivably be provided by local volunteers, both individuals and volunteers provided by organizations such as churches, synagogues, or fraternal and service groups. There is a large number of intelligent, articulate, and compassionate citizens in this country, particularly the healthy elderly,[76] who might be willing to volunteer for service as nursing home resident advocates regarding medical decisions. For some of the healthy elderly, however, this may be a difficult and unpleasant task. Their involvement as advocates for the sick elderly may force them to contemplate their future and make them fearful of what may lie ahead for them. This approach, however, offers the enticements of relatively low cost and a cadre of advocates anxious to be trained, to empathize with their clients and to serve in this fashion.

The volunteer approach is not without its drawbacks. Among these are the questions of experience and expertise; at the least, extensive training efforts would be essential.[77] In addition, skeptics may harbor doubts concerning the motivations of individuals who are anxious to volunteer themselves for a role that most people would find extremely demanding, difficult, and even traumatic. Perhaps volunteering to serve as a resident advocate should be grounds for immediate disqualification for the role. Certainly, a careful external monitoring system would need to operate to assure that volunteer advocates are

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In 1984, Medicaid paid approximately forty-two percent of the nation's nursing home bill. U.S. GEN. ACCOUNTING OFFICE, LONG-TERM CARE INSURANCE: COVERAGE VARIES WIDELY IN A DEVELOPING MARKET 10 (May 1987) [hereinafter U.S. GEN. ACCOUNTING OFFICE].

[74] Private third-party insurance for long-term care is quite underdeveloped at present. It comprised around only one percent of the total nursing home bill in 1984. U.S. GEN. ACCOUNTING OFFICE, *supra* note 73, at 10. Regarding efforts to develop this potential source of long-term care funding, see *id.*; Burda, *supra* note 72, at 54.

[75] Private payments by residents or their families accounted for more than fifty percent of total nursing home payments in 1984. U.S. GEN. ACCOUNTING OFFICE, *supra* note 73, at 10.

[76] *See* Zischka & Jones, *Volunteer Community Representatives as Ombudsmen for the Elderly in Long-Term Care Facilities*, 24 GERONTOLOGIST 9 (1984).

[77] *See* Veatch, *supra* note 29, at 441.

not guided by motivations other than the sincere desire to protect the rights and well-being of the vulnerable client, that extreme positions are eschewed, and that the orientation of the advocate and the known preferences and apparent best interests of the resident are in harmony.[78]

8. Staff as Resident Advocates

Finally, we should not overlook or minimize the important natural role of nurses — including the nurse aides who provide the bulk of patient care social service professionals, and medical staff working in nursing homes, in functioning as resident advocates. Most professional staff who care for residents on a regular, long term, intimate basis would, in fact, claim that in many instances, they are already functioning as the residents' chief ally, especially where there are no actively involved family members present. In the absence of family, staff are most likely to have important information regarding the patient's quality of life and wishes. This situation is highly desirable.[79] Relying on professional staff to act as the sole or primary resident advocate concerning acute medical decisionmaking, however, raises some troublesome issues.

In some cases, the possibility exists of a serious conflict of interest between the resident's known or reasonably surmised preferences concerning a specific medical intervention, and the course of care that the professional, in his or her independent judgment, feels to be in the resident's best interests. In the case of Mrs. S, we can reasonably assume that, had she been asked when the infection first began, Mrs. S would have chosen to be treated more aggressively. Yet, due to her age and mental impairment, her physician and family elected a more limited treatment, and eventually she died.

Potential conflicts of interest may also surface based on the sincere religious or moral beliefs of members of the nursing, social service, or medical staff or the institutional governing body or administration. For example, there may be a written or unwritten policy against removing artificial feeding tubes under any circumstances.[80] In addition, some patients may be seen as a burden or as "undesirable" by caregivers. It

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[78] *See* Alessandroni, *supra* note 12, at 29.

[79] *Cf.* Kapp, *Promoting the Legal Rights of Older Adults: Role of the Primary Care Physician*, 3 J. LEGAL MED. 367, 373-75 (1982)(discussing how physicians should cooperate with attorneys representing older patients to promote the medicolegal well-being of those patients).

[80] On the legal significance of explicit institutional policies and procedures concerning such matters, see Matter of Rquena, 213 N.J. Super. 443, 517 A.2d 869 (1986). The New Jersey court held that where there is conflict between a resident's known preference for discontinuation of medical treatment and a nursing home's unwritten, unofficial, unannounced policy in favor of continuation of such treatment, the resident's wishes must prevail. The court, however, that the result might be the same if the institutional policy has been officially

could, therefore, be in the best interests of the staff not to treat such patients when they become acutely ill.[81] Finally, with the current emphasis within the health care system on cost containment, a conflict in certain cases interposing the financial interests of the nursing home — and, by extension, the professional staff who depend on that institution for their livelihoods — against the preference or best interests of the resident, is conceivable.[82] Each of these potential conflicts should give us pause before placing too great a reliance on this approach to resident advocacy.

III. SOME DIRECTIONS TO PURSUE

Each of the alternatives discussed above offers distinct advantages, as well as possible practical and philosophical drawbacks, that must be examined when crafting the best response to the need for resident advocacy. Although this Article makes no express endorsement of any particular advocacy alternative or combination of alternatives, we present for the consideration of long term care providers, consumer advocates, and policy makers several fundamental precepts that should guide future efforts in this area.

First, able and even mentally impaired residents should be encouraged to engage in self-advocacy to the greatest possible extent. Although most nursing home residents endure a variety of physical and mental impairments, many remain capable, to differing degrees, of making, expressing, and effectuating medical treatment choices. Prior to the acute illness episode, Mrs. S had been interviewed, and despite a diagnosis of Alzheimer's disease, her response to some questions were clear and rational. When asked if she would want to be treated if she should become ill and develop an acute infection such as pneumonia, she responded, "Yes." Yet, when she became ill, her opinion was not sought. The complexity of the medical choices may be relevant here. When self-advocacy is supplemented, rather than supplanted, by the

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adopted, put in writing, and made known to prospective residents and their families prior to admission.

The Congressional Office of Technology Assessment has produced a document explicating the legal and ethical implications of health care institutional policies and procedures concerning medical treatment issues. The coauthor of this article, Marshall B. Kapp, served as Chair of the OTA Working Group on this project. *See* OFFICE OF TECH. ASSESSMENT, U.S. CONG. INSTITUTIONAL PROTOCOLS FOR DECISIONS ABOUT LIFE-SUSTAINING TREATMENTS (July 1988).

[81] *See* Brown & Thompson, *Nontreatment of Fever in Extended Care Facilities*, 300 NEW ENG. J. MED. 1246, 1249 (1979)(nurses were less likely to report a fever if the patient required extensive nursing care).

[82] *See, e.g.*, Johnson, *Life, Death, and the Dollar Sign: Medical Ethics and Cost Containment*, 252 J. AM. MED. ASS'N 223 (1984); *see also* Kapp, *Hospital Reimbursement by Diagnosis Related Groups: Legal and Ethical Implications for Nursing Homes*, 14 J. LONG-TERM CARE ADMIN. 20 (1986).

assistance of facility staff, family, friends and the other types of advocates discussed above, it can be a powerful force for resident dignity and autonomy.

Second, when feasible, residents should be encouraged by their families and by health care professionals serving them,[83] while they are still capable, to name their preferred advocates before the need for acute medical decisionmaking arises. Legal instruments such as living wills and durable powers of attorney are available for this purpose.[84] Although these documents have been used mainly to name an individual's chosen proxy decisionmaker in the event of subsequent incapacity, there is no logical or policy reason that they could not be used also to name the desired advocate. The instrument would need to be drafted carefully to clarify whether the advocacy role or the decisionmaking role, or both, were being delegated.

Third, those who serve in advocacy roles should be encouraged to seek information regarding the patient's wishes and quality of life from those who know the patient well. In most cases this will be the family, but in some cases it is the nursing staff, especially the nursing assistant who provides the bulk of care to the resident on a day to day basis.[85]

Fourth, there is an extensive need for quality education and training of those who will serve in advocacy roles on behalf of nursing home residents regarding medical decisionmaking. As noted in the earlier discussion of potential advocates, experience and expertise in carrying out this complex and specialized role is not well developed. Families, and those who support families such as clergy, counselors, health care professionals and family attorneys can profit from informative and compassionate education to prepare them for their advocacy responsibilities. Possible educators in this campaign could include the local nursing home ombudsman program, the local bar,[86] the local medical society, community mental health centers, the local Area Agency on Aging, professional nursing organizations and other social service agencies.

Fifth, state laws, both in the form of statutes and court rules, regarding guardians ad litem urgently need to be revised to spell out unambiguously the responsibilities and loyalties of persons who serve in that capacity. Laws should further specify, more clearly than is cur-

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[83] *See supra* note 35.

[84] *See supra* notes 33-34.

[85] *See* Kayser-Jones, *Distributive Justice and the Treatment of Acute Illness in Nursing Homes*, 23 SOC. SCI. & MED. 1279 (1986)(discussing the important role of the nursing assistant in the decision-making process.

[86] *See, e.g.*, A.B.A. COMM. ON LEGAL PROBLEMS OF THE ELDERLY & NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM, ENFORCING NURSING HOME RESIDENTS' RIGHTS: A NEW ROLE FOR THE PRIVATE BAR (1982).

rently the case, the standards for judicial appointment of the guardian ad litem, the extent to which courts should defer to their decisions, and the means of monitoring their performance. Educational efforts must be directed toward those who serve as guardians ad litem and to trial judges who appoint and monitor them.[87]

Finally, where any formal group undertakes the responsibility of advocating on behalf of vulnerable nursing home residents in the sphere of acute medical decisionmaking, adequate funding must be present to enable that group to fulfill its role properly. The funding for advocacy should not be deducted from other, ongoing programs currently providing services to the same population to be served by the advocacy program. It would be a bitter irony indeed, but one that is not at all unimaginable, for advocacy services to be financed out of normal resident care allocations. At the same time, pains should be taken to guard against the creation of new bureaucracies where it is avoidable. The present aging network is already too complicated and fragmented to accommodate easily an additional bureaucratic entry fighting for professional territory, staff, and dollars.

IV. CONCLUSION

The case of Mrs. S raises a constellation of legal and ethical issues concerning acute medical decisionmaking for nursing home residents who are not able to speak for themselves. This Article has explored one set of these issues, those concerning the identification and responsibilities of advocates for the frail and vulnerable Mrs. Ss of our long term care world.

Attorneys, the professionals functioning most traditionally in the advocacy role, used to refer to their pleadings as "prayers." While health care practitioners and scholarly commentators have devoted a great deal of energy — albeit without achieving a definitive consensus — to the question of who should make decisions and "play God" on behalf of persons like Mrs. S, perhaps now we need to turn our attention to the issue of who should pray, or advocate, before those decisionmaking "gods" on behalf of incapacitated nursing home residents, what those prayers should consist of, how they ought to be formulated, and how we can assure that the correct prayers are being uttered and answered.

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[87] *Cf.* A.B.A. COMM. ON LEGAL PROBLEMS OF THE ELDERLY, STATEMENT OF RECOMMENDED JUDICIAL PRACTICES (E. Wood ed. 1986).

Social Work in Health Care

Forcing Services on At-Risk Older Adults: When Doing Good Is Not So Good

Marshall B. Kapp, JD, MPH

ABSTRACT. This essay examines the interplay between the ethical principles of autonomy and beneficence in the context of deciding whether to intervene in the life of an at-risk older adult by providing health and human services over the older person's objection. The need to distinguish between the rights and welfare of the older client, on one hand, and the interests and drives of the professional caregiver, on the other hand, is emphasized.

Questions regarding when and how to force medical and social services on at-risk older adults are ethically difficult ones, precisely because helping professionals care so deeply and sincerely about such persons. Through their education and professional socialization, helping professionals are trained to identify important human needs and to strive to fulfill them. For the helping professional, the highest calling is to "do good," to help bring about the "best" quality of life, both for individual clients and for the larger community served.

These intentions and attitudes, focused on ideals of individual and collective welfare and social responsibility, are noble, and should be embraced and encouraged. They define the essence of the helping professions.

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COMPETING ETHICAL PRINCIPLES

In practice, however, there are other forces that work toward counterbalancing the helping professional's benevolently inspired desire to respond affirmatively to all human needs. First, there is the central ethical principle of individual autonomy. This is the notion of self-determination, of freedom and liberty of choice concerning the various aspects of one's life. Fundamental questions concerning medical and social services clearly fall within this principle. Autonomy applies with full force, if not even greater force, in the case of older persons (Cole, 1983; May, 1982).

For proponents of autonomy, the greatest fear is that benevolently inspired services will devolve into paternalistically and involuntarily imposed interventions in the lives of persons who would rather choose to be left alone. As the essayist Lionel Trilling eloquently warned:

> Some paradox in our nature leads us, once we have made our fellow men or women the objects of our enlightened interest, to go on to make them the objects of our pity, then of our wisdom, and ultimately of our coercion. (Trilling, 1950)

A second ethical principle that may limit the helping professional's natural instinct to help is that of distributive or social justice. All who work in the human services field today are well aware of the increasing scarcity of human and financial resources, both public and private, available for addressing serious social needs. One significant implication of resource scarcity is the ethical imperative that, if we cannot provide every person with all of the human services from which he or she could profit (that is, if we cannot indulge the helping professional's desire to help everyone), at least we must devise a system for allocating (or "rationing") our scarce resources in as fair and equitable a manner as possible (Baily, 1984; Daniels, 1985; Menzel, 1983). This is the moral dilemma of distributive justice.

Let us imagine two older individuals, both with identical mental and physical capacities, personal resources, informal supports, and medical and social service needs. Mr. A. needs, and enthusiastically accepts, a wide variety of medical and social services recommended by helping professionals in his community. Mr. B., on the other hand, even after being fully informed of the likely negative implications of his choice, adamantly refuses to accept any offered services.

The principle of beneficence (Gorovitz, 1982) would suggest making no distinction between Mr. A. and Mr. B. Both gentlemen have the same service needs, and doing good by fulfilling needs lies at the heart of beneficence. However, this author would argue, the principle of distributive justice dictates a different result. There would be little controversy over providing optimal services to Mr. A., an individual who both needs and wants those services. There probably is disagreement, based on the ethical tension between beneficence and autonomy, over the appropriateness of forcing unwanted services on Mr. B. If resources are scarce and the principle of distributive justice compels us to ration services between these two persons, it is a more equitable distribution of those resources to assign them to Mr. A., who wants and needs them, than to Mr. B., who needs but resists them.

This is not to suggest that helping professionals should automatically accept client refusal of services at face value, without sufficient probing of whether a person's refusal is voluntary, authentic, and unequivocal (Jackson and Youngner, 1979). This is not a plea for therapeutic nihilism or neglect of the needy. We must not cavalierly abandon older at-risk persons to their freedom. If, however, tragic choices (Calabresi and Bobbitt, 1978) concerning resource allocation need to be made – and they are being made and will need to be made with greater frequency in the future (Haber, 1986) – a principle of priority based on a combination of need and clear, authentic desire for services seems to be both a logical and an equitable allocation criterion.

Thus, this author would provide services to the willing older individual first. If sufficient resources are left, we must then confront the issue of the ethical propriety of forcing those services on the at-risk but protesting older person.

THREAT TO OTHERS

In some situations, the failure of an older individual with significantly impaired physical or mental capacities to accept medical or social services may pose a danger of harm to other people in the community. For example, the woman whose twenty-six cats in a small apartment pose a health hazard to the other apartment dwellers, or the man whose unmonitored gas and electric appliances constitute a fire hazard to his neighbors, would fall in this category.

In these sorts of circumstances, even John Stuart Mill (Mill, 1859), the father of the modern philosophical concept of autonomy, would agree that ethical concern for the general public welfare and safety would justify some intervention into the life of the older person creating the public danger. This ethical concern is reflected in the well-established legal doctrine of police power (Kapp, 1986), the authority of society (i.e., the state), to act affirmatively to protect and promote the general health, safety, and welfare of the community.

Such state actions may be decisive but, to be both legal and ethical, also must be reasonable. Specifically, unwelcome interventions based on a public safety rationale should be governed by the least restrictive or least invasive alternative principle (Cohen, 1985a); that is, services should be forced on the individual only to the extent necessary to respond effectively to the severity and immediacy of the potential harm to others that the individual presents. Interventions going beyond the immediate public need would not be justified, at least on this basis.

In addition, we should only cite public safety as our grounds for intervention when that in fact is our justification, and not as a pretense. It would be unethical to purport to rely on the state's police power when the helping professional's actual motivation is to benefit or help not the potential victims of the recalcitrant older person, but rather the older, protesting person himself.

THE PARENS PATRIAE *RATIONALE*

This does not mean, of course, that wishing to help the at-risk older person is an illegitimate basis for imposing unwanted services on that person. On the contrary, beneficence is a noble ethical principle. It has been translated into the legal doctrine of *parens patriae*' (literally, "father of the country"), which empowers the state to intervene on behalf of citizens who cannot take care of themselves, to protect people who cannot protect themselves (even if that may mean protecting a person from himself). The key to the invocation of *parens patriae* authority of the state is the individual's incapacity (in legal jargon, the "incompetence") to engage in a rational decisionmaking process leading to the communication of authentic, voluntary, and hence autonomous, life decisions (Culver, 1985; President's Commission, 1982).

THE CONCEPT OF COMPETENCE

Both ethically and legally, every adult begins with the benefit of a presumption of sufficient capacity to make autonomous personal choices. The heavy burden of proof properly rests with whoever seeks to challenge and rebut, or overcome, that presumption in order to force some form of external intervention, such as protective services, on an at-risk but resisting person. Decision-making capacity is an extremely complex clinical, ethical, and legal concept, and there is nothing approaching unanimity or precision regarding definitions or operational tests. Nonetheless, a few general guidelines may be helpful (Culver, 1985; President's Commission, 1982; Meisel, Roth, and Lidz, 1977; Roth, Meisel, and Lidz, 1977).

First, it is vital to remember that competence refers to a relative, rather than an absolute, degree of ability. To say that a person is incompetent and that we are justified in imposing unwanted services implies that the individual is below some minimum level of capacity and range of opportunity, and not simply that the person has less capacity and opportunity than certain other people.

Helping professionals by their nature, quite understandably and admirably, aspire to perfect every person, both medically and in terms of social skills. Helping professionals want "the best" for their clients. However, perfection is too high a standard to set for the recognition of autonomy. Indeed, under that standard, none of us would be allowed to make and carry out our own life choices. Competency, upon which autonomy hinges, requires only a decent, adequate level of functioning: it serves as a floor or ethical safety net (to employ a much-maligned but descriptive figure of speech) below which we should not permit at-risk persons to fall. An individual is competent if she is able to decide not well, but well enough.

A second point is that, as a practical matter an individual's capacity often is questioned for the first time when that person refuses a helping professional's recommendation, although in theory the same considerations should also be raised where the individual accepts the professional's proposal. Put differently, if a person understands and appreciates the information needed to give informed consent for services, then that individual is competent both to give informed consent and to refuse consent.

While there is no universally accepted definition of competence, a variety of approaches to determining its presence or absence have been suggested. The three main approaches that have been proposed are outcome, status, and function (Annas and Densberger, 1984; Caplan, 1985).

Under the outcome approach, decisions that are inconsistent with the values of the helping professionals are conclusive of the person's incapacity; thus, a "wrong" decision, by definition, is incompetently made. Under the status test, an individual's capacity is judged by his or her physical or mental status (e.g., age, place of residence) or diagnosis (e.g., dementia or depression), without further inquiry about how that status or diagnosis actually affects the person. This is sometimes called the membership approach, since the person's membership in a particular class of persons is deemed controlling. The functional approach focuses on the individual's personal ability to function in decision-making situations.

Although in everyday practice most older persons probably are subjected to the outcome or status tests, almost all ethical commentators, legislators, and judges who have thought about the issue favor a functional orientation, emphasizing individual abilities or dysfunctions (Dubler, 1985; Nolan, 1984). The most thoughtful analyses urge that stress not be placed on the "objective" nature of the person's clinical categorization or on the specific choice made by the person, but rather on the capacity of the individual and the subjective thought process followed in arriving at the "good" or "bad" decision (President's Commission, 1982). The outcome and status approaches tend to take insufficient account of the particular values, goals, and perspectives of the person actually affected by a decision. Thus, for instance, an elderly individual who chooses short-term comfort over longer-term survival may not be acting irrationally, even though the same decision made by a younger, otherwise vibrant person would seem irrational in the helping professional's value scheme.

There certainly may be a connection between a person's clinical diagnosis and that person's capacity to make specific decisions. Factors such as dementia or depression may negatively affect the individual's functional capacity; however, the helping professional cannot go automatically from one finding to the other, assuming that the status equals the functional impairment. Where a clinical condition accounts for functional impairment rising to the level of incompetence, it is still the functional impairment, not the diagnosis, that necessitates a substitute decision maker (U.S. Congressional Office of Technology Assessment, 1987).

Under a functional inquiry, the fundamental questions suggested are these:

1. Can the person make and communicate (by spoken words or otherwise) choices concerning his or her life?
2. Can the person offer any reasons for the choices made?
3. Are the reasons underlying the choice "rational?" For instance, the person who declines amputation of a gangrenous leg because he does not wish to continue with only one leg is acting more rationally than someone making the same decision out of fear that with an amputation he will not be able to run away from invading Martians fast enough.
4. Is the person able to understand the implications (i.e., the likely risks and benefits) of the alternatives presented and the choices that are made, and the fact that those implications apply to that person?
5. Does the person actually understand the implications of those choices for him or her?

Under the functional approach, capacity must be determined on a decision-specific basis; that is, a person may be capable of rationally making certain sorts of decisions but not others. The minimally necessary degree of intellectual and emotional capacity may be visualized as falling somewhere on a sliding scale that depends on the nature of the decision being faced (Drane, 1985). Thus, capacity should not be treated as an all-or-nothing affair. Partial capacity is not the same thing as incapacity; the individual may be capable enough to make the decision in question.

Additionally, capacity may wax or wane for a particular individual, according to environmental factors such as time of day; day of the week; physical location; acute, transient medical problems; other persons involved in supporting or pressuring the individual's decision; or medication reactions. Helping professionals are under an obligation to manipulate, wherever possible, environmental barriers to capacity in an attempt to maximize the decision-making capacity of an individual. Thus, if a decision can be delayed until the person is in a more lucid phase, or medications can be altered to allow the person a more clear head to contemplate choices, this is preferable to proceeding unnecessarily to force services on the person on the basis of substituted decision-making. Also, many acute physical and mental problems of the elderly impinging on decision-making capacity can be successfully medically treated (Heikoff, 1986), and that course should be pursued vigorously before considering the person incapacitated.

Finally, many older people who are not totally independent are capable of "assisted" decision making (Caplan, 1985) with a little extra time and effort on the part of helping professionals. Wherever feasible, supporting an older person's own decision making is preferable to supplanting it; shared decision making is more desirable than substituting a professional's decisions for those of the client.

PROXY DECISION MAKING

Inevitably, however, there will be some older individuals who, even with the benefit of the most talented and sincere professional support, are not capable of engaging in personal decision making about their lives. In these cases, decisions regarding receipt of human services must be made by some other individual acting on behalf of the incapacitated elder.

The standard of proxy decision making much in vogue today in both ethical and legal circles is that of substituted judgment.[2] Under this test, the proxy decision maker is obligated to make the same decision that the incapacitated individual would make, if presently able to make and express autonomous choices. The substituted judgment standard works well in respecting autonomy in those situations where the incapacitated person, while earlier competent, left clear written or oral evidence of his or her values, goals, and preferences that can be interpolated to the decision at hand. For individuals who have not left such a clear record of autonomous values, goals, and preferences (i.e., most of us), the substituted judgment standard is considerably more artificial, although the courts recently have engaged in intricate contortions in order to utilize it, especially in cases involving limitation of medical treatment for dying persons (Annas, 1984: Gutheil and Appelbaum, 1985).

The traditional standard of proxy decision making, and the one that still makes the most sense where the evidence for substituted judgment is absent or inconclusive,[3] is that of best interests (President's Commission, 1983). Under this test, the proxy decision maker is required to act as a fiduciary or trust agent and to make choices that will promote the best interests of the incapacitated person, as the proxy determines those best interests. In particular circumstances, the best interests standard may or may not yield the same ultimate result as would the substituted judgment standard (Gutheil and Appelbaum, 1983).

Judgments about what courses of action will serve a client's best interests necessarily are determined by the subjective values, goals, and preferences of the proxy decision maker. Can we formulate criteria for applying the best interests standard in a manner that is more objective, uniform, and respectful of the incapacitated individual's autonomy? Probably not, but a few guidelines may be worth considering.

First, despite the helping professional's natural instinct, both ethics and law authorize unwanted intervention only to the extent necessary to assure a decent, adequate life for the incapacitated person, and not to the extent necessary to promote medical or social perfection. Services should be forced on someone over objection only to the minimal, not optimal, extent consistent with the basic purposes of the intervention. This is the least invasive or restrictive alternative principle (Cohen, 1985a). Even where some forced intervention is appropriate, as much freedom as possible should be retained by the individual. It is easy to forget how important personal control over the seemingly small, mundane details of life can be, especially for older persons for whom many life choices are severely constrained to begin with (Rodin, 1986).

Second, it is the client's best interests that must be foremost, and not those of the helping professional involved. Forced interventions should not be carried out merely because doing so will make the helping professional feel better. This statement in no way alleges or implies that helping professionals consciously place their own self-interest ahead of their clients' interests; for the vast majority of helping professionals, exactly the opposite is true. Nevertheless, many helping professionals tend to make the well-meaning but serious error of equating feeling good with doing good. The former is important, and most helping professionals well deserve to feel good about their efforts. The latter, however, depends upon the autonomous values, goals, and preferences of the person on the receiving end of the forced intervention. Sometimes doing good, in this calculation, may make one feel not so good.

Third, helping professionals should judge what is in the client's best interests not exclusively by the outcome of a particular decision, but also by the action or process leading up to that decision. While the results or consequences of a choice should not be minimized, how that choice was achieved (e.g., to what extent was the older individual involved in the decision?) also can vitally affect the older individual's perception and acceptance of that choice (Regan, 1985; Slivinske and Fitch, 1987). Achieving a good result through questionable means is not always doing good.

INFORMAL SUPPORT SYSTEMS

Each of these guidelines suggests the need for helping professionals to work closely with relevant informal support systems in getting appropriate assistance to older persons who are at risk. Such cooperation is highly laudatory. However, a few cautious considerations should guide this collaboration.

First, coordinated persuasion by a combination of helping professionals and informal supports must not become a form of "ganging up" on or manipulation of the older person. The ethical imperative is to work with, not on, the at-risk individual, to enhance rather than evade that individual's autonomy.

Second, abuses—of one's body, emotions, or sense of autonomy—make take place formally as well as informally. There should be a starting presumption in favor of services forced, if necessary and appropriate, on an older individual by an informal coalition of helping professionals and informal supports (Kapp, 1983; Schmidt, 1986); that presumption, though, may be overcome and replaced by more formal decision making and service delivery mechanisms where the well-being of the at-risk elder dictates.

Third, it is the job of the involved helping professionals to assure that the informal supports are guided in their decision making and implementation concerning services for an at-risk elder not primarily by motivations of guilt, or even love, but rather by respect for the older individual and his or her own values, goals, and preferences (Cohen, 1985b). To parallel a point made earlier, informal supports should make and carry out decisions in the best interests of the incapacitated elder, not in their own best interests. Feeling good does not necessarily equal doing good (where good is evaluated by respect for the autonomy of others), and doing good (from the older person's vantage point) may not always feel so good for the informal supports who are driven by guilt or love.

CONCLUSION

In conclusion, helping professionals have a tremendous, positive amount to offer to at-risk older individuals. Helping professionals should know their many strengths and when and how to use them.

But helping professionals must be aware of their limits too. There are substantial limitations in terms of available resources, both financial and human. There are legitimate, albeit frequently frustrating, limits imposed by the autonomous choices of would-be clients. There are also limitations imposed by the nature of the work done by helping professionals, by the "pragmatics of life." Even if a helping professional could govern the client, it is quite a different, and more formidable, task to govern the world.

There is a story told about a little boy who was late returning home from playing with his friend one day, and his mother was rather worried. When he finally arrived, she asked him what he had been doing. "I passed another little boy who had just had an accident and broken his tricycle," he explained, "and he was crying very hard, so I stopped so I could help him."

"That was nice of you to do," said his mother with some puzzlement, "but how could you help? You don't know anything about fixing tricycles."

"I know that," the boy replied. "I didn't help him fix his tricycle. I helped him to cry."

Helping professionals can help older people who are at-risk to laugh, to smile, and sometimes to cry. Each of these are important and, if done well and consistently with respect for the dignity and autonomy of the older individual, should be satisfying both professionally and personally.

NOTES

1. *Beverly's Case*, 4 Co. Rep. 123b, 16 Eng. Rul. Cas. 702 (1603); *Hawaii* v. *Standard Oil Co. of California*, 405 U.S. 251, 257 (1972).
2. *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985); *Brophy* v. *New England Sinai Hospital, Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986).
3. *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985); *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64 (1981).

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January 1, 1980

Senate Special Committee on Aging
SBD 31
U.S. Senate
Washington, D.C. 20510-6400
Attn: Anna Kinderman, Esq.

Dear Committee:

I deeply regret that I am unable to attend your meeting on June 2nd. As you meet, I will be in the air on my way to Athens. Your concern for the conservatorship/guardianship process is vital to an enormous group of your constituents and I hope to be asked to participate in your inquiry at a later stage.

As I was invited to contribute a written statement, I do so hereby. Of the three issues you are presently considering, I would like to address only the third.

Guardianship (which, with your permission, I will use for the process of that name, conservatorship and the variety of other procedures that accomplish the transfer of legal authority from a ward to others) have been a matter of academic concern to me for about thirty years. In the early years, when I studied the process in Upstate New York (the results are published in Alexander & Lewin, The Aged and the Need for Surrogate Management, Syracuse University Press 1972) I focused on the then undocumented abuses of guardianship. In California, I carried a reform bill on the subject to the legislature and saw it passed. The reform accomplished several seemingly major changes. The standard for guardianship (here called conservatorship) was made functional rather than medical, prospective wards were to be produced at their hearings and a new office of Court Investigator was established to insure that judges would be informed about the prospective ward by someone less biased than the petitioner for conservatorship.

After a few years it became clear to me that the reform had not accomplished what many of us hoped it would. At that point I wrote an article in the Stanford Law Review proposing what was to become the durable power of attorney solution to the problem of guardianship. With your permission, I append that article which I hope is still relevant to your consideration of durable powers.

I have watched the progress of the durable power alternative and of the important federal concern that education concerning such documents be made available. As you can tell from these brief comments, I still think that such documents are crucial in the effort to reestablishing the rights of elders to autonomy and control of their lives.

I have been published a number of times in my discussion of legal implications and problems of durable powers. Recently I have published a book entitled Writing a Living Will Using a Durable Power of Attorney (Praeger Press 1988). Perhaps, when I am invited to share my thoughts with you at a later time, I can summarize some of my published thoughts.

With your permission, I would like to append only one other of my articles which was recently published. The article, from the Hastings Law Journal, summarizes my thoughts about next steps in advance directives.

Thank you for this opportunity to cast an absentee opinion in your inquiry. I look forward to meeting with your committee in a future session and commend you on your recognition of the importance of this problem.

Sincerely,

George J. Alexander

GJA:pco
enclosures

The Hastings Law Journal

ARTICLE

Time for a New Law on Health Care Advance Directives

George J. Alexander

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UNIVERSITY OF CALIFORNIA • HASTINGS COLLEGE OF THE LAW

Time for a New Law on Health Care Advance Directives

by
GEORGE J. ALEXANDER*

During the last decade, states have enacted three different kinds of documents to deal with health care of incompetent patients. The legislation's main impetus and central focus have been to provide a procedure to approve life support termination in appropriate cases, although it also addresses other health care concerns. The earliest of the statutes was a natural death act, which authorizes a directive, popularly called a living will, to physicians. The second was a general durable power of attorney, sometimes in the form of a specially crafted health care durable power of attorney, which essentially empowers an appointed agent to make appropriate decisions for an incompetent patient. The agent is bound by directions contained in the appointing power. Finally, some states have enacted family consent laws empowering others, typically family, to decide health care matters absent a directive or power of attorney to guide them. At the end of 1990, Congress gave these laws new importance by mandating their observance.

The statutes differ;[1] provisions of one form conflict with provisions of another form.[2] Most contradictions raise problems, some nettlesome, others destructive of important interests. After more than a decade of experience with such forms, it is time to review the present state of the laws and to coordinate and debug them. In the author's view, a single statute incorporating the best of each of the three types of law is now in order. This Article suggests guidelines for that effort.

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The author thanks his research assistants, Kathleen Roberts and Stephen K. Meyer, for their tireless research in support of this Article.

[1] *See* Beschle, *Autonomous Decisionmaking and Social Choice: Examining the "Right to Die,"* 77 KY. L.J. 319, 335 (1989).

[2] *See generally* Waters, *Florida Durable Power of Attorney Law: The Need for Reform,* 17 FLA. ST. U.L. REV. 519 (1990) (arguing that Florida's durable power of attorney law is not in harmony with the 1989 guardianship reforms).

The Article builds on the assumption that the state primarily is interested in assisting patients to control their own medical destinies. Regrettably, it is not clear that all present law is so premised, but there are powerful reasons it should be. Paternalism often has been repudiated domestically, but is now on the defensive throughout much of the world.

Human autonomy is expressing itself as a paramount concern even in places that would have seemed unlikely spawning grounds just a few years ago.[3] Whatever else can be concluded about this development, it should be recognized that the desire for self-expression is a universal trait of overwhelming significance. National paternalism stands repudiated despite the substantial efforts of many governments to meet the needs of their constituents. The democracy wave has substituted its amalgam of wills for national planning.

Within the United States one hardly need compose a brief for self-governance. This country began as a noble experiment in universal suffrage over two hundred years ago. Despite an unswerving devotion to democratic principles, however, the country has had to awaken itself to the limits of popular participation. For almost a century, blacks were disenfranchised;[4] for a longer period, the same was true of women.[5] It is not always self-evident that pockets of powerlessness remain.

Among those presently disenfranchised are those said to be incompetent. Chief in that group are the frail elderly. Of course, because the elderly are our parents and friends we have not devised a system demonstrably uncaring. We simply have substituted the voices of the elderly with that of court appointed agents—normally called guardians, conservators, or a variety of less common names ("conservators")—allowing the conservators to plan the welfare of their wards. Some conservators are deeply sensitive and compassionate. They usually are shocked when accused of working against the interests of their wards. Self-determination, however, is no less desired locally than it is nationally. Conservatorship has failed repeatedly. It is in a constant state of "reform," but reform does not alter its fatal flaw:[6] conservatorship deprives the elderly of their cherished freedom to decide.

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[3] *See, e.g.*, Raufman, *Tunnel at End of the Light for Eastern Europe; Upheaval in Eastern Europe One Year Later*, Boston Globe, Oct. 21, 1990, National/Foreign, at 1; *Reunification of Germany*, L.A. Times, Oct. 17, 1990, at B6, col. 2.

[4] *See* U.S. CONST. amend. XV (enacted in 1870, disallowing the denial of the right to vote based on racial grounds).

[5] *See* U.S. CONST. amend. XIX (enacted in 1920, disallowing the denial of the right to vote based on gender).

[6] Alexander, *Avoiding Guardianship*, ____J. ELDER ABUSE ____(1990) (forthcoming).

Conservatorship has failed not only theoretically[7] but practically as well. Indeed, the abuses of the sixties appear to be the abuses of the nineties.[8] In the late seventies the author suggested adopting advance directives as an alternative to depriving people of their decisionmaking authority in the face of their declining capacities.[9] An advance directive enables a competent person to govern what happens after incompetency.

The idea of the advance directive was to create a document that would adopt the free form of contracts and express the will of its maker in the maker's terms.[10] What has emerged is far more complicated. Government again has asserted itself in the conditions that attach to the documents.

The rationale for advance directives is, of course, their enhancement of autonomy: they enable persons to protect their futures by foreclosing the plans of others to determine their destinies.[11] In that respect, they fundamentally differ from conservatorships. Both conservatorship and advance directives attempt to deal with problems arising in a future in which the person is unable to make competent decisions. Conservatorship imposes societal solutions and a court appointed enforcer.[12] Advance directives, however, provide either an agent to enforce a patient's stated desires or instruct physicians how their patient wants to be treated.

To some extent, forms of directives are a product of their history. The earliest type of law enacted to authorize directives, the natural death act, was popularly named a living will. The author has referred to durable powers of attorney for health care, the next set of directives, as second generation living wills. The new proposal embodied

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[7] As I have written about the abuses of conservatorships for a quarter of a century, I shall not repeat the discussion other than to refer the reader to a sampling of prior comments: G. ALEXANDER, WRITING A LIVING WILL: USING A DURABLE POWER OF ATTORNEY (1988) [hereinafter WRITING A LIVING WILL]; G. ALEXANDER & T. LEWIN, THE AGED AND THE NEED FOR SURROGATE MANAGEMENT (1972) [hereinafter SURROGATE MANAGEMENT]; Alexander, *Death by Directive*, 28 SANTA CLARA L. REV. 67 (1988) [hereinafter *Death by Directive*]; Alexander, *Premature Probate: A Different Perspective on Guardianship for the Elderly*, 31 STAN. L. REV. 1003 (1979) [hereinafter *Premature Probate*].

[8] *Compare* SURROGATE MANAGEMENT, *supra* note 7, at 9 (hypothesizing that "surrogate management . . . is conducted in the specific interest of some person other than the incompetent" *with* Friedman & Savage, *Taking Care: The Law of Conservatorship in California*, 61 S. CAL. L. REV. 273, 285 (1988) (noting that conservatorships sometimes are sought to protect the interests of the conservator rather than the ward).

[9] *See Premature Probate*, *supra* note 7, at 1031.

[10] *Id.* at 1018.

[11] *See id.* at 1006.

[12] *See, e.g.*, CAL. PROB. CODE § 1800.3 (West Supp. 1991) (authorizes court to appoint a conservator of the person or estate of an adult).

in this Article is for a third generation living will incorporating the first directive and its improvements.

Each of the three types of documents has an important function, and the three varieties can coexist fairly well despite their independent enactments and lack of extensive cross-referencing. Combining their provisions into a single law would clarify the alternative methods of health care decision making for incompetent persons.

Following the prominent plight of Karen Quinlan,[13] California led the country in passing a law designed to allow patients in terminal stages of disease to give directives to physicians to inform them of the patients' desires concerning life support.[14] Currently, natural death acts modelled on that law exist in forty-two other states.[15] California

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[13] *See In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied,* 429 U.S. 922 (1976) (with concurrence of guardian and family, no criminal or civil liability may attach for discontinuation of life support of patient in persistent vegetative state upon medical determination of no reasonable possibility of recovery and after consultation with hospital ethics committee or similar body).

[14] *See* Cal. Health & Safety Code §§ 7185-7195 (West Supp. 1990).

[15] *See* Alabama Natural Death Act, Ala. Code §§ 22-8A-1 to -10 (1981); Alaska Rights of the Terminally Ill, Alaska Stat. §§ 18.12.010-.100 (1990); Arizona Medical Treatment Decision Act, Ariz. Rev. Stat. Ann. §§ 36-3201 to -10 (1986 & Supp. 1989); Arkansas Rights of the Terminally Ill or Permanently Unconscious, Ark. Stat. Ann. §§ 20-17-201 to -202 (1987 & Supp. 1989); Colorado Medical Treatment Decision Act, Colo. Rev. Stat. §§ 15-18-101 to -113 (1989 & Supp. 1990); Connecticut Removal of Life Support Systems, Conn. Gen. Stat. Ann. §§ 19a-570 to -575 (West Supp. 1990); Delaware Patient's Right to Terminate Treatment, Del. Code Ann. tit. 16, §§ 2501-2509 (1983); District of Columbia Natural Death Act of 1981, D.C. Code Ann. §§ 6-2421 to -2430 (1989); Florida Right to Decline Life-Prolonging Procedures, Fla. Stat. Ann. §§ 765.01-.15 (West 1986); Georgia Living Wills Act, Ga. Code Ann. §§ 88-4101 to -4112 (Harrison 1986 & Supp. 1989); Hawaii Medical Treatment Decisions Act, Haw. Rev. Stat. §§ 327D-1 to -27 (Supp. 1989); Idaho Natural Death Act, Idaho Code §§ 39-4501 to -4509 (1985 & Supp. 1990); Illinois Living Will Act, Ill. Rev. Stat. ch. 110 1/2, paras. 701-710 (1988); Indiana Living Wills and Life-Prolonging Procedures Act, Ind. Code Ann. §§ 16-8-11-1 to -22 (Burns 1990); Iowa Life-Sustaining Procedures Act, Iowa Code Ann. §§ 144A.1-.11 (West 1989); Kansas Natural Death Act, Kan. Stat. Ann. §§ 65-28,101-,109 (1985); Louisiana Declaration Concerning Life-Sustaining Procedures, La. Rev. Stat. Ann. §§ 40:1299:58.1-.10 (West Supp. 1990); Maine Living Wills, Me. Rev. Stat. Ann. tit. 22, §§ 2921-2931 (Supp. 1989); Maryland Life-Sustaining Procedures, Md. Health-Gen. Code Ann. §§ 5-601 to -614 (1990); Minnesota Adult Health Care Decisions, Minn. Stat. Ann. §§ 145B.01-.17 (West Supp. 1990); Mississippi Withdrawal of Life-Saving Mechanisms, Miss. Code Ann. §§ 41-41-101 to -121 (Supp. 1990); Missouri Declarations, Life-Support, Mo. Ann. Stat. §§ 459.010-.055 (Vernon Supp. 1990); Montana Living Will Act, Mont. Code Ann. §§ 50-9-101 to -206 (1989); Nevada Withholding or Withdrawal of Life-Sustaining Procedures, Nev. Rev. Stat. Ann. §§ 449.540-.690 (Michie 1986 & Supp. 1989); New Hampshire Terminal Care Document, N.H. Rev. Stat. Ann. §§ 137-H:1 to :16 (Supp. 1989); New Mexico Right to Die Act, N.M. Stat. Ann. §§ 24-7-1 to -11 (1986); North Carolina Right to Natural Death; Brain Death, N.C. Gen. Stat. §§ 90-320 to -323 (1989); North Dakota Uniform Rights of Terminally Ill Act, N.D. Cent. Code §§ 23-06.4-01 to -14 (Supp. 1989); Oklahoma Natural Death Act, Okla. Stat. Ann. tit. 63, §§ 3101-3111 (West

also was the leader in enacting second generation living wills, durable powers of attorney for health care.[16] Thirty-two states have adopted second generation living wills[17] and further adoptions are almost certain. In addition, general durable power of attorney laws were pressed into similar service in several states by amendments expressly providing that the laws govern health care decisions as well.[18] Finally, a third round of laws[19] recently has been passed appointing members of the

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Supp. 1990); Oregon Directive to Physician, Or. Rev. Stat. §§ 127.605-.650 (Supp. 1990); South Carolina Death with Dignity Act, S.C. Code Ann. §§ 44-77-10 to -160 (Law. Co-op. Supp. 1989); South Dakota Health Care Consent Procedures, S.D. Codified Laws Ann. §§ 34-12C-1 to -8 (Supp. 1990); Tennessee Right to a Natural Death Act (Living Wills), Tenn. Code Ann. §§ 32-11-101 to -110 (Supp. 1990); Texas Natural Death Act, Tex. Health & Safety Code Ann. §§ 672.001-.021 (Vernon Supp. 1990); Utah Personal Choice and Living Will Act, Utah Code Ann. §§ 75-2-1101 to -1118 (Supp. 1989); Vermont Terminal Care Document, Vt. Stat. Ann. tit. 18, §§ 5251-5262 (1987); Natural Death Act of Virginia, Va. Code Ann. §§ 54.1-2981 to -2992 (1988 & Supp. 1990); Washington Natural Death Act, Wash. Rev. Code Ann. §§ 70.122.010-.905 (Supp. 1990); West Virginia Natural Death Act, W. Va. Code §§ 16-30-1 to -10 (1985); Wisconsin Natural Death Act, Wis. Stat. Ann. §§ 154.01-.15 (West 1989); Wyoming Living Will Act, Wyo. Stat. §§ 35-22-101 to -109 (1988).

16. *See* Cal. Civ. Code § 2400 (West Supp. 1989).

17. *See* Ark. Stat. Ann. § 20-17-202 (1989); Cal. Civ. Code § 2431 (West Supp. 1990); Del. Code Ann. tit. 16, § 2502 (1983); D.C. Code Ann. § 21-2201 (1989); 1990 Fla. Laws 223; Ga. Code Ann. § 31-36-1 (Harrison 1990); Idaho Code § 39-4505 (1990); Ill. Ann. Stat. ch. 110 1/2, para. 802-1 (Smith-Hurd Supp. 1990); Ind. Code Ann. § 16.8-12-5 (Burns 1990); Iowa Code Ann. § 144A.7(1)(a) (West 1989); 1989 Kan. Sess. Laws 181; 1990 Ky. Acts 123; La. Rev. Stat. Ann. § 40:1299.58.1 (West Supp. 1990); Me. Rev. Stat. Ann. tit. 18-A, § 5-501 (Supp. 1990); Md. Est. & Trusts Code Ann. § 13-601 (1981); Minn. Stat. Ann. § 145(B).01 (West Supp. 1990); Miss. Code Ann. § 41-41-151 (Supp. 1990); Nev. Rev. Stat. Ann. § 449.810 (Michie Supp. 1989); 1990 N.Y. Laws 752; Ohio Rev. Code Ann. § 1337.12 (Baldwin Supp. 1989); Or. Rev. Stat. § 127.510 (Supp. 1990); R.I. Gen. Laws § 23-4.10-1 (1989); S.D. Codified Laws Ann. § 59-7-2.5 (Supp. 1990); Tenn. Code Ann. § 34-6-202 (Supp. 1990); Tex. Rev. Civ. Stat. Ann. art. 4590h-1 (Vernon Supp. 1990); Utah Code Ann. §§ 75-2-1105 to -1106 (Supp. 1989); Vt. Stat. Ann. tit. 14, § 3453 (1989); Va. Code Ann. § 54.1-2986(2) (1988); Wash. Rev. Code Ann. § 11.94.046 (Supp. 1990); W. Va. Code § 16-30A-3 (Supp. 1990); 1989 Wis. Laws 200; Wyo. Stat. § 35-22-102 (1988).

These laws differ from state to state in several significant respects, some of which are addressed below.

18. *See* La. Rev. Stat. Ann. § 40:1299.58.1 (West Supp. 1990); Me. Rev. Stat. Ann. tit. 18-A, § 5-501 (Supp. 1990); Wash. Rev. Code Ann. § 11.94.046 (Supp. 1990).

19. *See* Conn. Gen. Stat. Ann. § 19a-571 (West Supp. 1990); D.C. Code Ann. § 21-2210 (1989); Fla. Stat. Ann. § 744.304 (West 1986 & Supp. 1990); Idaho Code § 39-4303 (1985); Ind. Code Ann. § 16-8-3-3 (Burns 1990); Iowa Code Ann. § 255.11 (West 1985); Md. Health-Gen. Code Ann. § 20-107 (1990); N.M. Stat. Ann. § 24-7-8.1 (1986); N.Y. Pub. Health Law § 2972 (McKinney 1989); N.C. Gen. Stat. § 90-322 (1985); S.C. Code Ann. § 44-77-10 to -80 (Law. Co-op. 1990); S.D. Codified Laws Ann. § 34-12C-3 (Supp. 1990); Tex. Health & Safety Code Ann. § 672.009 (Vernon Supp. 1990); Utah Code Ann. § 75-2-1107 (Supp. 1990); Va. Code Ann. § 54.1-2986 (1988); Wash. Rev. Code Ann. § 7.70.065 (Supp. 1990); W. Va. Code § 16-5c-5a (Supp. 1990).

These family consent laws allow the appointment of specified family members as health care surrogates without court intervention.

family as health surrogates in the absence of a prior writing by an incompetent patient.[20]

Of course, advance directives are not necessary for everyone. To the extent that one trusts the conservatorship process, there is little cause to make a directive, aside from avoiding the expense of obtaining the conservatorship appointment. Thus, a directive requiring acts that would not be expected from a conservator should be treated as a probable rejection of the conservatorship remedy. For example, directions to buy speculative stocks, to sell personal jewelry absent financial pressure to do so, to administer experimental drugs or perform experimental surgery, and certainly to remove life support would seem to indicate a knowing choice of outcomes that could not be expected from state administration.

A patient may create an advance directive merely to inform physicians of the patient's wishes, but that effort is hardly worthwhile if the desired treatment is ordinary care. To the extent a patient makes a choice among acceptable alternatives, the patient appears also to make a decision not to allow others to make that choice. Even if a patient makes a directive out of concern that the state would not deal with her medical needs by appointing a conservator, such a directive probably would be limited to facilitating the appointment of either a conservator or an agent. She thereby could not account for other provisions. Thus, having made a directive, especially a detailed one, a person should be assumed to have chosen self-direction over paternalistic care. As a corollary, the state should not impose a conservator in the alleged best interests of the ward since the ward has indicated that she considers the directive to be a superior method of guiding care.[21]

Probate is an apt analogy here.[22] Probate law provides for two forms of distribution upon death. If a person cares to have control over how the estate is distributed, she writes a will. There are numerous limits on what can be directed,[23] but in the main, property passes as the testator wished. If there is no valid will, the state provides

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[20] The list of cases is growing in which courts attempt to achieve a result appropriate for a particular patient without the benefit of an advance directive. For a discussion of these cases, see *Death by Directive, supra* note 7, at 86-92.

[21] This analysis depends on whether the maker understands the consequences of her acts and knows about available alternatives. If this is an incorrect assumption about a substantial number of present directives, it certainly would become a more correct assumption under the author's proposed new law.

[22] *See Premature Probate, supra* note 7, at 1018.

[23] For example, a testator may not intentionally omit a surviving spouse from her will or bequeath the family house to the detriment of her surviving spouse and children. J. RITCHIE, N. ALFORD & R. EFFLAND, DECEDENTS' ESTATES AND TRUSTS 146, 152, 182 (7th ed. 1989).

for distribution by intestacy.[24] The state's purpose is to get property into the right hands and to settle the estate by using *the state's* conception of what most people would (or should) want. If one likes the state's distribution scheme there is little reason to expend the time and money to make a will.

Most states appear to have modelled advance directives in this manner. Several expressly have indicated that the purpose of the directive is to avoid conservatorship or have provided ways to avoid the interference of a conservator if one is appointed.[25] Others have adopted the contrary position and have subordinated an agent appointed by a directive to a conservator.[26] Subordination, of course, invalidates the choice not to accept statutory solutions because the conservator likely will be bound to the state's general principles governing conservatorship rather than to the terms of the advance directive. At a minimum, the maker is deprived of the choice of administrator and, consequently, the guarantee of her chosen outcomes.

Subordination should run in the opposite direction. If a person appoints an agent under an advance directive, a court should appoint a conservator, if at all, only for matters not governed by the directive. Since conservatorship is established for those who cannot properly arrange for their needs, making an advance directive that appoints a person to satisfy needs arguably obviates the need for an additional appointment.[27]

Of course, conservatorship can be viewed and actually can function as a means of checking abuses by durable power agents or physicians. As a solution to the problem of abuse, however, conservatorship is grossly overbroad. Other ways exist to chasten errant delegatees. Statutes generally provide for court review of the handling of an advance directive on a petition supported by evidence of abuse.[28] Financial agents routinely are required to give accountings as conservators presently are required to do.[29] The directive itself might require the agent to be accountable to a named person or group on penalty of losing the agency in favor of an alternate agent. If a maker is particularly concerned about interference with her wishes, however, there

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[24] *Id.* at 85.

[25] *See, e.g.*, GA. CODE ANN. § 31-36-6(c) (Harrison 1990).

[26] *See, e.g.*, COLO. REV. STAT. § 15-18-112 (1989); MINN. STAT. ANN. § 145B.03 subdiv. 3 (West Supp. 1990).

[27] *Cf. In re* Estate of Brooks, 32 Ill. 2d 361, 374, 205 N.E.2d 435, 443 (1965) (holding that it is unconstitutional to appoint a conservator without notifying a patient to obtain consent to a blood transfusion if such transfusions are against the patient's religion).

[28] *See, e.g.*, CAL. CIV. CODE §§ 2431-2444 (West Supp. 1991).

[29] *See, e.g.*, CAL. PROB. CODE § 2620 (West Supp. 1991).

should be a method (though not an easy one) for making an advance directive unchallengeable. For example, one might borrow from the California Durable Power of Attorney law[30] the provision rendering difficult a challenge to the directive if an attorney has attested that she has fully informed the maker of the meaning of its provisions.[31] Also, the state should allow the potential ward to nominate a conservator if one is to be appointed.[32] One can anticipate and block some overreaching by disqualifying people such as health care providers and nursing home operators from accepting agency in an advance directive.[33] Naturally, any such disqualification deprives the maker of some degree of free choice, but the disqualification can be justified by the anticipated conflict of interest that otherwise might result.

Although most of the present legislative restrictions to autonomous choice are contained in natural death acts, there are similar complications in the durable powers of attorney statutes as well.[34] The principal focus of many of these restrictions has been on what is popularly called the right to die.[35] As impediments to autonomous choice, these restrictions must be reexamined.

To be sure, each state has an interest in the life and welfare of its citizens. The state's interest in a patient's life, according to the United States Supreme Court, is compelling.[36] Since many issues concerning the health care of incompetent patients, especially life support termination, are complex and difficult, it is understandable that various states arrive at different compromises among competing interests.[37] The clashing viewpoints on life support termination make it unlikely that there will be universal agreement.[38] The fact that most

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[30] CAL. CIV. CODE §§ 2400-2423 (West Supp. 1991).

[31] *See id.* § 2421.

[32] *See, e.g.*, MINN. STAT. ANN. § 145B.03 subdiv. 3 (West 1989).

[33] *See, e.g.*, GA. CODE ANN. § 31-36-5(b) (Harrison 1990).

[34] *See, e.g.*, CAL. CIV. CODE § 2435 (West Supp. 1991) (A durable power of attorney may not authorize the attorney-in-fact to consent to commitment of the principal to a mental health facility, or to consent to shock therapy, psychosurgery, sterilization, or abortion on behalf of the principal.).

[35] For example, some states restrict the removal of hydration and nutrition or require that patients be terminally ill before a directive's provisions apply. *See generally* Mayo, *Constitutionalizing the "Right to Die,"* 49 MD. L. REV. 103 (1990) (arguing that the constitutional right of privacy does not extend to decisions made on behalf of permanently unconscious patients to have life-sustaining treatment discontinued and that continued state supervision is appropriate).

[36] *See generally* Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841 (1990) (upholding a state's right to require clear and convincing evidence of a patient's wish in proceedings in which a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a persistent vegetative state).

[37] *See Death by Directive, supra* note 7, at 77-79.

[38] *See* Note, *I Have a Conscience, Too: The Plight of Medical Personnel Confronting*

(perhaps all) states agree that a terminal patient who desires treatment stopped and has clearly and competently so indicated has a right to refuse further medical aid[39] provides support for at least a provision of this type in a new law. Claims of a state interest in life or preventing suicide seem fairly feeble in this context.[40]

There are, of course, other concerns about authorizing patient autonomy respecting the right to die. Aside from the strong moral and religious opposition,[41] such permission might lead to disguised murder. More commonly, it surely would create psychological pressure on the patient to stop the expense, both financial and emotional, that critical care usually represents. Still, with medical science increasingly capable of keeping patients alive artificially, the incidence of the need to make life termination decisions increases.[42] Presently, seventy percent of the deaths occurring at a hospital result from the termination of treatment.[43]

The disabled may warrant special concern. Representatives of the disabled have led the opposition to any easing of the life support removal bans (let alone promoting euthanasia) on the ground that devaluing life will result in their charges' harm.[44] At the least, treatment will be less heroic; perhaps there will be stronger pressure to accept the desirability of ending the lives of the disabled. The specter of the Nazis' elimination of those they called unworthy of life springs to mind.[45] It may be true of the elderly, in general, that to ease an end to life is to jeopardize life. No easy answer exists to such problems except alertness to their possibility. Ultimately, the danger of their eventuation must be weighed against the pain of keeping those alive who have decided rationally, without outside pressure, that death with dignity is preferred. To the author, the latter seems the more difficult choice to make.

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the Right to Die, 65 Notre Dame L. Rev. 699, 710 (1990) (authored by Irene Prior Loftus) (discussing Gray v. Romeo, 697 F. Supp. 580 (D.R.I. 1988), wherein the individual patient's self-determination interest was held to outweigh the state's interest in preserving life, preventing suicide, protecting innocent third parties, and maintaining the integrity of medical ethics); *see also* Beschle, *supra* note 1, at 333 (noting that theoretically diverse approaches of Massachusetts and New York courts on treatment termination both essentially require the court to determine the choice an incompetent would make were she competent).

[39] *See Death by Directive, supra* note 7, at 86; *Cruzan,* 110 S. Ct. at 2851.

[40] *See Death by Directive, supra* note 7, at 79, 97.

[41] *See Cruzan,* 110 S. Ct. at 2853.

[42] *See Death by Directive, supra* note 7, at 69, 97.

[43] *Dying: Fear of Being Suspended in a Vegetative State Has Triggered an Unprecedented Demand for Living Wills Since High Court Ruling,* L.A. Times, July 17, 1990, at E1, col. 4.

[44] *See* Peters, *The State's Interest in the Preservation of Life: From* Quinlan *to* Cruzan, 50 Ohio St. L.J. 891, 938-45 (1989).

[45] K. Binding & A. Hoche, Die Freigabe der-Vernichtung Lebensunwerten Lebens (Leipzig' 1920).

An additional countervailing interest is sometimes urged on behalf of dependent children.[46] The loss of support gets little consideration in most life support termination cases because the former supporter generally cannot assist the dependent child either financially or psychologically because of imminent death. A notable exception is that a majority of states bar the termination of the life supporting care of a pregnant woman.[47] A few limit such negation of the woman's choice to pregnancies involving viable fetuses or fetuses that could develop to viability.[48] The latter seem in line with the present constitutional resolution of the abortion question.[49] The majority of states, which negate an advance directive that would lead to the maker's death, seem dubious. So long as women remain free to choose to have an abortion in the first trimester for any reason or none at all, imposing a higher standard of review on terminal patients appears to violate constitutional privacy doctrine as it now stands.

Can it be true that a state has a sufficient interest in a pregnancy (even one likely doomed by the ill health of the mother) to force a prospective mother to carry a child whom she probably will not have

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[46] *See* Application of President and Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir.), *cert. denied,* 377 U.S. 978 (1964) (sustaining a hospital's administration of emergency blood transfusion to a patient whose religious convictions prohibited such measures and whose husband refused to authorize transfusion on similar grounds, when the hospital was exposed to potential civil and criminal liability for failing to take appropriate action, when the patient was the mother of a seven-month old child whose "abandonment" it was in the state's interest to prevent, and when the patient's voluntary presence in the hospital gave rise to the inference that she wanted her life preserved though she could not "consent" to the means of doing it).

[47] *See* ARIZ. REV. STAT. ANN. § 36-3205 (1986); CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1990); CONN. GEN. STAT. ANN. § 19a-574 (West Supp. 1990); DEL. CODE ANN. tit. 16, § 2503 (1983); FLA. STAT. ANN. § 765.08 (West 1986); GA. CODE ANN. § 88-44103 (Harrison Supp. 1989); HAW. REV. STAT. § 327D-6 (Supp. 1989); IDAHO CODE § 39-4504 (Supp. 1990); IND. CODE ANN. § 16-8-11-11 (Burns 1990); KAN. STAT. ANN. § 65-28,103 (1985); MD. HEALTH-GEN. CODE ANN. § 5-605 (1990); MISS. CODE ANN. § 41-41-107 (Supp. 1990); MO. ANN. STAT. § 459.025 (Vernon Supp. 1990); NEV. REV. STAT. ANN. § 449.610 (Michie 1986); N.H. REV. STAT. ANN. § 137-H:14 (Supp. 1989); N.D. CENT. CODE § 23-06.4-03 (Supp. 1989); OKLA. STAT. ANN. tit. 63, § 3103 (West Supp. 1990); S.C. CODE ANN. § 44-77-70 (Law. Co-op. Supp. 1989); TEX. HEALTH & SAFETY CODE ANN. § 672.019 (Vernon 1990); UTAH CODE ANN. § 75-2-1109 (1990); WASH. REV. CODE ANN. § 70.122.030 (Supp. 1990); WIS. STAT. ANN. § 1514.03 (West 1989).

[48] *See* ALASKA STAT. § 18.12.040 (1986); ARK. STAT. ANN. § 20-17-206 (Supp. 1989); COLO. REV. STAT. § 15-18-104 (1989); ILL. ANN. STAT. ch. 110 1/2, para. 703 (Smith-Hurd Supp. 1990); IOWA CODE ANN. § 144A.6 (West 1989); MONT. CODE ANN. § 50-9-202 (1989); UNIF. RIGHTS OF TERMINALLY ILL ACT § 6, 9B U.L.A. 75 (Supp. 1990).

[49] *See* Webster v. Reproductive Health Servs., 109 S. Ct. 3040 (1989) (upholding state statute requiring physicians to perform fetal viability tests on women believed to be at least twenty weeks pregnant); Roe v. Wade, 410 U.S. 113 (1973) (subsequent to viability, state may regulate and even proscribe abortion except when necessary to preserve the life or health of the mother).

a chance to nourish? Can the state constitutionally choose between the two lives and cause the woman's death by procedures designed to save the child?

Under *Roe v. Wade,* the state must consider not only the mother's physical burden of the period of gestation but also the mother's interest in the life she may bring into the world.[50] Until a state can establish a right to interfere in a healthy person's decision not to give birth, the state should not be allowed to require a woman to give birth to a child doomed to be motherless. At the moment, the law seems to bar a state from merely inquiring about the reason for a woman's decision if she is a competent adult.

Many courts, however, have long recognized an additional interest in the medical profession that impinges on the rights of patients.[51] If physicians, in general, or the specific treating physician object to a call to cease treatment, that objection often is entitled to some weight. A majority of states have addressed the possible conflict between the treating physician and the patient by providing in their physician directive laws for the transfer of a patient by a doctor offended by the patient's wishes.[52] In many states, however, this conflict remains unresolved by statute. Although physicians ordinarily are involved in treatment and, thus, in treatment cessation, their most pressing interests should be satisfied if they are not required to participate in treatment cessation to which they are opposed. A fair balance between

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[50] *See Roe,* 410 U.S. at 153.

[51] *See, e.g.,* Gray v. Romeo, 697 F. Supp. 580, 589-91 (D.R.I. 1988) (The integrity of medical ethics is subordinate to the wishes of the patient. If prompt transfer of the patient to a facility that would respect the patient's wishes is impractical, the objecting hospital must terminate nutrition and hydration.); Brophy v. New England Sinai Hosp., 398 Mass. 417, 497 N.E.2d 626 (1986) (Hospital should not be compelled to withhold food and water contrary to generally established and accepted medical principles to comply with guardian's wishes. Hospital must assist guardian in transferring ward to suitable facility where guardian's wishes may be effected.).

[52] *See* ALA. CODE § 22-8A-8 (1990); ALASKA STAT. § 18.12.050 (1986); ARIZ. REV. STAT. ANN. § 36-3204 (1986); ARK. STAT. ANN. § 20-17-207 (Supp. 1989); CAL. HEALTH & SAFETY CODE § 7191 (West Supp. 1990); COLO. REV. STAT. § 15-18-113 (1989); D.C. CODE ANN. § 6-2427 (1989); FLA. STAT. ANN. § 765.09 (West 1986); GA. CODE ANN. § 88-4108 (Harrison 1986); HAW. REV. STAT. § 327D-11 (1985); IDAHO CODE § 39-4508 (Supp. 1990); ILL. ANN. STAT. ch. 110 1/2, para. 703 (Smith-Hurd Supp. 1990); IOWA CODE ANN. § 144A.8 (West 1989); KAN. STAT. ANN. § 65-28,107 (1985); ME. REV. STAT. ANN. tit. 22, § 2926 (Supp. 1989); MD. HEALTH-GEN. CODE ANN. § 5-604 (1990); MINN. STAT. ANN. § 145B.06 (West Supp. 1990); MISS. CODE ANN. § 41-41-115 (Supp. 1990); MO. ANN. STAT. § 459.030 (Vernon Supp. 1990); MONT. CODE ANN. § 50-9-203 (1989); N.H. REV. STAT. ANN. § 137-H:6 (Supp. 1989); N.D. CENT. CODE § 23-06.4-08 (Supp. 1989); TENN. CODE ANN. § 32-11-108 (Supp. 1990); UTAH CODE ANN. § 75-2-1112 (1990); VA. CODE ANN. § 54.1-2987 (1988); WASH. REV. CODE ANN. § 70.122.060 (Supp. 1990); WIS. STAT. ANN. § 154.07 (West 1989); WYO. STAT. § 35-22-104 (1988).

the pain of a dying patient and a physician's moral code would seem to justify depriving an offended physician of a more decisive role. A new act should explicitly adopt the transfer requirements already in use in a number of states.

Present natural death acts were not written to be all-inclusive. They typically recite that they do not affect other rights.[53] The natural death acts were born of a problem newly realized and are riddled with restrictions presumably attributable to excessive caution and lack of experience.[54] As a result, express provisions were made for the possibility of less restrictive treatment at common law. In contrast to the natural death acts, durable powers actually were borrowed from estate practice, a field in which they were not a novelty. In asset management, durable powers generally carry few restrictions;[55] thus, although only the basic durable power law has been adopted, few legislative restrictions attach to health care provisions. In the laws specifically passed to deal with health care, some of the excessive caution of natural death acts was carried forward.[56] As a general matter, however, these laws are still much less restrictive than natural death acts.[57]

It is a current curiosity that the strictures of natural death acts can be avoided by not making a directive at all[58] or by creating a durable power. Since the passage of the early natural death acts, there has been extensive examination of treatment termination issues. Appellate courts have written thoughtful opinions on the subject to guide lower courts.[59] Currently, there are enough carefully reasoned opinions that each state should be capable of writing a clearer, more comprehensive statute.

Natural death acts focus on instructions to physicians. A new law should have provisions with the same focus. These provisions specifically might contain whatever restrictions the state wishes to impose on self-determination of death, permitting options and dropping the present statement that these options are not in derogation of other rights. Presumably, by drawing on a number of court decisions resolving such issues, these restrictions could be significantly less onerous than those in present natural death acts. At least the statutes

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[53] *See, e.g.*, TENN. CODE ANN. § 32-11-110 (Supp. 1990); W. VA. CODE § 16-30-9 (1985).

[54] *See, e.g.*, FLA. STAT. ANN. § 765.08 (West 1986) (prohibiting the discontinuation of medical treatment if the patient is pregnant).

[55] WRITING A LIVING WILL, *supra* note 7, at 50.

[56] *See, e.g.*, CAL. CIV. CODE § 2436.5 (West Supp. 1991) (requiring renewal of durable power for health care every seven years).

[57] *See supra* note 17.

[58] *In re* Estate of Greenspan, 137 Ill. 2d 1, 25-28, 558 N.E.2d 1194, 1202-03 (1990).

[59] Many of the cases are reviewed in *Death by Directive, supra* note 7, at 78-92.

should be sufficiently flexible to encourage rather than deter the creation of directives.

With respect to a wish to have life support terminated, present natural death act statutes (and even durable power for health care laws) tend to be quite limited. For example, although statutes generally allow the removal of respirators and ventilators and the request for do-not-resuscitate orders by advance directive, most stop short of authorizing means of effecting what is popularly known as death with dignity.[60] No statute authorizes lethal injection, for example, even under circumstances in which a patient may die by withholding medical aid. Many physician directive statutes forbid the termination of hydration and nutrition even when food and liquids are administered by intubation.[61] These statutes intentionally discriminate between persons who have a mortal dependency on medical treatment and those who will survive if normal needs for food and shelter are provided. Although courts generally have placed tubal nutrition and hydration in the medical treatment category,[62] physician directive statutes often appear to prohibit any form of terminating the supply of food and liquids.[63]

It is curious that physician directive statutes that were spawned by the plight of Karen Quinlan would not have helped resolve her case. She, as many after her, was in a coma and might have survived for an indefinite period so long as food and fluids were continued.[64] As it turned out, she did not, but many patients in persistent vegetative states may live for decades in that condition, given shelter, food, and

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[60] *See, e.g.*, CAL. CIV. CODE § 2443 (West Supp. 1991) (prohibiting provisions for mercy killing or suicide).

[61] ALA. CODE § 22-8A-3 (1990); ALASKA STAT. § 18.12.040 (1990); ARIZ. REV. STAT. ANN. § 36-3201 (1986); ARK. STAT. ANN. § 20-17-206 (Supp. 1989); CONN. GEN. STAT. ANN. § 19a-570 (West Supp. 1990); D.C. CODE ANN. § 6-2421 (1989); FLA. STAT. ANN. § 765.03 (West 1986); GA. CODE ANN. § 84-4102 (Harrison 1986); HAW. REV. STAT. § 327D-4 (Supp. 1989); ILL. ANN. STAT. ch. 110 1/2, para. 703 (Smith-Hurd Supp. 1990); IND. CODE ANN. § 16-8-11-4 (Burns 1990); IOWA CODE ANN. § 144A.2 (West 1989); KAN. STAT. ANN. § 65-28,102 (1985); ME. REV. STAT. ANN. tit. 22, § 2922 (Supp. 1989); MD. HEALTH-GEN. CODE ANN. § 5-602 (1990); MO. ANN. STAT. § 459.010 (Vernon Supp. 1990); MONT. CODE ANN. § 50-9-202 (1989); N.H. REV. STAT. ANN. § 137-H:2 (Supp. 1989); N.D. CENT. CODE § 23-06.4-02 (Supp. 1989); OKLA. STAT. ANN. tit. 63, § 3102 (West Supp. 1990); OR. REV. STAT. § 127.605 (Supp. 1990); S.C. CODE ANN. § 44-77-20 (Law. Co-op. Supp. 1989); TENN. CODE ANN. § 32-11-103 (Supp. 1990); UTAH CODE ANN. § 75-2-1103 (1990); WIS. STAT. ANN. § 154.01 (West 1989); WYO. STAT. § 35-22-101 (1988).

[62] *See Death by Directive, supra* note 7, at 82.

[63] *See, e.g.*, N.H. REV. STAT. ANN. § 137-H:2 (Supp. 1989) (life sustaining procedures that may be terminated "shall not include the administration of medication, sustenance, or the performance of any medical procedure deemed necessary to provide comfort or eliminate pain").

[64] Friedrich, *A Limited Right to Die*, TIME, Jul. 9, 1990, at 59.

liquids.[65] A few states expressly permit the inclusion of a provision to terminate food and liquids along with other directives but do not prohibit such acts without this provision.[66] Some of these states limit removal authority to documents that expressly so direct.[67]

The result, in any event, is curious. Depending upon the form of statute and the type of patient need, some may have their suffering ended by using a directive while others may not. If nothing short of ending feeding and the supply of liquids will result in death, even patients in states permitting directives to include hydration and nutrition removal will probably at best die slowly by dehydration. Physicians are directed to make the patients as comfortable as possible during that time.[68] Nonetheless, the procedure appears cruel, which suggests it eventually may be replaced with a more palatable alternative. Active euthanasia is, of course, still extremely controversial.[69]

Even one of the least controversial forms of treatment for terminal patients, do-not-resuscitate orders, may raise difficult problems. For a variety of reasons, a number of terminally ill people prefer to die outside of hospitals. They may wish to refuse treatment should they have heart failure or otherwise be stricken while at home or in a public place.[70] In such circumstances, do-not-resuscitate orders may be demanded in advance directives. These orders should not be difficult to implement in a hospital. In public, on the other hand, they become very hard to enforce. Emergency medical personnel understandably are trained indiscriminately to resuscitate and transport the victim to a medical facility. Even if other problems concerning the appropriateness of refusal of life support are solved, it may be unreasonable for a person who lives in our society to expect not to be treated if stricken ill in a public place. The core of the problem is not

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[65] *Id.*

[66] *See* IDAHO CODE § 39-4504 (Supp. 1990); MINN. STAT. ANN. § 145B.03 (West Supp. 1990).

[67] *See, e.g.*, COLO. REV. STAT. § 15-18-104 (1989 & Supp. 1990).

[68] *See, e.g.*, ALA. CODE § 22-8A-4 (1990); ILL. ANN. STAT. ch. 110 1/2, para. 703 (Smith-Hurd Supp. 1990); ME. REV. STAT. ANN. tit. 22, § 2925 (Supp. 1989).

[69] *But see* Bouvia v. Superior Ct., 179 Cal. App. 3d 1127, 1147, 225 Cal. Rptr. 297, 307 (1986) (Compton, J., concurring). Compton stated,

> The right to die is an integral part of our right to control our own destinies so long as the rights of others are not affected. That right should, in my opinion, include the ability to enlist assistance from others, including the medical profession, in making death as painless and quick as possible.

Id.

[70] *See, e.g.*, New York's Do-Not-Resuscitate Law, N.Y. PUB. HEALTH LAW §§ 2960, 2978 (McKinney Supp. 1990).

legal but practical. Emergency forces have enough to do without becoming concerned with the state of advance directives when they arrive at the scene. Yet important reasons may justify allowing terminal patients who can do so to leave hospitals if they wish. For example, discharging these patients may free needed space, be less expensive, and allow more contact with loved ones. It seems more civilized to allow terminal patients a final surrounding of choice rather than the forced interior of an institution.

One might devise a way to wear identification indicating the wish not to be resuscitated, but that probably would be ineffective. Emergency personnel might well wonder whether the decision was made legally and correctly and even who attached the identification. Emergency personnel might want medical input. A registration system with a central emergency center might handle the problem. Once an appropriate do-not-resuscitate order is issued, the patient would receive an identification with an index number to be carried on the person of the patient. The identification could be discovered (ideally by the person calling for emergency aid) and a radio check on its validity and the identifying characteristics of the person who made the advance directive could be obtained from the registry. The check potentially could be completed before arrival at the scene. At worst, it could be initiated immediately on contact by emergency personnel. A registration system should be legislatively authorized.[71]

Even under the circumstances most favorable to following an advance directive, it does not seem likely that a state legislature would enact a statute that allows lethal injection. Assisting suicide generally is a criminal act despite the direction of the person who dies.[72] In most of the civilized world, assisted dying is prohibited.[73]

The Netherlands is a notable exception:[74] euthanasia is well established, but at least at the moment, there appears to be no provision for assisting foreigners wishing to die. Perhaps that will change. Perhaps other countries will adopt the position of the Netherlands. Possibly some states will enact an assisted suicide law. Recently, such an initiative was proposed in California, but did not make the ballot.[75]

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[71] Santa Cruz County, California, has a system for processing advance directives. The 911 emergency operator checks a file for registered physician directives before dispatching emergency aid.

[72] *See* Peters, *supra* note 44, at 963.

[73] *See generally Death by Directive, supra* note 7.

[74] *60 Minutes: The Last Right?* (CBS television broadcast, Jan. 5, 1986); *Washington State Confronts Euthanasia*, Wash. Post, Feb. 6, 1991, at A7, col. 2.

[75] Proposed "Humane and Dignified Death Act," November 1988.

Public opinion polls seem to favor a similar type of provision for the terminally ill.[76]

If a terminally ill person could travel to a place in which active assistance in dying was provided, would advance directives be allowed to authorize transportation of the maker for that purpose? This problem might be anticipated in drafting current documents.

Of course, treatment cessation is not the only issue of concern. While directives to physicians are limited to life support instructions, durable powers of attorney also can direct the many medical (and financial) issues that can be anticipated to arise on incapacity. An improved advance directive law should allow the maker this option as well. After all, incompetents may well require a variety of treatments, and there is no reason to require the appointment of either an agent or conservator to insure that physicians serve the patient as the patient wishes. To ensure that the broader potential does not delay addressing issues relating to dying, the law should allow codicils to expand the original directive like will codicils.[77]

At the same time, teeth should be put into directives to physicians. So long as the medical community ignored advance directives, the directives could be seen as either useless or only marginally effective.[78] Such a perception was likely to become self-fulfilling. Life support is almost invariably supplied in hospitals. Increasingly, the primary site of death is hospitals.[79] Physicians appear generally to believe that treatment decisions are theirs to make; some even believe that they have interests which must be balanced *against* the wishes of their patients. Some courts agree.[80]

Undoubtedly, the recent congressional passage of provisions concerning advance directives will address these problems. The Omnibus Budget Reconciliation Act of 1990[81] requires Medicare providers to take an active role in informing patients about their right to participate in and direct health care decisions and requires providers to encourage and honor advance health care directives. It further mandates that each provider maintain written policies[82] ensuring that patients are given written notice of their rights to control medical treatment under state

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[76] *Right to Die: The Publics View*, N.Y. Times, June 26, 1990, at A18, col. 2 (81% of persons polled would allow a feeding tube to be removed from a comatose individual with no brain activity upon the request of family).

[77] *See* J. Ritchie, N. Alford & R. Effland, *supra* note 23, at 7.

[78] *See* Mayo, *supra* note 35, at 146.

[79] *Death by Directive, supra* note 7, at 69.

[80] Note, *supra* note 38, at 707 n.53.

[81] Pub. L. No. 101-508, 104 Stat. 1388 (1990).

[82] *Id.* § 4206(f)(1).

law, including the right to make an advance directive,[83] and that patients' medical records are marked to indicate whether advance directives exist.[84] To ensure that decisions are made freely, the act prohibits conditioning medical care (or otherwise discriminating) on whether such a directive has been executed.[85] Finally, the Act provides that the provider must ensure compliance with both common law and statutory state law respecting advance directives[86] and educate the staff *and the community* about advance directives.[87] When the law becomes effective in 1992, its impact on issues discussed in this Article should be substantial.

States may want further to support patient control. To that end the proposed law might criminalize the refusal to follow a proper directive and make refusal actionable by private injunctive proceedings. Awarding attorney fees to the winning party may be justifiable and would dissuade harassing law suits against physicians while enabling agents without ample resources to pursue actions. Whether these additional enforcement measures are required might be best assessed after the federal law has had a chance to alter present practices. The routine inquiry about directives by hospitals and others should reduce the apprehension that patients presently exhibit.

One of the most promising aspects of the congressional provision is its requirement that medical staffs be educated about advance directives. If physicians become better informed, they may become effective promoters of such documents. At the moment, physicians are not well informed. One study found that eighty-five percent of California physicians surveyed either knew nothing or little about advance directives.[88] It is appropriate to urge a patient to consider making an advance directive incident to a routine hospital admissions.[89] The routine exercise of the request will lessen its threatening nature.

Of course, the necessity for a directive stems from the incapacity of the principal. Some states prohibit anyone from exercising health care powers while the maker is competent.[90] All states allow a com-

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[83] *Id.* § 4206(f)(1)(a)(i).

[84] *Id.* § 4206(f)(1)(B).

[85] *Id.* § 4206(f)(1)(C).

[86] *Id.* § 4206(f)(1)(D).

[87] *Id.* § 4206(f)(1)(E).

[88] Zinberg, *Decisions for the Dying: An Empirical Study of Physician's Responses to Advance Directives*, 13 Vt. L. Rev. 445, 472 (1989).

[89] Lowry, *Led by Court, Hospitals Take New Interest in Living Wills*, N.Y. Times, July 23, 1990, at A1, col. 1.

[90] *See, e.g.*, Cal. Civ. Code § 2434 (West Supp. 1990); Idaho Code § 39-4505 (Supp. 1990); W. Va. Code § 13-30A-3 (Supp. 1990).

petent maker to revoke the instrument. A greater problem exists with respect to a maker who, though now legally incompetent, wishes to change a directive.

Some statutes at least allow the revocation of authority to remove life support if the patient can communicate, irrespective of whether he or she is then thought to be competent.[91] At a minimum, a new statute should have such a provision. Decisions about competency are controversial. They should not be allowed to interfere with an announced decision not to die. After all, had the patient not given authority for a contrary position, life would have been maintained as a routine application of state law.

The result of revoking the authority to remove life support, however, is permanent. If an incompetent patient revokes, the presumption of competence cannot be used to revive the document or make a new one. There is, in other words, relatively easy revocation but not easy reinstatement. Although that rule is symmetrical, it is not sensible. The states presume competency revocation, defying the customary treatment of incompetency for strong policy reasons. The reasons for allowing patient self-determination are also strong. There are alternatives to voiding the document because of a change of mind. For example, the document might be considered suspended by the change of mind and the suspension dropped if the patient again sought its ends. The absence of continued resistance might end the suspension. Family or courts might be empowered to reinstate the document, even absent competent consent, subject to the patient's refusal assuming that the patient is in a condition to communicate refusal. Thus, the deliberate, competently chosen outcome would prevail over the effects of hesitation.

A related problem is whether states will require that advance directives be reexecuted periodically or whether they will allow older documents to govern conduct at a significantly later time. Most states allow directives, once valid, to remain in force indefinitely.[92] California, however, requires their reexecution periodically.[93] Periodic

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[91] *See, e.g.*, Alaska Stat. § 18.12.020 (1986); D.C. Code Ann. § 6-2424 (1989); Haw. Rev. Stat. § 327D-12 (Supp. 1989); Okla. Stat. tit. 63, § 3104 (Supp. 1990).

[92] *See, e.g.*, Wis. Stat. Ann. § 154.05 (West 1989) (providing that a directive is valid unless revoked or superceded by the express wish of a competent patient).

[93] California requires physician directives to be reexecuted every five years. Cal. Health & Safety Code § 7188 (West Supp. 1990) (California requires the reexecution of durable powers for health care only every seven years. Cal. Civ. Code § 2436.5 (West Supp. 1990)). Wisconsin and Idaho had similar requirements for physician directives but dropped them. Idaho Code § 39-4506 (1985) (current version at § 39.4507 (Supp. 1990)); Wis. Stat. Ann. § 1154.03 (West 1989).

reexecution is necessary only if a person remains competent or regains competency.

Most physician directive statutes also avoid the problem of outdated documents by requiring that the maker be in a terminal condition at the time of execution.[94] The original directive statute, enacted in California, takes an extreme view by requiring diagnosis of the terminal condition two weeks before the document becomes binding.[95] Colorado requires one week.[96] Studies indicate that these waiting provisions effectively bar most people from executing the document.[97]

Desires expressed earlier in life or while in better health may overexaggerate the limitations that age and infirmity actually impose. Commonly, many persons happily accept living with physical limitations they once would have thought unbearable.[98] Whether that supports dismissing an earlier writing is another matter. As the advance directive represents a position once formally adopted, it likely represents a deliberate position worthy of implementation. After all, it could have been revoked by the maker. Alternatively, an intermediate position could be adopted that would give the advance directive diminished effect with the passage of time.[99] Longevity of the document alone does not justify completely disregarding the expressed views of the maker.

The third generation advance directive should deal sensitively with this complex issue. Perhaps the best direction lies in requiring the maker to specify in the document any desired form of assistance in dying beyond suspension of medical machinery such as removal of tubal feeding or suspension of chemotherapy. It might be better to provide a substitute for starvation and dehydration as the only acceptable means of allowing a person not dependent on medical machinery to die. Once we confront the fact that removal of food and water kills all patients,[100] a form of more direct and less gruesome help can be accepted as an alternative. Careful screening would be required to ensure against the previously mentioned improprieties.

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[94] Only Arkansas and Texas allow patients who are not in a terminal condition to execute advance directives. ARK. STAT. ANN. § 20-17-202 (1987); TEX. REV. CIV. STAT. ANN. art. 4590h-1 (Vernon Supp. 1991).

[95] CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1990).

[96] COLO. REV. STAT. § 15-18-104 (Supp. 1990).

[97] Redleaf, *The California Natural Death Act: An Empirical Study of Physicians' Practices*, 31 STAN. L. REV. 913, 928 (1979).

[98] Peters, *supra* note 44, at 914.

[99] Gelfand, *Living Will Statutes: The First Decade*, 1987 WIS. L. REV. 737, 768 n.125.

[100] *See Death by Directive*, *supra* note 7, at 84.

A further word on the implementation of directives to allow dying is in order. Some consideration must be given to ensuring that a decision to be allowed to die remains acceptable to the patient. Life support termination decisions may cause almost immediate death, as in the case of turning off a ventilator for a dependent patient. On the other hand, they may cause death more slowly, as in the case of the removal of a feeding tube.[101] In the latter case, there appears to be no good reason for postponing action once it is determined that the decision was appropriately made and has not been repudiated. In the former, it may be wise to provide for a short term postponement to assure a cooling off period. During the cooling off period anyone who has the right to object to the procedure, including, of course, the patient if she can communicate, can effect a change in the cessation of treatment. Because many people who have made and confirmed a decision to be allowed to die change their mind, the law should allow a short time, after all other hurdles are crossed, for sober last minute contemplation.

Whatever choices are made concerning the issues discussed, durable powers of attorney for health care should provide the model for providing instructions on health care. Comparable provisions should deal with asset management. No directive can be as effective as an agent charged with carrying out instructions. The concept is good and needs little adjustment, but it does require the maker both to craft a document and to find a trusted agent to make it work. Actually, regression might be in order because durable power laws were less complicated when they merely addressed asset management before the new class of health care durable power laws were passed.

An additional problem of conflict of laws has not yet spawned reported cases. In an increasingly mobile society, it is unrealistic to expect that the drafter of advance directives necessarily will be in the state in which the document was drawn or, for that matter, in her then home state. A few statutes accommodate that problem by enforcing a document that is valid in the state in which it was made.[102] Minnesota accepts a directive that substantially complies with its own law.[103] At the opposite extreme lie California and Oregon, which prescribe a form to be used or at least prescribe a number of necessary provisions that

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[101] *See id.* at 84.

[102] ALASKA STAT. § 18-12.090 (1986); ARK. STAT. ANN. § 20-17-212 (Supp. 1989); ME. REV. STAT. ANN. tit. 22, § 2930 (Supp. 1989); MD. HEALTH-GEN. CODE ANN. § 5-612 (1990); MONT. CODE ANN. § 50-9-111 (1989); OKLA. STAT. tit. 63, § 3103.1 (Supp. 1991); UNIF. RIGHTS OF TERMINALLY ILL ACT § 13, 9B U.L.A. 80 (Supp. 1990).

[103] MINN. STAT. ANN. § 145B.15 (West Supp. 1990).

might well be omitted in a draft prepared elsewhere.[104] Worse yet, the requirements of those states differ from each other. The requirement that specific provisions or forms be used does not foreclose a court from accepting a conflicting document made by persons not under the state's jurisdiction at the time.[105]

The great majority of states do not prescribe the precise form or mandate the inclusion of specific provisions. They allow different forms and they do not resolve the conflicts of law question. Although their laws probably raise fewer problems than the restrictive states' statutes, they are not ideal either. The conflicts question is yet to be resolved, and it still remains open to the courts to refuse to enforce an out of state form.

No state appears to require its courts to allow the appointment of an agent who, because she is located outside the state, may not be easily amenable to the state's laws. Although a court seemingly could condition enforcement of a directive on the agent's voluntary compliance with state requirements, the uncertainties involved do not provide peace of mind for elders. The new law should contain a provision validating a directive that complies with the requirements of the maker's state of domicile when the directive was made. The state also could impose other requirements from its own laws if the maker becomes a domiciliary. Even then, the document should at least be accepted in any legal proceeding as an indication of the maker's wishes.

Natural death laws do not require the appointment of agents. That feature removes a nagging problem of durable powers of attorney. Many elders may have significant trouble finding a willing and able agent who is likely to remain healthy and competent. Many elders have no one. On the other hand, the presence of someone with legal authority to enforce the patient's wishes increases the likelihood of those wishes being effectuated. Although physicians must follow physician directives, patients by definition are incompetent to make—let alone enforce—their directives when the time comes. Because patients enforce their own mandates, many physicians likely control the medical fate of their patients.[106] At least, elders may fear that their documents are ineffectual.

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[104] CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1990); OR. REV. STAT. § 127.610 (Supp. 1990).

[105] Some statutes now so provide. *See, e.g.*, TEX. REV. CIV. STAT. ANN. art. 4590h-1, sec. 13 (Vernon Supp. 1991).

[106] *See Fear of Being Suspended in a Vegetative State Has Triggered an Unprecedented Demand for Living Wills Since High Court Ruling*, L.A. Times, July 17, 1990, at E1, col. 4.

The third generation living will could resolve the problem by enlarging the group of persons who are available for selection as attorney-in-fact. Since the primary reason for appointing an agent outside of available family probably is the avoidance of family interference with an elder's wishes, the agent need not be a close relative of the elder. It suffices that the person is willing to follow the provisions of the durable power and that she is competent to act. A corps of volunteers willing to serve such a purpose might be relatively easy to develop since there are already many models of community elder support. It would seem a worthy project for one of the many community-minded service organizations to adopt; perhaps funding for the organization of such groups might be appropriate. The sponsoring group could undertake training and supervision of volunteers. Laws should be amended to allow such organizations to be named as either the principal agent or as an alternate agent in an advance directive.[107]

At present, advance directives end at death. It might be wise to allow an agent-based directive to exist long enough for the agent to have an autopsy conducted as a means of enforcing predeath medical directives.[108]

One commentator has suggested that the doctrine of *cy pres* might be adapted to give effect to a maker's perspectives given changed circumstances.[109] Thus, the intent of the maker might be effectuated by substituting a feasible means of execution for one that has become impossible.

The fact that only those with an advanced education are likely to use physician directives and powers of attorney supports finding an appropriate alternative. Physician directive and powers of attorney put a high premium on expression skills and on experience with legal documents.[110] Many people made wards under conservatorship laws

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[107] Health care durable power of attorney laws generally require that the health agent be a named person. *See, e.g.*, Oregon Durable Power of Attorney for Health Care, OR. REV. STAT. §§ 127.505-.585 (1989).

[108] *See, e.g.*, GA. CODE ANN. § 31-36-7 (Harrison 1990) (agent may be empowered to make an anatomical gift, authorize an autopsy, or direct the disposition of a principal's remains); ILL. ANN. STAT. ch. 110 1/2, para. 802-5 (Smith-Hurd Supp. 1990) (unless agency states an earlier termination date, the agency continues until the death of the principal); KAN. STAT. ANN. § 58-625 to -632 (Supp. 1989) (agent may make decisions about organ donation, autopsy, and disposition of the body); MINN. STAT. ANN. § 145B.03 (West Supp. 1990) (since "health care" needs to cease at death, presumption must be that agency also ceases); TENN. CODE ANN. § 34-6-201 (Supp. 1990) (health care is limited to treatment decisions, thus creating the presumption that the agency ends at death).

[109] Gelfand, *supra* note 99, at 794 n.254.

[110] *Doing Justice to Life; For the Cruzans, Pain for Principle, a Triumph*, N.Y. Times, June 27, 1990, at A22, col. 1.

likely do not possess either skill.[111] If the law is to apply to all classes, the new law should provide alternative directions in the event that the dying person has never provided written directions. Of course, every effort should be made to facilitate the use of durable powers and directives, but not providing an adequate alternative is probably insensitive to the differences among people.

A significant problem lies in the small number of directives that presently are prepared. Death is an unpleasant subject that most people avoid discussing or even considering. Although in a recent poll the majority of those questioned approved of living wills, only fifteen percent had made one.[112] On the other hand, fifty-six percent had informed family members of their wishes.[113] The recently passed of federal law can be expected to increase the number of directives drawn.

To some extent, it is inappropriate to require that people use these documents rather than other alternatives when the intent is to promote self-determination. More effort must be made, however, to lessen the burden of making directives. State-approved forms, already available in most states,[114] are useful especially if they do not limit the ability of the maker to direct conduct in other terms. These forms provide an inexpensive and uncomplicated means of preserving a person's wishes.

Whether a thoughtful, literate person would adopt a form might depend on the extent to which that person had specific concerns that

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[111] In the New York study of guardianship, a large number of wards were state charges who, presumably, often would be undereducated. SURROGATE MANAGEMENT, *supra* note 7.

[112] L.A. Times, July 17, 1990, at E1, col. 4.

[113] *Developments in the Law—Medical Technology and the Law,* 103 HARV. L. REV. 1519, 1647 n.35 (1990).

[114] *See* ALA. CODE § 22-8A-4 (1990); ALASKA STAT. § 18.12.010 (1986); ARIZ. REV. STAT. ANN. § 36-3202 (1986); ARK. STAT. ANN. § 20-17-202 (Supp. 1989); CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1990); COLO. REV. STAT. ANN. § 15-18-104 (1989); CONN. GEN. STAT. § 19a-575 (West Supp. 1990); D.C. CODE ANN. § 6-2422 (1989); FLA. STAT. ANN. § 765.05 (West 1986); GA. CODE ANN. § 31-32-3 (1986); HAW. REV. STAT. § 327D-4 (Supp. 1989); IDAHO CODE § 39-4504 (Supp. 1990); ILL. ANN. STAT. ch. 110 1/2, para. 703 (Smith-Hurd Supp. 1990); IND. CODE ANN. § 16-8-11-12 (Burns 1990); IOWA CODE ANN. § 144A.3 (West 1989); KAN. STAT. ANN. § 65-28,103 (1985); LA. REV. STAT. ANN. § 40:1299:58.3 (West Supp. 1990); ME. REV. STAT. ANN. tit. 22, § 2922 (Supp. 1989); MD. HEALTH-GEN. CODE ANN. § 5-602 (1990); MINN STAT. ANN. § 145B.04 (West Supp. 1990); MISS. CODE ANN. § 41-41-107 (Supp. 1989); MO. REV. STAT. § 459.015 (Supp. 1990); MONT. CODE ANN. § 50-9-103 (1989); NEV. REV. STAT. ANN. § 449.610 (Michie 1986); N.H. REV. STAT. ANN. § 137H:3 (Supp. 1989); N.C. GEN. STAT. § 90-321 (1985); N.D. CENT. CODE § 23-06.4-03 (Supp. 1989); OKLA. STAT. ANN. tit. 63, § 3103 (West Supp. 1990); OR. REV. STAT. § 127.610 (Supp. 1990); S.C. CODE ANN. § 44-77-50 (Law. Co-op. Supp. 1989); TENN. CODE ANN. § 32-11-105 (Supp. 1990); TEX. HEALTH & SAFETY CODE ANN. § 672.004 (Vernon Supp. 1990); UTAH CODE ANN. § 75-2-1104 (1990); VT. STAT. ANN. tit. 18, § 5253 (1987); VA. CODE ANN. § 54.1-2984 (1988); WASH. REV. CODE ANN. § 70.122.030 (Supp. 1990); WYO. STAT. § 35-22-102 (1977); UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 2, 9B U.L.A. 70 (Supp. 1990).

would not be protected by the form. In that regard, it would be especially useful to have an authoritative interpretation of the form provisions enacted along with them. While the interpretations would not be as binding as the language of the form, they would provide a first step in dealing with ambiguities. The issue is of sufficient importance to make form drafting the subject of educational campaigns.

Finally, in the event that a person does not create a physician directive or durable power appointment, a statute could take care of problems without the necessity of court intervention. The new statute might continue to name the persons who would be empowered to act on behalf of the patient absent a directive and further be broadened to express the totality of health care the state would allow them to direct. Depending on the satisfaction with these provisions, a patient would choose whether to make an alternative document and, if so, what its provisions should be. Disagreement with the medical care provisions provided in the new statute would trigger at least a physician directive. If a patient does not trust one of those persons empowered to act on her behalf, she could appoint an agent.

Improvements in medical technology have made advance directives far more important than they would have been at an earlier time.[115] The authorizing laws have been passed quickly, but have not been coordinated with other state laws. Substantial overlap exists, and yet significant gaps exist as well. Cases relating to terminal care also have flourished in the past decade. It is a good time to differentiate and reorganize the laws that exist. A single package, especially one that spells out the results of failing to make a directive, would make directives more useful and, consequently, more likely to be used.

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[115] *Death by Directive, supra* note 7, at 69.

Premature Probate: A Different Perspective on Guardianship for the Elderly

George J. Alexander*

The management of an individual's property and health is, in large part, left to that person's discretion. The law considers most people competent to make the necessary decisions in these areas. However, for those who lack that competence, largely the elderly,[1] the law provides for the imposition of surrogate management in the form of guardianship or its equivalent.[2] Yet the substitution of a guardian's judgment as to what is best for the ward's health or property creates a grievious potential for abuse.

The guardian may make health treatment decisions for the ward which are contrary to the ward's wishes. For example, the guardian may hospitalize the ward for the ward's "protection." The hospital

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On April 23 and 24, 1979, the author chaired the Task Force on Protecting Human Rights, at the National Conference on Mental Health and the Elderly held by the United States House of Representatives Select Committee on Aging. The staff of the Select Committee circulated a prior draft of this article to the Task Force which then recommended that "appropriate legislative bodies . . . provide for legislative implementation of the right of individuals to file binding statements, while competent, to govern disposition of their person and property during incompetency." The proposal was unanimously accepted by the Conference.

[1] One study showed that 80% of the persons placed under guardianship in the Los Angeles County central district from July 1, 1973 to June 30, 1974 were over 65. *See* National Senior Citizens Center, Empirical Study of Guardianship and Conservatorship Filings in Los Angeles County (1977) (unpublished data on file with author) [hereinafter cited as Senior Center Study]. This study, conducted by the National Senior Citizens Center, a federally funded legal services center concerned with the legal problems of the elderly poor, included examination of 1,010 cases filed under CAL. PROB. CODE §§ 1460–1470 (West 1956) (amended 1959, 1976, 1978), and *id.* §§ 1701-2207 (West Supp. 1979) in the Los Angeles County central district.

[2] *See, e.g.*, CAL. PROB. CODE §§ 1460–1463, 1701-2207 (West Supp. 1979).

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may use a form of treatment, such as electroconvulsive therapy, which the ward may particularly fear. Or the guardian may involuntarily commit the ward to an institution if the guardian feels the ward is suicidal or dangerous to others.

The guardian may also deny the ward the benefit of possessions or savings, or require the ward to receive those benefits as a dole from an appointed manager. The guardian may manage the property in a way that channels funds away from individuals the ward would like to benefit, and toward persons the guardian prefers. Alternatively, the guardian may restrict the ward's expenses with an eye to enlarging the estate that will pass on death.

Since the law conceives of surrogate management as a benefit to the ward, the law imposes such management in a nonadversary setting. Consequently, claims to the ward's property are not openly raised and adjudicated, but instead are subsumed in litigation on the single issue of the ward's competence.[3] Moreover, although the importance of benefit to the ward in the competency determination causes that proceeding to become laden with a concern for due process—on the assumption that such procedures will guarantee fairness—that guarantee is uncertain, and shocking inequities often come to light.

Although guardianship of property and health have much in common, the two forms of surrogate management raise different problems. In Part I of this article, I consider the problems attending guardianship of property, and examine the approaches used to protect the ward's property interest. I conclude that the "living will" suggested by probate law provides the best substitute for the present model of guardianship. In Part II, I look at the problems raised by the surrogate management of health needs—principally the excessive use of involuntary commitment—and I conclude that a living will also allows individuals to control their *treatment* in the event of incompetence.

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[3] *See, e.g.*, *id.* §§ 1460-1461. "In most jurisdictions, the petition [for guardianship] may be filed by either the disabled person or by one or more of his friends or relatives." Rohan, *Caring for Persons Under a Disability: A Critique of the Role of the Conservator and the "Substitution of Judgment Doctrine"*, 52 ST. JOHN'S L. REV. 1, 6 (1977). Moreover, "[s]everal jurisdictions impose the additional requirement that notice be furnished to the spouse, 'descendants, ascendants and next of kin' of the proposed conservatee," *id.*, thus including in the proceedings the vast majority of potential heirs.

I. THE LIVING WILL AND SURROGATE MANAGEMENT OF PROPERTY

The fall of a wealthy man demonstrates the scope of possible personal tragedy inherent in a guardianship proceeding.[4] Ben Weingart was ordered into conservatorship, the rough equivalent of guardianship, in October 1974.[5] At that time, he appeared to own property valued at about one-half billion dollars.[6] The petition for surrogate management alleged that he was likely to be imposed on by "artful and designing" persons, naming the woman with whom he had lived for 16 years.[7] The petitioners, who would become the managers of Mr. Weingart's property, were personally indebted to him for sub-

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[4] Shakespeare often wrote about the tragedies of kings rather than of common folk. "The pangs of despised love and the anguish of remorse, we say, are the same in a peasant and a prince; but . . . the story of the prince, the triumvir, or the general, has a greatness and dignity of its own . . . . [W]hen he falls suddenly from the height of earthly greatness to the dust, his fall produces a sense of contrast, of the powerlessness of man, and of the omnipotence—perhaps the caprice—of Fortune or Fate, which no tale of private life can possibly rival." Bradley, *The Substance of Shakespearean Tragedy*, in APPROACHES TO SHAKESPEARE 1, 5-6 (N. Rabin ed. 1964).

But most guardianship proceedings do not concern the wealthy. *See* G. ALEXANDER & T. LEWIN, THE AGED AND THE NEED FOR SURROGATE MANAGEMENT 71-72, 159 (1972) (table 5). Information from Onondaga County, New York records revealed that the total average estate involved in guardianship proceedings was approximately $24,000. *Id.* The vast majority of petitions for guardianship, those concerning state hospital patients, involved an average estate of approximately $19,000. *Id.* And guardianship proceedings sometimes involve only the right to make decisions about publicly provided benefits. "[T]he incompetent poor have almost as many meaningful decisions to be made for them as have incompetents with property." Zicklin & Libow, *The Penultimate Will*, 47 N.Y. ST. B.J. 31, 32 (1975). Studies in California and New York revealed that a state hospital was the petitioner for an adjudication of incompetency in a vast majority of the cases examined. *See* G. ALEXANDER & T. LEWIN, *supra*, at 12; Senior Center Study, *supra* note 1. State hospitals institute such proceedings to secure reimbursement for the costs of care, maintenance, and medical treatment of the patient. G. ALEXANDER & T. LEWIN, *supra*, at 67-69; *see* OFFICE OF THE ATTORNEY GENERAL, STATE OF NEW YORK, HANDBOOK OF INSTRUCTIONS FOR COMMITTEES OF PATIENTS OF STATE INSTITUTIONS (1968). Regardless of the theoretical solicitude of the law toward small estates, those persons classed as relatively indigent are not accorded the same procedural opportunities and safeguards as their more affluent counterparts. *See* Senior Center Study, *supra* note 1.

[5] *In re* Weingart, No. P-607498 (Super. Ct. Prob. Div. L.A. County, Cal. Oct. 29, 1974); *see* Hamill, *For the Ben Weingarts, There Oughtta Be a Law*, L.A. Herald Examiner, Jan. 10, 1979, § A, at 3, col. 1; Hamill, *The 'Cinderella' Who Loved Ben Weingart*, *id.*, Jan. 8, 1979, § A, at 3, col. 1; Hamill, *Ben Weingart: Rags to Riches . . . Back to Rags*, *id.*, Jan. 5, 1979, § A, at 3, col. 1; Hamill, *They Spoke for His Money, Not Him*, *id.*, Jan. 3, 1979, § A, at 3, col. 1; Hamill, *Tycoon's Millions Began with 35¢ Loan*, *id.*, Dec. 31, 1978, § A, at 1, col. 1; Hamill, *Her Fight Over a Tycoon's Millions*, *id.*, Dec. 29, 1978, § A, at 1, col. 1.

[6] Hamill, *Her Fight Over a Tycoon's Millions*, *supra* note 5, at 3.

[7] Mr. Weingart's generosity to his cohabitant, Laura Winston, precipitated the conservatorship proceedings. Eight days prior to the institution of the proceedings, Ben Weingart tried to increase the corpus of a trust he had set up for Laura Winston from $1 million to $2

stantial amounts of money.[8]

The court declared a temporary conservatorship in October 1974,[9] and permanent conservatorship that November.[10] Mr. Weingart was present at neither proceeding.[11] To excuse his absence, the petitioners presented the court with a medical certificate stating that Mr. Weingart had a moderately severe organic brain syndrome and was, for that reason, not able to attend the hearing.[12] Once appointed, the managers stopped all payments to the woman who had been living with Mr. Weingart and barred her from seeing him.[13] They also transferred substantial sums of money from their control as conservators—subject to conservatorship accounting to the court—to a trust of which they were trustees.[14]

The story of Ben Weingart abounds in procedural unfairness, hidden conflicts of interests, and tragic disregard for the wishes of the ward. Those who, unlike Mr. Weingart, escape surrogate management, ultimately dispose of all of their property through probate. Both surrogate management and probate principally affect the elderly. Both processes often benefit spouses and children—surrogate management by conserving property so that it might later pass to these heirs through probate, and by sometimes increasing the allowances given to them during the ward's life. But unlike probate, surrogate management denies the ward the right to determine the use of property, since it does not follow the ward's previously expressed intent. I argue in this part that even though guardianship proceedings have been conducted with an increasing regard for procedural due process, they fail to protect the ward's property interests. I suggest that better results are possible by substituting probate for the present model of guardianship. Such a change would stress certainty of result, and shift the focus from what is "best" for the ward to implementation of the ward's previously stated objectives as expressed in a "living will."

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million. The petitioners for conservatorship alleged that Ms. Winston coerced Mr. Weingart's attempt. *See* Hamill, *The 'Cinderella' Who Loved Ben Weingart*, *supra* note 5.

[8] Hamill, *Her Fight Over a Tycoon's Millions, supra* note 5, at 3.

[9] *Id.* at 1.

[10] *Id.* at 1, 3.

[11] *Id.* at 1.

[12] *Id.*

[13] *Id.* at 3.

[14] *Id.*

A. *Inadequacy of Present Guardianship Law*

A court imposes guardianship[15] on individuals when it finds that they are unable to care properly for themselves.[16] When a court makes such a determination, it may then appoint a guardian to care for the ward's health.[17] The same guardian, or another court appointee, may assume management control of the ward's property.[18] Both health and property guardianships label the ward as unable to manage,[19] and substitute a surrogate to act in the ward's best interests.[20] But because of broadly drawn standards of incompetence and illusory procedural safeguards in guardianship statutes, courts frequently find an individual incompetent and appoint a guardian where the alleged incompetent is still capable of managing property. And even where a ward is incompetent and does require a guardian, present guardianship statutes do not ensure that the guardian will manage the ward's property in accordance with the ward's wishes. Nor do these statutes ensure that the court will recognize the conflict of interests between the petitioners and the ward. In this section I examine these inadequacies of guardianship statutes.

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[15] The history of guardianship is closely linked to the law of insanity. If insane, an individual could be deprived of various rights, including those of property management, through guardianship proceedings. *See* Horstman, *Protective Services for the Elderly: The Limits of Parens Patriae*, 40 MO. L. REV. 215, 218-19 (1975); Regan, *Protective Services for the Elderly: Commitment, Guardianship, and Alternatives*, 13 WM. & MARY L. REV. 569, 570-73 (1972). A later statutory distinction between old age and insanity showed that many legislatures believed that aging itself might bring about functional disabilities creating property management problems. *See, e.g.*, CAL. PROB. CODE § 1435.2 (West 1956) (amended 1976) (word incompetent defined to include "insanity as well as incompetency arising by reason of old age, disease, weakness of mind, or other cause rendering a person unable, unassisted, properly to manage and take care of himself or his property").

In some states, separate provisions exist for the management of the insane—or mentally ill—and of those incompetent by reason of functional disability not traceable to mental illness. The older practice of treating the groups alike was known as guardianship. *See, e.g.*, *id.* §§ 1435.2, 1460-1462 (amended 1959, 1976, 1977, 1978). The newer process of conservatorship, used for the surrogate management of those incompetent by reason of functional disability, is intended to recognize the difference between insanity and disfunction. *See, e.g.*, *id.* §§ 1701-2201 (West Supp. 1979). *See generally* G. ALEXANDER & T. LEWIN, *supra* note 4, at 81-124. Since the two terms have become confused, this article will refer to the two processes as guardianship.

[16] *See* CAL. PROB. CODE § 1435.2 (West Supp. 1979). While this standard may seem overly vague, it is common in the statutes.

[17] *Id.* § 1460 ("Any superior court to which application is made . . . may appoint a guardian for the person and estate or person or estate of an incompetent person . . . ."). For further discussion of the surrogate management of health needs, see notes 92-123 *infra* and accompanying text.

[18] CAL. PROB. CODE §§ 1460, 1500 (West Supp. 1979).

[19] *See id.* §§ 1435.2, 1460.

[20] *Id.* §§ 1460, 1500.

1. *Adjudicating incompetency.*

Broadly drawn standards of incompetence. The California Probate Code under which *In re Weingart* was tried,[21] like the current probate statutes of many other states, allowed surrogate managers to be appointed on the basis of broadly drawn standards of incompetence.[22] The standards used in these current statutes, like the standards in the California statute prior to its amendment, presumably reflect a belief that the guardianship process principally benefits the ward. The spe-

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[21] The California law of guardianship was revised after *In re Weingart.* While the old law allowed a court to appoint a conservator based on broadly drawn standards of incompetence, the new law focuses on the ward's ability to function. *Compare* CAL. PROB. CODE §§ 1435.2, 1460 (West 1956) (amended 1976) (incompetency can arise "by reason of old age, disease, weakness of mind, or other cause rendering a person unable, unassisted, properly to manage and take care of himself or his property") *with id.* (West Supp. 1979) (person incompetent when "unable properly to provide for his own personal needs for physical health, food, clothing or shelter, and . . . substantially unable to manage his own financial resources"). The new law also no longer allows a court to appoint a conservator for individuals unable to resist "artful and designing" persons, but instead only directs that courts be concerned about whether the ward is capable of resisting "undue influence." *Compare id.* §§ 1460, 1751 (West 1956 & Supp. 1975) (amended 1976) *with id.* (West Supp. 1979). Moreover, while under the old law courts often considered emotional or psychological instability as valid reasons for the alleged incompetent's absence from the court proceeding, *see* notes 29-30 *infra* and accompanying text, the new law provides that these are not valid reasons in most instances, *see* CAL. PROB. CODE § 1461 (West Supp. 1979) (absence permitted only if "attendance at the hearing is likely to cause serious and immediate physiological damage"). If a potential ward's absence is excused, the court must send an official to the potential ward to explain his or her rights. *Id.* §§ 1461.1, .5; *see id.* § 1461 (official must explain to potentially incompetent person "that he shall have the right to legal counsel of his own choosing, including the right to have legal counsel appointed for him by the court if he is unable to retain one"). The new law strengthens the provision for representation by counsel, *see id.* § 1461.5, makes counsel more readily available, *see id.* (court may appoint attorney if alleged incompetent does not have attorney), and provides for automatic periodic review by court investigators, *see id.* § 1500.1 (1 year after inception of guardianship and bienially thereafter). These new provisions combine a concern for due process in the determination of incompetence with a direction that the court hear the potential ward.

Because of the breadth of discretion allowed by the statute, however, the statute is less effective than it appears on its face. In a case tried by the author under the new law, the trial judge, the Honorable Gerald E. Regan, refused to hear closing argument explaining the new law or applying it to the facts. Disregarding a trial memorandum referring to the new provisions, he found the ward to be susceptible to "artful and designing" persons. Told that this standard was no longer used in the law, the judge instead considered the ward's ability to manage property. Upon asking the conservator whether the ward met the statutory standard of competence and getting a simple "no" in reply, the judge continued the conservatorship. The same judge controlled the appointment of counsel for trial and for any possible appeal. *In re* Blatteis, No. 58476 (Super. Ct. San Mateo County, Cal. Nov. 17, 1977); *see* Guardianship of Boxley, 115 Cal. App. 2d 483, 486; 252 P.2d 348, 350 (2d Dist. 1953) (incompetent may not contract for services of attorney when seeking to remove guardian).

[22] *See* CAL. PROB. CODE §§ 1435.2, 1460 (West 1956) (amended 1976); Regan, *supra* note 15, at 603-05.

cific standards are broad, *e.g.*, "old age," and tend to encourage value judgments rather than neutral factfinding. For instance, while there is a good deal of controversy on the relevance of age to disfunction,[23] the statutory language allows the trier of fact to stereotypically link age and incompetence.[24] Similarly, although the elusive concept of mental illness evokes prejudice among lay persons,[25] the judge or jury can use mental illness in its most prejudicial sense when it becomes a reason for supposedly beneficial intervention through guardianship.

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[23] "[Old] people . . . cannot be judged to be incompetent. They know what they are doing, . . . and [want] to live the way they are living. Still, from our present sociological way of thinking they need care; some of them their estates, most of them their persons." McAvinchy, *The Not-Quite-Incompetent Incompetent*, 95 TRUSTS & EST. 872, 873 (1956).

[24] *See generally* T. SZASZ, LAW, LIBERTY, AND PSYCHIATRY (1963).

[25] Though there might be some agreement on what constitutes old age, mental illness is a more shifting concept. "Mental illness is [currently] defined so broadly that every human being is at times mentally ill." Turner & Carr, *Towards an Enlightened Commitment Law*, in *Hearings on Constitutional Rights of the Mentally Ill Before the Subcommittee on Constitutional Rights of the Senate Committee on the Judiciary*, 91st Cong., 1st & 2d Sess. 392, 415 (1969–1970). The edition of AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (2d ed. 1968) then in effect provided powerful examples of such inclusiveness:

"307.4 Adjustment reaction of late life. Example: Feelings of rejection associated with forced retirement and manifested by social withdrawal.

"301.82 Inadequate personality. This behavior pattern is characterized by ineffectual responses to emotional, social, intellectual and physical demands. While the patient seems neither physically nor mentally deficient, he does manifest inadaptability, ineptness, poor judgment, social instability, and lack of physical and emotional stamina.

"301.6 Asthenic personality. This behavior pattern is characterized by easy fatigability, low energy level, lack of enthusiasm, marked incapacity for enjoyment, and oversensitivity to physical and emotional stress. This disorder must be differentiated from Neurasthenic neurosis (q.v.).

"301.81 Passive-aggressive personality. This behavior pattern is characterized by both passivity and aggressiveness. The aggressiveness may be expressed passively, for example by obstructionism, pouting, procrastination, intentional inefficiency, or stubbornness. This behavior commonly reflects hostility which the individual feels he dare not express openly. Often the behavior is one expression of the patient's resentment at failing to find gratification in a relationship with an individual or institution upon which he is over-dependent."

Responding, perhaps, to criticism, the A.P.A. has eliminated all but the "passive-aggressive" classification from the latest version of its *Manual*, *see id.* (3d ed. 1978), and labelled that category as "controversial" and subject to future elimination, *id.* at K:27. However, the mutability of these definitions underscores the elusiveness of the concept of mental illness. *Id.*

One commentator has noted the shifting definition of mental illness as illustrated by the A.P.A.'s changing characterizations of homosexuality. Prior to 1973, he notes, the A.P.A. "considered homosexuality per se a mental disorder. In that year, by a vote of its membership, the Association decided that homosexuality was not a mental disorder. The nature of homosexuality did not change, nor were there any startling breakthroughs in the scientific understanding of homosexual behavior. . . . What changed were the *values* of a professional group empowered to affix labels of deviancy." Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527, 557 (1978).

Illusory procedural safeguards. California law, like current statutes in other jurisdictions, also provided Mr. Weingart with procedural safeguards. But, as for most alleged incompetents, these procedural safeguards were of no help to Mr. Weingart. For example, the law specifically provided for his presence at the hearing,[26] representation by counsel to controvert the petition,[27] and a judicial determination of incompetence.[28] But Mr. Weingart did not appear at either of his two hearings and was not represented by counsel opposing the petition.[29] His case was typical: According to a study by the National Senior Citizens Center, 93 percent of the respondents were not in court when their cases were tried.[30] Petitioners in each case presumably presented medical certificates similar to the one filed in *In re Weingart*, stating that the respondent was unable to withstand the rigors of a courtroom proceeding. In a sense, the medical certificate predetermined a finding of incompetency. The doctor's signature on a statement that the respondent's debility prevented an appearance at the hearing provided the first evidence of incompetency for the trial court. Also, like Mr. Weingart, 97 percent of those in the National Senior Citizens Center's study were unrepresented at their hearings.[31] It should not be surprising to find that potential wards who were themselves shunted away from the competency hearing would allow themselves to go unrepresented as well.

2. *Ward's wishes and conflicts of interests.*

Even where a court properly finds an individual incompetent, guardianship statutes do not ensure that the guardian will follow the ward's wishes or that the court will recognize the conflict of interests between the petitioners and the ward. That the ward earned the money and owns the property subject to the proceedings, and that the ward may have definite and competent plans for its disposition, are of no consequence if the court determines that the ward is *presently* incompetent to manage property. While knowledge of what the

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[26] *See* CAL. PROB. CODE § 1461 (West 1956) (amended 1976) (alleged incompetent, "if able to attend, must be produced at the hearing, and if not able to attend by reason of physical inability, such inability must be evidenced by the affidavit of a duly licensed physician or surgeon").

[27] Act of Sept. 17, 1973, ch. 546, 1973 Cal. Stat. 1066 (current version at CAL. PROB. CODE § 1461.5 (West Supp. 1979)).

[28] *See* CAL. PROB. CODE §§ 1460, 1751 (West 1956 & Supp. 1975) (amended 1976).

[29] Hamill, *For the Ben Weingarts, There Oughtta Be a Law*, *supra* note 5.

[30] Senior Center Study, *supra* note 1.

[31] *Id.*

ward would have done when competent may illuminate the question of what is in the ward's best interest, the guardian and the supervising court have responsibility for determining how the money is to be spent.[32]

Moreover, nothing in the typical guardianship proceeding recognizes or addresses the potential conflict of interests between petitioners, who may be future beneficiaries of the estate and thus want the estate preserved, and the potential ward, who may want to spend money from the estate.[33] Any one of a large number of persons may bring a proceeding to examine the competence of a person alleged to need a guardian.[34] The petitioners are typically members of the family, or near relatives, who are quite likely to benefit from a guardianship which will preserve assets which can be distributed to them when the ward dies.[35] Several competing beneficiaries may join in initiating proceedings, agreeing that the estate must be preserved undiminished, but expecting later to contest each other's claims.

In fact, the California Probate Code under which Mr. Weingart's case was tried, like the current probate statutes of many other states,[36] actually encouraged the court to ignore this conflict of interests between the petitioners and the potential ward, since it allowed the court to appoint a conservator for those persons who by reason of old age or other condition were unable to resist "artful and designing" persons.[37] While a provision of this nature appears at first blush to focus on the concern that a debilitated person may be victimized, the other provisions concerning mismanagement of property would probably suffice to handle that concern. Instead, the specific reference to "artful and designing" persons calls the court's attention to the relationship between the potential ward and the potential ward's present beneficiaries, and diverts the court's attention from the conflict between the potential ward's interests and the interests of the petitioners.[38] Thus, the court in *In re Weingart* presumably focused its

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[32] *See* CAL. PROB. CODE §§ 1500-1607, 1650-1669 (West 1956 & Supp. 1979).

[33] *See id.*; Note, *The Disguised Oppression of Involuntary Guardianship: Have the Elderly Freedom to Spend?*, 73 YALE L.J. 676, 676-78 (1964).

[34] *See, e.g.*, CAL. PROB. CODE § 1461 (West Supp. 1979); Rohan, *supra* note 3, at 6.

[35] G. ALEXANDER & T. LEWIN, *supra* note 4, at 71-75.

[36] *See* Alexander, *Surrogate Management of the Property of the Aged*, 21 SYRACUSE L. REV. 87, 129 (1969).

[37] CAL. PROB. CODE §§ 1435.2, 1460, 1751 (West 1956 & Supp. 1975) (amended 1976).

[38] As the author has pointed out elsewhere, the "artful and designing" person language is a singularly instructive example of a statutory invitation to value judgment. Alexander, *On Being Imposed Upon By Artful and Designing Persons—The California Experience with the Involuntary Placement of the Aged*, 14 SAN DIEGO L. REV. 1083, 1089-90 (1977). The clear focus of the test

attention on whether Mr. Weingart's younger roommate was "designing," while newspaper reports on the proceedings focused on the avarice of the petitioners.[39] While both considerations bear on the potential ward's need for a surrogate manager, the law appears to exclude from the court's consideration those interests of petitioners which might conflict with those of the potential ward.

Consequently, it appears that present guardianship law is inadequate, both because courts too readily find individuals incompetent, and because there is no guarantee the ward's wishes will be followed even if the ward actually is incompetent. In the next section I explore whether these deficiencies in present guardianship law can be cured under the due process clause of the 14th amendment.

B. *Limits of the Due Process Model*

Considering the effect of guardianship on a ward, it seems surprising that there is a dearth of cases holding its invocation unconstitutional.[40] Two reasons may explain this void. First, the proceedings have not been viewed as depriving the ward of property; quite to the

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is on protecting the potential ward's heirs and keepers from the overreaching of third parties and, like the pattern of statutory schemes in the guardianship area, on preserving the assets of the alleged incompetent's estate. Moreover, actual depletion of the estate is not necessary; it is sufficient that a threat of loss exists. *Id.* at 1089. Seeking to "protect" the alleged incompetent from the influence of a perceived "artful and designing" person, a judge may place the ward's estate in the hands of the petitioners, who may or may not protect the interests of the ward. *See, e.g.*, Guardianship of Estate of Brown, 16 Cal. 3d 359, 546 P.2d 298, 128 Cal. Rptr. 10 (1976). In *In re* Cassidy's Guardianship, 95 Cal. App. 641, 273 P. 69 (1st Dist. 1928), the court found that the ward's desire to invest in the building business on assurance of "big money" available, in spite of inexperience in the building business, together with inability to carry on a long conversation, formed adequate grounds to appoint a guardian. In *In re* Olson's Guardianship, 236 Wis. 301, 295 N.W. 24 (1940), the trial court had appointed a guardian for the alleged incompetent solely on the testimony of the petitioner, his niece, in the face of contrary testimony by those who saw him most frequently. The trial court had stated, "If [appointment of a guardian] isn't done now, won't it have to be done sometime in the near future? Probably." *Id.* at 303, 295 N.W. at 25. The court of appeals reversed, stating " 'Only with great hesitation should courts, by the appointment of a guardian, interfere with the discretion of elderly people, owing no legal duty of support to anyone, in devoting the property accumulated by them to their comfort according to their own tastes.' " *Id.* at 304–05, 295 N.W. at 26 (quoting *In re* Guardianship of Warner, 232 Wis. 467, 473, 287 N.W. 803, 805 (1939), which quotes in part *In re* Guardianship of Welch, 108 Wis. 387, 390, 84 N.W. 550, 551 (1900)). The language of this court is the very point of this article. *See In re* Lyon, 52 A.D.2d 847, 382 N.Y.S.2d 833 (1976); *In re* Guardianship of Waite, 14 Cal. 2d 727, 731, 97 P.2d 238, 240 (1939).

[39] *See* note 5 *supra*.

[40] The related question of civil commitment has only recently emerged as one of constitutional importance. *See* O'Connor v. Donaldson, 422 U.S. 563 (1975); Jackson v. Indiana, 406 U.S. 715 (1972); *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190, 1271–1316 (1974) [hereinafter cited as *Civil Commitment*].

contrary, they have been seen as preserving the property for the ward.[41] Second, legislation has been altered to provide the kinds of protection in guardianship proceedings which courts often impose when they reach constitutional issues affecting individual rights: notice, hearing, and the right to counsel.[42] In this section I explore the constitutionality of surrogate management. Since surrogate management can be seen as a deprivation of liberty or property, I consider its constitutionality under both theories.

1. *Surrogate management as a deprivation of property.*

The imposition of surrogate management is probably not an unconstitutional deprivation of property under the due process clause of the 14th amendment. In the recent past, the Supreme Court has given little protection to property interests, in contrast to the considerable protection it has afforded life and liberty interests. At least since the late 1930s, the Court has accepted a generalized fairness standard of protection for property interests, while insisting on individualized fairness for life and liberty concerns,[43] even though the Constitution speaks *equally* of life, liberty, and property as protected by due process.[44] Thus, the state may deprive a person of life and liberty only after a sufficient—and sometimes quite elaborate—individualized procedure,[45] while courts normally validate states' legislative determinations as to the disposition of property, even though they may cause individual hardship, if they are rational and basically fair to the entire group governed.[46] Consequently, if surrogate man-

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[41] The protection of assets is also stressed in state conservatorship laws. Rohan, *supra* note 3, at 12.

[42] *See generally* G. ALEXANDER & T. LEWIN, *supra* note 4; Alexander, *supra* note 38. Peter M. Horstman has argued that a full adversary hearing on the issue of incompetency would provide the protection needed by those facing guardianship. Horstman, *supra* note 15, at 231-78. While this protection would be an important step, it suffers from the continuing possibility that the property owner's will may nonetheless be thwarted, since the ward is stripped of control of his property once he is adjudged incompetent.

For further discussion of the due process model and its applicability to civil commitment proceedings, see Task Panel, President's Comm'n on Mental Health, Mental Health and Human Rights: Report of the Task Panel on Legal and Ethical Issues (Feb. 15, 1978), *reprinted in* 20 ARIZ. L. REV. 49 (1978); *Civil Commitment, supra* note 40, at 1271-1316.

[43] L. TRIBE, AMERICAN CONSTITUTIONAL LAW 413-70, 564-72 (1978).

[44] U.S. CONST. amends. V, XIV.

[45] *See, e.g., In re* Gault, 387 U.S. 1 (1967).

[46] Justice Black accurately summarized this development in his opinion for the Court in Ferguson v. Skrupa, 372 U.S. 726 (1963): "Under the system of government created by our Constitution, it is up to legislatures, not courts, to decide on the wisdom and utility of legislation. There was a time when the Due Process Clause was used by this Court to strike down laws which were thought unreasonable, that is, unwise or incompatible with some particular

agement is characterized as a deprivation of property, courts will probably hold that it is constitutionally permissible, even without the same procedural safeguards provided in a criminal trial. The state need merely adopt a general scheme of guardianship which rationally balances competing economic considerations.

2. *Surrogate management as a deprivation of life/liberty.*

But even the life/liberty due process model, with its individualized justice, cannot ensure fairness in guardianship proceedings, since its standard is uncertain and totally dependent on *procedural* vindica-

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economic or social philosophy. . . . The doctrine that prevailed in *Lochner*, *Coppage* [and] *Adkins* . . . has long since been discarded. We have returned to the original constitutional proposition that courts do not substitute their social and economic beliefs for the judgment of legislative bodies, who are elected to pass laws." *Id.* at 729-30.

To be sure, the Supreme Court once took a more protective view of property interests. *See, e.g.*, Adkins v. Children's Hospital, 261 U.S. 525 (1923); Coppage v. Kansas, 236 U.S. 1 (1915); Lochner v. New York, 198 U.S. 45 (1905). Presently, however, the property interests that are protected tend to be interests of the "new" rather than the "old" property, where the focus is not so much on the thing owned as on the owner. *See* Goldberg v. Kelly, 397 U.S. 254 (1970); Reich, *The New Property*, 73 YALE L.J. 733 (1964). Thus, welfare entitlements may be protected because of the desperate needs of the recipients. *See* Goldberg v. Kelly, 397 U.S. at 261-64. Debtors may be protected against seizure of their property by creditors, presumably because debtors, also, are uniquely vulnerable as a group. *See* Fuentes v. Shevin, 407 U.S. 67 (1972). Accused violators of trade ethics are protected from the power of their accusers not because their interests sound in property, but because they are relatively helpless. *See* Silver v. New York Stock Exch., 373 U.S. 341 (1963).

It is difficult to state a litmus test to distinguish between property and life/liberty interests, since many economic relationships affect basic personal liberties, and liberty has an economic component. Further, the present dichotomy may not properly represent the original rationale behind the distinction. Chief Justice Stone's famous footnote in United States v. Carolene Products Co., 304 U.S. 144 (1938), introduced the dichotomy: "There may be narrower scope for operation of the presumption of constitutionality when legislation appears on its face to be within a specific prohibition of the Constitution, such as those of the first ten amendments, which are deemed equally specific when held to be embraced within the Fourteenth. . . .

"It is unnecessary to consider now whether legislation which restricts those political processes which can ordinarily be expected to bring about repeal of undesirable legislation, is to be subjected to more exacting judicial scrutiny under the general prohibitions of the Fourteenth Amendment than are most other types of legislation.." *Id.* at 152 n.4 (citations omitted).

Stone's point was to distinguish between rights which legislatures would likely champion because they affect a significant political constituency and rights which could only rarely command a legislative majority. Economic concerns of the sort the Court had addressed in its due process heyday were an illustration of the former. The then nascent individual rights of minority groups and persons accused of crime seem to fit the latter. While the present-day distinction between property interests and life/liberty interests, which gives greater protection to life/liberty interests, is consistent with Justice Stone's dichotomy, it may misrepresent the rationale behind the dichotomy. For a further discussion of the relationship between property and liberty, see Reich, *supra*, at 771-74.

tion. As Justice Frankfurter pointed out in *Joint Anti-Fascist Refugee Committee v. McGrath*:[47] "Fairness of procedure is 'due process in the primary sense.' It is not a yardstick. It is a delicate process and adjustment inescapably involving the exercise of judgment . . . ."[48]

Procedural due process is an attempt to individualize justice. It accommodates the general interests of society to the individual needs and limitations of the person affected, forbidding that which is unfair, indecent, or shocking to the conscience. Such notions seem to work well in guaranteeing the fairness of the criminal justice system, the principal field of the application of procedural due process. The events relevant to the charged conduct have all taken place in the past and will not change; no one is required to predict the future. The standard of criminality is sharply drawn in most situations. The questions of fact often are questions which average people can answer routinely in their normal lives. The substantive issues are well articulated and procedural protections ensure fairness. But similar procedural protections cannot ensure fairness in guardianship proceedings. As *In re Weingart* poignantly demonstrates, such standards leave untouched the fundamental unfairness inherent in guardianship proceedings, the subordination of the ward's wishes to the judgment of others.

Moreover, even if one could hope to approximate the ward's intent through guardianship, the adjudication of incompetency simply does not lend itself to precision through procedural protection. In this section I discuss the two reasons why guardianship proceedings do not lend themselves to procedural protection. First, the standards used in guardianship proceedings, unlike those used in criminal trials, cannot be defined. Second, the court in a guardianship proceeding must predict the future, while the criminal justice system examines events which have taken place in the past.

Problem of nebulous standards. The ambiguous standards of the substantive law in guardianship proceedings preclude effective application of procedural due process analysis to guardianship proceedings. In particular, the standard of what is an appropriate ability to manage property is unclear.[49] Are persons who manage to meet the

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[47] 341 U.S. 123 (1951).

[48] *Id.* at 161, 163 (Frankfurter, J., concurring) (citation omitted). Justice Brandeis noted in his dissent in Burdeau v. McDowell, 256 U.S. 465 (1921), that "in the development of our liberty insistence upon procedural regularity has been a large factor." *Id.* at 477.

[49] "The problem of determining the kind of performance which represents good or poor management is . . . easy at the extremes; in the middle ground no amount of scientific

challenges of daily life with assistance from friends and family incompetent because they could not do it alone? Are they incompetent when they make decisions preventing the dissipation of their property but are noticeably less effective than those who managed it before? Are they incompetent if their property management skills are marginal, irrespective of their prior abilities? What does the word "properly" mean in the statutes relating to property management? Do persons whose survival is not in question manage "improperly" if they fail to live up to standards the trial court finds appropriate? How does the court decide on an appropriate standard?

The statutory standards seem to allow definitions of functional ability ranging from simple improvidence in occasional transactions[50] to incapacity to provide for food or medical care for extended periods of time. Since one can almost always find property managers who can improve on a particular owner's management, it is unclear when it becomes appropriate to impose such a manager on an unwilling recipient.[51]

Problem of predicting the future. Even if the underlying standards could be clarified, due process procedural protection must still fail to ensure fairness. Guardianship laws necessarily attempt to predict *future* conduct, in contrast to those areas of law concerned with *prior* events, where the due process approach has been successful. For example, in the typical criminal trial the central question is whether the defendant committed a specific criminal act. As difficult as it may be to reconstruct the past, it is far easier than predicting the future. While the law generally prohibits the state from setting stan-

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evidence will be helpful. It is a question of what kinds of performance 'count' as good management or poor management, and this is a matter of personal taste since the rules of language are flexible enough to allow either judgment in the middle area." Leifer, *The Competence of the Psychiatrist to Assist in the Determination of Incompetency: A Skeptical Inquiry Into the Courtroom Functions of Psychiatrists*, 14 SYRACUSE L. REV. 564, 567 (1963).

[50] *See* Note, *supra* note 33, at 682-83.

[51] This inherent problem is further exacerbated by the needlessly ambiguous language found in many of the present guardianship statutes. The "artful and designing" person standard is a prime example of such a statute. Because Mr. Weingart and Ms. Winston were not married, she can be described as an "artful and designing" person. Viewed from that perspective, the question becomes less one of the sincerity of his intentions to support the relationship, and more one of his ability to resist it. What might in other circumstances be described as Mr. Weingart's love, making him want to be near her and to provide for her, becomes his inability to resist her and a statutory reason for guardianship. The needlessness of the "artful and designing" person standard is illustrated by California's rejection of this standard in 1976. *See* note 21 *supra*.

dards of criminality that depend on the prediction of future behavior,[52] the focus in guardianship is *necessarily* prospective. The court is instructed to discern how the potential ward would manage without a guardian. Prior acts provide the basis for initiating proceedings and assist in the prognostication, but the important question is how the respondent will behave after the hearing.

Courts often rely on experts, at least in cases warranting the expense, to help make predictions of future conduct. Physicians (especially psychiatrists) and psychologists often testify. The great weight given to expert testimony introduced by a party when the issues in question are relatively precise has been frequently criticized.[53] When, as in guardianship, the issues are hard to define, the influence of experts is probably magnified. Moreover, it is unclear that a scientific basis for prediction exists. Empirical studies demonstrate substantial prediction failures.[54] For example, experts have frequently overapplied diagnoses of irreversible chronic brain syndrome.[55] A recent review of expert testimony about future dangerousness casts grave doubts on the predictive ability of these experts.[56] There is no reason to believe that experts can better predict the ability to manage property in the future.[57]

Certainly greater procedural protection may reduce the likelihood of improper adjudication of incompetency. Yet even with the greatest possible procedural protection, the adjudication of incompetency may still be inaccurate. And, if inaccurate, great unfairness is possible under guardianship, where the ward's wishes are so easily lost in the fray. Since present guardianship law cannot be declared

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[52] "In both [criminal confinement and civil commitment] cases the state decides that society at large will benefit from deprivation of the individual's liberty. But criminal imprisonment normally is imposed only after a defendant has committed or attempted a dangerous act. If a sociologist predicted that a person was eighty per cent likely to commit a felonious act, no law would permit his confinement." Note, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 HARV. L. REV. 1288, 1289-90 (1966).

[53] Recent articles have pointed to the problems arising from the use of partisan experts, whose viewpoints are established in response to "pecuniary stimulus." *See, e.g.*, Moenssens, *The 'Impartial' Medical Expert: A New Look at an Old Issue*, 25 MED. TRIAL TECH. Q. 63 (1978); Molinari, *The Role of the Expert Witness*, 9 FORUM 789 (1974). Often the finder of fact may simply be determining which party has the better experts. Moenssens, *supra*, at 65-66; Molinari, *supra*, at 791.

[54] *See* Ennis & Litwak, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693, 711-16 (1974); Morse, *supra* note 25, at 595-99.

[55] *See* Alexander, *supra* note 38, at 1096; Regan, *supra* note 15, at 577-79, 590-91. *See also* Horstman, *supra* note 15, at 275 & n.269.

[56] Ennis & Litwak, *supra* note 54, at 711-16.

[57] Morse, *supra* note 25, at 596.

unconstitutional, and since its failings cannot be cured by a procedural approach, a more radical restructuring by the legislature is needed. In the next section I examine probate law as a possible substitute for guardianship proceedings.

C. *The Probate Model: Substitution of a Living Will for Guardianship Proceedings*

Guardianship proceedings brought by members of the family against an elderly parent or spouse often look superficially like probate proceedings. The judge very often is a probate judge, and the participants in the proceedings tend to introduce evidence of a failure to properly provide for them as an indication of fiscal mismanagement. But since the ward is still alive probate would be premature. If the issue were posed as a question of traditional inheritance, much of the controversy would be quickly resolved either by the presence of a will or by intestate succession. In this section I contrast probate law with present guardianship law, and suggest how the legislature could use probate law as the basis for authorizing creation of a "living will"—a document which would allow individuals to direct the management of their property in case of future incompetence. If adjudicating incompetency must inevitably be inexact, we can at least ensure that in all cases the wishes of the ward are paramount and explicit.

1. *Formalities of probate as advancing the testator's intent.*

Certainty of result is a significant, if not the primary, feature of the law of inheritance. Consequently, fixed rules are commonplace and tend to apply even in the face of countervailing considerations of fairness. For example, in *Estate of Moore*,[58] the California Court of Appeals invalidated a will which had been signed at the beginning rather than at the end, although the will complied with all other statutory requirements. There was no question that the document was the decedent's will, yet the court refused to allow it into probate. The court recognized the probable specific unfairness to the decedent's estate, but relied on a broader view of justice, noting that when they are strictly construed, "statutes in the long run promote justice—which is their sole object—by shutting out opportunities of fraud. When they defeat one honest purpose they prevent unnumbered frauds, which in their absence would be feasible and measura-

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[58] 92 Cal. App. 2d 120, 206 P.2d 413 (3d Dist. 1949).

bly safe."[59] It is easy to find similar examples in the law of formalities which when disobeyed apparently thwart a drafter's intent in the interest of avoiding fraud.[60]

Although insistence on correct form appears at first to thwart the accomplishment of a property owner's wishes, the purpose of that insistence may actually be the opposite. By providing for a certain result, such rules enable those willing to take the trouble to adopt the proper form to be certain about the outcome of their actions. The formality prevents competing claims of unfairness from becoming issues. If form were not so important, courts would continuously be confronted with the invitation to balance countervailing interests against the precision of the property owner's statement of intent. But instead a court can reject a document when improperly expressed—however "unfair" that rejection may be—and accept a property owner's statement made in the proper form—however "unfair" its disposition of property may be. In that light, one can understand the court's decision in *Estate of Moore*, even if the "unfairness" in that case is extreme. Ironically, individual fairness is better effected by rules leading to certain outcomes than by individual adjudication.

2. *Application of probate law to guardianship: the living will.*

Probate may be an appropriate model for the disposition of property belonging to allegedly incompetent individuals. Legislatures have already committed similar issues involving events after death or incapacity to will-like processes. For example, it is now possible, in some states, to donate one's body, or parts of one's body, upon death.[61] Some jurisdictions also recognize written declarations directing that life-sustaining techniques be abandoned when death is inevitable.[62] Further still from the point of death, some states allow

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[59] *Id.* at 124, 206 P.2d at 415; *accord*, Estate of Seaman, 146 Cal. 455, 462–63, 80 P. 700, 702–03 (1905).

[60] The Statute of Frauds, which requires that a broad range of contracts be in writing, is one such doctrine outside of probate law. *See, e.g.*, U.C.C. §§ 1-206, 2-201; RESTATEMENT (SECOND) OF CONTRACTS §§ 178–224 (1973). Other examples include recording statutes, *see, e.g.*, CAL. CIV. CODE §§ 1169–1218 (West 1954 & Supp. 1979), and the requirement that deeds be delivered by the grantor to the grantee, R. POWELL, THE LAW OF REAL PROPERTY ¶ 896 (rev. ed. 1979). Perhaps the most colorful example was the common law method of conveyancing by feoffment with livery of seisin, whereby the parties to a transaction would call together a jury of neighbors and in their presence exchange a twig or clod of dirt to evidence the transfer of title. *See* 2 F. POLLOCK & F. MAITLAND, THE HISTORY OF ENGLISH LAW 82–83 (2d ed. 1898).

[61] The model statute is the Uniform Anatomical Gift Act. *See, e.g.*, CAL. HEALTH & SAFETY CODE §§ 7150–7157 (West 1970 & Supp. 1979).

[62] *See, e.g.*, *id.* §§ 7185–7195 (West Supp. 1979) (California Natural Death Act).

individuals to file a will-like document nominating a guardian, should there ever be a need to appoint one.[63] A similar device is the power of attorney, which delegates authority for specified acts to named persons;[64] the delegation survives later incompetency of the maker in states which have authorized such instruments. All such statutes leave discretion with the court to choose a guardian, but they allow a person to take responsibility by proposing an arrangement for a fiscal caretaker, should one be required in the future.[65] If a similar device existed by which those now alleged to be incompetent could have recorded their wishes concerning the disposition of their property while they were competent, courts might be spared the type of fraud which the court in *Estate of Moore* said it avoided,[66] but which is certainly possible in today's guardianship proceedings.

Contrast between probate and guardianship. The contrast between probate and present guardianship law is great. First, the intent of a ward is less likely to be followed than is the intent of a decedent. A decedent's previously expressed wishes control the distribution of the estate in probate, except to the extent that there are interests legally enforceable by others against the estate.[67] But while guardianship also purports to effectuate the true wishes of the ward,[68] the ward's wishes are not necessarily heeded in practice.[69] Second, probate and guardianship also differ because *death* prevents decedents from enjoying their property, while the *law* prevents wards from enjoying theirs. Third, in a probate proceeding, those who contest the will do

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[63] *See* Regan, *supra* note 15, at 616.

[64] UNIFORM PROBATE CODE § 5-501; Lombard, Miller, Gother & Houghton, *Legal Problems of the Aged and Infirm—The Durable Power of Attorney*, 13 REAL PROP., PROB. & TR. J. 1, 2-11 (1978).

[65] *See, e.g.*, CAL. PROB. CODE § 1463 (West Supp. 1979).

[66] *See* note 59 *supra* and accompanying text.

[67] Both individuals and entities not named in a will can make claims against a decedent's estate. Creditors' claims receive high priority in distribution and a wide range of procedural safeguards. *See, e.g.*, UNIFORM PROBATE CODE §§ 3-605, -607, -801 to -816, -909, -1004, 6-107. Government claims to estate and inheritance taxes are protected, *see, e.g.*, I.R.C. § 2001; CAL. REV. & TAX. CODE §§ 13401, 13601 (West 1970), and the testator's family is protected through such devices as homesteads, exemptions, and allowances, *see, e.g.*, UNIFORM PROBATE CODE §§ 2-401 to -403.

[68] For example, guardianship provisions protecting wards from "artful and designing" persons ostensibly protect the ward's true wishes by eliminating undue influence. *See* notes 36–38 *supra* and accompanying text.

[69] Under UNIFORM PROBATE CODE § 5-424, for example, the conservator is given broad powers to manage the property, subject only to the rare need for court approval. There is no check by the incompetent on the power of the conservator.

so openly, as adversaries.[70] In guardianship proceedings, however, their interests may be hidden behind their roles as petitioners. Finally, third parties cannot generally question the propriety of the distribution of a decedent's estate unless they claim a statutory interest. But in guardianship, "wasteful" earlier distributions can become a principal reason for the declaration of incompetency and for thwarting the ward's intent.

The main difference between probate law and guardianship law, and the principal advantage of probate law, is that while guardianship does not necessarily follow a ward's intent, probate courts seldom interfere with a testator's wishes for property disposition. As we have seen, a primary principle of probate law is to follow the testator's *stated* intention.[71] Wills pass property from the estate to beneficiaries selected by the decedent. Assuming competency to make a will,[72] a testator is free to exercise sound judgment or whim. Except in limited circumstances,[73] a court will not review the property disposition for fairness, or to substitute the court's judgment for that of the testator.[74] Third parties who believe that they should have been preferred to those named in the will are not allowed to contest the court's distribution.[75]

Probate and the living will. The advantages and disadvantages of allowing a probate-like prior determination to control the management of property are similar to those of allowing wills to control the

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[70] Under most modern statutes, the administrator's role resembles that of the defendant in a collection action. *See, e.g.*, UNIFORM PROBATE CODE §§ 3-801 to -816.

[71] This is the basic rule of construction in interpreting wills. *See* UNIFORM PROBATE CODE § 2-603.

[72] *See* notes 88–90 *infra* and accompanying text.

[73] For an explanation of those instances in which courts deviate from the terms of a will, see note 67 *supra* and accompanying text.

[74] Even in the absence of a written document, the law prefers not to give courts discretion in the distribution of a decedent's property. Intestacy law provides mechanical formulae for the apportionment of property where a decedent did not leave a will meeting statutory criteria, and courts do not undertake to adjust these formulae in light of what might appear to be fair under the circumstances. *See, e.g.*, UNIFORM PROBATE CODE §§ 2-101 to -113 (intestacy provisions). An intestacy statute is the legislature's determination of what is generally fair. In order to reduce litigation and promote judicial economy, this standard is imposed even in the cases where, because of unusual circumstances, inequities result.

[75] But the right to pass property by will in a relatively unfettered manner is not unlimited; the state regulates the process in several ways. For example, it provides that interests may be claimed "against the will" because of a desire to protect certain types of people from the testator's total discretion. *See* note 67 *supra*. Also, legal claims against the decedent may generally be collected from the estate. *Id.* Beyond such limits, however, the testator's choice controls.

distribution of property after death. There is, of course, the opportunity for improvidence. Even so, one knows that the disposition was determined by the person most able to understand appropriate uses of the ward's wealth and the ward's possible needs for management help—the ward's prior self. The ward's written directions would bind the surrogate manager appointed by the living will, or if the instrument were silent on a particular point, the surrogate would act as he or she believed the incompetent would have intended. Incompetents would have had an opportunity to spell out such concerns in whatever detail they deemed appropriate at an earlier point in life.

In common with a decedent, the incompetent may have legal obligations to others. Present probate laws may be useful in determining these obligations. For example, it is clear that creditors may bring claims against a debtor's estate.[76] Similarly, spouses have claims to the estate, whether by way of community property or through an elective share.[77] The state exacts taxes, which may be claims against the estate.[78] Probate laws protect other interests by giving homestead exemptions to surviving spouses or dependent children,[79] providing spouses and minor children with family allowances,[80] and granting property allowance exemptions generally, which preserve property for spouses and children in preference to other beneficiaries.[81]

If the law allowed individuals to prepare living wills directing the course of their possible future guardianships, then statutes could allow overriding claims to be met as they presently are met by probate law. For example, if a husband made no provision for his wife during his guardianship, the state would direct that the guardian support her. In addition, the continuing needs of the ward might necessitate claims by the ward on others; it might be desirable for a statute to recognize a parent's claim for emergency medical funds from children. In any event, the legislature has ample precedents should it ever choose to recognize claims against living wills which are not presently allowed against decedents' wills.

Further, the living will might significantly reduce adjudicated incompetence. Statistics are difficult to find, but anecdotes indicate that incompetency proceedings are sometimes improperly used to ad-

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[76] *See* UNIFORM PROBATE CODE §§ 3-801 to -816.

[77] *Id.* §§ 2-201 to -207.

[78] *See* I.R.C. § 2001; CAL. REV. & TAX. CODE §§ 13401, 13601 (West 1970).

[79] *See* UNIFORM PROBATE CODE § 2-401.

[80] *Id.* § 2-403.

[81] *Id.* § 2-402.

just property concerns among competing claimants. *In re Weingart* is a case in point. The debts of the conservators and Mr. Weingart's generosity to his roommate were fundamentally altered.[82] It seems possible that if individuals were unable to benefit from a determination of incompetence, they would be less likely to bring such proceedings. Perhaps living wills would shift the concern in incompetency proceedings from control of property to the welfare of the alleged incompetent, a type of case which the apparently self-serving nature of present guardianship proceedings brought by members of the family may actually inhibit. At the very least, the living will would reduce the grievous potential for abuse caused by the inevitably imprecise adjudication of incompetency.

D. *Creating and Enforcing a Living Will*

The "living will" suggested by this article would direct the course of the testator's guardianship, should such a guardianship become necessary. Enforcement of living wills would hinge on meeting formalities similar to those used in the law of decedents' wills. If the formalities were met, the testator would be certain that the wishes expressed in the living will would be followed. The need to meet a set of formal requirements would usually promote reliance on professional help to write the living will, because of the complexity of competing concerns in arranging a possible future guardianship. This section examines the creation and enforcement of a living will.

1. *Formalities.*

Many questions which would otherwise plague the interpretation of living wills, such as the requisite formalities or rules of interpretation, can be satisfied by reference to the law of wills. As we have seen, the law of wills provides a good guide to forced shares of the estate when spousal shares and benefits to pretermitted children and spouses are at issue.[83] For instance, just as the surviving spouse is entitled to a share of the decedent's estate, the ward's mate should be able to keep part of the ward's property even if the living will provides otherwise. However, if the testator's statutory duty of support[84]

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[82] *See* notes 8, 13-14 *supra* and accompanying texts.

[83] *See* notes 77, 79-81 *supra* and accompanying texts.

[84] Statutes often impose upon certain family members the duty to support specified kin. For example, a parent must support minor children, CAL. CIV. CODE § 196 (West Supp. 1979), and, in certain circumstances, a child must support needy parents, *id.* § 206. *See generally id.* §§ 241-254 (imposing civil liability for such support); *id.* § 246 (establishing criteria for amount of support due).

exceeds the income from the forced share, the greater obligation seems appropriate, since it is the amount that would be due from the ward if competent.

But while the maker of a living will may be directly affected by the instrument's provisions, decedents derive no personal benefit from the carrying out of their wills' directions. The maker of a living will, therefore, has a different concern about that instrument than does the testator of a will effective only at death. Consequently, the formalities required for living wills should deviate from those applied to decedents' wills. First, makers of living wills should be encouraged to file them with a public authority, and the act of filing should provide legally binding notice to those who might wish to contest the document. Second, a process should be established to permit individuals to challenge living wills before they become operative. This would allow concerned persons to protest what they considered to be undue influence or overreaching which might indicate functional debility; it would also help to establish that the will was competently made, if no challenge occurred for a substantial time after the will's execution and filing.[85]

A concern for privacy dictates that only the fact of filing, and not the content of the living will, be made public. Family harmony might suffer from greater disclosure, and few testators would welcome the pressures brought to bear by those with contrary views urging modification of the living will.[86] However, since the proposed dispositions might indicate confusion or other functional lapses, in extraordinary cases courts should have the power to permit inspection of the document by others, after in camera review. Modification and revocation would be required to meet the filing requirements and the principles of the law of decedents' wills.

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[85] Adoption of the insurance concept of incontestability might also be desirable. The law presumes that the holder of a life insurance policy did not intend to defraud the insurer by committing suicide, if 5 or more years passed between the initial signing of the policy and the suicide. Similarly, the law might provide that if a person executes a document and is not declared incompetent within a certain period from the date of execution, the competency of the person would be incontestable for purposes of effecting the document. Such a rule would certainly entail some risk, as it does when used in insurance policies. But it would both mitigate the difficulty of establishing prior competence and further the goal of allowing personal responsibility. Also, it would avoid a good deal of litigation and promote relative certainty of result.

[86] *In re* Weingart, No. P-607498 (Super. Ct. Prob. Div. L.A. County, Cal. Oct. 29, 1974), is a case in point.

2. *Discretion of the guardian.*

The living will need not dispose of all the testator's property. It could provide, for example, that certain family members were to continue an existing business, manage the stock portfolio, or the like. It could provide for or against support of children in enterprises they might undertake. It might specify the support of loved ones. It could forbid the sale by the guardian of certain assets particularly important to the maker. It could name those to be given management roles and those to be excluded, or it could specify only limited management roles for certain individuals.

But however detailed the living will, it must leave many issues unresolved.[87] Much discretion will necessarily pass to the guardian; a provision nominating an appropriate list of alternative guardians is probably equally crucial to avoid the naming of a possibly undesirable guardian by the court. Given the specific directions of other provisions, the surrogates would be free to fill in what they assumed to be the maker's intention.

3. *Challenges to the living will.*

Third parties might challenge the living will, as they can a decedent's will, on the grounds that the testator was incompetent or under undue influence when the instrument was executed. Such challenges to a living will, however, should be as generally unsuccessful as they are when made to decedents' wills.

The law requires that to be valid a will must be executed while the maker is competent. Although one might argue that a testator's self-doubts about competency at the time of execution might be the motive for making a living will, the mere act of making a living will should not generally lead to a court finding the maker incompetent. Rather the test of competence for a living will should be as it is in the law of probate. The test of competence used there is sufficient age, the ability to understand the nature of one's acts, the ability to recollect and understand the nature and location of one's property, and the ability to remember and understand one's relations to the persons who have claims upon the testator's bounty and whose interests are

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[87] Management of one's estate is probably so unique that model wills would be of little use, since it is far more complicated to continue one's affairs than to distribute the wealth they represent. Indeed, the use of a model form is fundamentally inconsistent with the idea of persons taking responsibility for themselves and would likely lead to the types of abuses in the present system.

affected by the will.[88] Challenges to the probate of wills on the ground of incompetency of the maker are rarely successful.[89] The passage of time since making the document generally suffices to indicate that the maker was competent at the time when the instrument was executed. "[I]solated acts, foibles, idiosyncrasies, moral and mental irregularities or departures from the normal" by themselves are insufficient to show incompetency.[90] Similarly generous treatment should be given to living wills, so that the property owner's wishes will be followed.

Third parties might also contend that the maker of the instrument, although otherwise functioning adequately, has fallen under undue influence, and that the living will therefore should be disregarded. The availability of living wills would motivate those concerned about undue influence to challenge the instruments when made, much as they may presently institute proceedings for guardianship or challenge improvidently made gifts. Their failure to challenge the living will soon after its execution should also be probative of the competence of its maker.

Courts should apply the doctrine of substituted judgment[91]—an attempt to determine what the ward would wish if competent—when third parties question the competency of the maker of a living will, just as courts apply the doctrine to similar cases involving decedents' wills. In my opinion the use of the doctrine of substituted judgment is preferable to disregarding a person's wishes altogether, although it shares with the current unsatisfactory law of incompetency the uncertain benevolence of deciding what is in the best interest of someone else. Nonetheless, substituted judgment is better than total disregard of the ward's intent. The terms of a living will could direct decisions about substituted judgment even though that document would be denied direct effect.

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[88] *E.g.*, Estate of Smith, 200 Cal. 152, 158, 252 P. 325, 328 (1926); T. ATKINSON, HANDBOOK ON THE LAW OF WILLS § 51 (2d ed. 1953); Note, *Psychiatric Assistance in the Determination of Testamentary Capacity*, 66 HARV. L. REV. 1116, 1116-17 (1953).

[89] "[A]n examination of the [California] cases discloses comparatively few in which the attack on the ground of incompetency was successful." 7 B. WITKIN, SUMMARY OF CALIFORNIA LAW *Wills and Probate*, § 99, at 5616 (8th ed. 1974).

[90] Estate of Wright, 7 Cal. 2d 348, 356, 60 P.2d 434, 438 (1936).

[91] The doctrine and its philosophical rationale are discussed in Robertson, *Organ Donations by Incompetents and the Substituted Judgment Doctrine*, 76 COLUM. L. REV. 48, 57-68 (1976).

II. THE LIVING WILL AND SURROGATE MANAGEMENT OF HEALTH NEEDS

This article has concerned itself principally with the disposition of an elderly person's wealth. Guardianships are available for the surrogate management of an elderly person's health needs as well. As a form of involuntary intervention, such "protective" services of all sorts have frightening potential. While comparative data is not available, one would suppose that wards perceive guardianships of their persons, especially those resulting in hospitalization, as greater invasions of personal autonomy than guardianships of their estates. Whether or not this conjecture is true, empirical evidence suggests that involuntary hospitalization may be lethal.[92] The Benjamin Rose Institute, in a study of the effectiveness of protective services, compared an involuntarily hospitalized group with a control group to determine, among other things, how much longer involuntarily hospitalized patients lived. Its findings indicated that the involuntarily hospitalized group died sooner than the control group.[93] The study noted the generally recognized belief that people, especially the elderly, resent forced relocation, and that involuntary hospitalization creates very high levels of anxiety.[94]

In this part I examine the legitimacy of the grounds used to involuntarily commit elderly persons for health reasons, and I discuss how a living will might allow individuals to determine the nature of their health care after they have become incompetent.

A. *Grounds for Involuntary Commitment*

The decision whether involuntary intervention is necessary to provide medical care is generally made under standards quite similar to, or identical with, those used for property management.[95] Consequently, the vagaries that attend guardianship determinations for property management plague determinations for health care as well.[96] The distortion caused by expert testimony is increased, since the testimony of physicians about the ward's need for care appears far more clearly to fall within their expertise, and is therefore proba-

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[92] *See* Blenker, *Environmental Change and the Aging Individual*, 7 GERONTOLOGIST 101 (1967); Gottesman, *The Response of Long-Hospitalized Aged Psychiatric Patients to Milieu Treatment*, 7 GERONTOLOGIST 47 (1967).

[93] BENJAMIN ROSE INSTITUTE, PROTECTIVE SERVICES FOR OLDER PEOPLE: FINDINGS FROM THE BENJAMIN ROSE INSTITUTE STUDY (1974).

[94] *Id.*

[95] G. ALEXANDER & T. LEWIN, *supra* note 4, at 81-96.

[96] *See* notes 19-20 *supra* and accompanying text.

bly given greater weight by the court than is a medical prediction of fiscal improvidence. Although testimony as to the health care which can be provided a ward does lie within medical expertise, the question of whether involuntary intervention is needed to provide treatment raises the same problems of prediction that exist in property management cases.[97] Since courts have difficulty distinguishing between the issues, they give excessive weight to medical testimony.[98]

If a guardian is appointed, the health care the guardian provides the ward may vary from simply furnishing nutritional needs and occasional medicine, to having the ward involuntarily committed to an institution. The interests protected by the guardian's intervention are a bit more complex than those protected in the property cases. In addition to protecting wards from their own improvidential inability to provide for their needs—the best interest standard—there may be a specific concern that the wards not commit suicide or harm others. While guardianship laws do not expressly impose these concerns on the guardian, civil commitment law reflects the societal interest in all three by recognizing them as grounds for commitment.[99] In this section I consider the legitimacy of involuntarily committing elderly persons because they are dangerous to others or to themselves—grounds that complicate this article's consideration of a ward's self-determination because they introduce significant claims by others.

1. *Dangerousness to others.*

The most clearly legitimate claim by third parties is that the ward may be dangerous to others.[100] Persons committed because they are considered dangerous owe their commitment at least in part to public safety considerations. This type of commitment, however, has been under strong attack recently.[101] Commentators have pointed out that psychiatrists forced to confront the prospect of possible violence from an unrestrained patient have a strong motivation to predict dangerousness, thus obtaining the safety of the patient's incarceration in a neutral hospital.[102] While doubts about the relia-

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[97] *See* notes 52-57 *supra* and accompanying text.

[98] *See* Schulman, *To Be or Not To Be an Expert*, 1973 WASH. U.L.Q. 57, 63; Wexler & Scoville, *The Administration of Pyschiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1, 60-61 (1971).

[99] *See Civil Commitment*, *supra* note 40, at 1201-07; Note, *supra* note 52, at 1289-97.

[100] *See Civil Commitment*, *supra* note 40, at 1201-07; Note, *supra* note 52, at 1289-93.

[101] *See* Ennis & Litwak, *supra* note 54.

[102] *See, e.g.*, Dershowitz, *The Psychiatrist's Power in Civil Commitment: A Knife that Cuts Both Ways*, PSYCH. TODAY, Feb. 1969, at 43, 47.

bility of psychiatric testimony do not alter the state's concern for public safety, the doubts certainly suggest that involuntary commitment may be an overreaction.

Moreover, hospitalization because of feared future dangerousness is similar to criminal preventive detention (incarceration because of feared future criminality). But a belief that a person may be dangerous in the future is not an acceptable ground for criminal punishment.[103] A therapeutic approach does not help legitimate the state's claim in the civil area, since dangerousness is not an illness and a dangerous person may not be "treatable." By incarcerating persons thought to be dangerous, the state fills mental hospitals with persons detained for the public welfare without regard to whether they can benefit from treatment.[104]

Further, the confusion of interests on this issue has led to the anomaly of laws such as California's Lanterman-Petris-Short Act,[105] in which "legal" officials select persons for the mental health establishment and physicians must "diagnose" their dangerousness.[106] The initial decision to treat rather than prosecute is made by a legally trained person who initiates the mental health review, and physicians are then asked to determine whether a person is dangerous. In other words, the treatment decision is made by people trained in the law; the question of criminality is left to physicians.

Because of these problems and others, commitment for dangerousness to others is falling into disrepute. Recent interdisciplinary studies, such as that made by the California Bar's Commission on Law and Mental Health Problems, have concluded that danger to others is not a legitimate ground for civil commitment.[107] The state's interest in the protection of the public can be satisfied by the more traditional process of the criminal law.

2. *Dangerousness to self.*

The societal concern about suicide[108] raises slightly different issues. The evidence which demonstrates that psychiatrists cannot reliably predict when individuals are dangerous to others does not

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[103] *See* note 52 *supra*.

[104] Cal. Bar Comm'n, Report on Law and Mental Health Problems (1979) (on file with author) [hereinafter cited as Cal. Bar Comm'n Report].

[105] CAL. WELF. & INST. CODE §§ 5000-5404.1 (West 1972 & Supp. 1979).

[106] *Id.* § 5150 (West Supp. 1979).

[107] *See* Cal. Bar Comm'n Report, *supra* note 104. Candor requires the author to disclose that he was a member of the Commission.

[108] *Civil Commitment*, *supra* note 40, at 1201-07; Note, *supra* note 52, at 1293-95.

expressly address the ability of psychiatrists to predict danger to self, though one would suppose that the two are closely linked. In any event, there is a dearth of studies demonstrating the reliability of psychiatric predictions of suicide. Some insight into this form of psychiatric prediction is provided by the change in California law after the adoption of the Lanterman-Petris-Short Act.[109] Prior to this Act, patients thought to be suicidal could be involuntarily incarcerated until rehabilitated. Under the Act, after an emergency 72-hour period,[110] initial involuntary commitment is limited to 30 days; thereafter legal process is required for further incarceration.[111] A followup study of the Lanterman-Petris-Short Act demonstrated that recertification was very infrequently sought[112] and patients were routinely released. Nonetheless, the study found no suicides among the released group.[113] This limited data suggests that involuntary hospitalization—certainly *long term* involuntary commitment—was unnecessary to achieve the societal goal of preventing suicide.

Moreover, society's concern about suicide is inconsistent with its ambivalence to other acts proven to be dangerous, though not immediately lethal, to individuals. For example, smoking, publicly condemned as lethal,[114] is not illegal. Similarly, saccharin is generally available despite some concern that it might be a carcinogen.[115] It is true that persons are generally free to choose to receive medical care or to reject it.[116] Such choices are routinely afforded in the interest of individual freedom.

Further, while the state may have an interest in preventing death, individuals have a strong philosophical claim to determine their longevity. Some have asserted a categorical right to die.[117] Many have asserted such a right under limited circumstances, as is seen in a number of statutes permitting persons to direct termination of life

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[109] CAL. WELF. & INST. CODE §§ 5000-5404.1 (West 1972 & Supp. 1979).

[110] *Id.* § 5151 (West Supp. 1979).

[111] *Id.* § 5254 (West 1972).

[112] *See* ENKI RESEARCH INSTITUTE, A STUDY OF CALIFORNIA'S NEW MENTAL HEALTH LAW 152 (1972).

[113] *See id.*

[114] *See The Smoking Report*, SCIENTIFIC AM., Feb. 1964, at 66.

[115] *See generally* Batzinger, Ou & Bueding, *Saccharin and Other Sweeteners: Mutagenic Properties*, 198 SCI. 944 (1977); Bryan, Ertürk & Yoshida, *Production of Urinary Bladder Carcinomas in Mice by Sodium Saccharin*, 168 SCI. 1238 (1970).

[116] *See* Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 FORDHAM L. REV. 1 (1975); Note, *Suicide and the Compulsion of Lifesaving Medical Procedures: An Analysis of the Refusal of Treatment Cases*, 44 BROOKLYN L. REV. 285 (1978); Comment, *Informed Consent to Immunization: The Risks and Benefits of Individual Autonomy*, 65 CALIF. L. REV. 1286 (1977).

[117] Brecher, *Opting for Suicide*, N.Y. Times, Mar. 18, 1979, § 6 (Magazine), at 72.

support systems after hope of recovery passes.[118] The California Bar's Commission on Law and Mental Health Problems rejected the danger of suicide as a legitimate reason for involuntary incarceration.[119]

Yet the state may argue that in committing an individual to prevent suicide, it acts on the "true" wishes of that individual: In response to committed patients' claims of autonomy, the state might counter that the patients would have wished intervention but-for their illnesses. If the only rationale for intervention in such cases is the "true" intent of the patient, and if only this justification is consistent with society's belief in personal autonomy, then greater effort should be made to discover this intent. A document executed prior to the onset of mental illness, specifying whether the patient actually wanted intervention, should determine whether the patient is committed. In the next section I explore how the living will might serve as such a document.

B. *Using the Living Will*

A living will competently executed should determine whether a ward can be given treatment involuntarily. Through a living will, wards can, while competent, decide whether treatment is in their best interest. Under the standard approved by the California Bar's Commission on Law and Mental Health Problems as the only legitimate standard for involuntary intervention,[120] physicians are asked to address the treatability of emotional conditions affecting patients, rather than to predict or treat future dangerousness to self or others. Since a knowledge of a patient's competently made treatment decision is necessary to treat that patient,[121] the living will could, by furnishing this knowledge, determine whether treatment would be supplied. Living wills might also provide advance consent to treat-

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[118] Horan, *The "Right to Die": Legislative and Judicial Developments*, 13 FORUM 488 (1978); Note, *The Legal Aspects of the Right to Die: Before and After the* Quinlan *Decision*, 65 KY. L.J. 823 (1977); Comment, *The Living Will: Already a Practical Alternative*, 55 TEX. L. REV. 665 (1977); Comment, *North Carolina's Natural Death Act: Confronting Death with Dignity*, 14 WAKE FOREST L. REV. 771 (1978). The highly respected California Poll recently reported that Californians approve of passive euthanasia by an eight to one margin, and that active euthanasia was approved by better than a two to one margin. Field, *Californians More Liberal than the New Law About Right to Die*, San Jose Mercury, Apr. 25, 1979, § C, at 25, col. 1.

[119] *See* Cal. Bar Comm'n Report, *supra* note 104.

[120] *Id.*

[121] The patient's informed consent to treatment, where it can be obtained, is a necessary prerequisite to medical action. *See, e.g.*, Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

ment by those who would fear jeopardizing their status or employment through irrational acts more than they would fear the hospitalization designed to cure them. These individuals would file documents to short-cut admission procedures and to facilitate early treatment.[122]

The practical considerations making living wills difficult as instruments of *property* management are dwarfed by the difficulties of attempting to delimit future *medical* intervention. Forms of treatment change radically from time to time. The quality of institutions and forms of therapy change as well. It is likely that only *categorical* consent or refusal of *any* sort of treatment in the living will could withstand the changes brought by time. Nonetheless, some benefits can be obtained through a less-than-comprehensive instrument. For example, some people may particularly fear electroconvulsive therapy,[123] and wish specifically to provide against its administration. Similarly, psychotropic drugs may be anathema to some. Psychosurgery may be particularly unattractive to some but attractive to others. Some may wish to limit the length of involuntary treatment, providing, for example, that involuntary hospitalization should be limited to 3 months whatever its form, or to express a preference for a certain facility if available or a predilection against another.

The importance of the ability to file a binding document controlling future medical intervention is that it transfers control back to the individual and thus relieves possible anxiety about being overpowered when growing old. That the instrument would likely be incomplete, failing to consider all possible alternatives or to reflect advances in medical treatment, should not be as significant as the capacity the instrument gives to people to be responsible for themselves.

III. CONCLUSION

Adoption of the legislation necessary for living wills would, of course, be experimental. A large number of people would not execute the required documents. Those who did not execute living wills would not be affected by the change in the law; the small number of people initially taking advantage of the statute would allow legisla-

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[122] The living will would, of course, only govern the ward's treatment and would not prevent the state from applying criminal process to interdict dangerous acts performed by the maker.

[123] *See* J. FRIEDBERG, SHOCK TREATMENT IS NOT GOOD FOR YOUR BRAIN (1976); A SCHEFLIN & E. OPTON, THE MIND MANIPULATORS 354-402 (1978).

tive monitoring of the results. Possibly the management schemes provided in some living wills may prove to be unfair to children, parents, spouses, or others. Yet this is equally true of wills. The potential unfairness of wills is outweighed by the importance of providing for individual choice; the same seems true for the living will.

The principal advantage of the living will proposal is that it places the question of what to do with the property and health of a living human being whose judgment can no longer be trusted in the hands of the one person who will surely deal with the problem with the best interests of the incompetent in mind: the individual's prior self. It will at least remove from the judicial process the spectacle of cases in which avarice controls and wards are deprived of their property in the name of benevolence. It will remove doubt as to the most appropriate disposition of property and thus relieve courts and relatives of the burden which they now face in trying to determine the best interests of the ward. It will certainly provide a perceived benefit to those who fear that they will be overwhelmed when they grow old by others who will take control of their lives. The right to determine the future course of health care and the use of possessions would add an important element to the right of individuals to be responsible for themselves.

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