

Substituted Decision Making: Elder Guardianship

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This guest article by Drs. Leatherman and Goethe is written especially for the many psychiatrists and other clinicians who work with older patients, or who consult in matters in which an elder has lost mental capacity to care for him- or herself. Guardianships and related competency issues are an important fact of life for a growing number of individuals and families. Psychiatrists can help a lot, but they need to know what they are doing.

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The goal of this column is to help experienced clinicians navigate the judicial system when they are confronted with requests for capacity evaluations that involve guardianship (conservatorship). The interface between the growing elderly medical population and increasing requests for substituted decision making is becoming more complex. This column will help practicing psychiatrists understand the medical, legal, and societal factors involved in adult guardianship. Such understanding is necessary in order to effectively perform guardianship evaluations and adequately inform courts, patients, and families about the psychiatric diagnoses central to substituted decision making. (*Journal of Psychiatric Practice* 2009;15:470-476)

KEY WORDS: capacity, competency, guardianship, dementia, conservatorship, incapacity

The population of the United States (and the world) is aging. In 2006, there were 37.3 million persons 65 years of age or older in the United States, and these numbers are increasing. By 2030, there will be about 71.5 million seniors, representing approximately 20% of the population.¹ Thus, psychiatrists are increasingly likely to encounter questions about guardianship and substituted decision making when members of this rapidly growing and vulnerable population come to psychiatric attention. Unfortunately, most psychiatrists, even those with geriatric expertise, have not received adequate training in how to

perform capacity examinations and the factors that courts consider when instituting guardianships,

In this article, we present an overview of guardianship issues in geriatric patients and discuss the framework of the guardianship system and psychiatrists' place in that system. Key terms are defined in a glossary at the end of the article. Although guardians are often appointed for minors or adults with developmental disabilities, our discussion focuses on the specific issues surrounding guardianship of elders, since this evolving area presents special ethical and medical pitfalls for the unwary physician.

WHAT IS GUARDIANSHIP?

A new elderly patient may come to your office accompanied by someone claiming to be the person's "guardian." Always ask to see court documents proving guardianship, since patients and family members, as well as administrators, social workers, physicians, and even lawyers, often confuse guardianship and power of attorney. Adult children who have power of attorney or who simply care for an older parent often think of themselves as "guardians." *Guardianship*, however, has a specific legal meaning. Whereas power of attorney is a self-initiated, private process in which one voluntarily confers decision-making authority on a designee, guardianship (called "conservatorship" in some states) is an other-initiated, public process in which one's decision-making authority is given to a designee regardless of one's will. Because guardianship is a public process, documents (e.g., medical

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This column contains general information which should not be construed as applying to any specific patient, nor as any form of legal advice.

reports) and decisions are usually a matter of public record. Unlike power of attorney, a guardianship requires judicial involvement and is very difficult to reverse. Physicians are rarely called to opine about a person's cognitive function when a power of attorney is contemplated, but most states require a physician's opinion before a guardianship can be established. Guardianship has sometimes been described as having the potential to "unperson" elders or make them "legally dead."²

The concept of adult guardianship is evolving, with increasing discussion of related issues and past abuses paralleling the growing number of guardianship applications for elders being filed.³ Guardianship provisions and statutes vary by state, as do the types of courts responsible for guardianship proceedings. Guardianship cases are often heard by probate courts, but they sometimes also take place in district courts. In some states, guardianship requires a letter or certificate from a physician licensed in that state asserting that a proposed ward is partially or totally incapacitated. In other states, the examining professional can be a licensed psychologist. Some states, such as Florida, use a system in which a proposed ward is examined by a committee that provides a report to the court. It is important to know the pertinent laws in your area. Courts, court investigators, elder attorneys, and the National Guardianship Association (www.guardianship.org) are all good resources for this type of information.

Guardianship is not necessarily an "all or nothing" proposition. Individual courts, hearing the facts of the case, have the authority to grant permanent or temporary, limited or full guardianships, or a combination, reflecting efforts to craft innovative solutions to ethical concerns about nullifying a person's rights. When a person has partial capacity, there may be a guardian of the person or estate, but with certain functional activities (e.g., marriage, travel, medical consent) excluded from the guardian's powers. For example, an elder who can no longer drive or manage finances may still be able to live independently if helped with transportation and banking. It is very important for psychiatrists to understand the legal status of patients with surrogate decision makers.

WHY DO PEOPLE SEEK GUARDIANSHIP?

People seek guardianships for many reasons, some appropriate and others not; often the true reason is

not immediately apparent. Sometimes the most important role a psychiatrist plays is helping families consider why they are seeking guardianship. Psychiatrists are in a unique position to understand the dynamics that drive family actions, the impact of medical illnesses on the proposed ward, and psychiatric disorders that might limit the person's capacity. Such information is invaluable to the courts that make guardianship decisions. The guardianship process can be instigated by an individual or by a state agency. Adult Protective Services may initiate guardianship in response to notification about an elder in a dangerous, abusive, or exploitative situation. Concerned family members often seek guardianship because of an elder's declining capacity to care for him- or herself, especially when the individual resists assistance. However, family members are sometimes unaware of other avenues available to help a declining elder and seek guardianship prematurely.

One of the authors was asked to assess an elderly woman because her son was concerned that she had been exploited and wished to see her financial records. In the course of the pre-examination interview, Dr. Goethe discovered that the son had never even asked his mother if he could look at her financial records. Skillful family counseling helped to avert guardianship proceedings

Sometimes a guardianship is sought by one family member because of concern that another family member might take "control" of an elder.

One of the authors was ordered by the probate court to examine a profoundly demented woman who was in her 90s. It was apparent that the woman required full-time care, but the odd thing was that she had been living with and receiving excellent care from her daughter for 10 years. After extensive questioning of the family and the court, it was revealed that the custodial daughter was seeking guardianship to protect her mother from a son (the custodial daughter's brother) who was escorting the proposed ward to banks to have her sign her pension checks over to him. A guardianship was needed to protect the woman, despite the fact that an informal care situation had worked well for the preceding 10 years.

The guardianship process is sometimes misused as a legal weapon among family members, often in a misguided attempt to settle long-simmering hostilities. Such situations are a particular concern for psychiatrists who want to avoid being unwittingly drawn into complex and contentious legal battles.

An elderly man diagnosed with Alzheimer's dementia and his caregiver wife lived alone in their own home. The woman had a history of alcohol abuse. When she fell and fractured her humerus, three of their six children sought guardianship of their father in order to remove him from her care. The other three children wanted their father to remain with his wife until his physical health made a move necessary. Four legal teams were involved in the guardianship application and its contestation. Ultimately, two geriatric psychiatrists, an internist, and an addiction psychiatrist were called in to examine the woman in order to satisfy the parties involved.. All four physicians independently opined that a) no guardianship was necessary, b) the situation could be remedied with 24-hour in-home caregivers, and c) the man would likely suffer from institutionalization as planned by the guardianship applicants. Unfortunately, a large part of the couple's estate was spent in the legal proceedings. The man died 2 months after the case was closed, at home, in the company of his wife. She then agreed to enter an assisted living facility.

Finally, relatives may seek guardianship inappropriately and illegally in order to seize control of a person's estate, as seen in a number of recent high-profile cases.⁴ As physicians we see ourselves as advocates for our patients and their families, whom we generally tend to trust. However, in dealing with guardianship issues, three principles should be kept in mind:

1. Do not allow yourself to be intimidated or bullied by family members.
2. Be reasonably suspicious and exercise appropriate caution.
3. Do not rely solely on information provided by parties who are personally involved in the case (e.g., family, friends); instead carefully review information from attorneys, service agencies such as Adult Protective Services, medical professionals, and other trustworthy sources.

THE PHYSICIAN'S ROLE IN THE PROCESS

Physicians typically become involved in guardianship proceedings in one of two ways. First, they are often asked to provide an informal opinion regarding the cognitive status of one of their patients. Although such a request occasionally comes from a court or attorney, usually a family member asks for "just a letter" to "to help Mom with her finances." Families, attorneys, and even courts may not understand the level of duty physicians have to their patients. Therefore, physicians first need to educate the parties involved about their duties of confidentiality, privacy, and advocacy,⁵ and then act in the patient's best interest and within the law. A physician who releases information about a patient's functioning to anyone other than a legal surrogate (i.e., person holding power of attorney) would be seriously compromising his or her ethics and would likely be found legally culpable in court (note exceptions such as in cases of threat of harm to self or others.) Families and attorneys may request a written opinion because of a crisis or emergency. While the physician may believe that he or she is doing the best thing for the patient, releasing information without the appropriate legal authority is unethical, illegal, and can have severe negative repercussions for both the physician and patient.

The second common manner in which physicians become involved in guardianship proceedings is when they are requested by an attorney, court, or state agency to perform an Independent Medical Evaluation (IME) to assess a person's capacity. When such requests are made in a lawful fashion, the right to privilege of the evaluatee (not "patient" if the doctor is retained solely to do a guardianship evaluation) may not apply, but the examiner should alert the evaluatee, insofar as is feasible given his or her mental condition, to the purpose of the assessment, the role of the examining doctor, and the fact that the results of the examination will not be confidential. The clinician should carefully consider not accepting the request if he or she has a doctor-patient relationship with the evaluatee, because of possible conflict of interest.

Sometimes, a psychiatrist is asked by the proposed ward or an attorney to provide a second opinion after the patient has been examined by another professional. This can present an especially sticky situation, whether you are the proposed ward's treating physician or not. If the patient does not have capacity, can he or she consent to your exam?

The authors observed a situation such as this, which blew up into an expensive legal battle after a well-meaning attorney arranged a "competency exam" for an elderly woman in order to pre-empt her son's expected application for guardianship. Ultimately, the original "competency exam" was dismissed because it was not seen as independent. Two more "independent" exams were ordered and obtained (both of which came to the same conclusion as the first) before the case was finalized.

Many problems related to issues such as clarity, legality, confidentiality, compensation, and agency (for whom one is working) can be avoided by obtaining a court order whenever possible. If one cannot get a court order, it is advisable to require a formal, written request from the proposed ward's attorney, attorney *ad litem*, or guardian *ad litem*, in which it is clearly stated that, although the physician is being paid by the examinee, the examination will be objective and unbiased. In our view, absent a court order, a request from a guardian *ad litem* is the most desirable form of request, since the court has designated that person to be the surrogate decision maker for the proposed ward. Next in preference is the attorney *ad litem*, who is appointed by the court and bound to represent the interests of the proposed ward.

CONDUCTING A GUARDIANSHIP ASSESSMENT

Courts, attorneys, and the guardianship system often do not hold physicians' opinions in guardianship proceedings in high regard. They have been described as "notoriously lax, generalized, and incomplete."³ We agree with this general assessment, but believe that the poor quality of reports is usually the result of ignorance of the critical importance of the report in the proceedings, what the court needs to know, and how the report will be used. Physicians with this knowledge can produce helpful, high quality reports.

Diagnosis alone is usually of little value to the court, since a finding of incapacity and the need for guardianship is not triggered solely by diagnosis but also involves a number of medical and functional parameters. A thorough capacity evaluation includes careful consideration of the patient's baseline functioning, diagnosis, and level of cognition necessary to successfully remain independent (since in crafted guardianships, the Court may mandate assistance measures to allow the elder to remain more inde-

pendent). Inexperienced physicians often base their assessment of incapacity solely on a diagnosis of dementia. However, capacity is not a static construct; rather it is task-relative and is also influenced by medical conditions. The court needs to know the extent to which each psychiatric and physical diagnosis impairs the proposed ward's functioning. For example, in the case of severe depression, a physician's report should indicate the manner and extent to which the depression affects the person's ability to work, pay bills, seek medical care, and provide food and shelter for him- or herself. Do delusions markedly impair the proposed ward's ability to trust family members? Does pathological indecision prevent the proposed ward from making medical decisions?

A woman with frontal lobe dementia retained excellent memory, calculating ability, orientation, and daily functional skills. She was in good physical health, took her medications accurately, drove, and maintained her apartment. She was without delusions or hallucinations and had no mood or anxiety disorder. Over the previous year, however, she had given over \$300,000 dollars to a nefarious lottery scheme. The court was not interested in her diagnosis of frontal lobe dementia per se, but needed to know how her dementia symptoms of lack of insight and judgment made her specifically vulnerable to lottery scams.

The court also needs information about course and prognosis. For example, a guardianship due to functional incapacity arising from a diagnosis of depression or delirium would be needed only until the proposed ward recovers from the incapacitating episode. On the other hand, incapacity associated with dementia is likely to be irreversible and progressive, so that the court requires information to help craft a guardianship to meet the needs of the proposed ward for the present and the foreseeable future.

The psychiatrist may need to educate the court that capacity is not an all or nothing construct, but varies with level of cognitive impairment in relationship to task complexity.⁶ For example, the level of cognitive capacity needed to handle a simple bank account differs from that required to appropriately manage a complex portfolio of stocks, bonds, and mutual funds. In the example of the woman who squandered her savings on lottery scams, the court crafted a guardianship in which she was able to determine her residence

and medical providers and provide input into financial decisions, but a guardian of the estate was ultimately responsible for financial decisions, protecting her from the consequences of her poor insight and judgment. Psychiatrists are expert at determining the fine gradations of functional capacity, and the report to the court should reflect the psychiatrist's thoughtful consideration of the effect of the psychiatric illness on multiple levels of task performance.

THE CAPACITY EXAMINATION

Medical Records

The capacity examination is a careful balance of thoroughness and practicality. The more information one has, the easier it is to validate history given by a proposed ward or agents acting for or against the person. Do not allow your assessment to be guided by information from only one side of the litigation, and do not provide an opinion without personally examining the proposed ward, unless you also provide a suitable disclaimer about the limitations of such an incomplete evaluation. Reputable attorneys provide all relevant records, not just those that seem to support their client. It is not always possible to obtain all of a proposed ward's medical records, but be very suspicious of attorneys who say they want to withhold records or other information from you in order to get a so-called "unprejudiced" assessment. The person who decides the relevance of records or other information should be the evaluator, not the attorney or a litigant.

Sometimes, a determination of incapacity is possible in the absence of complete medical records.

One of the authors was asked to evaluate the capacity of a young man who had been comatose in a custodial care facility for 3 years after sustaining a head injury in a bar fight. Full medical records were not only unavailable, but efforts to obtain them would have added unnecessary expense to a relatively straightforward opinion. Recent medical records, summaries of the injury and past care, and a fairly brief examination were sufficient to form reasonably certain opinions about the young man's functioning and prognosis.

If medical records are not available or are sparse, the psychiatrist should make clear to all involved parties (including the court) that the evaluation will be

limited by the quality and quantity of objective medical information available to the examiner. A mental and sometimes a physical examination, as well as psychological, laboratory, or radiographic tests in some cases, are critical parts of the assessment. As mentioned above, one should only rarely give an opinion without a personal examination, and should be very cautious when medical information is lacking. The examiner should always be prepared to say that he or she is unable to render an opinion if insufficient credible information is available. Professional (expert) opinions in guardianship matters generally must reach a threshold of "reasonable medical/psychiatric certainty" (in legal terms, "more likely than not"), and the decision to uphold the guardianship generally requires "clear and convincing" evidence (more than a mere preponderance, but less than "beyond reasonable doubt"). Nowhere is it written that an expert evaluator must come to an opinion. Remember also that the court can be a valuable ally. Like you, it is independent and its primary interest is the fair hearing of all the evidence. Thus, the court can compel a physical examination or release of records.

Confidentiality and Impartiality

It is important to examine the proposed ward alone, unless paranoia or anxiety are so intense that an examination is not possible without a chaperone. In fact, court orders often stipulate that no one be present during the examination except the evaluator and his or her agents. The jury verdict in a recent lawsuit over a contested will was influenced by the fact that the examining clinician evaluated the person in the presence of the beneficiary to the new will.

Nevertheless, family members and attorneys often try to contact the examining physician prior to, or sit in on, the examination. Reassure family members that, as an evaluator, you are aware that the evaluatee may not be fully truthful or may be disoriented, anosognosic, or confabulating. We assume the family's motives are honorable and we try to reassure them about our experience in examining cognitively impaired elders. However, it is also important to be wary of the possibility that a party in the case may be trying to sway your opinion. Thus, it is good policy to speak only to representatives of the court or Adult Protective Services or to the attorney *ad litem* or guardian *ad litem* early in the process of examination. Of course, one must sometimes gather information

from family members and attorneys, but it is best to try to deal primarily with the court and the *ad lita* in order to keep as much objective distance as possible. Ask family members to submit any information they want reviewed through the court or one of the *ad lita*.

The Examination

Using the principles of a good clinical psychiatric examination, the psychiatrist assesses four general areas of cognition: awareness of situation, factual understanding of the issues, appreciation of the likely consequences of decisions, and rational manipulation of information. A simple way to evaluate the proposed ward's awareness of the situation is simply to ask, "Do you know why you are here?" If a proposed ward really does not know why he or she is being examined, the examiner has an opportunity to test ability to learn new material. She might mention guardianship and ask if the examinee knows what it means to have a guardian, whether there is an attorney representing the proposed ward or if he or she has been to court. Many times the attorney *ad litem* will have been to the proposed ward's place of residence, brought paperwork to the proposed ward, and is present in the waiting room during the examination, but the proposed ward is unaware he or she has an attorney and might refer to the attorney *ad litem* as "that nice lady." Such information provides valuable insight into the proposed ward's memory, insight, judgment (why would you go to a strange doctor with "a nice lady?"), and ability to understand certain abstract legal matters, while keeping the examination low-key and informal.

Of course, the capacity examination should contain the main components of the mental status examination, including appearance, mood, affect, sensorium, suicidal or homicidal ideation, and thought processes and content, but it generally focuses heavily on cognition. Although the Mini-Mental State Examination (MMSE) of Folstein et al.⁷ was not designed to diagnose dementia, many agencies involved in adult guardianship are accustomed to its use and like the numerical assessment it produces. The psychiatrist should educate the other parties involved, perhaps by pointing out the areas of the MMSE on which the proposed ward made errors, and the way in which those errors are indicative of functional impairment.

More extensive cognitive testing should also be performed, including a clock drawing test, tests of frontal

lobe functioning, simple calculations (we find that switching operations, such as mixing addition, subtraction, multiplication, and division problems, is a useful way to evaluate attention), and some practical tasks such as writing a check and discussing advanced directives in a variety of hypothetical situations. On many occasions, we have seen proposed wards who were lucid, had college degrees, and had "normal MMSEs" but were unable to do simple two-digit addition or fill out a sample check. On one memorable occasion, an experienced plaintiff's attorney hounded one of the authors on the stand about a patient who had profound frontal lobe dementia, yet scored a "perfect" MMSE. Dr. Leatherman's description of the proposed ward's bizarre answers to questions about advanced directives and his inability to do a series of simple calculations with changing operations helped educate the court about his dementia and enabled him to get the protection he needed from the consequences of his dementia.

Finally, it is important to ask the proposed ward about medical illnesses and medications. If the examinee reports no illnesses but has medications for several chronic conditions that provides valuable information about the person's cognition. The examining psychiatrist should ask the examinee to bring his or her medications to the examination. If it is a home examination, the psychiatrist can check the medicine cabinets. The psychiatrist should always count the pills in the bottles against the prescription fill date.

Fees

Oddly, this is the question we are most commonly asked, yet it is one that is rarely addressed in forensic psychiatry texts or articles. Part of the problem is that the guardianship process is changing, but more challenging is the role of government reimbursement in the process. If you are providing an opinion regarding a proposed ward with whom you have a physician-patient relationship, your billing needs to conform to federal billing regulations for administrative duties involved with patient care. Contact your carrier to determine allowable billing practices for Medicare and other federally funded programs. Insurance conflicts and the enormous amount of time that capacity evaluations can consume (especially if they go to court) are further reasons that it is better to refer an established patient to an independent examiner if a capacity evaluation is indicated.

If you have set up the examination as an independent examiner, you may charge whatever rate you believe is reasonable for your work. Expert review, evaluations, reports, and testimony should generally be done for an hourly fee, with appropriate charges for ancillary time (e.g., travel, waiting, unkept appointments) and expenses. You should bill the attorney or court that retains you, rather than a litigant (such as the proposed ward or guardianship applicant). This is to minimize the risk of the physician being an agent of one of the litigants rather than an independent agent. Some attorneys and courts request a flat rate for guardianship evaluations. We recommend against this, because the evaluator must be free to expend whatever time and effort is needed to perform the professional task. Flat-rate contracts routinely suffer from overpayment for too little time spent or underpayment when a case which deserves more attention.

Whatever the payment agreement, never accept payment contingent on the outcome of the case. Such arrangements are unethical and may be illegal. A pre-examination contract is advisable, but the specifics of such contracts are outside the scope of this article.

SUMMARY

With the aging population, questions of capacity will increasingly come before psychiatrists from a number of fronts, including family members, financial institutions, and courts. The use of adult guardianship for substituted decision making is growing and evolving. Psychiatrists are in a unique position to enlighten and educate the courts about cognition and psychiatric conditions in adults undergoing guardianship proceedings. It is important for psychiatrists to understand how attorneys and guardians utilize psychiatric examinations in order to provide fair, impartial, and meaningful safeguards for proposed wards. The principles of careful psychiatric examination combined with adherence to ethical practice will be increasingly valuable in the emerging maze that is guardianship.

GLOSSARY

Guardianship: legal arrangement wherein one individual (the guardian) possesses the legal right and

duty to care for another individual (the ward) and his or her property.² Also termed “conservatorship” in some states.

Proposed ward: an individual who is the subject of a proposed guardianship.³ Also termed “respondent,” “allegedly incapacitated person,” and “proposed conservatee.”

Power of attorney: a document giving someone authority to act on behalf of the grantor; also used to designate the holder of the document (i.e. the decision maker).

Attorney ad litem: attorney appointed by a court to act on behalf of the proposed ward and to represent his or her interests.

Guardian ad litem: a person appointed by a court to act in the best interest of the the person with diminished capacity and give opinions to the court as to whether a guardianship should be imposed.

Applicant: a person requesting that a guardianship be imposed on another.

Limited guardianship: something less than a full guardianship in which the removal of rights of a ward are tailored to his or her functional disabilities.³

Temporary guardianship: a time-limited guardianship.

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