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Abstract

This Article explores the guardian's role in making, or assisting the ward to make, health care decisions, and provides an overview of existing standards and tools that offer guidance in this area. Part II outlines briefly the legal decisions and statutory developments assuring patient autonomy in medical treatment, and shows how these legal texts apply to and structure the guardian's role as health care decision-maker. Part III examines the range of legal and practical approaches to such matters as decision-making standards, determining the ward's likely treatment preferences, and resolving conflicts between guardians and health care agents appointed by the ward. Part IV offers a general road map for legal and ethical decision-making in the health care arena. Finally, Part V offers scenarios based on real-life stories to illustrate how these standards and tools can guide guardians towards appropriate decisions in particular cases.

Keywords

guardianship, health care, ward, medical treatment, living wills, health care directives, medical ethics

Disciplines

Elder Law | Family Law | Health Law and Policy | Medical Jurisprudence | Social Welfare Law

STANDARDS FOR HEALTH CARE DECISION-MAKING: LEGAL AND PRACTICAL CONSIDERATIONS

Kim Dayton*

I. INTRODUCTION

In contemporary guardianship systems, it is likely that most court-appointed guardians will eventually be called upon either to make or to assist the ward to make health care decisions of many sorts. These decisions may involve matters as simple as scheduling physician or dental appointments for the ward, helping her to complete medical history forms, and authorizing nonemergency treatment for minor illnesses or injuries.¹ They may also involve such critical decisions as whether to permit risky surgical procedures, to switch from curative care that is unlikely to cure in favor of palliative care and aggressive pain management, or to direct health care providers to terminate ongoing, life-sustaining treatments including artificial respiration, nutrition, or hydration. Often, these health care decisions must be made in circumstances where time is of the essence or stress levels are high due to the seriousness of the ward's medical situation and the possible deleterious, irreversible consequences of a "wrong" decision. Persons other than the guardian—a family member or care giver, for example—may wish to, or feel entitled to, have a role in the decision-making process. Persons interested in the ward's welfare, but who do not have legal authority to make decisions in her behalf, may seek to involve themselves in health care decision-making, although not always in ways that would best serve the preferences, interests, and needs of the person under guardianship.

In most states, guardians are charged by statute with exercising "substituted judgment" for or acting in the "best interests of" the wards in their charge.² The meaning of such concepts is never clear, but in the context of health care decision-making they can be particularly problematic. Even relatively minor medical procedures can sometimes implicate a person's most deeply held spiritual or humanistic values. For example, most seriously ill individuals do not consider receiving a blood transfusion to involve their religious views, but for the majority

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¹ While case or care managers are often involved in developing care plans for persons under guardianship, and such plans may address health care and medical treatment, only a court-appointed guardian can make final decisions authorizing particular treatments. This responsibility cannot be delegated. *See infra* notes 111–135 and accompanying text.

² *See generally* Linda S. Whitton & Lawrence A. Frolik, *Surrogate Decision-Making Standards for Guardians: Theory and Reality*, 2012 UTAH L. REV. 1491; *see infra* notes 83–90 and accompanying text.

of Jehovah's Witnesses, receiving another person's blood violates the fundamental biblical proscription "to 'keep abstaining from . . . blood.'"³ Health care decisions that involve consenting to or withholding treatment whose primary purpose is to prolong life irrespective of its "quality," on the other hand, implicitly involve the question of whether personhood or self has ended even if the physical body still functions through technological assistance. Deciding what a fully or partially incapacitated ward would do, or what is in the "best interests" of that ward, in such circumstances is no simple matter.

This Article explores the guardian's role in making, or assisting the ward to make, health care decisions, and provides an overview of existing standards and tools that offer guidance in this area. Part II outlines briefly the legal decisions and statutory developments assuring patient autonomy in medical treatment, and shows how these legal texts apply to and structure the guardian's role as health care decision-maker. Part III examines the range of legal and practical approaches to such matters as decision-making standards, determining the ward's likely treatment preferences, and resolving conflicts between guardians and health care agents appointed by the ward. Part IV offers a general road map for legal and ethical decision-making in the health care arena. Finally, Part V offers scenarios based on real-life stories to illustrate how these standards and tools can guide guardians towards appropriate decisions in particular cases.

II. THE HISTORICAL AND CONSTITUTIONAL CONTEXTS OF SUBSTITUTED DECISION-MAKING FOR MEDICAL TREATMENT

The expanded role of guardian as health care decision-maker, and the challenges this role presents, coincide with the evolution of American common and constitutional law pertaining to patient autonomy respecting medical treatment. Over the past century, the legal right of patients to self-determination in health care decisions has transitioned from a relatively simple tort-based principle relating to the law of battery, to one of constitutional proportions. Because guardians serve principally as alter egos of the ward with regard to personal decision-making,⁴ they have both the authority and the obligation to assure that the ward's legal right to autonomy in medical decision-making is respected and enforced.

This section offers a basic history of the evolution of patient autonomy in health care decision-making and discusses how the case law in this area applies to guardianship. It includes brief synopses of several cases involving the intersection of guardianship and health care decision-making. These cases must be understood

³ *Our View of Medical Care: Blood Transfusions*, JEHOVAH'S WITNESSES, OFFICIAL MEDIA WEB SITE, <http://www.jw-media.org/aboutjw/article01.htm> (last visited March 29, 2012) (citing Acts 15:29; Genesis 9:3, 4; Leviticus 7:26, 27; 17:1, 2, 10–12; Deuteronomy 12:23–25).

⁴ *But see* Lawrence A. Frolik, *Is a Guardian the Alter-Ego of the Ward?*, 37 STETSON L. REV. 53, 54 (2007) (discussing the nature of guardians' fiduciary standards as articulated in law and as actually practiced, and noting that guardians in effect serve two masters—the ward, and the court (state)—whose interests sometimes do not coincide).

not only because they establish important principles pertaining to health care decision-making by guardians, but also because they serve as useful examples of both the legal and practical issues facing guardians as they attempt to honor their wards' independence in the face of incapacity. The discussion shows how this history serves as an implicit, but critically important, aid to statutory interpretation of guardianship laws' provisions pertaining to health care decision-making by guardians. It also establishes how it can inform the decision-making process in those hard cases where the laws' mandates and other standards of practice do not provide clear guidance as to the "correct" decision.

A. *Informed Medical Consent in the Common Law*

The common-law doctrine of informed consent, which dates back to the early twentieth century, represented a significant step down the road to full patient autonomy in all aspects of medical decision-making.⁵ Most scholars perceive the doctrine to have originated in the 1914 decision of *Schloendorff v. Society of New York Hospital*,⁶ involving a woman who received an operation she had specifically forbidden her doctors to perform. The plaintiff in the case had been admitted to a hospital facility and had authorized her physicians to use a nonsurgical "ether examination" to determine the cause of a lump in her abdomen.⁷ She had told them specifically not to operate on her while she was undergoing the "ether examination."⁸ Despite her express wishes, her physicians performed surgery to remove the fibroid tumor while she was etherized.⁹ She later developed complications from the surgery that resulted in amputation of some of her fingers.¹⁰ Schloendorff sued the hospital on, *inter alia*, a state law claim of battery.¹¹ The trial court directed a verdict in favor of defendants, which the plaintiff appealed.¹² Although the New York Court of Appeals upheld the directed

⁵ For detailed discussions of the history of the informed consent doctrine in U.S. common law, see, for example, PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. & BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS: THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP, VOLUME ONE 15–35 (1982) [hereinafter PRESIDENT'S COMMISSION REPORT], available at http://bioethics.georgetown.edu/pcbe/reports/past_commissions/making_health_care_decisions.pdf; Janet L. Dolgin, *The Legal Development of the Informed Consent Doctrine: Past and Present*, 19 CAMBRIDGE Q. HEALTHCARE ETHICS 97 (2010), available at <http://ssrn.com/abstract=1625306>; Hana Osman, *History and Development of the Doctrine of Informed Consent*, 4 INT'L ELEC. J. HEALTH EDUC. 41 (2001), available at <http://www.aahperd.org/aahe/publications/iejhe/loader.cfm?csModule=security/getfile&pageid=39142>.

⁶ 105 N.E. 92 (N.Y. 1914).

⁷ *Id.* at 93.

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

verdict, it stated that except in emergency situations,¹³ a physician may not perform a medical procedure on a patient unless that patient has consented to it.¹⁴ Otherwise, the physician has committed a “trespass” (battery) on the person, and may be liable for any damages that the patient suffers as a result of the procedure.¹⁵

Although this decision was an interpretation of New York state law, the principles expressed in *Schloendorff* quickly became ensconced in American common law. The term “informed consent,” which first appeared in the 1957 decision of *Salgo v. Leland Stanford Junior University Board of Trustees*,¹⁶ has come to mean that, before health care providers may undertake treatment of a patient, the patient must be provided with basic information about the risks and benefits of the treatment and give consent to it. The parameters of the doctrine of informed consent have expanded to include not only surgery and other invasive procedures, but all kinds of medical treatment, including medical and psychological research conducted by academics, scientists, and even the federal government.¹⁷ Moreover, every court that has considered the question has said that a corollary of the doctrine of informed consent is the right of competent patients to refuse unwanted medical treatment, even that which is necessary to save or sustain the patient’s life.¹⁸

Over the years, a number of exceptions to the informed consent doctrine have evolved and remain entrenched even after the doctrine developed its constitutional component. The most notable of these exceptions include medical emergencies when the patient is not capable of giving informed consent and a failure to treat would have dire consequences, some public health emergencies, and many situations involving psychiatric treatment.¹⁹

¹³ *Id.* To this day, informed consent is not necessary as a prelude to emergency medical treatment. See Dolgin, *supra* note 5, at 102; see also *infra* notes 19–20 and accompanying text.

¹⁴ *Schloendorff*, 105 N.E. at 93.

¹⁵ *Id.*

¹⁶ 317 P.2d 170 (Cal. Dist. Ct. App. 1957); see Osman, *supra* note 5, at 42–43 (discussing *Salgo*).

¹⁷ The federal government’s complicity in undermining patient autonomy in medical decision-making is most starkly apparent with respect to the notorious “Tuskegee” study. See generally U.S. DEPT. OF HEALTH, EDUC. & WELFARE, PUB. HEALTH SERV., FINAL REPORT OF THE TUSKEEGEE SYPHILIS STUDY AD HOC COMM. (1973), available at <http://biotech.law.lsu.edu/cphl/history/reports/tuskegee/tuskegee.htm>.

¹⁸ Justice Rehnquist, writing for the majority in *Cruzan*, observed that “[t]he informed consent doctrine has become firmly entrenched in American tort law. . . . The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment.” *Cruzan v. Mo. Dept. of Health*, 497 U.S. 261, 269–70 (1989) (citations omitted).

¹⁹ See generally, e.g., PRESIDENT’S COMMISSION REPORT, *supra* note 5, at 93–96; James G. Hodge, Jr. et al., *A Hidden Epidemic: Assessing the Legal Environment Underlying Mental and Behavioral Health Conditions in Emergencies*, 4 ST. LOUIS U. J. HEALTH L. & POL’Y 33 (2010) (discussing exceptions to informed consent requirement particularly in the context of mental health treatment); Osman, *supra* note 5, at 45–46. For

The precise scope and nature of these exceptions to the informed consent doctrine are not always clear. In general terms, however, the emergency exception can be summarized as follows:

If informed consent is suspended in an emergency, it should be because the time it would take to make disclosure and obtain patients' decisions would work to the disadvantage of some compelling interest of patients . . . [such] an emergency situation . . . would involve the following factors: (1) there must be a clear, immediate, and serious threat to life and limb; (2) the treatment that will be provided without informed consent should be the one that . . . is in keeping with the standard of practice; and (3) the time it would take to offer an informed consent would significantly increase the patient's risk of mortality and morbidity, either because these are presently occurring, or because the effectiveness of a given treatment will be significantly diminished if not immediately instituted.²⁰

Public health emergencies can sometimes justify the state in demanding that certain treatments—for example, vaccinations to prevent pandemics or treatments to stop the spread of particularly dangerous contagious diseases—be imposed on patients over their objection.²¹

The parameters of the psychiatric treatment exception are perhaps the least certain of the three exceptions to informed consent principles.²² Because mental illness can cloud a person's judgment regarding what is in her own interests, or

an excellent analysis of the guardian's role in making psychiatric treatment decisions for a ward, see generally *Steele v. Hamilton Cnty. Cmty. Mental Health Bd.*, 736 N.E.2d 10 (Ohio 2000).

²⁰ STEPHEN WEAR, INFORMED CONSENT: PATIENT AUTONOMY AND CLINICIAN BENEFICENCE WITHIN HEALTH CARE 156–57 (2d ed. 1998) (citations omitted). For a brief, yet comprehensive, discussion of the ethical dilemmas associated with the “emergency” exception to informed consent in clinical settings, see generally Arthur R. Derse, *What Part of “No” Don’t You Understand? Patient Refusal of Recommended Treatment in the Emergency Department*, 72 MOUNT SINAI J. MED. 221 (2005).

In rare circumstances, the emergency exception to informed consent doctrine may even extend to research. See generally, e.g., U.S. DEPT. OF HEALTH & HUMAN SERVS. ET AL., EXCEPTION FROM INFORMED CONSENT REQUIREMENTS FOR EMERGENCY RESEARCH, GUIDANCE FOR INSTITUTIONAL REVIEW BOARDS, CLINICAL INVESTIGATORS, AND SPONSORS (2011), available at <http://www.fda.gov/downloads/RegulatoryInformation/Guidances/UCM249673.pdf>.

²¹ See generally JAMES F. DRANE, CLINICAL BIOETHICS: THEORY AND PRACTICE IN MEDICAL ETHICAL DECISION MAKING 128 (1994) (discussing informed consent requirement and public health emergencies).

²² For an excellent overview of law and policy at the intersection of informed consent doctrine and psychiatric treatment, see generally Breanne M. Sheetz, Note, *The Choice to Limit Choice: Using Psychiatric Advance Directives to Manage the Effects of Mental Illness and Support Self-Responsibility*, 40 U. MICH. J.L. REFORM 401 (2007).

because a failure to treat mental illness can result in harm to the patient or others, treatment decisions involving serious psychiatric disorders often involve consideration of many factors other than the patient's own preferences. While the legal trend has been towards expanding the rights of patients with mental health issues in favor of greater personal autonomy over psychiatric treatment decisions, there are many situations in which mentally ill patients can be forced to receive unwanted medical treatment. These cases require that the patient receive certain due process protections that are embodied in state civil commitment statutes.²³ In essence, the psychiatric treatment exception to informed consent requires the intervention of a court before the patient's right to direct her own medical treatment can be set aside in favor of more compelling state interests.²⁴

It is also important to note that the right of informed consent is waivable. Although patients are entitled to receive sufficient information about the risks and benefits of a proposed medical treatment and the possible alternatives, they are not required to access or use this information. In some cultures, laypersons historically have relied exclusively on their doctors to make all health care decisions and actually prefer not to know the details of their own condition or the risks and benefits of various treatment options. For example, "[c]ultures that emphasize hope, such as the Navajo tribe, opt to receive limited information."²⁵ With such patients, it might be inappropriate as a matter of practice for a physician to provide the detail necessary to obtain informed consent.

Exceptions aside, the informed consent doctrine is independently relevant to the guardian's role as health care decision-maker, as it is the starting point in the

²³ See generally, e.g., Samuel Jan Brakel & John M. Davis, *Overriding Mental Health Treatment Refusals: How Much Process Is "Due"?*, 52 ST. LOUIS U. L.J. 501 (2008) (discussing the history and development of legal regimes allowing mentally ill defendants to refuse treatment); Teresa Cannistraro, *A Call for Minds: The Unknown Extent of Societal Influence on the Legal Rights of Involuntarily and Voluntarily Committed Mental Health Patients*, 19 ANNALS HEALTH L. 425 (2010) (discussing the due process implications of civil commitment).

²⁴ For a discussion of psychiatric advance directives, which permit patients who have mental illnesses to express their treatment preferences in the event that their disease makes them incapable of directing their own treatment, see *infra* note 115.

²⁵ Osman, *supra* note 5, at 45. See generally, e.g., Linda A. McLaughlin & Kathryn L. Braun, *Asian and Pacific Islander Cultural Values: Considerations for Health Care Decision Making*, 23 HEALTH & SOC. WORK 116 (1998) (discussing cultural considerations affecting patient autonomy and informed consent); Monica E. Peek et al., *Race and Shared Decision-Making: Perspectives of African-Americans with Diabetes*, 71 SOC. SCI. & MED. 1 (2010) (discussing the implications of race in patient-physician decision-making).

Although some commentators have said that incompetent persons (e.g., minors, incapacitated adults) are not entitled to the benefits of the informed consent doctrine, see Osman, *supra* note 5, at 46, this is not entirely correct. At least with regard to adults who are incapacitated, legal surrogates are entrusted with the authority to give or withhold treatment decisions in their behalf, applying the principles inherent in the doctrine. Likewise, in most circumstances, the parents or legal guardians of minors stand in the shoes of the patient regarding informed consent.

process of decision-making in the health care realm. Thus, a guardian *must* assert the ward's right to give informed consent, which in some cases entails information gathering and a discussion of the risks and benefits of particular medical treatments and procedures prior to authorization.²⁶ A guardian who fails to take these basic steps is not fulfilling her obligations as the ward's alter-ego, and lacks the information necessary to exercise her statutory duties.

The informed consent doctrine standing alone is not, however, responsible for the expanded place of patient autonomy in health care decision-making, especially in the realm of critical care and at the end of life. In most cultures, including our own, physicians have historically occupied exalted societal and economic positions; their recommendations regarding appropriate care have been given tremendous deference by their patients, who trust their physicians in much the same way that they trust their spiritual advisers. There is little doubt that even after the informed consent doctrine became well settled, the vast majority of patients have relied upon their physicians to control the course and content of their medical treatment.²⁷ The available empirical evidence suggests that most patients do not read or understand the consent forms that they sign.²⁸ Thus, while the informed consent doctrine has been part of health care for almost 100 years, it was not until relatively recently that its full ramifications have begun to be realized.

*B. The "Living Will" Movement and the Rise of Advance Directives
for Health Care*

As medical science and technology developed interventions and cures for diseases and conditions that had once been considered untreatable, American medicine became increasingly preoccupied with prolonging patients' lives, often at great personal cost (both financial and personal) to those patients.²⁹ For many

²⁶ See *infra* notes 95–98 and accompanying text.

²⁷ For an excellent discussion of the evolution of the physician-patient relationship from patient as "passive recipient of care" to "active and informed consumer" in the modern era, see James G. Anderson et al., *The Impact of CyberHealthcare on the Physician-Patient Relationship*, 27 J. MED. SYS. 67, 70 (2003).

²⁸ See generally, e.g., Matthew E. Falagas et al., *Informed Consent: How Much and What Do Patients Understand?*, 198 AM. J. SURGERY 420 (2009) (reviewing empirical studies of informed consent in pre-surgical patients and participants in clinical studies). Moreover, many members of the medical establishment have never fully embraced the concept that patients ought to have a significant role in making their own health care decisions. See generally, e.g., PRESIDENT'S COMMISSION REPORT, *supra* note 5, at 69–112 (discussing physician-patient communication). For a discussion of the medical profession's various attempts (through academic literature and other means) to ridicule and undermine the informed consent doctrine, see Alan Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413.

²⁹ For a comprehensive account of the relationship between advances in medical technology and treatments and ethical debates concerning health care towards the end-of-

physicians, the only situation in which nontreatment was considered to be ethical was if that treatment could be deemed futile.³⁰ Given the significant expansion of the informed consent doctrine during the 1950s and 1960s, it was inevitable that advocates would eventually begin looking closely at the practice of medicine at the end of life.

The term “living will” is usually traced to a law review article written by civil rights attorney Louis Kutner published in 1968.³¹ Placing the right to refuse life-sustaining treatment in the context of the informed consent doctrine, Kutner wrote:

Where a patient undergoes surgery or other radical treatment, the surgeon or the hospital will require him to sign a legal statement indicating his consent to the treatment. The patient . . . while still retaining his mental faculties and the ability to convey his thoughts, could append to such a document a clause providing that, if his condition becomes incurable and his bodily state vegetative with no possibility that he could recover his complete faculties, his consent to further treatment would be terminated. . . . [A] patient may not have had, however, the opportunity to give his consent at any point before treatment. He may have become the victim of a sudden accident, or a stroke or coronary. . . .

life, see generally WILLIAM H. COLBY, UNPLUGGED: RECLAIMING OUR RIGHT TO DIE IN AMERICA 57–72 (2006).

³⁰ Medical futility is defined as

interventions that are unlikely to produce any significant benefit for the patient. Two kinds of medical futility are often distinguished:

- (1) *quantitative futility*, where the likelihood that an intervention will benefit the patient is exceedingly poor, and
- (2) *qualitative futility*, where the quality of benefit an intervention will produce is exceedingly poor.

Both quantitative and qualitative futility refer to the prospect of benefiting the patient. A treatment that merely produces a physiological effect on a patient's body does not necessarily confer any benefit that the patient can appreciate.

Ethics in Medicine: Futility, UNIV. WASH. SCH. MED., <http://depts.washington.edu/bioethx/topics/futil.html> (last visited Apr. 4, 2012). That a particular course of treatment is not likely to “cure” a patient does not mean the treatment is futile—for example, delivering nutrition and hydration to a comatose patient will not resolve the condition(s) causing the coma, but it will maintain the status quo—but the distinction between “futility” and “inefficacy” is not always clear. What is certain, however, is that if a health care provider, for example, a physician guided by the relevant ethics committee, concludes that a treatment is futile, that provider is not bound by law or ethical principles to continue the treatment, even if the patient or her advocate insists on it. In 1999, the state of Texas became the first and only state to codify the futility doctrine as positive law. See TEX. HEALTH & SAFETY CODE ANN. § 166.046 (West 2010) (articulating procedures to be followed when further medical care is deemed “futile”).

³¹ Luis Kutner, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 IND. L.J. 539 (1968).

[T]he suggested solution is that the individual . . . indicate to what extent he would consent to treatment. The document indicating such consent may be referred to as “a *living will*.”³²

The notion that the informed consent doctrine and patient autonomy could be carried this far was revolutionary in an era when physicians routinely practiced the principle of “benevolent lying” as a means of concealing from patients information about the terminal nature of their conditions if that information might be disturbing to the patients or their families.³³

Yet the concept of living wills caught on at the policy level, and in 1976 California became the first state to enact a so-called “living will” statute.³⁴ During the late 1970s and the 1980s, at least forty-one states enacted similar statutes.³⁵ These statutes were typically quite narrow in scope; in most jurisdictions their purpose was to codify the right of terminally ill patients whose prognosis was grim (typically, those with a life expectancy of three to six months) the option to refuse curative treatment altogether. Patients who opted to execute living wills under these statutory provisions usually experienced a more comfortable and natural dying process, often accompanied by aggressive pain management. Over time, living will laws eventually came to be called “right-to-die” laws in both the popular and academic literature.

The next step towards codification of the informed consent doctrine and patient autonomy in health care decision-making was in 1983, when California passed the first health care “power of attorney” statute.³⁶ The California statute went well beyond the limited scope of the living will laws. The statute allowed an individual—usually designated “the principal”—to designate, via a written document, a surrogate who could make health care decisions for the principal in the event of incapacity. This trend spread quickly, and by 1997 every state had

³² *Id.* at 550–51. The term “living will” was not a particularly apt choice of name for the document it purports to describe, which does not remotely resemble a will and is concerned substantively with the dying process. Unfortunately, the term continues to be used widely by lawyers, health care providers, and other professionals (who should know better) to describe not just living wills, but any document that addresses health care treatment preferences or names a health care surrogate to act for a principal who can no longer express her own wishes regarding treatment.

³³ See generally RUTH R. FADEN ET AL., A HISTORY AND THEORY OF INFORMED CONSENT 84–86 (1986) (history of benevolent lying in medicine); PRESIDENT’S COMMISSION REPORT, *supra* note 5, at 69–112 (discussing medical professionals’ attitudes and other barriers to effecting informed consent principles); Dolgin, *supra* note 5, at 100 (“A survey described in [the Journal of the American Medical Association] in 1961 reported that almost 90% of doctors generally refrained from telling patients about a cancer diagnosis.”).

³⁴ For a comprehensive discussion of the history of state living will and advance health care directive laws, see, for example, Charles P. Sabatino, *The Evolution of Health Care Advance Planning Law and Policy*, 88 MILBANK Q. 211 (2010).

³⁵ See *id.* at 213.

³⁶ See CAL. CIV. CODE §§ 2430–2443 (West 1993).

enacted some form of health care power of attorney law.³⁷ Over the next decade, many living will laws were replaced by comprehensive “health care directive” statutes permitting patients to provide written instructions addressing all aspects of the principal’s medical treatment, not just terminal illness.³⁸

State law is regarded as preeminent in codifying the right to autonomy in health care decision-making. But the federal role in creating public awareness of this right, and in providing an impetus for health care providers to respect it, should not be understated. The Patient Self-Determination Act of 1991 (PSDA)³⁹—which was enacted shortly after the Supreme Court’s decision constitutionalizing the right of autonomy in health care decision-making⁴⁰—mandates that all patients admitted to health care facilities that receive federal funding be told at the time of admission of their right to make their own health care decisions, and of their right to name a surrogate to make those decisions if they are unable to do so themselves.

As a result of this mandate, virtually all persons who receive treatment in a hospital, emergency room, nursing home, or via a home health agency are told about their statutory rights and given an opportunity to assert them. Although the PSDA does not require facilities to help patients execute written health care directives, many providers do so at the time of admission, and even provide health care directive forms and counseling services aimed at guiding patients who wish to complete a directive on-site. Thus, even though the PSDA does not speak to the substance of the right to health care autonomy, it has arguably done more to effect that right than the statutes and case law that actually embody it.

C. Patient Autonomy as a Constitutional Imperative and the Implications for Decisional Standards

1. Decisional Foundations

The formal “constitutionalization” of patient autonomy in health care decision-making is generally traced to the New Jersey Supreme Court’s decision in *In re Quinlan*.⁴¹ In that case, twenty-two-year-old Karen Ann Quinlan had suffered two extended periods of anoxia, which eventually caused her to lapse into a

³⁷ See Sabatino, *supra* note 34, at 214–15.

³⁸ *Id.* at 215–17.

³⁹ Pub. L. 101-508, § 4206, 104 Stat. 1388 (codified as amended in scattered sections of 42 U.S.C.).

⁴⁰ See *infra* note 66 and accompanying text.

⁴¹ 355 A.2d 647 (N.J. 1976). Although the case involved an interpretation of New Jersey law, every guardian who has health care decision-making authority for an incapacitated adult ward should read and understand the legal and ethical principles discussed in the *Quinlan* decision due to its enormous significance in the history of surrogate health care decision-making. The facts of the case also serve to illustrate the process by which the preferences of an incapacitated adult can be inferred from that adult’s personal history, past statements, and other evidence.

persistent vegetative state (PVS)⁴² from which her physicians had concluded there was no possibility of recovery.⁴³ Karen was on a respirator and received all her nutrition and hydration through artificial means.⁴⁴ Her father sought removal of the guardian previously appointed for her, asking that the court appoint him as guardian instead, and requesting that the letters of guardianship explicitly delegate to him the authority to discontinue his daughter's artificial respiration.⁴⁵ Mr. Quinlan's petition was opposed by many parties, including the hospital where Karen was being treated, her physicians, the local prosecutor, who claimed that withdrawing artificial respiration from someone in Karen's condition would violate New Jersey's criminal homicide provisions, and the state attorney general, who intervened for the purpose of asserting the state's interest in the preservation of Karen's life.⁴⁶ Ultimately, the trial court denied the petition, and Mr. Quinlan appealed.⁴⁷

In a long and eloquent opinion that touches on many legal, medical, and ethical issues, the New Jersey Supreme Court ultimately held that Mr. Quinlan was suitable and appropriate to be named as the guardian of his daughter,⁴⁸ and that in that capacity he could and should exercise his daughter's (the ward's) rights with regard to her own medical treatment.⁴⁹ Specifically, the court held that under the New Jersey constitution,⁵⁰ a right to privacy existed and this right was broad enough to encompass a right to refuse "extraordinary" medical procedures, including artificial respiration.

⁴² PVS is "a condition in which a person exhibits motor reflexes but evinces no indications of significant cognitive function." *Cruzan v. Mo. Dept. Health*, 497 U.S. 261, 266 (1990).

⁴³ *Quinlan*, 355 A.2d at 655.

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ *Id.* at 651–53.

⁴⁷ *Id.*

⁴⁸ Under the New Jersey guardianship statute in place at the time, "next of kin" was presumptively entitled to be named guardian unless appointment of a different person was in the "best interests" of the proposed ward. *See* N.J. STAT. ANN. § 3A:6–36 (repealed 1981). Nothing in the record supported the view that Karen's father was not suited to serve as her guardian; to the contrary,

we sense from the whole record before us that while Mr. Quinlan feels a natural grief, and understandably sorrows because of the tragedy which has befallen his daughter, his strength of purpose and character far outweighs these sentiments and qualifies him eminently for guardianship of the person as well as the property of his daughter.

Quinlan, 367 A.2d at 671.

⁴⁹ *Quinlan*, 355 A.2d at 671.

⁵⁰ The *Quinlan* court also discussed the right to privacy under the federal Constitution, but its decision ultimately rested on an "adequate and independent state ground" and as such was not subject to review in the United States Supreme Court.

We have no doubt . . . that if Karen were herself miraculously lucid for an interval (not altering the existing prognosis of the condition to which she would soon return) and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of natural death.⁵¹

The evidence presented in the trial court showed that Karen, while she did have capacity, had said that she would not have wanted to be kept alive through artificial means if she were ever to be in a condition of PVS.⁵² If in fact Karen's current state was incurable and irreversible, and if Karen herself would not have agreed to remain on a respirator with no hope of recovery were she able to express her wishes, then Karen's guardian could, and in fact had an obligation to, assure that her wishes were respected. The court ordered the appointment of Mr. Quinlan as Karen's legal guardian, and remanded the case to the trial court with specific instructions pertaining to the need to confirm Karen's medical diagnosis as a condition to delegating the authority to withdraw artificial respiration via the letters of guardianship.⁵³

In re Quinlan was the first of a wave of state judicial decisions constitutionalizing the doctrine of informed consent. Most state court decisions addressing the nature and scope of the right to control health care decisions—including the right to refuse life-saving and life-prolonging treatments—generally grounded this personal right in state constitutional interests, particularly the right

⁵¹ *Id.* at 663.

⁵² The trial court had admitted numerous statements

made by Karen while competent as to her distaste for continuance of life by extraordinary medical procedures, under circumstances not unlike those of the present case. These quoted statements were made in the context of several conversations with regard to others terminally ill and being subjected to like heroic measures. The statements were advanced as evidence of what she would want done in such a contingency as now exists. She was said to have firmly evinced her wish, in like circumstances, not to have her life prolonged by the otherwise futile use of extraordinary means.

Id. at 653.

⁵³ One of the ironies of the *Quinlan* case is that, after the medical diagnosis of PVS was confirmed and the respirator withdrawn, Karen did not die, but instead lived in that condition for more than a decade, breathing on her own but dependent on artificial nutrition and hydration. Her father did not seek to terminate this part of her life support on the ground that the Catholic Church, of which Karen and her family were members, specifically forbade (and still does forbid) withdrawal of feeding tubes from patients in PVS. See, e.g., *Ethical and Religious Directives for Catholic Health Care Services, Fourth Edition: Issues in Care for the Dying*, U.S. CONF. CATH. BISHOPS, <http://nccbuscc.org/bishops/directives.shtml#partfive> (last visited Apr. 4, 2012).

of privacy.⁵⁴ A common theme among all of these decisions is that this constitutionalized the informed consent doctrine as a personal right. While the right can be exercised by surrogates, it is the obligation of those surrogates to determine from all the available evidence what the patient would have done, and make decisions for the patient accordingly.

Fifteen years after *In re Quinlan*, the Supreme Court finally had occasion to consider whether there is a right to direct one's own medical treatment under the federal Constitution. In *Cruzan v. Director, Missouri Department of Health*,⁵⁵ the United States Supreme Court implicitly acknowledged that the right to autonomy in health care decision-making is protected by the Fifth and Fourteenth Amendment due process clauses of the federal Constitution.⁵⁶ In 1983, twenty-five-year-old Nancy Cruzan was in a car accident; the resulting injuries caused her brain to be deprived of oxygen for twelve to fourteen minutes.⁵⁷ She remained in a coma for three weeks, and eventually degenerated to PVS. Nancy was able to breathe on her own, but received all her nutrition and hydration through artificial means.⁵⁸ Her life expectancy was predicted to be thirty years as long as this life-prolonging support continued.

⁵⁴ See, e.g., *Myers v. Alaska Psychiatric Inst.*, 138 P.3d 238 (Alaska 2006) (right to refuse psychotropic medication was inherent in the federal and state constitutions); *Rasmussen v. Fleming*, 741 P.2d 674 (Ariz. 1987) (Arizona constitution provides for a right to refuse medical treatment); *Bartling v. Superior Court*, 209 Cal. Rptr. 220 (Cal. Ct. App. 1984) (right of a competent adult patient to refuse medical treatment has its origins in the constitutional right of privacy and this right is specifically guaranteed by the California Constitution); *Severns v. Wilmington Med. Ctr., Inc.*, 421 A.2d 1334 (Del. 1980); *In re Guardianship of Barry*, 445 So. 2d 365, 370 (Fla. Dist Ct. App. 1984) (noting that state constitution was amended after *Satz* to recognize that right to privacy encompassed decisions affecting medical treatment); *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977) (Massachusetts Constitution assures right to refuse medical treatment and this right extends to incapacitated individuals); *Cruzan v. Harmon*, 760 S.W.2d 408, 416–17 (Mo. 1988) (there is a general common-law and constitutional right to refuse medical treatment); *In re Lydia E. Hall Hosp.*, 455 N.Y.S.2d 706 (N.Y. Sup. 1982); *In re Welfare of Colyer*, 660 P.2d 738, 742 (Wash. 1983) (an adult who is incurably and terminally ill has a constitutional right of privacy that encompasses the right to refuse treatment that serves only to prolong the dying process, given the absence of countervailing state interests); see also *In re Estate of Longeway*, 549 N.E.2d 292 (Ill. 1989) (right to refuse medical treatment is enshrined in the common law and in provisions of the Illinois Probate Act). For a recent survey of state decisions on the nature of the right to control one's own medical treatment and to refuse unwanted care, see Kia Thrasher, *50 State Survey on the Right to Make Health Treatment Decisions* (Sept. 2011) (contained *infra* at Appendix A).

⁵⁵ 497 U.S. 261 (1990).

⁵⁶ For a detailed account of the *Cruzan* litigation and its aftermath, written by the attorney who represented Nancy Cruzan's parents, see WILLIAM H. COLBY, *THE LONG GOODBYE: THE DEATHS OF NANCY CRUZAN* (2002).

⁵⁷ *Cruzan*, 497 U.S. at 266.

⁵⁸ *Id.*

By 1987, there was no medical question that Nancy Cruzan had no chance of regaining her mental faculties.⁵⁹ Nancy's parents, who were serving as her coguardians, asked hospital employees to terminate Nancy's artificial nutrition and hydration so that she could die a natural death.⁶⁰ The hospital employees refused to do so without court approval, and when the Cruzan family sought such approval, the state of Missouri intervened on behalf of Nancy to prevent withdrawal of the feeding tube. The trial court authorized withdrawal of Nancy's ongoing treatment, but the Missouri Supreme Court reversed.⁶¹ The Supreme Court ultimately granted certiorari for the purpose of determining whether the state of Missouri's purported interest in the preservation of life *per se* outweighed Nancy Cruzan's right to refuse medical treatment that included artificial life support.

In *Cruzan*, the Supreme Court considered a number of issues arising from Nancy's parents'/guardians' request to withdraw their daughter's artificial nutrition and hydration. The relatively tailored and technical opinion of the Court, representing a five-member majority, upheld Missouri's requirement that nutrition and hydration may be withdrawn from a person in a persistent vegetative state only after a demonstration by "clear and convincing evidence" that such action is consistent with the patient's previously manifested wishes.⁶²

The *Cruzan* decision was a narrow one in the sense that it held only that Missouri's evidentiary requirement did not violate the due process clauses.⁶³ The sum and substance of the Court's opinion in *Cruzan*, however, is that a competent person has a right, well settled at common law and grounded in federal due process rights, to refuse medical treatment, including life-sustaining artificial hydration and nutrition. In addition—and it is this aspect of *Cruzan* that has the most significance to guardianship law—a majority of the Court indicated that surrogate decision-makers are bound to honor and enforce not their own perspectives on medical treatment and life-sustaining treatment, but rather those of the incapacitated persons in their charge.

2. *Medical Decisions and the Meaning of the "Best Interests" Standard*

The *Quinlan* and *Cruzan* cases are most commonly discussed for their important conclusions that the right of autonomy in health care decisions has constitutional dimensions under both state and federal constitutional law. One of the most critical implications of these and similar cases for guardians, however, is something rarely addressed in the literature discussing them. *Quinlan* articulates

⁵⁹ *Id.* at 267.

⁶⁰ *Id.* at 268–69.

⁶¹ *Id.*

⁶² *Id.* at 280.

⁶³ "A State is entitled to guard against potential abuses" that can occur if family members do not protect a patient's best interests, and "may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and [instead] simply assert an unqualified interest in the preservation of human life to be weighed against the . . . interests of the individual." *Id.* at 261.

the principles that the informed consent doctrine applies to all health care decisions, including end-of-life decisions, and that surrogate decision-makers have a legal obligation to make such decisions as the ward would, and not according to some external standard existing independently of the ward's desires.⁶⁴ *Cruzan* suggests that, in the context of health care decision-making, a ward's "best interests" are the interests that the ward herself would assert were she capable of doing so.⁶⁵ The state may, in effect, erect a presumption that patients opt for treatment in most cases, even in situations such as Nancy Cruzan's, in order to further the abstract principle that life is worthy of state protection no matter what its "quality."⁶⁶ But when a patient's preferences can be established to the degree of certainty represented by the applicable evidentiary standard, no one—not the ward's family or friends, nor her guardian, nor even the state—should impose treatments that the ward herself would not authorize.⁶⁷

Many states describe the guardian's fiduciary obligation as an obligation to act in "the best interests of" the protected person.⁶⁸ *Quinlan* and *Cruzan* lead to the conclusion that state law "best interest" standards governing guardians' decision-making must be interpreted as substituted decision-making standards *at least with respect to health care decisions*. This is true even if the ward would choose or refuse treatments that others—her physicians, her family, or her guardian—deem to be against her own best interests. This same principle bears on whether a court may delegate health care decision-making authority to a guardian in the first instance. In *Lane v. Candura*,⁶⁹ for example, the Massachusetts Court of Appeals held that appointment of a guardian for a person who was competent to make her own health care decisions was not appropriate even if the proposed ward's own decision was perceived by her physicians and family members as irrational and against her "best" (that is to say, medical) interests.⁷⁰ Against the advice of her physicians, seventy-seven year old Rose Candura refused to authorize amputation of her gangrenous right leg.⁷¹ Her daughter filed a petition to be named Rose's guardian for the sole purpose of authorizing the operation.⁷²

⁶⁴ *Quinlan*, 355 A.2d at 663–64.

⁶⁵ *Cruzan*, 497 U.S. at 274–80.

⁶⁶ *Id.* at 282. Such a presumption is almost certainly unjustified by actual patient preferences. See, e.g., KIM PARKER, PEW RESEARCH CTR., COPING WITH END-OF-LIFE DECISIONS: FEW HAVE LIVING WILLS (2009) (discussing results of a survey on attitudes about death, dying, and the withholding of life-prolonging treatment).

⁶⁷ See, e.g., Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 435 (Mass. 1977) (recognizing right to refuse medical treatment under the Massachusetts state constitution).

⁶⁸ Whitton & Frolik, *supra* note 2, at 1504; see Christine Jensen, *50-State Statutory Survey: Health Care Decision-Making by Guardians* (Sept. 2011) (contained *infra* at Appendix B).

⁶⁹ 376 N.E.2d 1232 (Mass. App. Ct. 1978).

⁷⁰ *Id.* at 1233–36.

⁷¹ *Id.* at 1233.

⁷² *Id.*

The trial court found Rose to be incompetent, based in large part on the very fact that she was refusing to agree to an amputation, and appointed her daughter as guardian.⁷³ Candura appealed, and the appellate court dismissed her daughter's petition.⁷⁴ Although the evidence indicated that an amputation was a reasonable treatment and in fact probably necessary to save the life of the patient, the court found that Candura was competent to make her own health care decisions.⁷⁵ The facts of *Candura* are useful to understanding the relationship (or lack thereof) between unwise decision-making and incapacity. *Candura* is also instructive regarding the limits of guardians' authority respecting medical treatments that might on one had be considered in the best interests of a ward, but are not consistent with the ward's prior-expressed views about such treatments. The concept of "best interests" cannot be applied in a vacuum, and under *Quinlan*, *Cruzan*, and other cases involving guardians making health care decisions, it is apparent that a patient's best interests are considered to be served by actions that are consistent with that patient's *own* expressed and inferred preferences.

A number of important and controversial cases litigated in state courts over the past two decades are consistent with this fundamental premise. The most well-known of these are the several judicial decisions known collectively as the *Schiavo* cases. The underlying facts that led to this protracted litigation are remarkably similar to those of *Quinlan* and *Cruzan*. At age twenty-seven, Terri Schiavo suffered an apparent heart attack that left her brain deprived of oxygen for many minutes.⁷⁶ Like Karen Ann Quinlan and Nancy Cruzan, she was eventually diagnosed as in PVS. Like both women, she received all nutrition via a feeding tube.⁷⁷ In 1990, Terri Schiavo's husband was appointed in as her plenary guardian, and in that capacity authorized many medical procedures aimed at "curing" her condition, including some experimental (and ultimately fruitless) treatments.⁷⁸ After eight years, Terri's treating physicians were in agreement that nothing could be done to cure or even improve her condition. In his capacity as guardian, Michael Schiavo petitioned the court for permission to remove Terri's feeding tube.⁷⁹

Ultimately, the critical and dispositive factual determination in the case—one that was reviewed, challenged, and otherwise revisited more than twenty times over the course of the next five years—was whether the guardian's decision to withdraw the feeding tube was consistent with Terri Schiavo's prior-expressed

⁷³ *Id.* at 1235.

⁷⁴ *Id.* at 1236.

⁷⁵ *See id.* ("Mrs. Candura's decision may be regarded by most as unfortunate, but on the record in this case it is not the uninformed decision of a person incapable of appreciating the nature and consequences of her act. We cannot anticipate whether she will reconsider and will consent to the operation, but we are all of the opinion that the operation may not be forced on her against her will.")

⁷⁶ *Bush v. Schiavo*, 885 So. 2d 321, 324–25 (Fla. 2004).

⁷⁷ *Id.*

⁷⁸ *In re Guardianship of Schiavo*, 851 So. 2d 182, 183 (Fla. Dist. Ct. App. 2003).

⁷⁹ *Schiavo*, 885 So. 2d at 324.

wishes and preferences.⁸⁰ In the end, each court to consider this issue on its merits concluded that—based on the available evidence—Terri Schiavo was in a persistent vegetative state from which she would never recover, that she would not want to continue artificial hydration and nutrition given her condition, that she had adequately expressed that preference, and that her guardian was effecting her wishes in requesting that the feeding tube be removed.⁸¹ Those opposing the guardians in these circumstances were doing so without regard for Terri’s wishes, preferences, or right to control her own destiny. Florida’s best interest standard not only allowed, but compelled the guardian to request that her treatment be terminated.⁸²

III. HEALTH CARE DECISIONS BY GUARDIANS: LAWS, GOALS, AND STANDARDS

The transition of patient self-determination regarding health care decision-making from a common-law principle stemming from the law of battery to one of constitutional imperative has important implications for the guardianship system. It is clear from *Cruzan* itself that all persons, including those with severe impairments, enjoy the personal liberty interests involved when medical treatment is at issue. This necessarily implies that a court-appointed guardian is obligated to ensure that the ward’s own preferences are reflected in every health care-related decision the guardian makes, in every context, unless doing so is impossible or an exception to the principle of self-determination regarding health care exists in a particular situation.

A. Legal Standards

The theoretical literature of many divergent disciplines, including philosophy, medicine, and a number of the social sciences, offers a wide range of perspectives on what is an ethical approach to decision-making for persons of limited capacity.⁸³ For guardians, however, the starting point for obtaining guidance respecting health care decision-making is the statutory framework within which the guardian operates. A guardian’s legal authority to make decisions for an adult under a disability derives solely from state law. Guardianship statutes usually

⁸⁰ *In re Guardianship of Schiavo*, 851 So. 2d at 183–84.

⁸¹ *See, e.g., In re Guardianship of Schiavo*, 780 So. 2d 176, 180 (Fla. Dist. Ct. App. 2001).

⁸² One fact seldom reported in the popular accounts of the Terri Schiavo case is that her parents testified explicitly that, were they appointed as her guardians, they would continue artificial nutrition and hydration even if they knew for certain that she would not want such treatment. JAY WOLFSON, GUARDIAN AD LITEM FOR THERESA MARIE SCHIAVO, A REPORT TO GOVERNOR JEB BUSH AND 6TH JUDICIAL CIRCUIT IN THE MATTER OF THERESA MARIE SCHIAVO 14 (2003), available at <http://abstractappeal.com/schiavo/WolfsonReport.pdf>.

⁸³ *See generally* Whitton & Frolik, *supra* note 2.

contain language describing the nature of the guardian's fiduciary obligation to the ward.⁸⁴ In addition, the letters of guardianship sometimes outline restrictions or conditions that limit the guardian's independence with respect to particular types of health care treatment or procedures. Both these sources of authority and duty must be the guardian's starting point for making health care decisions.

Elsewhere in this symposium issue, professors Frolik and Whitton have provided a comprehensive overview of current law pertaining to the fiduciary obligations of guardians to wards, and it is not necessary to elaborate on that discussion here.⁸⁵ In the majority of jurisdictions that have codified decision-making standards for guardians,⁸⁶ the guardian's obligation in most jurisdictions can usually be cast as either a "substituted judgment" or "best interests" standard—or some hybrid of these—even if the statutory text does not use that precise terminology. For example, the Uniform Guardianship and Protective Proceedings Act states that

[e]xcept as otherwise limited by the court, a guardian shall make decisions regarding the ward's support, care, education, health, and welfare. A guardian shall exercise authority only as necessitated by the ward's limitations and, to the extent possible, shall encourage the ward to participate in decisions, act on the ward's own behalf, and develop or regain the capacity to manage the ward's personal affairs. A guardian, in making decisions, shall consider the expressed desires and personal values of the ward to the extent known to the guardian. A guardian at all times shall act in the ward's best interest and exercise reasonable care, diligence, and prudence.⁸⁷

⁸⁴ For a table listing the health care decision-making standards by guardians of adults, see Christine Jensen, *50-State Statutory Survey: Health Care Decision-Making by Guardians* (Sept. 2011) (contained *infra* at Appendix B).

⁸⁵ See Whitton & Frolik, *supra* note 2, at 1491. According to Whitton and Frolik, "Of the fifty-two jurisdictions examined, twenty-eight have guardianship statutes with no general decision-making standard for guardians. Eighteen have statutes that contain substituted judgment language, most in combination with a best interest component. The statutes in six jurisdictions make reference to best interest, but without a substituted judgment component." *Id.* at 1495 (internal citations omitted).

⁸⁶ It is quite astonishing and disturbing that twenty-eight states have yet to articulate such standards. Given the loss of liberty that is inevitably associated with even the most limited guardianships, it is this author's view that states have an obligation to clarify the nature of guardians' duties in terms that are understandable to professional and family guardians alike.

⁸⁷ UNIF. GUARDIANSHIP & PROTECTIVE PROCEEDINGS ACT § 313(a) (1997). Several states have adopted the UGPPA in whole or in substantial part. See *Guardianship and Protective Proceedings Act: Enactment Status Map*, UNIF. L. COMM'N, <http://www.nccusl.org/Act.aspx?title=Guardianship%20and%20Protective%20Proceedings%20Act> (last visited Apr. 17, 2012).

Adult guardianship statutes based on Article V of the Uniform Probate Code generally incorporate the standards in place for guardians of minors, which for all intents and purposes comprise a “best interest” standard.⁸⁸

Frolik and Whitton also note that some jurisdictions explicitly articulate a separate standard applicable to health care decision-making. For example, in Maine,

[a] guardian may give or withhold consents or approvals related to medical or other professional care, counsel, treatment or service for the ward. Except as authorized by a court of competent jurisdiction, a guardian shall make a health-care decision in accordance with the ward’s individual instructions, if any, and other wishes expressed while the ward had capacity to the extent known to the guardian. Otherwise, the guardian shall make the decision in accordance with the guardian’s determination of the ward’s best interest. In determining the ward’s best interest, the guardian shall consider the ward’s personal values to the extent known to the guardian. A decision of a guardian to withhold or withdraw life-sustaining treatment is effective without court approval unless the guardian’s decision is made against the advice of the ward’s primary physician and in the absence of instructions from the ward made while the ward had capacity.⁸⁹

In practice, the application of substituted judgment or a best interests standard in specific decision-making contexts—for example where the ward will live or whether the ward may enjoy the company of a particular visitor—could produce different outcomes in some cases. With regard to health care decision-making, however, it is clear from cases such as *Quinlan*, *Cruzan*, and many others that even a pure “best interest” standard must always be interpreted as a substituted judgment standard, except in those situations where there is no possible way to predict, infer, or extrapolate from all available evidence what the ward’s preferences would be. Any other interpretation of state fiduciary standards in the medical decision-making context would be inconsistent with the constitutional right to self-determination in medical decision-making enshrined in *Cruzan* and a host of lower court decisions since issued.⁹⁰ And because evidence of an incapacitated person’s preferences and wishes regarding medical treatment can be derived from a variety of sources, there are relatively few cases in which guardians should deviate from the obligation to use a substituted judgment standard. In hard cases, therefore, the challenge for the guardian is not to determine whether a

⁸⁸ Whitton & Frolik, *supra* note 2, at 1496–97.

⁸⁹ ME. REV. STAT. tit. 18, § 5-312(a)(3) (2011).

⁹⁰ Under this view, a health care decision-making standard such as Delaware’s, which implies that a guardian should make health care decisions that are in the “best interest” of the ward even if they conflict with the ward’s preferences articulated while competent, would arguably be unconstitutional. *See* DEL. CODE ANN. tit. 12, § 3922(b)(3) (West 2006).

particular treatment is in the ward's "best interests," but rather what the ward would want if she were able to articulate her preferences.

In short, the constitutional imperatives developed in the state court decisions on medical decision-making, as well as *Cruzan*, require use of a substituted judgment standard with respect to all health care decision-making unless there is no possible way to infer the ward's likely treatment preferences. Insofar as statutory language suggests or implies a best interest standard, this language must be interpreted in light of the constitutionally protected principle of personal autonomy in health care decision-making. This view of the somewhat disparate statutory standards governing guardians in the medical decision-making arena is fully consistent with other sources of practical and ethical guidance, as developed more fully below.

*B. The Relationship Between the Guardian and
Previously Appointed Health Care Agent*

In most jurisdictions, a health care agent named by the ward in a valid health care directive has priority over a guardian with regard to all health care decisions explicitly or implicitly addressed in the directive.⁹¹ These laws are consistent with the very purpose of advance directives laws, which exist in part to prevent the need for guardianship in the first place. A strong argument can be made that the common-law-based, constitutionally protected right to make one's own health care decisions incorporates a correlative right to name one's own personal health care agent, such that a state guardianship law to the contrary would violate these fundamental precepts.

Even in jurisdictions where the state guardianship statute provides that a guardian has priority over a health care agent named by the ward, however, the views of the health care agent should be given considerable deference, at least when the agent's articulation of the ward's likely preferences, or interpretation of the ward's instructions, is reasonable. The ward should be presumed to have chosen an agent who understands and is capable of expressing the ward's preferences. Honoring this choice is an aspect of furthering the patient's autonomy notwithstanding current incapacity.⁹²

⁹¹ For a survey of state law pertaining to priority between health care agents versus guardians, see ABA COMM. ON LAW & AGING, HEALTH CARE DECISION-MAKING AUTHORITY OF HEALTH CARE AGENTS VS. COURT-APPOINTED GUARDIANS (2003), available at http://www.americanbar.org/content/dam/aba/migrated/aging/docs/guardian_chart.authcheckdam.pdf.

⁹² This is not to say that if there are questions about whether the ward/principal had capacity to name an agent, or if there are reasons to believe that the agent is acting inconsistently with the ward's views and preferences about her health care, the guardian has no role to play. Nevertheless, the guardian's duty to honor the ward's autonomy dictates that the ward's choice of an agent should be respected and to the extent possible implemented by involving the chosen agent in all aspects of the ward's health care.

C. *Health Care Decision-Making: Standards and Tools*

As so many judicial decisions have made clear, whether a guardian's fiduciary obligation is statutorily defined as a best interest or substituted judgment standard, the guardian's mission—and challenge—is to use her authority to make medical decisions in a manner that reflects the preferences, values, and goals of the ward. This section will discuss in general terms the tools, standards, and guidelines available to surrogates, including guardians, who must determine the personal values and preferences of a person under guardianship. It will also offer suggestions for those relatively rare situations in which a ward's likely preferences cannot reasonably be identified.

1. *Sources of Practical, and Ethical Guidance*

(a) *National Guardianship Association: Standards of Practice*

One of the most useful sources of guidance to guardians charged with making medical decisions is the National Guardianship Association's Standards of Practice (hereinafter, NGA Standards).⁹³ The NGA Standards address all aspects of the guardian's role in relation to the ward, the ward's family members and friends, and other professionals with whom guardians must interact when exercising their authority in behalf of the ward. With regard to decision-making generally, these standards generally reflect the fundamental principles set out above, including the importance of allowing the ward to participate as fully as possible in the decision-making process,⁹⁴ the importance of informed consent,⁹⁵ and the duty to exercise substituted judgment except when there is no possible way to ascertain the ward's likely preferences.⁹⁶ They also offer explicit and detailed guidance regarding medical decision-making specifically.⁹⁷ Among the general principles embodied in the medical decisions-specific standards are the principles that the ward has a right to appropriate medical treatment if she needs and wants such treatment, that the guardian has a duty to secure such treatment, and that the ward has a right to refuse treatment that must be honored and enforced by the guardian.

The ward's autonomy. In making health care decisions for the ward, the guardian is required by law and ethical norms to honor the ward's autonomy to the fullest extent possible. NGA Standard 9 affirms this principle. It provides that

[t]he guardian shall provide the ward with every opportunity to exercise those individual rights that the ward might be capable of exercising as

⁹³ STANDARDS OF PRACTICE (Nat'l Guardianship Ass'n 2000) (amended 2007).

⁹⁴ STANDARDS OF PRACTICE 9 (Self-Determination of the Ward).

⁹⁵ STANDARDS OF PRACTICE 6 (Informed Consent).

⁹⁶ STANDARDS OF PRACTICE 7 (Standards for Decision-Making).

⁹⁷ STANDARDS OF PRACTICE 14 (Decision-Making About Medical Treatment); STANDARDS OF PRACTICE 15 (Decision-Making About Withholding and Withdrawing Medical Treatment).

they relate to the care of the ward's person. The guardian shall attempt to maximize the self-reliance and independence of the ward [and] . . . shall understand and advocate for person-centered planning and the least restrictive alternative on behalf of the ward. The guardian shall encourage the ward to participate, to the maximum extent of the ward's abilities, in all decisions that affect him or her, to act on his or her own behalf in all matters in which the ward is able to do so, and to develop or regain his or her own capacity to the maximum extent possible.

Standard 9, which is applicable to the full range of personal decisions that a guardian will make during the course of the guardianship, is particularly important with regard to health care decisions.

Informed consent. NGA Standard 6 provides an excellent account of the informed consent doctrine as it applies to guardians' decision-making. Standard 6 reflects the legal principles set out in Part II above and should be regarded as the starting point for the guardian when making health care decisions of every sort. It states:

Decisions the guardian makes on behalf of the ward shall be based on the principle of Informed Consent. Informed Consent is a person's agreement to a particular course of action based on a full disclosure of facts needed to make the decision intelligently. Informed Consent is based on complete information regarding [a]dequate information . . . , voluntary action; and [l]ack of coercion.

[In exercising informed consent], [t]he guardian stands in the place of the ward and is entitled to the same information and freedom of choice as the ward would have received if he or she were competent. In evaluating each requested decision, the guardian shall . . . [1] [h]ave a clear understanding of the issue for which informed consent is being sought; [2] [d]etermine the conditions that necessitate treatment or action; [3] [a]dvice the ward of the decision that is required and determine, to the extent possible, the ward's current preferences; [4] [d]etermine whether the ward has previously stated preferences in regard to a decision of this nature; [5] [d]etermine the expected outcome of each alternative; [6] [d]etermine the benefit of each alternative; [7] determine the risks of each alternative; [8] [d]etermine why this decision needs to be made now rather than later; [9] [d]etermine what will happen if a decision is made to take no action; [10] [d]etermine what the least restrictive alternative is for the situation; [11] [o]btain a second medical opinion, if necessary; [12] [o]btain information or input from family and from other

professionals; [13] [o]btain written documentation of all reports relevant to each decision.⁹⁸

This guideline captures not only the essence of both the informed consent doctrine as it has evolved at law, but also the means by which a guardian can make legally and ethically appropriate decisions that honor the ward's right to autonomy in health care decision-making.

Special guidance regarding health care decisions. Finally, two NGA standards speak specifically to the issue of medical decision-making by wards. NGA Standard 14 addresses health care decision-making generally, while NGA Standard 15 concerns those hard cases in which the guardian is called upon to make decisions regarding beginning, withholding, or withdrawing life-sustaining treatment. These standards should be read in conjunction with the principles set out in Standards 9 and 6.

NGA Standard 14 provides:

The guardian shall promote, monitor, and maintain the ward's health and well-being. . . . [and] shall ensure that all medical care necessary for the ward is appropriately provided. The guardian shall determine whether the ward, before the appointment of a guardian, executed any advance directives, such as a living will, a durable power of attorney, or any other specific written or oral declaration of intent. On finding such documents, the guardian shall consider the ward's wishes in the decision-making process. The guardian shall inform the court and other interested parties of the existing documents.

Absent an emergency or the execution of a living will, durable power of attorney for health care, or other advance directive declaration of intent that clearly indicates the ward's wishes with respect to medical intervention, a guardian who has proper authority may not grant or deny authorization for medical intervention until he or she has given careful consideration to the criteria listed in Standard 6 - Informed Consent and Standard 7 - Standards for Decision-Making. In the event of an emergency, a guardian who has proper authority shall grant or deny authorization of emergency medical treatment based on a reasonable assessment of the criteria listed in Standards 6 and 7, within the time allotted by the emergency.

The guardian shall seek a second opinion for any medical treatment or intervention that would cause a reasonable person to do so or in circumstances where any medical intervention poses a significant risk to

⁹⁸ STANDARDS OF PRACTICE 6. In quoting the NGA Standards, I have dispensed with the official formatting of the standards in favor of a narrative, verbatim presentation of their content.

the ward. The guardian shall obtain a second opinion from an independent physician. Under extraordinary medical circumstances, in addition to assessing the criteria and using the resources outlined in Standards 6 and 7, the guardian shall enlist ethical, legal, and medical advice, with particular attention to the advice of ethics committees in hospitals and elsewhere. The guardian may speak directly with the treating or attending physician before authorizing or denying any medical treatment.

The guardian shall not authorize extraordinary procedures without prior authorization from the court unless the ward has executed a living will or durable power of attorney that clearly indicates the ward's desire with respect to that action. Extraordinary procedures may include, but are not limited to, the following medical interventions: Psychosurgery, [e]xperimental treatment, [s]terilization, [a]bortion, [e]lectroshock therapy.⁹⁹

NGA Standard 15 comprises an illustration of how the general principles embodied in Standard 14 apply when end-of-life health care treatment is implicated by the informed consent doctrine. It also recognizes that, in some cases, the guardian's role may involve seeking prior court approval for a decision to terminate treatment. Standard 15 provides:

The NGA recognizes that there are circumstances in which, with the approval of the court if necessary, it is legally and ethically justifiable to consent to the withholding or withdrawal of medical treatment, including artificially provided nutrition and hydration, on behalf of the ward. In making this determination there shall in all cases be a presumption in favor of the continued treatment of the ward. If the ward had expressed or currently expresses a preference regarding the withholding or withdrawal of medical treatment, the guardian shall follow the wishes of the ward. If the ward's current wishes are in conflict with wishes previously expressed when competent, the guardian shall have this ethical dilemma reviewed by an ethics committee and if necessary, submit the issue to the court for direction. When making this decision on behalf of the ward, the guardian shall gather and document information as outlined in Standard 6—Informed Consent and shall follow the Standards for Decision-Making, Standard 7.¹⁰⁰

⁹⁹ STANDARDS OF PRACTICE 14. In many jurisdictions, state law requires prior court approval of extraordinary treatments, including those listed in Standard 14. *See infra* Part III.D.

¹⁰⁰ STANDARDS OF PRACTICE 15. NGA Standard 7 sets out general guidelines pertaining to the substituted judgment and best interests standard. STANDARDS OF PRACTICE 7. These standards are of general applicability to the full range of personal decisions that a guardian might be entrusted to make. Thus, while they are useful in some

The NGA Standards are an important and helpful resource because they describe a number of specific means by which the guardian can ascertain the treatment goals and preferences of the ward for purposes of medical decision-making. These include collecting information about the ward's preferences that might be found in a preexisting health care directive or similar evidentiary material¹⁰¹ and inferring likely preferences that might arise as a result of the ward's past or current ethnic, cultural, social, and spiritual affiliations¹⁰² as well as from the ward's attitudes and views regarding "illness, pain, and suffering, . . . death and dying, . . . quality of life issues, . . . societal roles and relationships, and . . . funeral and burial customs."¹⁰³

(b) American Medical Association Ethics Opinion 8.081

Less than a half century ago, the medical establishment was quite resistant to the general notion that patients should play a significant role in charting the course of their own health care treatment.¹⁰⁴ Over time, however, the American Medical Association (AMA) and other organizations representing the health professions have contributed significantly to the public discourse around patient autonomy and the role of surrogates in assuring that decisions made for incapacitated patients reflect, to the extent possible given the patient's degree of incapacity and other factors, the values and preferences of the patient. One notable example of such contributions is the AMA's Ethical Opinion 8.081, which provides explicitly that "when there is evidence of the patient's preferences and values, decisions concerning the patient's care should be made by substituted judgment."¹⁰⁵ This opinion also offers guidance regarding the importance of consulting all patients, including those of limited capacity, to help guide specific treatment decisions, and suggest the means by which these preferences can be identified and documented.¹⁰⁶ In virtually all substantive aspects, Opinion 8.081 mirrors both formal legal and NGA practice standards, and confirms the general principle that an abstract "best interest" standard should be considered only if there is no feasible way to effect patient autonomy.

situations, the more specific guidance contained in Standards 14 and 15 should be considered the Standards' most relevant source of direction *with respect to medical decisions*.

¹⁰¹ STANDARDS OF PRACTICE 14, 15.

¹⁰² STANDARDS OF PRACTICE 10.I.A.

¹⁰³ STANDARDS OF PRACTICE 10.I.B.

¹⁰⁴ See, e.g., Meisel, *supra* note 28, at 413 n.2, 428 n.65 and authorities cited therein.

¹⁰⁵ Am. Med. Ass'n Code of Ethics, Op. 8.081 (2004).

¹⁰⁶ *Id.*

D. Other General and State-Specific Guidance

In many if not all states, guardians have access to detailed, state-specific guidance regarding decision-making on a range of topics that includes health care decisions. This guidance may be found in manuals or other materials prepared by state judicial councils, attorneys general offices, and other entities that have worked with guardianship associations, advocacy organizations, or similar groups. For example, the American Bar Association has published an excellent guide to medical decision-making by surrogates entitled “Making Medical Decisions for Someone Else: A How-To Guide.”¹⁰⁷ The Minnesota Conference of Chief Judges’ handbook for guardians and conservators in Minnesota contains specific guidance on health care and psychiatric treatment decisions by guardians under Minnesota law.¹⁰⁸ One immensely useful resource is the Washington State Hospital Association’s End of Life Care Manual, Section Five, which concerns surrogate decision-making generally, including decision-making by guardians.¹⁰⁹ Many of these resources can be useful even though they are presented as state specific.

In summary, the broad parameters of guardians’ obligations when making health care decisions are essentially the same in all jurisdictions, due to their constitutional underpinnings and the universally accepted principles of patient autonomy and informed consent. State-specific guidance is also important, however, because the particulars of the process by which guardians make medical decisions for the ward is different across jurisdictions. In a few states, a guardian may not make certain decisions—for example, authorizing sterilization or an abortion or refusing or withdrawing life-sustaining treatment—without seeking court approval.¹¹⁰ In some jurisdictions, a ward’s health care preferences regarding

¹⁰⁷ ABA COMM’N ON LAW AND AGING, MAKING MEDICAL DECISIONS FOR SOMEONE ELSE: A HOW-TO GUIDE (2009), *available at* http://www.americanbar.org/content/dam/aba/uncategorized/2011/2011_aging_bk_proxy_guide_gen.authcheckdam.pdf. This guide was based on an earlier publication, ABA COMM’N ON LAW AND AGING IN COLLABORATION WITH THE MARYLAND OFFICE OF THE ATTORNEY GENERAL, MAKING MEDICAL DECISIONS FOR SOMEONE ELSE: A MARYLAND HANDBOOK (2006), *available at* <http://www.oag.state.md.us/Healthpol/proxyHandbook.pdf>.

¹⁰⁸ MINN. CONF. OF CHIEF JUDGES, CONSERVATORSHIP AND GUARDIANSHIP IN MINNESOTA (2010), *available at* http://www.mncourts.gov/forms/public/forms/Guardianship_Conservatorship/Guardianship_Manual/GAC101.pdf.

¹⁰⁹ WASH. STATE HOSP. ASS’N, END OF LIFE CARE MANUAL, SECTION 5: SURROGATE DECISION-MAKING (2009) [hereinafter END OF LIFE CARE MANUAL], *available at* <http://www.wsha.org/EOL-SurrogateDecisions.cfm>.

¹¹⁰ *See, e.g.*, MINN. STAT. § 524.5-313 (2010); N.D. CENT. CODE § 30.1-28-12 (2010). In addition, the letters of guardianship may require the guardian to obtain prior judicial approval of sensitive or irreversible medical decisions. The National College of Probate Judges specifically recommends that,

When establishing the powers of the guardian, the court should be aware that certain decisions by a guardian may be irreversible or result in irreparable damage or harm. As a result, unless otherwise provided by statute, the court may

certain highly invasive procedures, or to withholding or withdrawing life-sustaining treatment, must be established by clear and convincing evidence. Accessing state-specific resources for guardians is an important first step in fulfilling the guardian's fiduciary obligations in medical decision-making.

IV. HEALTH CARE DECISION-MAKING: A ROAD MAP FOR GUARDIANS¹¹¹

Every health care decision that a guardian makes for the ward should involve the same basic process of thought and action. Unless doing so is impossible, the standard for decision-making should be the doctrine of substituted judgment, with a best interest standard used only as a last resort. This standard controls whether the health care decision at stake is merely the choice of physician on the one hand, or whether to authorize a high-risk surgical procedure, invasive and often unsuccessful procedures such as chemotherapy, or the insertion of a feeding tube to extend the ward's life.¹¹² Some medical treatment-related decisions are much

specifically limit the ability of the guardian to make certain decisions without prior court approval (*e.g.*, sensitive personal or medical decisions such as abortion, organ donation, sterilization . . .). The ability of the guardian to make routine medical decisions should not ordinarily be curtailed, but where extraordinary decisions of an irreversible or irreparable nature are involved, authorization for those decisions should be included in the initial court order or the guardian should be required to return to the court for specific authorization before proceeding.

COMM'N ON NAT'L PROBATE CT. STANDARDS AND ADVISORY COMM. ON INTERSTATE GUARDIANSHIPS, NATIONAL PROBATE COURT STANDARDS § 3.3.12 cmt. (1999).

¹¹¹ This road map derives from a number of sources, but relies most heavily on the following guides to health care surrogate decision-making: ABA COMM'N ON LAW AND AGING, *supra* note 107; THERESA DROUGHT, MARKULA CTR. FOR APPLIED ETHICS AT SANTA CLARA UNIV., MEDICAL DECISION MAKING FOR PUBLICLY CONSERVED INDIVIDUALS: POLICY RECOMMENDATIONS (2004), available at <http://www.scu.edu/ethics/practicing/focusareas/medical/conserved-patient/policy.html>; END OF LIFE CARE MANUAL, *supra* note 109; STANDARDS OF PRACTICE (Nat'l Guardianship Ass'n 2000) (amended 2007); VERMONT ETHICS NETWORK, MAKING MEDICAL DECISIONS FOR SOMEONE ELSE: A VERMONT HANDBOOK (2009), available at http://www.vtethics.network.org/forms/making_medical_decisions.pdf.

¹¹² It is important to note that the guardian may not delegate ultimate decision-making authority to a third person, although others may certainly assist the guardian to fill this role by gathering information, proposing alternative courses of treatment, and the like. For example, many professional guardians who have heavy caseloads, and even some family guardians, rely on care- or case-managers who are responsible for the ward's day-to-day living situations. Such third parties often take the lead in managing the ward's health care, keeping track of the need for preventive or acute care, and so forth. It is the guardian's responsibility, however, to make all final decisions regarding each proposed health care decision, and to make those decisions consistently with the principles set forth in this Article.

simpler than others, and will not likely involve, for example, extensive inquiries of providers on the risks and benefits of a procedure.¹¹³ Nevertheless, all medical decision-making by a guardian implicitly involves the steps set out below. One simple way to think of this process is as follows: in the realm of health care decision-making, it is the guardian's role to *gather, assess, decide, discuss, and advocate*.¹¹⁴ This road map, which derives from a wide variety of practical standards guidelines including those described above, affords a process for assuring legally sustainable and ethically permissible health care decision-making in behalf of incapacitated wards.

A. *Gather*

A guardian who becomes legally responsible for health care decision-making should not wait until a medical crisis occurs to gather information that might be needed to perform her duties in this area. A guardian who is delegated medical decision-making authority should promptly collect, document, and retain all available evidence that might be relevant when particular decisions must be made. This process might include locating prior health care directives,¹¹⁵ living wills, or

¹¹³ See ALISON REIN, ROBERT WOOD JOHNSON FOUND., ISSUE BRIEF: THE CURRENT AND FUTURE ROLE OF CONSUMERS IN MAKING TREATMENT DECISIONS (2007), available at <http://www.academyhealth.org/files/issues/RoleofConsumers.pdf> (“Of course, not all choices are equally important or involve the same decision-making processes. A patient’s choice of whether or not to undergo chemotherapy is very different from the choice of whether to have cosmetic surgery. Some choices must be made within a discrete time frame and lead patients down a defined path; others are small decisions repeated over time that may—in total—affect an individual’s overall health in the context of a chronic condition.”).

¹¹⁴ As with Kubler-Ross’s five stages of grief, see ELISABETH KÜBLER-ROSS, ON DEATH AND DYING (1969), the order in which these steps occur can vary, and not every single health care decision will involve all five steps. In the main, though, keeping these simple words at the forefront can help the guardian to proceed in an orderly fashion through the morass of considerations that are crucial to legal, effective, efficient, and ethical decision-making for the protected person.

¹¹⁵ The guardian’s obligation to consider the patient’s stated preferences on medical treatment extends to those contained in traditional and so-called psychiatric health care directives. In many states, persons who wish to control, or at least influence, psychiatric treatment decisions may execute a psychiatric advance directive that is separate from their more general advance health care directive. Unlike treatment preferences clearly stated in a general directive, however, physicians are not always required to honor the patient’s directives stated in a psychiatric advance directive. Because mental illness can in some circumstances cloud a person’s judgment, or because a failure to treat mental illness can result in harm to the patient or others, treatment decisions involving serious psychiatric disorders often involve consideration of many factors other than the patient’s own preferences. For general information on the legal and practical issues associated with psychiatric advance directives, see generally, for example, Lisa Brodoff, *Planning for Alzheimer’s Disease with Mental Health Advance Directives*, 17 ELDER L.J. 239 (2010); Jennifer Colangelo, *Current Issues in Public Policy: The Right to Refuse Treatment for*

similar documents, talking with the ward's friends, family members, and spiritual advisers about values, and preferences, and so forth. Evidentiary materials that are collected before crisis erupts (for example, recollections by family members of the ward's past articulated statements) may be more reliable than those "remembered" in the emotional and exigent circumstances in which some health decisions must be made.

B. Assess

Once this initial process is complete, the guardian should assess the available information regarding the ward's health care preference. To what extent does this evidence establish with clarity, or near-clarity, either specific treatment preferences or general perspectives that can guide surrogates when the need arises? If a gap exists, are there ways in which the "record" can be further developed? Most Americans do not have health care directives, nor have they formally documented their preferences and wishes regarding health care treatment in other ways. To assure that a ward's health care preferences are reflected in all health care decisions, it may be necessary for the guardian to assist the ward to articulate and record her preferences *now*, to the extent she has capacity to do so. The term "capacity" as used in modern guardianship law refers to a person's ability to make particular kinds of decisions.¹¹⁶ One of the key challenges in guardianship litigation is that many states require a medical evaluation of "capacity" in guardianship proceedings even though the construct of incapacity in guardianship law is a legal one that is considerably removed from medical definitions of incapacity. With respect to legal decision-making, for example, a person may have capacity to make a will but lack capacity to sell real property—in most jurisdictions, these standards of capacity are substantively different, involving qualitatively and quantitatively different degrees of "understanding" the legal consequences of one's choices. Similarly, a guardianship proceeding may produce a judicial determination that a person has the capacity to choose her place of abode, but lacks capacity to make health care decisions. The measures by which capacity is calculated and the line between capacity and incapacity is drawn are, unfortunately, seldom clear.¹¹⁷

Moreover, because capacity can fluctuate—over time, or even within a single day—it is important for the guardian to recognize that even after a court has made

Mental Illness, 5 RUTGERS J.L. & PUB. POL'Y 492 (2008); Hodge et al., *supra* note 19; Jeffrey W. Swanson & Eric B. Elbogen, *Psychiatric Advance Directives: Practical, Legal, and Ethical Issues*, 4 J. FORENSIC PSYCHOL. PRAC. 97 (2004); *see also, e.g., Legal Issues*, NAT'L RESOURCE CTR. ON PSYCHIATRIC ADVANCE DIRECTIVES, <http://www.nrc-pad.org/content/blogsection/21/72/> (last visited Mar. 30, 2012). For an excellent analysis of the guardian's role in making psychiatric treatment decisions for a ward, see *Steele v. Hamilton Cty. Cmty. Mental Health Bd.*, 736 N.E.2d 10 (Ohio 2000).

¹¹⁶ *See, e.g.,* Mary F. Radford, *Is the Use of Mediation Appropriate in Adult Guardianship Cases?*, 31 STETSON L. REV. 611, 627–32 (2002).

¹¹⁷ *Id.* at 630–31.

a finding of legal incapacity and imposed a guardianship, a ward may be able to participate in some decision-making processes despite the judicial finding. A judicial determination that a person is in need of guardianship necessarily involves a determination that the person lacks decisional capacity with respect to one or more important broad areas of personal decision-making that are necessary to living autonomously. A guardian has authority to make health-care decisions only if, and to the extent that, the letters of guardianship explicitly delegate that role. If a guardian does not have such authority, then there is no legal basis for her to be involved in this aspect of the ward's life; the guardian is entitled to participate in medical decision-making only to the extent invited to do so by the ward. All of us, wards included, have a right to seek input from medical professionals, family members, friends and others when we make medical decisions; a person under guardianship is no different.

But even in a plenary guardianship, the ward's decision-making is—or should be—restricted only to the extent necessary to protect the ward's safety and well-being. That a ward has been deemed by a court to lack sufficient capacity to make final medical decisions does not mean that the ward lacks the ability to participate in the process that leads to these final decisions. The ranges of individuals ultimately placed under guardianship is very broad, and includes persons who have “acquired” their incapacity suddenly as an incident of an acute or chronic illness or disease as well as persons who have never had complete decisional capacity due to early-onset mental illness or a significant developmental delay. A person who is “incapacitated” might in fact have only the mildest of cognitive impairments and have views and preferences that must be considered when making medical decisions. One of the challenges of serving as guardian for persons who have some but not full decisional capacity is knowing when and how to include the ward's current values and preferences in a way that ensures that ward's fullest participation in the decision-making process.¹¹⁸

In an ideal guardianship regime, the scope of a legal guardianship would be precisely and comprehensively defined to reflect both the exact nature and degree of the ward's legal incapacity with respect to every category of personal decision-making conceivable, and within those categories, every possible decision that might be made. Of course such detail and precision is not possible, pragmatically, fiscally, or administratively. Accordingly, the guardian's duties with respect to a particular ward are painted with a broad brush. In the realm of medical decision-making, therefore, it is the guardian's legal and ethical obligation to exercise her authority consistently with the goal of a *limited* guardianship and the fundamental principle of patient autonomy that underlies the *Cruzan* decision. Even significantly compromised wards may have ways to communicate values and preferences that are relevant to medical decision-making. Moreover, such wards' family situation, or their ethnic, cultural, and religious backgrounds, can

¹¹⁸ *Id.* at 632–34.

sometimes serve as reliable surrogates for expressly communicated medical treatment goals and preferences.¹¹⁹

Some health care decisions—such as whether to share medical information otherwise protected by HIPAA—are probably well within the range of decision-making capacity of most wards, and the guardian can, with relatively little difficulty or effort, help the ward to execute waivers and other appropriate documents that can be used later as evidence of the ward’s preferences. Tools are available that can help even significantly impaired persons express preferences about health care, spirituality, and quality of life. For example, “Thinking Ahead: My Way, My Choice, My Life at the End” is a health care planning workbook “designed by and for people with developmental disabilities to enable them to do their own advance care planning . . . [and can also be used] when working with the frail elderly, people with low reading comprehension or anytime simplification of complex advance health care planning issues would be helpful.”¹²⁰ Such tools provide an alternative to statute-based health care directive forms that generally require a particular level of capacity to execute.¹²¹ The guardian should also consider whether the ward’s health status and expressed or inferred preferences justify executing anticipatory documents such as do-not-resuscitate (DNR) orders¹²² or (in the handful of jurisdictions that allow them) physician’s orders for life-sustaining treatment.¹²³

¹¹⁹ For a listing of state evidentiary requirements pertaining to capacity determinations in guardianship cases, see, for example, ABA COMM’N ON LAW AND AGING, JUDICIAL DETERMINATION OF CAPACITY OF OLDER ADULTS IN GUARDIANSHIP PROCEEDINGS: A HANDBOOK FOR JUDGES (2006) [hereinafter JUDICIAL DETERMINATION]; ABA COMMISSION ON LAW AND AGING, ASSESSMENT OF OLDER ADULTS WITH DIMINISHED CAPACITY: A HANDBOOK FOR PSYCHOLOGISTS (2006) [hereinafter ASSESSMENT OF OLDER ADULTS]; PAMELA B. TEASTER ET AL., PUBLIC GUARDIANSHIP: IN THE BEST INTERESTS OF INCAPACITATED PEOPLE? (2010).

¹²⁰ See STATE OF CAL, DEP’T OF DEVELOPMENTAL SERVS., THINKING AHEAD: MY WAY, MY CHOICE, MY LIFE AT THE END (2010), available at <http://www.dds.ca.gov/ConsumerCorner/ThinkingAhead.cfm>.

¹²¹ See generally, e.g., JUDICIAL DETERMINATION, *supra* note 119; ASSESSMENT OF OLDER ADULTS, *supra* note 119.

¹²² As noted earlier, the emergency exception to the informed consent can result in medical treatment that, in retrospect, is clear the particular person would not have wanted. DNR and DNI (do-not-intubate) orders, if properly executed and filed or otherwise made available to providers as required by applicable laws and regulations, assure that some kinds of emergency medical treatment will not be administered notwithstanding the general exception. An important part of “gathering and assessing,” therefore, is making sure appropriate documentation of preferences are available to health care providers when decisions are being made.

¹²³ The POLST movement began in Oregon in 1991 and has spread to a number of other jurisdictions. In some states, the POLST or MOLST (“medical orders on life sustaining treatment”) concept has been codified as part of the state’s health care directives law. The goal of the POLST concept’s originators was to find a way of assuring that patient preferences regarding health care treatment near the end of life were actually enforced

C. Decide

1. Decision-Making Using a Substituted Judgment Standard

(a) Exercising the Ward's Right to Informed Consent

Incapacitated patients have a right to exercise informed consent respecting medical treatment. The guardian, therefore, has a responsibility to give consent on behalf of the ward only in those situations in which the patient would have authorized the particular treatment if he or she had capacity to do so. As a general matter, one can give informed consent only after determining what the risks and benefits of the proposed treatment are as compared with the alternatives. This kind of information can be obtained from written materials typically furnished by the provider, through conversations with physicians and others who will be involved in the treatment, and by consulting with third parties or obtaining second opinions. The nature of the information necessary for guardians to evaluate the risks and benefits of a medical procedure depends greatly on the nature of the procedure, its invasiveness, and potential consequences for the patient if the treatment is not provided. In deciding whether to give informed consent on behalf of the ward, a guardian should consider anything that might pertain to what this particular patient/ward would do were she able to speak for herself. Among these considerations are factors relating to the ward's personal views regarding health care as well as "neutral factors"—things that all of us are likely to take into account prior to making a health care decision. Considerations that should be weighed when deciding whether to give informed consent on the ward's behalf are:

- Any past statements made prior to the onset of incapacity (oral or written, contained in an advance directive for health care or otherwise) regarding health care generally, specific treatment options, or recently articulated preferences, including statements made after the judicial determination of incapacity. Such statements must be accorded a weight that is appropriate given the ward's capacity to understand the nature and consequences of the proposed treatment.
- The ward's actual or likely religious or moral views regarding medical care or the dying process. Such views can be inferred not only from the

through physician orders implementing those preferences. The concept has received broad endorsement from both the medical and legal communities. *See, e.g.*, NAOMI KARP & CHARLES SABATINO, IMPROVING ADVANCED ILLNESS CARE: THE EVOLUTION OF STATE POLST PROGRAMS (2011), available at <http://www.aarp.org/health/doctors-hospitals/info-04-2011/polst-04-11.html>. However, not all patient- and disability-rights advocates are fully on board with the POLST movement. *See, e.g.*, CAL. ADVOCATES FOR NURSING HOME REFORM, PHYSICIAN ORDERS FOR LIFE SUSTAINING TREATMENT "POLST": PROBLEMS AND RECOMMENDATIONS (2010), available at http://www.canhr.org/reports/2010/POLST_WhitePaper.pdf.

ward's past or current statements or conduct, but also from her cultural, religious, and ethnic background.

- The ward's past or current expressed concerns for how particular medical decisions and treatments will affect family and friends' well-being.
- The opinions and preferences of family or other individuals, and the values of the ward's cultural community, if there is reason to believe that the ward would have considered or relied upon such opinions and values.¹²⁴
- The likely outcome or prognosis if the ward is left untreated.
- The likely outcome of alternative treatments that might be available.
- The risk of adverse side effects from the proposed treatment as compared with no treatment and with alternative treatments.
- The intrusiveness of the proposed treatment as compared with no treatment or with the alternatives.
- Whether the ward is capable of participating fully in any posttreatment therapy that might be required following the proposed treatment.¹²⁵

It is unlikely that evidence deriving from all of these considerations will be available in all situations. But the well-prepared and conscientious surrogate will have access to some information from which reliable informed consent can be given or withheld respecting most decisions for most wards. Ultimately, it is up to the guardian to do the right thing, avoid imposing her own concept of what is in the ward's best interests, and exercise her legal authority in a manner that preserves the ward's autonomy, dignity, and personal liberty interests in this important area.

(b) Obligation to Ensure the Fullest Participation by the Ward in the Decision-Making Process

The various sources of guidance to guardians, including state laws and the various standards and tools discussed throughout this article, are virtually unanimous in admonishing guardians to "provide the ward with every opportunity to exercise those individual rights that the ward might be capable of exercising as they relate to the care of the ward's person."¹²⁶ The imprecise concept of "incapacity" and its fluid nature means that a ward's ability to participate in health care decision-making may or may not be evident, and may or may not exist with

¹²⁴ Unless there are good reasons to do otherwise, it is generally appropriate to impute to an incapacitated person the values of her family and of the community within which she lives or chose while still competent to do so. In the important *Quinlan* case, for example, the court discussed at length the position of the Catholic Church with regard to withdrawing artificial ventilation, on the ground that Karen Ann had been a relatively devout Catholic her entire life and as such would likely have followed its dictates were she in a position to make her own choices. See *In re Quinlan*, 355 A.2d 647, 657–60 (N.J. 1976).

¹²⁵ See sources cited *supra* note 111.

¹²⁶ STANDARDS OF PRACTICE 9.I (Nat'l Guardianship Ass'n 2000) (amended 2007).

respect to any particular medical decision. Nevertheless, the guardian should always respect the ward's autonomy to the degree reasonably allowed by the ward's cognitive abilities *at the time the decision must be made*. This is no easy task, and demands that the guardian be sensitive to the ward's level of capacity to participate in a discussion of risks and benefits, the consequences of treatment versus nontreatment, and the extent to which the ward might, if he or she had the capacity, rely on the input of family members, friends, or other important persons in the ward's life.

2. *Decision-Making Using a Best-Interests Standard*

As we have seen, using a substituted judgment standard for health care decisions is not only the preferred best practice, as articulated by entities as diverse and broadly representative as the National Guardianship Association, the American Bar Association, and the American Medical Association, but *required* when it is feasible to exercise by constitutional and common-law principles alike. In the rarest of circumstances, however, there may be no way to determine a ward's likely preferences from her past statements or other measures of and substitutes for direct articulation of her views. This could conceivably occur if the ward is a person who never had decisional capacity—as, for example, with a severely developmentally disabled person—who lacks family and cultural, ethnic, or spiritual community from which values might be inferred and imputed to the ward. If the guardian “cannot in good faith ascertain whether the patient, if competent, would have consented to the proposed health care, [the guardian] must determine that the medical treatment is in the patient's best interests before giving consent.”¹²⁷

It bears repeating that the best interest standard should not be construed as one that requires, or even allows, the guardian to impose the guardian's personal values upon the ward. The best interest standard is, practically speaking, comparable to the reasonable person standard in other areas of law. It is often described as objective, although that characterization is highly questionable.¹²⁸ A more realistic (albeit overly simplistic) explanation is that the best interests standard comprises the guardian's best guess as to what most competent persons would do in the situation facing the ward. Accordingly, the guardian should consider those factors

¹²⁷ END OF LIFE CARE MANUAL, *supra* note 109, at Section 5.

¹²⁸ See CODE OF MEDICAL ETHICS, Op. 8.081 (Am. Med. Ass'n 2004); Whitton & Frolik, *supra* note 2, at 1504. As Professor Frolik has observed, however, it is “folly” to claim that a “best interest” standard is objective in any respect. See Frolik, *supra* note 4, at 69–70 (“Even if the guardian successfully ignores her own values and preferences, she is necessarily applying someone's value under the guise of the reasonable person, or more likely, the guardian is merely doing what ‘most folks’ would do; unless, of course, the guardian believes that what the reasonable person would do is the minority position, and therefore, most patients are not reasonable. In that case, the guardian has little choice but to assume that when faced with the ward's situation, the reasonable choice is to do what the majority of patients would do.”).

that persons needing medical treatment normally take into account, including but not limited to the following:

- the range of available treatment options and the risks, side effects, and benefits of each of the options
- the patient's past and present level of physical, sensory, emotional, and cognitive functioning
- the ward's potential life expectancy with and without treatment
- whether the proposed treatment will sustain the status quo
- the degree of physical pain resulting from the medical condition, treatment, or termination of treatment
- whether pain management can mitigate the ward's potential suffering resulting from treatment or nontreatment
- the degree of dependency and loss of dignity resulting from the medical condition and treatment

The starting point for applying a best interest standard is the relevant statutory language, but this language may be vague or, in some states, nonexistent. In general, this standard is best understood as involving what a "reasonable person" would likely do in the circumstances facing the ward.¹²⁹ Reasonable persons do not normally refuse treatment for minor illnesses, embrace pain without efforts to mitigate it, or agree to surgical procedures when the risks grossly outweigh the potential benefits. But as professors Frolik and Whitton have noted, the empirical information suggests that the application of best interest standards takes many forms and can involve a consideration of how particular treatments of *the ward* will affect third persons, including family members or others who have strong personal connections to that person.¹³⁰

Perhaps the most that can be said regarding interpreting the best interest standard in the context of health care decision-making is that, unless the guardian has a preexisting, long-term, and (possibly) familial relationship with the ward, it is important for the guardian to resist imposing his or her own concept of what is "best" for the ward as a substitute for a careful evaluation of the factors set out above. For example, a guardian's personal aversion to a particular medical treatment, or strongly held views that artificial ventilation, nutrition, and hydration should be continued in all circumstances, no matter what the ward's condition was before such treatment began or the prognosis for regaining prior health status, should not bear in an assessment of what is in the ward's best interests.¹³¹

¹²⁹ For a more comprehensive, generic discussion of the best interest standard in adult guardianship law, see Whitton & Frolik, *supra* note 2.

¹³⁰ *Id.* at 1504–15.

¹³¹ Consider, for example, the following situation: A nursing home resident—an unbefriended elder, age ninety-two—with advanced Alzheimer's disease, is diagnosed with a mildly aggressive cancer. There is no documentation on file of the resident's views on medical treatment, spirituality, or other values that might bear on decision-making; she is unable to communicate and spends about nineteen hours a day sleeping. The resident's

D. Discuss

Discussing the ward's likely health care preferences with persons who know the ward is, as noted above, an important aspect of the "gather" and "assess" stages of the decision-making process. But once a decision has been made with regard to medical care, the guardian should make a reasonable effort to discuss the decision with third parties who may be affected by it. Even when a guardian has full legal authority to make health care decisions, the guardian should be mindful of the ward's personal relationships and how particular decisions will affect those who know and care for the ward. This constellation of discussants might include family members, close friends who have been in contact with the ward during the ward's incapacity, caregivers, and spiritual advisers. As always, the nature of the medical decision involved will necessarily bear on the degree to which it should be discussed in advance with third parties.

E. Advocate

As noted above, a guardian has a duty to advocate for the ward.¹³² This means that the guardian must be diligent in communicating the decisions made on the ward's behalf to a wide range of professionals, some of whom may resist the very idea of patient autonomy in health care decision-making. Advocacy in this context entails avoiding conflicts of interest that may compromise the guardian's ability to exercise independent judgment regarding the ward's medical care.¹³³ In rare circumstances, the duty to advocate may involve seeking redress for the ward in official forums, including the courts. A guardian whose personal predilections, beliefs, or other considerations will prevent him or her from advocating fully and powerfully on the ward's behalf should immediately seek appointment of an alternate guardian.

F. Collateral Obligations

The guardian's role as medical decision maker implies certain collateral obligations relating to the provision and aftermath of health care treatments.

guardian is a court-appointed professional guardian who manages over 200 wards. He has met the patient only once, several years ago. It is the guardian's policy to demand aggressive medical treatment for all his wards. When asked by the facility to authorize hospice care for the resident, he refuses to authorize it based on this policy. Such a decision would, by almost any definition of "best interests," be inconsistent with the guardian's legal and ethical obligations. This example is, unfortunately, based on a true story.

¹³² The nature of this duty varies with context, and may in some circumstances conflict with the guardian's duties to the court. *See, e.g.*, Frolik, *supra* note 4, at 56–59 (discussing guardian's dual role as advocate for the ward and officer of the court).

¹³³ *See* STANDARDS OF PRACTICE 16 (Nat'l Guardianship Ass'n 2000) (amended 2007).

Because these duties are intimately connected to the guardian's role as health care decision-maker, they also require the guardian to utilize a substituted judgment standard if there is sufficient evidence of what the ward would do. A nonexhaustive list of these collateral obligations includes

- identification of existing health care providers and communication with those providers regarding the ward's future need for preventive, routine, acute, and long term care;¹³⁴
- determining the availability of payment sources for long-term care and timely communicating with the ward, the ward's agent under a power of attorney, or a court-appointed conservator about paying for health care that is provided to the ward;¹³⁵
- complying with enrollment and application guidelines and deadlines that affect eligibility for both public and private health insurance programs; and
- reviewing, understanding, and completing medical privacy forms relating to the ward's privacy rights under the Health Insurance Portability and Accountability Act (HIPAA). A guardian's release of information protected by HIPAA's privacy provisions must be consistent with the principles of informed consent and substituted judgment.

V. APPLICATIONS

Scenario 1: Velma is a seventy-seven-year-old widow who was diagnosed four years ago with Alzheimer's disease. She has been taking an experimental medication that her geriatrician has said may slow its course. Prior to her diagnosis, she was exceptionally active—physically, intellectually, and socially. Velma was involved in a book group, went to Curves (a gym for women only) four times a week, and traveled extensively with family members and friends. She was a member of the Bethlehem Lutheran Church, although she had not attended

¹³⁴ See STANDARDS OF PRACTICE 5.

¹³⁵ It should be noted that the demarcation between "personal" and "financial" decisions is not always completely clear with regard to some matters, including health care and housing decisions. In some jurisdictions, for example, matters such as applying for Medicaid or other public benefits are considered to be an aspect of "financial" decision-making. See generally Robert B. Fleming & Rebecca C. Morgan, *Standards for Financial Decision-Making: Legal, Ethical, and Practical Issues*, 2012 UTAH L. REV. 1275. In Minnesota, in contrast, it is the guardian who has this responsibility due to the critical connection between authorizing health care and paying for it. See MINN. STAT. § 524.5-313(c)(2) (2010). The conservator's role in this process, if any, is to assure that health care payments for which the ward is legally responsible are made in a timely fashion. If the ward has both a guardian and a conservator, it is imperative that these two surrogates act in concert to serve the needs and desires of the ward. For an example of what happens when guardian and conservator fail to collaborate to serve the needs and interests of the ward, see Paul Levy, *Whistleblower: Blind and in Need of Special Care, Veteran May Be Evicted from VA Home*, MINNEAPOLIS STAR TRIB., Aug. 28, 2011, <http://www.startribune.com/local/north/128513008.html>.

regularly for many years. Her most recent trip was five years ago when she traveled to Costa Rica on an “eco journey” through the rain forest.

In the four years after her diagnosis, however, Velma grew increasingly reclusive. She had problems with balance and spatial orientation, and stopped going out of the house, even with others, except when absolutely necessary. She continued to read the paper, but in the last several months had stopped reading novels because she could not remember what she had read from day to day. Velma usually recognized her family members when they called or visited, but in recent weeks there had been several incidents when she did not remember her grandchildren’s names. She believed (erroneously) that two cats had taken up residence in her house. Velma had fallen several times in her home, but had not injured herself seriously. She had begun forgetting to make and keep her many doctors’ appointments, and on one occasion she failed to obtain treatment for a burn that subsequently became infected. Neighbors who came to call realized what had happened and took her to Urgent Care for treatment.

Velma’s three children all live out of state. Her eldest daughter Sarah wanted Velma to move to an assisted living facility, but Velma refused to leave her home of twenty-seven years. Sarah filed a petition for guardianship in Velma’s home state seeking to be appointed as guardian so she could move her mother. Sarah’s two siblings cross-petitioned, requesting that *they* be named as coguardians with plenary authority. After a contentious proceeding in which many deep-seated sibling rivalries were revealed, the court appointed a professional guardian/conservator to manage some aspects of Velma’s personal affairs; most notably her health and long-term care needs and her day-to-day financial matters. The guardian was not given authority to make residential decisions on her behalf. Although Velma had executed an advance directive for health care several years prior, the named agent was her deceased husband; no alternates were identified therein.

Through a care manager, the guardian arranged for a personal care attendant (PCA) to visit twice a day and help Velma with dressing and undressing, medication management, and shopping. Velma refused to allow the PCA to participate in bathing and toileting activities, even though she had begun having some difficulties with these activities. Velma once told the PCA “the day someone else has to give me a bath is the day I take the poison pill.”

On August 1, Velma fell while alone in her bathroom, and hit her head. The PCA heard her fall and called 911. During the ride to the emergency room, Velma was aware and coherent. The x-ray revealed that she had broken a vertebra in her upper neck, and Velma was transported to the nearest trauma center for further evaluation. On the way, Velma fell asleep. When Velma’s three children arrived the next day, she was still sleeping and could not be awakened. The neurologists found no evidence of a brain injury and could not account for the fact that she would not wake up, but stated emphatically that she was not comatose. Soon after they arrived, Velma’s children asked her doctors to keep them informed of their mother’s situation and consult with them at all times.

Issue 1: Under HIPAA, physicians may not release medical information to third parties without the consent of the patient. A court-appointed guardian with the power to make health-care decisions for the ward, however, must be provided with all personal medical information needed to exercise that authority. The guardian can also waive this privacy right on the ward's behalf. Should the guardian allow Velma's children to have access to their mother's medical information so that they may discuss their mother's situation with her doctors?

Analysis: As alter-ego for the ward, the guardian's duty is to make medical decisions consistent with the ward's preferences. The guardian should, therefore, waive Velma's HIPAA privacy rights if Velma herself would have done so. Velma seems to have a good relationship with her children, and there is no particular reason to think she would not want them to talk with doctors about her current situation. Although Velma did not name any of her children as alternate agents in her health care directive—many principals choose not to name an alternate agent—this fact alone does not suggest that she would not want her children to know about her medical situation. The guardian could likely consult with other health providers to determine what Velma's general approach to health information privacy (formal or informal) had been in the past. If, for example, Velma had permitted her children or other third parties to discuss her health care with her on prior occasions, it is likely that she would do so now. On balance, it seems likely that the guardian should sign the HIPAA waiver.

Issue 2: The day after she was transported to the trauma facility, the hospital physicians (who did not know Velma personally) determined that two medically reasonable treatment options were available to Velma. The first was surgery to fuse the broken vertebra. Although the surgical procedure itself was not especially risky, the anesthesiologist said that patients with advancing Alzheimer's disease often fare poorly in the long run when given general anesthesia and "sometimes never recover." Otherwise, however, the postsurgery recovery and rehabilitation period was relatively short—Velma would probably need to stay in a rehab or skilled nursing home for two to three weeks. The alternative treatment proposed was to place Velma in a "halo," a heavy steel brace that would stabilize her neck until the vertebra healed. This option was noninvasive and involved few risks, but because of Velma's generally fragile state would likely require that Velma stay in a nursing home for at least three months, or until her neck healed. Which procedure should the guardian authorize?

Analysis: Assuming that both options are equally medically appropriate, the guardian's obligation once again is make the decision that Velma would in these circumstances. The guardian should discuss these options thoroughly with Velma's children to seek their input on how Velma would likely feel about an operation that might leave her significantly more compromised than she was already, versus the prospect of a lengthy stay in a nursing home during which she would lose much of her independence. If Velma has a regular family physician or geriatrician, that physician might have input on both the medical options and on Velma's preferences. Velma's health care directive could have information on Velma's preferences regarding long-term care that would be instructive when making this

decision. Assuming that they are all in agreement, Velma's children's predictions about what their mother would choose should be given great weight, as they are likely to know far more about their mother than does a professional guardian. Based on all sources of information and considering, in particular, Velma's views as expressed in any prior statements as well as her children's predictions, the guardian should choose the medical treatment that most likely reflects what Velma would do were she able to speak for herself.

Issue 3: Assume now that the guardian (with the agreement of Velma's children) decided to authorize the halo rather than the surgery. Three days after placement of the halo, Velma was still sleeping, largely unresponsive (although not comatose), and unable to eat. Neurologists had no explanation as to why she was sleeping, but stressed that "there was no reason whatsoever" that Velma would not recover from the neck injury and be "back to where she was before this happened." They said that "older patients sometimes take longer to recover from a head trauma than younger people" but there was no medical reason for her current condition (sleeping) to last for more than a few days. It is standard medical practice to insert a feeding tube in patients in Velma's condition (that is, unable to eat after four days) to assure that they receive all necessary nutrition and hydration. The procedure to insert a tube is very simple, does not require general anesthesia, and allows a sleeping patient to be fed until she is able to eat on her own.

As it happens, Velma's health care directive explicitly addresses the issue of feeding tubes, and states: "Feeding tubes: I do not want a feeding tube if the only purpose for a feeding tube is to keep me alive or prevent me from dying." Based on this statement, should the guardian authorize Velma's physicians to insert a feeding tube?

Analysis: Hospital physicians seem unable to account for Velma's failure to awaken for four days, but they have told Velma's family and the guardian that she will "recover" from this injury and eventually return to her former cognitive state. Although Velma's disease is progressive, in a sense "terminal" (because there is no cure for Alzheimer's), and was clearly progressing at the time of her fall, she was still engaging in many if not all of the activities from which she had derived enjoyment. Based on the information provided by the hospital physicians, use of a feeding tube in Velma's current situation would not be for the sole purpose of prolonging her life, but enabling her to recover the status quo or something close to it. Advance directives often require interpretation; in Velma's current situation (and given the extreme consequences of declining to authorize the feeding tube), it seems likely that her instructions restricting use of a feeding tube does not apply to the present situation. In this example, it is especially important for the guardian to consult with Velma's children and attempt to secure their consensus prior to authorizing a feeding tube.

Issue 4: Two weeks after her injury, while she was still hospitalized, Velma spontaneously awoke. Unfortunately, she was extremely weak physically, unable to walk, engage in self-care, or otherwise participate in activities necessary to live independently. More problematically, her cognitive functioning appeared to have declined precipitously, to the extent that she rarely if ever recognized family

members or close friends (although she often made reference to them by name, and seemed to enjoy their company). On August 17, Velma was transferred from the hospital to a skilled nursing facility. Her neurologist left the feeding tube in place because, even though Velma could eat (with assistance), he believed that she might at some point need supplemental nutrition. Over the next three months, Velma remained in the nursing home. Her physical and cognitive functions continued to decline at a rapid rate. By early October, she was sleeping at least eighteen hours a day and receiving at least 50 percent of her total nutritional intake via the feeding tube. She required full assistance with all activities of daily living, including bathing and toileting. Nonetheless, Velma appeared to enjoy the company of her many visitors, and would participate when they sang familiar songs, laugh when they laughed after telling a funny story, and so on. Her children, each of whom took extended leave from their jobs to remain with their mother, agreed “this is not our mom.”

On October 29, Velma’s feeding tube was displaced—her care assistant believes that Velma actually pulled it out herself. Velma’s geriatrician advised her family and the guardian that in her current state Velma was not likely to eat enough food on her own to sustain her daily caloric needs. He had also taken her off the experimental medication, which is not approved for use in patients with advanced Alzheimer’s disease due to certain side effects. For the second time, it was necessary to make a decision regarding inserting a feeding tube. Should the guardian authorize this?

Analysis: The situation confronting Velma, her family, and the guardian has changed significantly since the feeding tube was originally placed. The neurologists’ predictions about Velma’s recovery have proven incorrect. In fact, in the past three months Velma has actually fast-forwarded through some two years in the normal progression of Alzheimer’s. Looking again at the language in Velma’s advance directive, it would appear that the situation she anticipated and feared has arrived. (Recall her comment about a “poison pill.”) Withdrawing the feeding tube will not necessarily result in a speedy death for Velma, but inserting a tube will certainly prolong the dying process and accomplish nothing else. Velma, whose life prior to her disease reflects a dynamic, engaged individual who was active in many arenas, has little if any ability to interact with her loved ones. She has been reduced to the position of total dependency, including reliance on strangers for highly personal care, which she indicated was her worst nightmare. It seems almost certain from the context that if Velma were able to make this decision for herself, she would not approve a feeding tube.

Given the serious nature and consequences of this decision, the guardian should spend as much time as necessary with Velma’s children discussing this decision and, to the extent possible, securing their agreement. It *might* be appropriate to talk with Velma’s pastor as well to get any available input on her spiritual values and views on death and dying. In some jurisdictions, a decision of this magnitude requires prior judicial approval, which should be sought expeditiously. In the event that a family member, health care provider, or other person seeks to intervene and oppose the guardian on this issue, the guardian must

be prepared to advocate vigorously on the ward's behalf to assure that the ward's common-law and constitutional rights are honored and protected.¹³⁶

Scenario 2: Professional guardian making health decisions for an individual who has never had capacity and is incapable of articulating health care preferences.¹³⁷

Joe is sixty-seven years old. His IQ has been estimated to be twenty; he is thought (due to his behavior) to have the cognitive abilities of a three-year-old. He lived for most of his life in a state facility for the severely mentally disabled. About ten years ago he moved into a group home where he lives with several other adults who have comparable impairments. Joe is a large man who can become physically aggressive when he is frustrated, frightened, or experiences pain. He is mostly nonverbal, although he has a small vocabulary that consists primarily of words relating to food, animals, toys, games, his roommates, and his caregivers. He is unable to articulate abstract concepts of any kind, although his conduct evidences that he feels affection, anger, and other emotions. His life in the group home is very routinized. Most of his outings into the community are for doctors' appointments and to the grocery store with PCAs who live or work at the home. Joe has been generally healthy most of his life, although his personal hygiene issues have resulted in serious dental issues. He has suffered two broken bones in his life, both of which occurred when he got into fights while he lived in the state institution. Joe has been a ward of the state since he was six; his biological mother has not been heard from for more than fifty years and there are no other known relatives.

Issue: In July, after a routine physical examination that involved an array of blood tests with follow-up (which Joe did not handle very well) Joe was diagnosed with acute myeloblastic monocytic leukemia, an aggressive cancer with a five-year survival rate that is very low, particularly among the elderly. Treatment for this cancer involves a lengthy period of chemotherapy, bone marrow transplants, and radiation. A typical course of chemotherapy lasts several months. Due to the advanced nature of Joe's cancer at the time it was diagnosed, the oncologist has urged that treatment begin immediately. He has been unwilling to offer a prognosis beyond saying that "it doesn't look good." Should Joe's guardian authorize the proposed course of treatment?

¹³⁶ In the real life situation on which this hypothetical was based, Velma (not her real name) lived through the end of December. Velma's health care decision-making surrogate was not a guardian but her husband of nearly sixty years, whose four children assisted him in making each decision called for by her deteriorating medical condition. Velma died peacefully on December 30, 2011, surrounded by her husband, children, daughters- and sons-in-law, and several grandchildren. I would like to thank to Velma's family for allowing me to use her story in this Article.

¹³⁷ This scenario is based on the facts of *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977), an important decision in the body of state constitutional law on the right to autonomy in medical decision-making, and the role of the guardian in protecting and implementing that right on behalf of the ward.

Analysis: Joe's severe cognitive limitations, which have existed all or most of his life (the record above is not clear) and his lack of family connections or a discernable cultural/religious background suggest that Joe is one of the extremely rare wards as to whom a "best interest" standard for health care decision-making may legitimately be applied, at least with respect to complex decisions such as whether to begin a likely ineffectual attempt to cure his cancer. Joe's guardian should strive to exercise her judgment in accordance with the general principle of informed consent to maximize Joe's autonomy, understanding that Joe's actual preferences regarding an inherently complex course of treatment cannot realistically be known. Imagining what is in the "best interests" of a person like Joe in this case involves difficult practical and moral questions and there is certainly no legally "right" course of action. There are, however, defensible and indefensible courses of action.

The guardian's obligation in Joe's case is to make the kinds of inquiries that a fully capacitated person would and then make a judgment regarding Joe's treatment that is in Joe's "best interests": that is, reasonable under the circumstances. In view of the first physician's unwillingness or inability to provide useful information concerning Joe's prognosis, the guardian should seek a second opinion on treatment options and how the treatment will likely affect Joe, both while he is undergoing it and in the long term. Assuming that this information indicates that Joe's prognosis is typical for those of his age, the likelihood of a successful treatment without remission is less than 15 percent.

The suggested and necessary (if the cancer is to be "cured") course of treatment will be highly traumatic for a person like Joe, who experiences pain but cannot explain or understand it. His rituals will be disturbed for reasons that will not be even remotely clear to him, and the treatment that has been proposed will likely be ineffectual. It is not precisely correct to ask whether most persons would agree to what is probably going to be a failed treatment plan. Persons who have full capacity might well choose a course of treatment that is unlikely to result in recovery, no matter how painful or disruptive, if they fully understand the alternative to be death. Many, in fact, do make this choice. Joe is not capable of weighing such alternatives.

The guardian's problem can be best described as follows: Would a person who had capacity to consent to a medical treatment that would cause them enormous pain and discomfort consent to it, even if he knew it would be highly unlikely to be effective? Would he do so if the treatment's purposes were not explained to him and no reasons could be given for it? Would the person want the treatment if he understood that he would be unable to do any of the things he did enjoy for at least the full duration of the treatment? If the guardian concludes that treatment for cancer is not in Joe's best interests, considering not her own personal perspectives on this question but rather her ward's reality, she should not consent to it. Instead, the guardian should ensure that Joe has access to hospice, palliative care, and all other measures that will maximize his enjoyment of his existing lifestyle and reduce any pain that might accompany the progression of his cancer. It is not legitimate for the guardian to withhold treatment for the sole reason that

Joe's current "quality of life" (stemming from his severe cognitive impairment) does not justify his treatment that would likely be provided to capacitated persons.

Whatever decision the guardian makes with regard to Joe should be discussed with those in his life with whom he has personal relationships. This includes his caregivers, those with whom he lives (to the extent they are capable of understanding that Joe may die soon, or leave them), and others who will likely be affected by Joe's death. The mere fact that Joe has severe limitations and has no family to support him does not mean that he is alone in the world; health care decisions affecting Joe will affect others and he is entitled to the same respect in this regard as a person having full capacity would enjoy.

VI. CONCLUSION

Many articles in this symposium have documented the lack of clear guidance that state law currently provides to guardians and conservators regarding decision-making standards. This is as true with respect to health care decision-making as in other areas. Few state guardianship statutes incorporate the basic principles of informed consent and absolute autonomy regarding health care treatment into their provisions pertaining to standards. States further undermine the goal of maximizing personal autonomy in the face of guardianships when they allow a guardian's decision to "trump" that of an agent named in a valid directive—thereby ignoring the ward's ability to control health care decisions in the event of incapacity through an advance directive. Guardianship reform efforts at the state level should include amending statute guardianship laws to articulate explicit health care decision-making standards based primarily on the personal autonomy that the substituted judgment standard fosters, and to ensure that a ward's choice before incapacity, with respect to who will be her health care surrogates, are honored.

In the meantime, however, it is up to individual guardians to understand and apply the legal and ethical guidelines and processes described herein. It has been this Article's purpose to show that guardians who have been delegated health care decision-making authority are responsible to the ward in an area that implicates the ward's most fundamental privacy and liberty interests. Discharging this obligation in a manner that assures the greatest degree of personal autonomy is rarely easy. Nonetheless, by anticipating the ward's likely future health care needs, documenting preferences to the extent permitted by the ward's past and current acts and statements, and the myriad considerations discussed above, the guardian will be prepared to exercise her fiduciary obligations and honor the ward's right to the fullest autonomy permitted by the ward's condition. In so doing, the guardian will achieve the highest possible level of competence in ethical health care decision-making.

APPENDIX A:
50 STATE SURVEY—UNITED STATES:
STATE CONSTITUTIONAL RIGHT TO REFUSE MEDICAL TREATMENT¹³⁸

ALABAMANone Found

ALASKAMyers v. Alaska Psychiatric Inst.
138 P.3d 238 (Alaska 2006)

Facts: Patient involuntarily committed to state psychiatric institute. District Court approved the institution's nonconsensual administration of psychotropic drugs. Patient appealed.

Person Making Medical Decision: Patient

Holding: Supreme court held “in absence of emergency, court could not authorize state to administer psychotropic drugs to non-consenting patient unless . . . [it is] the best interest of the patient” and there is no less intrusive alternative available. *Id.* at 238.

ARIZONARasmussen *ex rel.* Mitchell v. Fleming
741 P.2d 674 (Ariz. 1987)

Facts: “Public fiduciary brought action seeking appointment as guardian of a nursing home patient [who was in a] chronic vegetative state for the purpose of consenting the removal” of a feeding tube. *Id.* at 674–75.

Person Making Medical Decision: Public Fiduciary.

Holding: Some state courts have held that the right to refuse medical treatment is also a state constitutional right. The court held here that the Arizona Constitution also provides for a right to refuse medical treatment.

ARKANSASNone Found

CALIFORNIABartling v. Superior Court
209 Cal. Rptr. 220 (Ct. App. 1984)

Facts: Adult patient sought to disconnect respirator.

Person Making Medical Decision: Patient and his spouse.

¹³⁸ Compiled September 2011 by Kia Thrasher, William Mitchell College of Law, J.D. expected 2012.

Holding: The right of a competent adult patient to refuse medical treatment has its origins in the constitutional right of privacy. This right is specifically guaranteed by the California Constitution (art. I § 1).

..... Bouvia v. Superior Court
225 Cal. Rptr. 297 (Ct. App. 1986)

Facts: Patient sought removal of a feeding tube which had been “inserted and maintained against her will and without her consent.” *Id.* at 297.

Person Making Medical Decision: Patient.

Holding: The right to refuse medical treatment is basic and fundamental. It is recognized as a part of the right of privacy protected by both the state and federal constitutions.

COLORADO..... People *ex rel.* Ofengand
183 P.3d 688 (Colo. App. 2008)

Holding: “A patient has a qualified right to refuse medical treatment. The right to refuse medical treatment is rooted in both the common law and Colorado’s statutory scheme relating to the civil commitment process.” *Id.* at 693.

CONNECTICUT..... See *McConnell v. Beverly Enters.-Conn., Inc.*
553 A.2d 596 (Conn. 1989)

Holding: There is a common-law interest, but no constitutional interest.

DELAWARE Severns v. Wilmington Med. Ctr., Inc.
421 A.2d 1334 (Del. 1980)

Facts: Husband of comatose wife sought authorization, as the guardian, to request the removal of wife’s feeding tubes and life support.

Person Making Medical Decision: Husband of comatose wife (guardian).

Holding: “We conclude that Mr. Severns, as guardian of the person of his wife, has standing to invoke her constitutional rights (including the right to privacy . . .), under the circumstances presented in the present record we so hold.” *Id.* at 1347.

FLORIDA.....*In re Barry*
445 So. 2d 365 (Fla. Dist. Ct. App. 1984)

Facts: “Natural parents petitioned as legal guardians for approval to terminate use of their terminally ill child’s life support system.” *Id.* at 365.

Person Making Medical Decision: Guardian

Holding: Noting the state constitution was amended after *Satz* to recognize that right to privacy encompassed decisions affecting medical treatment.

GEORGIA Zant v. Prevatte
286 S.E.2d 715 (Ga. 1982)

Facts: The state petitioned to prevent a prisoner on a hunger strike from starving himself to death.

Holding: “Under these circumstances, we hold that Prevatte, by virtue of his right of privacy, can refuse to allow intrusions on his person, even though calculated to preserve his life.” *Id.* at 717.

HAWAII None Found

IDAHO None Found

ILLINOIS *In re Estate of Longeway*
549 N.E.2d 292 (Ill. 1989)

Facts: “Guardian of incompetent patient petitioned for an order permitting her to withdraw artificially administered nutrition and hydration sustaining the patient at a nursing facility.” *Id.* at 292.

Person Making Medical Decision: Guardian

Holding: “[W]e follow the wisdom of the Supreme Court in avoiding constitutional questions when the issue at hand may be decided upon other grounds. In the present case, we find a right to refuse life-sustaining medical treatment in our State’s common law and in provisions of the Illinois Probate Act.” *Id.* at 297.

Note: The right does not come from the state constitution.

INDIANA None Found

IOWA Polk Cnty. Sheriff v. Iowa Dist. Court for Polk Cnty.
594 N.W.2d 421 (Iowa 1999)

Facts: “County sheriff filed [an] application to compel pretrial detainee to submit to kidney dialysis treatment.” *Id.* at 421.

Holding: State’s interests—including the preservation of life, the prevention of suicide, the protection of interests of innocent third parties, the maintenance of integrity of medical profession, and the maintenance of prison, security, and order—prevailed in this case, and court declined to recognize a constitutional interest.

KANSAS..... State v. Davison
105 P.3d 742, 2005 WL 331747 (Kan. Ct. App. 2005)

Holding: “The State has failed to even argue the existence of a countervailing State interest which would override Davison’s constitutional right to refuse medical treatment.” *Id.* at *5.

KENTUCKY..... Woods v. Kentucky
142 S.W.3d 24 (Ky. 2004)

Holding: “[T]he right to refuse medical treatment embodied in the constitutional liberty interest extends not only to the competent but also to the incompetent, ‘because the value of human dignity extends to both.’” *Id.* at 32.

LOUISIANA See Causey v. St. Francis Med. Ctr
719 So. 2d 1072 (La. Ct. App. 1998)

Holding: There is a right, but it does not come from the Constitution.

MAINE..... See *In re Gardner*
534 A.2d 947 (Me. 1987)

Holding: There is a right, but it does not come from the Constitution.

MARYLAND.....None Found

MASSACHUSETTS..... Superintendent of Belchertown State Sch. v. Saikewicz
370 N.E.2d 417 (Mass. 1977)

Holding: There is an “unwritten constitutional right of privacy found in the penumbra of specific guarantees of the Bill of Rights . . . [that] encompasses the right of a patient to preserve his or her right to privacy against unwanted infringements of bodily integrity.” *Id.* at 424.

MICHIGAN.....None Found

MINNESOTANone Found

MISSISSIPPINone Found

MISSOURI.....Cruzan v. Harmon
760 S.W.2d 408 (Mo. 1988)

Holding: There is a general common-law and constitutional right to refuse medical treatment.

MONTANA.....Baxter v. State
224 P.3d 1211 (Mont. 2009)

Holding: The court declined to address the constitutionality of the issue.

NEBRASKA.....None Found

NEVADA.....None Found

NEW HAMPSHIRE.....*In re Caulk*
480 A.2d 93 (N.H. 1984)

Holding: Court stated that the right of a competent individual to refuse medical treatment is a liberty interest which is protected by the state constitution, but that liberty interests such as this could be trumped by the state's interests in maintaining an effective criminal justice system if the individual was not ill, but simply seeking to take his own life.

NEW JERSEY.....*In re Quinlan*
355 A.2d 647 (N.J. 1976)

Holding: that the New Jersey constitution protects a patient's privacy interests in refusing unwanted medical treatment, including life-sustaining treatment.

NEW MEXICO.....None Found

NEW YORK.....*Fosmire v. Nicoleas*
551 N.E.2d 77 (N.Y. 1990)

Holding: Court "reaffirmed the basic right of a competent adult to refuse treatment even when the treatment may be necessary to preserve the person's life." *Id.* at 81. "[T]his fundamental common-law right is coextensive with the patient's liberty interest protected by the due process clause of our State Constitution," and that right could be overcome only by a compelling state interest. *Id.* at 81.

NORTH CAROLINA.....None Found

NORTH DAKOTA.....None Found

OHIOSteele v. Hamilton Cnty. Cmty. Mental Health Bd.
736 N.E.2d 10 (Ohio 2000)

Holding: “The right to refuse medical treatment is a fundamental right in our country, where personal security, bodily integrity, and autonomy are cherished liberties.” *Id.* at 15. The court emphasized that “[t]hese liberties were not created by statute or case law. Rather, they are rights inherent in every individual” and find explicit protection under the Ohio Constitution. *Id.*

OKLAHOMA.....None Found

OREGON.....None Found

PENNSYLVANIA.....None Found

RHODE ISLANDNone Found

SOUTH CAROLINA.....None Found

SOUTH DAKOTA.....None Found

TENNESSEE San Juan-Torregosa v. Garcia
80 S.W.3d 539 (Tenn. Ct. App. 2002)

Holding: “This Court has held that the citizens of our state are afforded a greater right of privacy by the Tennessee Constitution than that provided in the Federal Constitution, and that . . . the Tennessee Constitution and especially the Declaration of Rights in Article I, indicate a strong historic commitment by the citizens of this State to individual liberty and freedom from governmental interference in their personal lives. . . . The United States Supreme Court in *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), recognized that a competent person had a constitutionally protected liberty interest in refusing unwanted medical treatment.” *Id.* at 541–42.

TEXASNone Found

UTAH.....None Found

VERMONT.....None Found

VIRGINIA.....None Found

WASHINGTON *In re Colver*
660 P.2d 738 (Wash 1983)

Facts: “Husband of an incompetent patient in a chronic vegetative state sought court order to discontinue life-sustaining systems.” *Id.* at 738.

Holding: “In harmony with other jurisdictions, we now hold that an adult who is incurably and terminally ill has a constitutional right of privacy that encompasses the right to refuse treatment that serves only to prolong the dying process, given the absence of countervailing state interests. Support for this holding is also found in our state constitution.” *Id.* at 742.

WEST VIRGINIANone Found

WISCONSIN Prof’l Guardianships, Inc. v. Ruth E.J.
540 N.W.2d 213 (Wis. Ct. App. 1995)

Facts: “Guardian of incompetent ward moved for order permitting ward’s doctors to perform electroconvulsive treatment (ECT) on her.” *Id.* at 213.

Holding: “The Wisconsin Supreme Court has held that the right to liberty ‘includes an individual’s choice of whether or not to accept medical treatment.’ The constitutional right to choose or refuse medical treatment extends to incompetent as well as competent individuals.” *Id.* at 217.

WYOMINGNone Found

APPENDIX B:
50-STATE STATUTORY SURVEY:
HEALTH CARE DECISION-MAKING BY GUARDIANS¹³⁹

ALABAMAALA. CODE §§ 26-2A-108, 26-2A-78 (2009)

§ 26-2A-108 General powers and duties of guardian.

Except as limited pursuant to Section 26-2A-105(c), a guardian of an incapacitated person is responsible for health, support, education, or maintenance of the ward, but is not liable to third persons by reason of that responsibility for acts of the ward. In particular and without qualifying the foregoing, a guardian has the same duties, powers and responsibilities as a guardian for a minor as described in Section 26-2A-78(b), (c) and (d).

§ 26-2A-78 Powers and duties of guardian of minor.

(b) In particular and without qualifying the foregoing, a guardian shall:

- (1) Become or remain personally acquainted with the ward and maintain sufficient contact with the ward to know of the ward's capacities, limitations, needs, opportunities, and physical and mental health; . . .
- (3) Apply any available money of the ward to the ward's current needs for health, support, education, or maintenance;
- (4) Conserve any excess money of the ward for the ward's future needs, but if a conservator has been appointed for the estate of the ward, the guardian, at least quarterly, shall pay to the conservator money of the ward to be conserved for the ward's future needs; and
- (5) Report the condition of the ward and of the ward's estate that has been subject to the guardian's possession or control, as ordered by the court on petition of any person interested in the ward's welfare or as required by court rule.

(c) A guardian may: . . .

- (2) If consistent with the terms of any order by a court of competent jurisdiction relating to detention or commitment of the ward, take custody of the person of the ward and establish the ward's place of abode within or without this state; . . .
- (4) Consent to medical or other professional care, treatment, or advice for the ward without liability by reason of the consent for injury to the ward resulting from the negligence or acts of third persons unless a parent would have been liable in the circumstances; . . .

¹³⁹ Compiled September 2011 by Christine Jensen, William Mitchell College of Law, J.D. expected May 2013.

(6) If reasonable under all of the circumstances, delegate to the ward certain responsibilities for decisions affecting the ward's well-being. . . .

ALASKAALASKA STAT. § 13.26.150 (2010)

§ 13.26.150 General powers and duties of guardian.

- (a) A guardian shall diligently and in good faith carry out the specific duties and powers assigned by the court. In carrying out duties and powers, the guardian shall encourage the ward to participate to the maximum extent of the ward's capacity in all decisions that affect the ward, to act on the ward's own behalf in all matters in which the ward is able, and to develop or regain, to the maximum extent possible, the capacity to meet the essential requirements for physical health or safety, to protect the ward's rights, and to manage the ward's financial resources.
- (b) A partial guardian of an incapacitated person has only the powers and duties respecting the ward enumerated in the court order.
- (c) A full guardian of an incapacitated person has the same powers and duties respecting the ward that a parent has respecting an unemancipated minor child except that the guardian is not liable for the care and maintenance of the ward and is not liable, solely by reason of the guardianship, to a person who is harmed by acts of the ward. Except as modified by order of the court, a full guardian's powers and duties include, but are not limited to, the following:
- (1) the guardian is entitled to custody of the person of the ward and shall assure that the ward has a place of abode in the least restrictive setting consistent with the essential requirements for the ward's physical health and safety;
 - (2) the guardian shall assure the care, comfort, and maintenance of the ward;
 - (3) the guardian shall assure that the ward receives the services necessary to meet the essential requirements for the ward's physical health and safety and to develop or regain, to the maximum extent possible, the capacity to meet the ward's needs for physical health and safety;
 - (4) the guardian shall assure through the initiation of court action and other means that the ward enjoys all personal, civil, and human rights to which the ward is entitled;
 - (5) the guardian may give consents or approvals necessary to enable the ward to receive medical or other professional care, counsel, treatment, or services except as otherwise limited by (e) of this section; . . .
- (e) A guardian may not
- (1) place the ward in a facility or institution for the mentally ill other than through a formal commitment proceeding under AS 47.30 in which the ward has a separate guardian ad litem;
 - (2) consent on behalf of the ward to an abortion, sterilization, psychosurgery, or removal of bodily organs except when necessary to

preserve the life or prevent serious impairment of the physical health of the ward;

- (3) consent on behalf of the ward to the withholding of lifesaving medical procedures; however, a guardian is not required to oppose the cessation or withholding of lifesaving medical procedures when those procedures will serve only to prolong the dying process and offer no reasonable expectation of effecting a temporary or permanent cure of or relief from the illness or condition being treated unless the ward has clearly stated that lifesaving medical procedures not be withheld; a guardian is not civilly liable for acts or omissions under this paragraph unless the act or omission constitutes gross negligence or reckless or intentional misconduct;
- (4) consent on behalf of the ward to the performance of an experimental medical procedure or to participation in a medical experiment not intended to preserve the life or prevent serious impairment of the physical health of the ward;
- (5) consent on behalf of the ward to termination of the ward's parental rights;
- (6) prohibit the ward from registering to vote or from casting a ballot at public election;
- (7) prohibit the ward from applying for and obtaining a driver's license;
- (8) prohibit the marriage or divorce of the ward.

ARIZONA.....ARIZ. REV. STAT. ANN. §§ 14-5312 (2005); 36-3231 (2009)

§ 14-5312 General powers and duties of guardian

- A. A guardian of an incapacitated person has the same powers, rights and duties respecting the guardian's ward that a parent has respecting the parent's unemancipated minor child, except that a guardian is not liable to third persons for acts of the ward solely by reason of the guardianship. In particular, and without qualifying the foregoing, a guardian has the following powers and duties, except as modified by order of the court: . . .
2. If entitled to custody of the ward the guardian shall make provision for the care, comfort and maintenance of the ward and, whenever appropriate, arrange for the ward's training and education. . . .
 3. A guardian may give any consents or approvals that may be necessary to enable the ward to receive medical or other professional care, counsel, treatment or service. . . .
 5. A guardian is required to report the condition of the ward and of the estate that has been subject to the guardian's possession or control, as required by the court or court rule. . . .
 8. A guardian shall find the most appropriate and least restrictive setting for the ward consistent with the ward's needs, capabilities and financial ability.

9. A guardian shall make reasonable efforts to secure appropriate medical and psychological care and social services for the ward. . . .
11. In making decisions concerning his ward, a guardian shall take into consideration the ward's values and wishes.
12. The guardian is authorized to act pursuant to title 36, chapter 32.
13. The guardian of an incapacitated adult who has a developmental disability as defined in section 36-551 shall seek services that are in the best interest of the ward, taking into consideration:
 - (a) The ward's age.
 - (b) The degree or type of developmental disability.
 - (c) The presence of other handicapping conditions.
 - (d) The guardian's ability to provide the maximum opportunity to develop the ward's maximum potential, to provide a minimally structured residential program and environment for the ward and to provide a safe, secure, and dependable residential and program environment.
 - (e) The particular desires of the individual.

§ 36-3231 Surrogate decision makers; priorities; limitations

- A. If an adult patient is unable to make or communicate health care treatment decisions, a health care provider shall make a reasonable effort to locate and shall follow a health care directive. A health care provider shall also make a reasonable effort to consult with a surrogate. If the patient has a health care power of attorney that meets the requirements of section 36-3221, the patient's designated agent shall act as the patient's surrogate. However, if the court appoints a guardian for the express purpose of making health care treatment decisions, that guardian shall act as the patient's surrogate. If neither of these situations applies, the health care provider shall make reasonable efforts to contact the following individual or individuals in the indicated order of priority, who are available and willing to serve as the surrogate, who then have the authority to make health care decisions for the patient and who shall follow the patient's wishes if they are known:
 1. The patient's spouse, unless the patient and spouse are legally separated.
 2. An adult child of the patient. If the patient has more than one adult child, the health care provider shall seek the consent of a majority of the adult children who are reasonably available for consultation.
 3. A parent of the patient.
 4. If the patient is unmarried, the patient's domestic partner.
 5. A brother or sister of the patient.
 6. A close friend of the patient. For the purposes of this paragraph, "close friend" means an adult who has exhibited special care and concern for the patient, who is familiar with the patient's health care views and desires and who is willing and able to become involved in the patient's health care and to act in the patient's best interest.

- B. If the health care provider cannot locate any of the people listed in subsection A of this section, the patient's attending physician may make health care treatment decisions for the patient after the physician consults with and obtains the recommendations of an institutional ethics committee. If this is not possible, the physician may make these decisions after consulting with a second physician who concurs with the physician's decision. For the purposes of this subsection, "institutional ethics committee" means a standing committee of a licensed health care institution appointed or elected to render advice concerning ethical issues involving medical treatment.
- C. A person who makes a good faith medical decision pursuant to this section is immune from liability to the same extent and under the same conditions as prescribed in section 36-3205.
- D. A surrogate may make decisions about mental health care treatment on behalf of a patient if the patient is found incapable. However, a surrogate who is not the patient's agent or guardian shall not make decisions to admit the patient to a level one behavioral health facility licensed by the department of health services, except as provided in subsection E of this section or section 14-5312.01, 14-5312.02 or 36-3281.
- E. If the admitting officer for a mental health care provider has reasonable cause to believe after examination that the patient is incapable as defined in section 36-3281, subsection D and is likely to suffer serious physical harm or serious illness or to inflict serious physical harm on another person without immediate hospitalization, the patient may be admitted for inpatient treatment in a level one behavioral health facility based on informed consent given by any surrogate identified in subsection A of this section. The patient shall be discharged if a petition for court ordered evaluation or for temporary guardianship requesting authority for the guardian to consent to admission to a level one behavioral health facility has not been filed within forty-eight hours of admission or on the following court day if the forty-eight hours expires on a weekend or holiday. The discharge requirement prescribed in this section does not apply if the patient has given informed consent to voluntary treatment or if a mental health care provider is prohibited from discharging the patient under federal law.

ARKANSAS ARK. CODE ANN. § 28-65-301 (2004)

§ 28-65-301 Duties of guardians generally.

- (a) (1) It shall be the duty of the guardian of the person, consistent with and out of the resources of the ward's estate, to care for and maintain the ward and, if he or she is a minor, to see that he or she is protected, properly trained and educated and that he or she has the opportunity to learn a trade, occupation, or profession.
- (2) The guardian of the person may be required to report the condition of his or her ward to the court, at regular intervals or otherwise, as the court may direct. . . .

CALIFORNIA CAL. PROB. CODE §§ 2353, 2354, 2355, 2356, 2356.5, 2357 (2002)

§ 2353

- (a) Subject to subdivision (b), the guardian has the same right as a parent having legal custody of a child to give consent to medical treatment performed upon the ward and to require the ward to receive medical treatment.
- (b) Except as provided in subdivision (c), if the ward is 14 years of age or older, no surgery may be performed upon the ward without either (1) the consent of both the ward and the guardian or (2) a court order obtained pursuant to Section 2357 specifically authorizing such treatment.
- (c) The guardian may consent to surgery to be performed upon the ward, and may require the ward to receive the surgery, in any case where the guardian determines in good faith based upon medical advice that the case is an emergency case in which the ward faces loss of life or serious bodily injury if the surgery is not performed. In such a case, the consent of the guardian alone is sufficient and no person is liable because the surgery is performed upon the ward without the ward's consent.
- (d) Nothing in this section requires the consent of the guardian for medical or surgical treatment for the ward in any case where the ward alone may consent to such treatment under other provisions of law.

§ 2354

- (a) If the conservatee has not been adjudicated to lack the capacity to give informed consent for medical treatment, the conservatee may consent to his or her medical treatment. The conservator may also give consent to the medical treatment, but the consent of the conservator is not required if the conservatee has the capacity to give informed consent to the medical treatment, and the consent of the conservator alone is not sufficient under this subdivision if the conservatee objects to the medical treatment.
- (b) The conservator may require the conservatee to receive medical treatment, whether or not the conservatee consents to the treatment, if a court order specifically authorizing the medical treatment has been obtained pursuant to Section 2357.
- (c) The conservator may consent to medical treatment to be performed upon the conservatee, and may require the conservatee to receive the medical treatment, in any case where the conservator determines in good faith based upon medical advice that the case is an emergency case in which the medical treatment is required because (1) the treatment is required for the alleviation of severe pain or (2) the conservatee has a medical condition which, if not immediately diagnosed and treated, will lead to serious disability or death. In such a case, the consent of the conservator alone is sufficient and no person is liable because the medical treatment is performed upon the conservatee without the conservatee's consent.

§ 2355

- (a) If the conservatee has been adjudicated to lack the capacity to make health care decisions, the conservator has the exclusive authority to make health care decisions for the conservatee that the conservator in good faith based on medical advice determines to be necessary. The conservator shall make health care decisions for the conservatee in accordance with the conservatee's individual health care instructions, if any, and other wishes to the extent known to the conservator. Otherwise, the conservator shall make the decision in accordance with the conservator's determination of the conservatee's best interest. In determining the conservatee's best interest, the conservator shall consider the conservatee's personal values to the extent known to the conservator. The conservator may require the conservatee to receive the health care, whether or not the conservatee objects. In this case, the health care decision of the conservator alone is sufficient and no person is liable because the health care is administered to the conservatee without the conservatee's consent. For the purposes of this subdivision, "health care" and "health care decision" have the meanings provided in Sections 4615 and 4617, respectively.
- (b) If prior to the establishment of the conservatorship the conservatee was an adherent of a religion whose tenets and practices call for reliance on prayer alone for healing, the treatment required by the conservator under the provisions of this section shall be by an accredited practitioner of that religion.

§ 2356

- (a) No ward or conservatee may be placed in a mental health treatment facility under this division against the will of the ward or conservatee. Involuntary civil placement of a ward or conservatee in a mental health treatment facility may be obtained only pursuant to Chapter 2 (commencing with Section 5150) or Chapter 3 (commencing with Section 5350) of Part 1 of Division 5 of the Welfare and Institutions Code. Nothing in this subdivision precludes the placing of a ward in a state hospital under Section 6000 of the Welfare and Institutions Code upon application of the guardian as provided in that section. The Director of Mental Health shall adopt and issue regulations defining "mental health treatment facility" for the purposes of this subdivision.
- (b) No experimental drug as defined in Section 111515 of the Health and Safety Code may be prescribed for or administered to a ward or conservatee under this division. Such an experimental drug may be prescribed for or administered to a ward or conservatee only as provided in Article 4 (commencing with Section 111515) of Chapter 6 of Part 5 of Division 104 of the Health and Safety Code.
- (c) No convulsive treatment as defined in Section 5325 of the Welfare and Institutions Code may be performed on a ward or conservatee under this division. Convulsive treatment may be performed on a ward or conservatee only as provided in Article 7 (commencing with Section 5325) of Chapter 2 of Part 1 of Division 5 of the Welfare and Institutions Code.

- (d) No minor may be sterilized under this division.
- (e) This chapter is subject to a valid and effective advance health care directive under the Health Care Decisions Law (Division 4.7 (commencing with Section 4600)).

§ 2356.5

- (a) The Legislature hereby finds and declares: (1) That people with dementia, as defined in the last published edition of the “Diagnostic and Statistical Manual of Mental Disorders,” should have a conservatorship to serve their unique and special needs. (2) That, by adding powers to the probate conservatorship for people with dementia, their unique and special needs can be met. This will reduce costs to the conservatee and the family of the conservatee, reduce costly administration by state and county government, and safeguard the basic dignity and rights of the conservatee. (3) That it is the intent of the Legislature to recognize that the administration of psychotropic medications has been, and can be, abused by caregivers and, therefore, granting powers to a conservator to authorize these medications for the treatment of dementia requires the protections specified in this section.
- (b) Notwithstanding any other provision of law, a conservator may authorize the placement of a conservatee in a secured perimeter residential care facility for the elderly operated pursuant to Section 1569.698 of the Health and Safety Code, or a locked and secured nursing facility which specializes in the care and treatment of people with dementia pursuant to subdivision (c) of Section 1569.691 of the Health and Safety Code, and which has a care plan that meets the requirements of Section 87724 of Title 22 of the California Code of Regulations, upon a court’s finding, by clear and convincing evidence, of all of the following: (1) The conservatee has dementia, as defined in the last published edition of the “Diagnostic and Statistical Manual of Mental Disorders.” (2) The conservatee lacks the capacity to give informed consent to this placement and has at least one mental function deficit pursuant to subdivision (a) of Section 811, and this deficit significantly impairs the person’s ability to understand and appreciate the consequences of his or her actions pursuant to subdivision (b) of Section 811. (3) The conservatee needs or would benefit from a restricted and secure environment, as demonstrated by evidence presented by the physician or psychologist referred to in paragraph (3) of subdivision (f). (4) The court finds that the proposed placement in a locked facility is the least restrictive placement appropriate to the needs of the conservatee.
- (c) Notwithstanding any other provision of law, a conservator of a person may authorize the administration of medications appropriate for the care and treatment of dementia, upon a court’s finding, by clear and convincing evidence, of all of the following: (1) The conservatee has dementia, as defined in the last published edition of the “Diagnostic and Statistical Manual of Mental Disorders.” (2) The conservatee lacks the capacity to give informed consent to

- the administration of medications appropriate to the care of dementia, and has at least one mental function deficit pursuant to subdivision (a) of Section 811, and this deficit or deficits significantly impairs the person's ability to understand and appreciate the consequences of his or her actions pursuant to subdivision (b) of Section 811. (3) The conservatee needs or would benefit from appropriate medication as demonstrated by evidence presented by the physician or psychologist referred to in paragraph (3) of subdivision (f).
- (d) Pursuant to subdivision (b) of Section 2355, in the case of a person who is an adherent of a religion whose tenets and practices call for a reliance on prayer alone for healing, the treatment required by the conservator under subdivision (c) shall be by an accredited practitioner of that religion in lieu of the administration of medications.
- (e) A conservatee who is to be placed in a facility pursuant to this section shall not be placed in a mental health rehabilitation center as described in Section 5675 of the Welfare and Institutions Code, or in an institution for mental disease as described in Section 5900 of the Welfare and Institutions Code.
- (f) A petition for authority to act under this section shall be governed by Section 2357, except: (1) The conservatee shall be represented by an attorney pursuant to Chapter 4 (commencing with Section 1470) of Part 1. (2) The conservatee shall be produced at the hearing, unless excused pursuant to Section 1893. (3) The petition shall be supported by a declaration of a licensed physician, or a licensed psychologist within the scope of his or her licensure, regarding each of the findings required to be made under this section for any power requested, except that the psychologist has at least two years of experience in diagnosing dementia. (4) The petition may be filed by any of the persons designated in Section 1891.
- (g) The court investigator shall annually investigate and report to the court every two years pursuant to Sections 1850 and 1851 if the conservator is authorized to act under this section. In addition to the other matters provided in Section 1851, the conservatee shall be specifically advised by the investigator that the conservatee has the right to object to the conservator's powers granted under this section, and the report shall also include whether powers granted under this section are warranted. If the conservatee objects to the conservator's powers granted under this section, or the investigator determines that some change in the powers granted under this section is warranted, the court shall provide a copy of the report to the attorney of record for the conservatee. If no attorney has been appointed for the conservatee, one shall be appointed pursuant to Chapter 4 (commencing with Section 1470) of Part 1. The attorney shall, within 30 days after receiving this report, do one of the following: (1) File a petition with the court regarding the status of the conservatee. (2) File a written report with the court stating that the attorney has met with the conservatee and determined that the petition would be inappropriate.
- (h) A petition to terminate authority granted under this section shall be governed by Section 2359.

- (i) Nothing in this section shall be construed to affect a conservatorship of the estate of a person who has dementia.
- (j) Nothing in this section shall affect the laws that would otherwise apply in emergency situations.
- (k) Nothing in this section shall affect current law regarding the power of a probate court to fix the residence of a conservatee or to authorize medical treatment for any conservatee who has not been determined to have dementia.
 - (1)(1) Until such time as the conservatorship becomes subject to review pursuant to Section 1850, this section shall not apply to a conservatorship established on or before the effective date of the adoption of Judicial Council forms that reflect the procedures authorized by this section, or January 1, 1998, whichever occurs first. (2) Upon the adoption of Judicial Council forms that reflect the procedures authorized by this section or January 1, 1998, whichever occurs first, this section shall apply to any conservatorships established after that date.

§ 2357

- (a) As used in this section: (1) “Guardian or conservator” includes a temporary guardian of the person or a temporary conservator of the person. (2) “Ward or conservatee” includes a person for whom a temporary guardian of the person or temporary conservator of the person has been appointed.
- (b) If the ward or conservatee requires medical treatment for an existing or continuing medical condition which is not authorized to be performed upon the ward or conservatee under Section 2252, 2353, 2354, or 2355, and the ward or conservatee is unable to give an informed consent to this medical treatment, the guardian or conservator may petition the court under this section for an order authorizing the medical treatment and authorizing the guardian or conservator to consent on behalf of the ward or conservatee to the medical treatment.
- (c) The petition shall state, or set forth by medical affidavit attached thereto, all of the following so far as is known to the petitioner at the time the petition is filed:
 - (1) The nature of the medical condition of the ward or conservatee which requires treatment. (2) The recommended course of medical treatment which is considered to be medically appropriate. (3) The threat to the health of the ward or conservatee if authorization to consent to the recommended course of treatment is delayed or denied by the court. (4) The predictable or probable outcome of the recommended course of treatment. (5) The medically available alternatives, if any, to the course of treatment recommended. (6) The efforts made to obtain an informed consent from the ward or conservatee. (7) The name and addresses, so far as they are known to the petitioner, of the persons specified in subdivision (c) of Section 1510 in a guardianship proceeding or subdivision (b) of Section 1821 in a conservatorship proceeding.
- (d) Upon the filing of the petition, unless an attorney is already appointed the court shall appoint the public defender or private counsel under Section 1471, to

consult with and represent the ward or conservatee at the hearing on the petition and, if that appointment is made, Section 1472 applies.

- (e) Notice of the petition shall be given as follows: (1) Not less than 15 days before the hearing, notice of the time and place of the hearing, and a copy of the petition shall be personally served on the ward, if 12 years of age or older, or the conservatee, and on the attorney for the ward or conservatee. (2) Not less than 15 days before the hearing, notice of the time and place of the hearing, and a copy of the petition shall be mailed to the following persons: (A) The spouse or domestic partner, if any, of the proposed conservatee at the address stated in the petition. (B) The relatives named in the petition at their addresses stated in the petition.
- (f) For good cause, the court may shorten or waive notice of the hearing as provided by this section. In determining the period of notice to be required, the court shall take into account both of the following: (1) The existing medical facts and circumstances set forth in the petition or in a medical affidavit attached to the petition or in a medical affidavit presented to the court. (2) The desirability, where the condition of the ward or conservatee permits, of giving adequate notice to all interested persons.
- (g) Notwithstanding subdivisions (e) and (f), the matter may be submitted for the determination of the court upon proper and sufficient medical affidavits or declarations if the attorney for the petitioner and the attorney for the ward or conservatee so stipulate and further stipulate that there remains no issue of fact to be determined.
- (h) The court may make an order authorizing the recommended course of medical treatment of the ward or conservatee and authorizing the guardian or conservator to consent on behalf of the ward or conservatee to the recommended course of medical treatment for the ward or conservatee if the court determines from the evidence all of the following: (1) The existing or continuing medical condition of the ward or conservatee requires the recommended course of medical treatment. (2) If untreated, there is a probability that the condition will become life-endangering or result in a serious threat to the physical or mental health of the ward or conservatee. (3) The ward or conservatee is unable to give an informed consent to the recommended course of treatment.
- (i) Upon petition of the ward or conservatee or other interested person, the court may order that the guardian or conservator obtain or consent to, or obtain and consent to, specified medical treatment to be performed upon the ward or conservatee. Notice of the hearing on the petition under this subdivision shall be given for the period and in the manner provided in Chapter 3 (commencing with Section 1460) of Part 1.

COLORADO..... COLO. REV. STAT. §§ 15-14-314, 15-14-315 (2011)

§ 15-14-314 Duties of guardian

- (1) Except as otherwise limited by the court, a guardian shall make decisions regarding the ward's support, care, education, health, and welfare. A guardian shall exercise authority only as necessitated by the ward's limitations and, to the extent possible, shall encourage the ward to participate in decisions, act on the ward's own behalf, and develop or regain the capacity to manage the ward's personal affairs. A guardian, in making decisions, shall consider the expressed desires and personal values of the ward to the extent known to the guardian. A guardian, at all times, shall act in the ward's best interest and exercise reasonable care, diligence, and prudence.
- (2) A guardian shall:
- (a) Become or remain personally acquainted with the ward and maintain sufficient contact with the ward to know of the ward's capacities, limitations, needs, opportunities, and physical and mental health; . . .
 - (c) Expend money of the ward that has been received by the guardian for the ward's current needs for support, care, education, health, and welfare;
 - (d) Conserve any excess money of the ward for the ward's future needs, but if a conservator has been appointed for the estate of the ward, the guardian shall pay the money to the conservator, at least quarterly, to be conserved for the ward's future needs;
 - (e) Immediately notify the court if the ward's condition has changed so that the ward is capable of exercising rights previously removed;
 - (f) Inform the court of any change in the ward's custodial dwelling or address; and
 - (g) Immediately notify the court in writing of the ward's death.

§ 5-14-315 Powers of guardian

- (1) Subject to the limitations set forth in section 15-14-316 and except as otherwise limited by the court, a guardian may: . . .
- (d) Consent to medical or other care, treatment, or service for the ward; and
 - (e) If reasonable under all of the circumstances, delegate to the ward certain responsibilities for decisions affecting the ward's well-being. . . .

CONNECTICUT..... CONN. GEN. STAT. § 45a-656 (2011)

§ 45a-656 Duties of conservator of the person.

- (a) The conservator of the person shall have the duties and authority expressly assigned by the court pursuant to section 45a-650, which duties and authority may include: (1) The duty and responsibility for the general custody of the conserved person; (2) the authority to establish the conserved person's

residence within the state, subject to the provisions of section 45a-656b; (3) the authority to give consent for the conserved person's medical or other professional care, counsel, treatment or service; (4) the duty to provide for the care, comfort and maintenance of the conserved person; and (5) the duty to take reasonable care of the conserved person's personal effects.

- (b) In carrying out the duties and authority assigned by the court, the conservator of the person shall exercise such duties and authority in a manner that is the least restrictive means of intervention and shall (1) assist the conserved person in removing obstacles to independence, (2) assist the conserved person in achieving self-reliance, (3) ascertain the conserved person's views, (4) make decisions in conformance with the conserved person's reasonable and informed expressed preferences, (5) make all reasonable efforts to ascertain the health care instructions and other wishes of the conserved person, and (6) make decisions in conformance with (A) the conserved person's expressed health care preferences, including health care instructions and other wishes, if any, described in section 19a-580e, or validly executed health care instructions described in section 19a-580g, or (B) a health care decision of a health care representative described in subsection (b) of section 19a-580e, except under a circumstance set forth in subsection (b) of section 19a-580e. The conservator shall afford the conserved person the opportunity to participate meaningfully in decision-making in accordance with the conserved person's abilities and shall delegate to the conserved person reasonable responsibility for decisions affecting such conserved person's well-being.
- (c) The conservator shall report at least annually to the probate court that appointed the conservator regarding the condition of the conserved person, the efforts made to encourage the independence of the conserved person and the conservator's statement on whether the appointment of the conservator is the least restrictive means of intervention for managing the conserved person's needs. The duties, responsibilities and authority assigned pursuant to section 45a-650 or set forth in this section shall be carried out within the resources available to the conserved person, either through the conserved person's own estate or through private or public assistance. (d) The conservator of the person shall not have the power or authority to cause the respondent to be committed to any institution for the treatment of the mentally ill except under the provisions of sections 17a-75 to 17a-83, inclusive, 17a-456 to 17a-484, inclusive, 17a-495 to 17a-528, inclusive, 17a-540 to 17a-550, inclusive, 17a-560 to 17a-576, inclusive, 17a-615 to 17a-618, inclusive, and 17a-621 to 17a-664, inclusive, and chapter 359.

DELAWARE DEL. CODE ANN. tit. 12, § 3922 (2007)

§ 3922 General powers and duties of the guardian of the person.

- (a) The Court shall grant to the guardian of the person such powers, rights and duties which are necessary to protect, manage and care for the disabled person. The Court may at any time change the powers of the guardian of the person.
- (b) The guardian of the person may exercise the same powers, rights and duties respecting the care, maintenance and treatment of the disabled person that a parent has respecting the parent's own unemancipated minor child, except that the guardian of the person is not liable to third persons for acts of the disabled person solely by reason of the guardianship relationship. Except as modified by the order of guardianship and without qualifying the foregoing, a guardian of the person has the following powers and duties:
 - (1) To the extent that it is consistent with the terms of any order by a court of competent jurisdiction relating to detention or commitment of the disabled person, the guardian is entitled to custody of the disabled person and may establish the disabled person's place of abode within or without this State. The guardian may not waive any right of the disabled person respecting involuntary commitment to any facility for the treatment of mental illness or deficiency.
 - (2) If entitled to custody of the disabled person, the guardian shall make provision for the care, comfort and maintenance of the disabled person and, if appropriate, arrange for the disabled person's training and education. Without regard to custodial rights of the disabled person, the guardian shall take reasonable care of the disabled person's clothing, furniture, vehicle and other personal effects in the immediate possession of the disabled person and commence guardianship of the property proceedings if other property of the disabled person is in need of protection.
 - (3) The guardian may give such consent or approval as may be necessary to enable the disabled person to receive medical or other professional care, counsel, treatment or service and shall have power to authorize release of medical records. The guardian shall not unreasonably withhold such consent or approval nor withhold such consent or approval on account of personal beliefs held by the guardian or the disabled person, but shall take such action as the guardian objectively believes to be in the best interest of the disabled person. . . .

DISTRICT OF COLUMBIAD.C. CODE §§ 21-2047, 21-2047.02 (2008)

§ 21-2047 Powers and duties of general guardian and limited guardian.

Except as limited pursuant to section 21-2044, a general guardian or a limited guardian of an incapacitated individual is responsible for care, custody, and control

of the ward, but is not personally liable to third persons by reason of that responsibility for acts of the ward.

- (a) In particular and without qualifying the foregoing, a general guardian or limited guardian shall:
 - (1) Become or remain personally acquainted with the ward and maintain sufficient contact with the ward to know of the ward's capacities, limitations, needs, opportunities, and physical and mental health; . . .
 - (6) Make decisions on behalf of the ward by conforming as closely as possible to a standard of substituted judgment or, if the ward's wishes are unknown and remain unknown after reasonable efforts to discern them, make the decision on the basis of the ward's best interests;
 - (7) Include the ward in the decision-making process to the maximum extent of the ward's ability; and
 - (8) Encourage the ward to act on his or her own behalf whenever he or she is able to do so, and to develop or regain capacity to make decisions in those areas in which he or she is in need of decision-making assistance, to the maximum extent possible.
- (b) A general guardian or limited guardian may: . . .
 - (4) Consent to medical examination and medical or other professional care, treatment, or advice for the ward, without liability, by reason of the consent for injury to the ward resulting from the negligence or acts of third persons, unless the guardian fails to act in good faith;
 - (5) Obtain medical records for the purpose of applying for government entitlements or private benefits and have the status of a legal representative under the District of Columbia Mental Health Information Act of 1978, effective March 3, 1979 (D.C. Law 2-136; § 7-1201.01 et seq.); . . .

§ 21-2047.02 Powers and duties of emergency and health-care guardians.

- (a) Except as limited by sections 21-2046 and 21-2047.01, an emergency guardian or health-care guardian is responsible for providing substituted consent for an incapacitated individual and for any other duties authorized by the court, but is not personally liable to third persons by reason of that responsibility or acts of the incapacitated individual. (b) An emergency or health-care guardian shall:
 - (1) Become or remain personally acquainted with the ward and maintain sufficient contact with the ward to know of his or her capacities, limitations, needs, opportunities, and physical and mental health;
 - (2) Make decisions on behalf of the ward by conforming as closely as possible to a standard of substituted judgment or, if the ward's wishes are unknown and remain unknown after reasonable efforts to discern them, make the decision on the basis of the ward's best interests;

- (3) Include the ward in the decision-making process to the maximum extent of the ward's ability.
- (4) Encourage the individual to act on his or her own behalf whenever he or she is able to do so, and to develop or regain capacity to make decisions in those areas in which he or she is in need of decision-making assistance, to the maximum extent possible; and
- (5) Make any report the court requires.
- (c) An emergency or health-care guardian may:
 - (1) Grant, refuse, or withdraw consent to medical examination and health-care treatment for an individual who has been deemed incapacitated pursuant to section 21-2204;
 - (2) Obtain medical records for the purpose of providing substituted consent pursuant to section 21-2210; and
 - (3) Have the status of a legal representative under Chapter 12 of Title 7.

FLORIDA..... FLA. STAT. § 744.361 (2011)

§ 744.361 Powers and duties of guardian.

- (1) The guardian of an incapacitated person may exercise only those rights that have been removed from the ward and delegated to the guardian. The guardian of a minor shall exercise the powers of a plenary guardian.
- (2) The guardian shall file an initial guardianship report in accordance with s. 744.362.
- (3) The guardian shall file a guardianship report annually in accordance with s. 744.367.
- (4) The guardian of the person shall implement the guardianship plan. . . .
- (9) A professional guardian must ensure that each of the guardian's wards is personally visited by the guardian or one of the guardian's professional staff at least once each calendar quarter. During the personal visit, the guardian or the guardian's professional staff person shall assess:
 - (a) The ward's physical appearance and condition.
 - (b) The appropriateness of the ward's current living situation.
 - (c) The need for any additional services and the necessity for continuation of existing services, taking into consideration all aspects of social, psychological, educational, direct service, health, and personal care needs.
 This subsection does not apply to a professional guardian who has been appointed only as guardian of the property.

GEORGIA..... GA. CODE ANN. §§ 29-4-20, 29-4-21 (2007)

§ 29-4-20 Rights of the ward; impact on voting and testamentary capacity

- (a) In every guardianship, the ward has the right to:
 - (1) A qualified guardian who acts in the best interest of the ward;

- (2) A guardian who is reasonably accessible to the ward;
 - (3) Have the ward's property utilized to provide adequately for the ward's support, care, education, health, and welfare;
 - (4) Communicate freely and privately with persons other than the guardian, except as otherwise ordered by a court of competent jurisdiction;
 - (5) Individually, or through the ward's representative or legal counsel, bring an action relating to the guardianship, including the right to file a petition alleging that the ward is being unjustly denied a right or privilege granted by this chapter and Chapter 5 of this title and including the right to bring an action to modify or terminate the guardianship pursuant to the provisions of Code Sections 29-4-41 and 29-4-42;
 - (6) The least restrictive form of guardianship assistance, taking into consideration the ward's functional limitations, personal needs, and preferences; and
 - (7) Be restored to capacity at the earliest possible time.
- (b) The appointment of a guardian is not a determination regarding the right of the ward to vote.
- (c) The appointment of a guardian is not a determination that the ward lacks testamentary capacity.

§ 29-4-21 Rights and privileges removed from ward upon appointment of guardian

- (a) Unless the court's order specifies that one or more of the following powers are to be retained by the ward, the appointment of a guardian shall remove from the ward the power to:
- (1) Contract marriage;
 - (2) Make, modify, or terminate other contracts;
 - (3) Consent to medical treatment;
 - (4) Establish a residence or dwelling place;
 - (5) Change domicile;
 - (6) Revoke a revocable trust established by the ward; and
 - (7) Bring or defend any action at law or equity, except an action relating to the guardianship.
- (b) The mere appointment of a guardian does not revoke the powers of an agent who was previously appointed by the ward to act as an agent under a durable power of attorney for health care or health care agent under an advance directive for health care.

HAWAII HAW. REV. STAT. § 560:5-314 (West 2008)

§ 560:5-314 Duties of guardian

- (a) Except as otherwise limited by the court, a guardian shall make decisions regarding the ward's support, care, education, health, and welfare. A guardian shall exercise authority only as necessitated by the ward's limitations and, to the

extent possible, shall encourage the ward to participate in decisions, act on the ward's own behalf, and develop or regain the capacity to manage the ward's personal affairs. A guardian, in making decisions, shall consider the expressed desires and personal values of the ward to the extent known to the guardian. A guardian at all times shall act in the ward's best interest and exercise reasonable care, diligence, and prudence.

(b) A guardian shall:

- (1) Become or remain personally acquainted with the ward and maintain sufficient contact with the ward to know of the ward's capacities, limitations, needs, opportunities, and physical and mental health; . . .
- (3) Expend money of the ward that has been received by the guardian, for the ward's current needs for support, care, education, health, and welfare;
- (4) Conserve any excess money of the ward for the ward's future needs; provided that if a conservator has been appointed for the estate of the ward, the guardian shall pay the money to the conservator, at least quarterly, to be conserved for the ward's future needs;
- (5) Immediately notify the court if the ward's condition has changed so that the ward is capable of exercising rights previously removed; and
- (6) Inform the court of any change in the ward's custodial dwelling or address.

IDAHO IDAHO CODE ANN. § 15-5-312 (2009)

§ 15-5-312 General Powers and Duties of Guardian

- (1) A guardian of an incapacitated person has the powers and responsibilities of a parent who has not been deprived of custody of his unemancipated minor child except that a guardian is not legally obligated to provide from his own funds for the ward and is not liable to third persons for acts of the ward, and except as hereinafter limited. In particular, and without qualifying the foregoing, a guardian has the following powers and duties, except as modified by order of the court when the guardianship is limited:
 - (a) To the extent that it is consistent with the terms of any order by a court of competent jurisdiction relating to detention or commitment of the ward, he is entitled to custody of the person of his ward and may establish the ward's place of abode within or without this state. The guardian shall take reasonable measures to ensure that a convicted felon does not reside with, care for or visit the ward without court approval.
 - (b) If entitled to custody of his ward he shall make provision for the care, comfort and maintenance of his ward, and, whenever appropriate, arrange for his training and education. . . .
 - (c) A guardian may give any consents or approvals that may be necessary to enable the ward to receive medical or other professional care, counsel, treatment or service. A guardian shall be automatically entitled to any information governed by the health insurance portability and

accountability act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160 through 164, and the appointment of such guardian shall be deemed to grant such release authority. . . .

- (3) A guardian may delegate certain of his responsibilities for decisions affecting the ward's well-being to the ward when reasonable under all of the circumstances.

ILLINOIS755 ILL. COMP. STAT. 5/11a-17 (2011)

§ 11a- 7 Duties of personal guardian.

- (a) To the extent ordered by the court and under the direction of the court, the guardian of the person shall have custody of the ward and the ward's minor and adult dependent children and shall procure for them and shall make provision for their support, care, comfort, health, education and maintenance, and professional services as are appropriate, but the ward's spouse may not be deprived of the custody and education of the ward's minor and adult dependent children, without the consent of the spouse, unless the court finds that the spouse is not a fit and competent person to have that custody and education. The guardian shall assist the ward in the development of maximum self-reliance and independence. . . . A guardian of the person may not admit a ward to a mental health facility except at the ward's request as provided in Article IV of the Mental Health and Developmental Disabilities Code and unless the ward has the capacity to consent to such admission as provided in Article IV of the Mental Health and Developmental Disabilities Code. . . .
- (b) If the court directs, the guardian of the person shall file with the court at intervals indicated by the court, a report that shall state briefly: (1) the current mental, physical, and social condition of the ward and the ward's minor and adult dependent children; (2) their present living arrangement, and a description and the address of every residence where they lived during the reporting period and the length of stay at each place; (3) a summary of the medical, educational, vocational, and other professional services given to them; (4) a resume of the guardian's visits with and activities on behalf of the ward and the ward's minor and adult dependent children; (5) a recommendation as to the need for continued guardianship; (6) any other information requested by the court or useful in the opinion of the guardian. The Office of the State Guardian shall assist the guardian in filing the report when requested by the guardian. The court may take such action as it deems appropriate pursuant to the report.
- (c) Absent court order pursuant to the Illinois Power of Attorney Act directing a guardian to exercise powers of the principal under an agency that survives disability, the guardian has no power, duty, or liability with respect to any personal or health care matters covered by the agency. This subsection (c) applies to all agencies, whenever and wherever executed.
- (d) A guardian acting as a surrogate decision maker under the Health Care Surrogate Act shall have all the rights of a surrogate under that Act without

court order including the right to make medical treatment decisions such as decisions to forgo or withdraw life sustaining treatment. Any decisions by the guardian to forgo or withdraw life sustaining treatment that are not authorized under the Health Care Surrogate Act shall require a court order. Nothing in this Section shall prevent an agent acting under a power of attorney for health care from exercising his or her authority under the Illinois Power of Attorney Act without further court order, unless a court has acted under Section 2-10 of the Illinois Power of Attorney Act. If a guardian is also a health care agent for the ward under a valid power of attorney for health care, the guardian acting as agent may execute his or her authority under that act without further court order.

- (e) Decisions made by a guardian on behalf of a ward shall be made in accordance with the following standards for decision making. Decisions made by a guardian on behalf of a ward may be made by conforming as closely as possible to what the ward, if competent, would have done or intended under the circumstances, taking into account evidence that includes, but is not limited to, the ward's personal, philosophical, religious and moral beliefs, and ethical values relative to the decision to be made by the guardian. Where possible, the guardian shall determine how the ward would have made a decision based on the ward's previously expressed preferences, and make decisions in accordance with the preferences of the ward. If the ward's wishes are unknown and remain unknown after reasonable efforts to discern them, the decision shall be made on the basis of the ward's best interests as determined by the guardian. In determining the ward's best interests, the guardian shall weigh the reason for and nature of the proposed action, the benefit or necessity of the action, the possible risks and other consequences of the proposed action, and any available alternatives and their risks, consequences and benefits, and shall take into account any other information, including the views of family and friends, that the guardian believes the ward would have considered if able to act for herself or himself.
- (f) Upon petition by any interested person (including the standby or short term guardian), with such notice to interested persons as the court directs and a finding by the court that it is in the best interest of the disabled person, the court may terminate or limit the authority of a standby or short-term guardian or may enter such other orders as the court deems necessary to provide for the best interest of the disabled person. The petition for termination or limitation of the authority of a standby or short-term guardian may, but need not, be combined with a petition to have another guardian appointed for the disabled person.

INDIANA IND. CODE §§ 29-3-8.5-3, 29-3.8.5-4, 29-3-8-1 (2004)

§ 29-3-8.5-3 Duties

Sec. 3. (a) A volunteer advocates for seniors program or a volunteer advocates for incapacitated adults program shall:

- (1) serve as a guardian to represent and protect the best interests of an incapacitated person or senior including the person's property;
 - (2) investigate and gather information regarding the health, welfare, and financial circumstances of the incapacitated person or senior, as directed by a court;
 - (3) facilitate and authorize health care, social welfare, and residential placement services as needed by the incapacitated person or senior;
 - (4) advocate for the rights of the incapacitated person or senior;
 - (5) facilitate legal representation for the incapacitated person or senior;
 - (6) provide the court with the required reports under section 2 of this chapter; and
 - (7) perform any other responsibilities required by the court.
- (b) A volunteer advocates for seniors program or a volunteer advocates for incapacitated adults program has the duties of the guardian of a minor listed in IC 29-3-8-1 and IC 29-3-8-3.

§ 29-3-8.5-4 Powers

Sec. 4. (a) A volunteer advocates for seniors program or a volunteer advocates for incapacitated adults program may:

- (1) consent to medical and other professional care and treatment for the incapacitated person's or senior's health and welfare;
 - (2) secure the appointment of a guardian or coguardian in another state;
 - (3) take custody of the incapacitated person or senior and establish the incapacitated person's or senior's residence within Indiana or another state in accordance with IC 29-3-9-2;
 - (4) institute proceedings or take other appropriate action to compel the performance by any person of a duty to support the incapacitated person's or senior's health or welfare;
 - (5) protect and preserve the property of the incapacitated person or senior and preserve any property in excess of the incapacitated person's or senior's current needs; and
 - (6) delegate to the incapacitated person or senior certain responsibilities for decisions affecting the incapacitated person's or senior's business affairs and well-being.
- (b) A volunteer advocates for seniors program or a volunteer advocates for incapacitated adults program may exercise the powers of a guardian of a minor listed in IC 29-3-8-2 and IC 29-3-8-4.

§ 29-3-8-1 Enumerated responsibilities

Sec. 1. (a) The guardian of a minor (other than a temporary guardian) has all of the responsibilities and authority of a parent and, unless otherwise ordered by the court, is responsible for the preservation of all the minor's property regardless of where the property is located. In addition and without limitation, the guardian:

- (1) must be or shall become sufficiently acquainted with the minor and maintain sufficient contact with the minor to know of the minor's capabilities, disabilities, limitations, needs, opportunities, and physical and mental health;
 - (2) shall, upon termination of the guardianship, comply with the applicable provisions of IC 29-3-12;
 - (3) to the extent the available parental income and property are insufficient to fulfill the parental obligation of support to the minor, shall apply the guardianship income and, to the extent the guardianship income is insufficient, the principal of the guardianship property to the minor's current needs for support, and protect and conserve that portion of the minor's property that is in excess of the minor's current needs;
 - (4) shall report the physical and mental condition of the minor to the court as ordered by the court; and
 - (5) has any other responsibilities that the court may order.
- (b) The guardian (other than a temporary guardian) of an incapacitated person is responsible for the incapacitated person's care and custody and for the preservation of the incapacitated person's property to the extent ordered by the court. In addition and without limitation, the guardian of an incapacitated person:
- (1) has, with respect to the incapacitated person, the same responsibilities as those of a guardian of a minor enumerated in subsection (a)(1), (a)(3), and (a)(4);
 - (2) shall, upon termination of the guardianship, comply with the applicable provisions of IC 29-3-12; and
 - (3) has any other responsibilities that the court may order.

IOWAIOWA CODE § 633.562 (2011)

§ 633.562 Notification of guardianship powers.

In a proceeding for the appointment of a guardian, the proposed ward shall be given written notice which advises the proposed ward that if a guardian is appointed, the guardian may, without court approval, provide for the care of the ward, manage the ward's personal property and effects, assist the ward in developing self-reliance and receiving professional care, counseling, treatment or services as needed, and ensure that the ward receives necessary emergency medical services. The notice shall also advise the proposed ward that, upon the court's approval, the guardian may change the ward's permanent residence to a more restrictive residence, and arrange for major elective surgery or any other nonemergency major medical procedure. . . .

KANSAS..... KAN. STAT. ANN. §§ 59-3075, 59-3077 (2008)

§ 59-3075: Guardian's duties, responsibilities, powers and authorities.

- (a)(1) The individual or corporation appointed by the court to serve as the guardian shall carry out diligently and in good faith, the general duties and responsibilities, and shall have the general powers and authorities, provided for in this section as well as any specific duties, responsibilities, powers and authorities assigned to the guardian by the court. In doing so, a guardian shall at all times be subject to the control and direction of the court, and shall act in accordance with the provisions of any guardianship plan filed with the court pursuant to K.S.A. 59-3076, and amendments thereto. The court shall have the authority to appoint counsel for the guardian, and the fees of such attorney may be assessed as costs pursuant to K.S.A. 59-3094, and amendments thereto.
- (2) A guardian shall become and remain personally acquainted with the ward, the spouse of the ward and with other interested persons associated with the ward and who are knowledgeable about the ward, the ward's needs and the ward's responsibilities. A guardian shall exercise authority only as necessitated by the ward's limitations. A guardian shall encourage the ward to participate in making decisions affecting the ward. A guardian shall encourage the ward to act on the ward's own behalf to the extent the ward is able. A guardian shall encourage the ward to develop or regain the skills and abilities necessary to meet the ward's own essential needs and to otherwise manage the ward's own affairs. In making decisions on behalf of the ward, a guardian shall consider the expressed desires and personal values of the ward to the extent known to the guardian. A guardian shall strive to assure that the personal, civil and human rights of the ward are protected. A guardian shall at all times act in the best interests of the ward and shall exercise reasonable care, diligence and prudence.
- (b) A guardian shall have the following general duties, responsibilities, powers and authorities: . . .
- (2) if the ward is an adult, to take charge of the person of the ward, and to provide for the ward's care, treatment, habilitation, education, support and maintenance;
 - (3) to consider and either provide on behalf of the ward necessary or required consents or refuse the same;
 - (4) to assure that the ward resides in the least restrictive setting appropriate to the needs of the ward and which is reasonably available;
 - (5) to assure that the ward receives any necessary and reasonably available medical care, consistent with the provisions of K.S.A. 59-3077, and amendments thereto, when applicable, and any reasonably available nonmedical care or other services as may be needed to preserve the health of the ward or to assist the ward to develop or retain skills and abilities;
 - (6) to promote and protect the comfort, safety, health and welfare of the ward;

- (7) to make necessary determinations and arrangements for, and to give the necessary consents in regard to, the ward's funeral arrangements, burial or cremation, the performance of an autopsy upon the body of the ward, and anatomical gifts of the ward, subject to the provisions and limitations provided for in K.S.A. 2010 Supp. 65-3228, K.S.A. 65-2893 and 65-1734, and amendments thereto; and
 - (8) to exercise all powers and to discharge all duties necessary or proper to implement the provisions of this section. . . .
- (d) A guardian shall not be liable to a third person for the acts of the ward solely by virtue of the guardian's appointment, nor shall a guardian who exercises reasonable care in selecting a third person to provide any medical or other care, treatment or service for the ward be liable for any injury to the ward resulting from the wrongful conduct of that third person.
- (e) A guardian shall not have the power:
- (4) to consent, on behalf of the ward, to any psychosurgery, removal of any bodily organ, or amputation of any limb, unless such surgery, removal or amputation has been approved in advance by the court, except in an emergency and when necessary to preserve the life of the ward or to prevent serious and irreparable impairment to the physical health of the ward;
 - (5) to consent, on behalf of the ward, to the sterilization of the ward, unless approved by the court following a due process hearing held for the purposes of determining whether to approve such, and during which hearing the ward is represented by an attorney appointed by the court;
 - (6) to consent, on behalf of the ward, to the performance of any experimental biomedical or behavioral procedure on the ward, or for the ward to be a participant in any biomedical or behavioral experiment, without the prior review and approval of such by either an institutional review board as provided for in title 45, part 46 of the code of federal regulations, or if such regulations do not apply, then by a review committee established by the agency, institution or treatment facility at which the procedure or experiment is proposed to occur, composed of members selected for the purposes of determining whether the proposed procedure or experiment:
 - (A) Does not involve any significant risk of harm to the physical or mental health of the ward, or the use of aversive stimulants, and is intended to preserve the life or health of the ward or to assist the ward to develop or regain skills or abilities; or
 - (B) involves a significant risk of harm to the physical or mental health of the ward, or the use of an aversive stimulant, but that the conducting of the proposed procedure or experiment is intended either to preserve the life of the ward, or to significantly improve the quality of life of the ward, or to assist the ward to develop or regain significant skills or abilities, and that the guardian has been fully informed concerning the potential risks and benefits of the proposed procedure or experiment or of any aversive stimulant

- proposed to be used, and as to how and under what circumstances the aversive stimulant may be used, and has specifically consented to such;
- (7) to consent, on behalf of the ward, to the withholding or withdrawal of life-saving or life sustaining medical care, treatment, services or procedures, except:
- (A) In accordance with the provisions of any declaration of the ward made pursuant to the provisions of K.S.A. 65-28,101 through 65-28,109, and amendments thereto; or
 - (B) if the ward, prior to the court's appointment of a guardian pursuant to K.S.A. 59-3067, and amendments thereto, shall have executed a durable power of attorney for health care decisions pursuant to K.S.A. 58-629, and amendments thereto, and such shall not have been revoked by the ward prior thereto, and there is included therein any provision relevant to the withholding or withdrawal of life-saving or life-sustaining medical care, treatment, services or procedures, then the guardian shall have the authority to act as provided for therein, even if the guardian has revoked or otherwise amended that power of attorney pursuant to the authority of K.S.A. 58-627, and amendments thereto, or the guardian may allow the agent appointed by the ward to act on the ward's behalf if the guardian has not revoked or otherwise amended that power of attorney; or
 - (C) in the circumstances where the ward's treating physician shall certify in writing to the guardian that the ward is in a persistent vegetative state or is suffering from an illness or other medical condition for which further treatment, other than for the relief of pain, would not likely prolong the life of the ward other than by artificial means, nor would be likely to restore to the ward any significant degree of capabilities beyond those the ward currently possesses, and which opinion is concurred in by either a second physician or by any medical ethics or similar committee to which the health care provider has access established for the purposes of reviewing such circumstances and the appropriateness of any type of physician's order which would have the effect of withholding or withdrawing life-saving or life sustaining medical care, treatment, services or procedures. Such written certification shall be approved by an order issued by the court; . . .
- (9) to place the ward in a treatment facility as defined in K.S.A. 59-3077, and amendments thereto, except if authorized by the court as provided for therein. . . .

§ 59-3077 Authority of guardian to admit ward to treatment facility; petition; contents; notice; hearing; procedure.

- (a) At any time after the filing of the petition provided for in K.S.A. 59-3058, 59-3059, 59-3060 or 59-3061, and amendments thereto, any person may file in addition to that original petition, or as a part thereof, or at any time after the appointment of a temporary guardian as provided for in K.S.A. 59-3073, and amendments thereto, or a guardian as provided for in K.S.A. 59-3067, and amendments thereto, the temporary guardian or guardian may file, a verified petition requesting that the court grant authority to the temporary guardian or guardian to admit the proposed ward or ward to a treatment facility, as defined in subsection (h), and to consent to the care and treatment of the proposed ward or ward therein. The petition shall include: . . .
- (4) the factual basis upon which the petitioner alleges the need for the proposed ward or ward to be admitted to and treated at a treatment facility, or for the proposed ward or ward to continue to be treated at the treatment facility to which the proposed ward or ward has already been admitted, or for the guardian to have continuing authority to admit the ward for care and treatment at a treatment facility pursuant to subsection (b)(3) of K.S.A. 59-2949, or subsection (b)(3) of K.S.A. 59-29b49, and amendments thereto; . . .
 - (6) a request that the court find that the proposed ward or ward is in need of being admitted to and treated at a treatment facility, and that the court grant to the temporary guardian or guardian the authority to admit the proposed ward or ward to a treatment facility and to consent to the care and treatment of the proposed ward or ward therein.
- (b) The petition may be accompanied by a report of an examination and evaluation of the proposed ward or ward conducted by an appropriately qualified professional, which shows that the criteria set out in K.S.A. 39-1803, subsection (e) of K.S.A. 59-2946, subsection (f) of K.S.A. 59-29b46 or K.S.A. 76-12b03, and amendments thereto, are met. . . .
- (h) As used herein, “treatment facility” means the Kansas neurological institute, Larned state hospital, Osawatomie state hospital, Parsons state hospital and training center, the rainbow mental health facility, any intermediate care facility for the mentally retarded, any psychiatric hospital licensed pursuant to K.S.A. 75-3307b, and amendments thereto, and any other facility for mentally ill persons or mentally retarded or developmentally disabled persons licensed pursuant to K.S.A. 75-3307b, and amendments thereto, if the proposed ward or ward is to be admitted as an inpatient or resident of that facility.

KENTUCKY..... KY. REV. STAT. ANN. § 387.660 (West 2006)

387.660 Specific powers and duties of guardian.

A guardian of a disabled person shall have the following powers and duties, except as modified by order of the court:

- (1) To take custody of the ward and to establish his place of abode within the state, except that, if at any time a guardian places a ward in a licensed residential facility for developmentally disabled persons, the guardian shall, within thirty (30) days of such placement, file with the court notice of the placement, stating with specificity the reasons for such placement, and an interdisciplinary evaluation report detailing the social, psychological, medical or other considerations on which such placement is predicated, a description of the treatment or habilitation programs which will benefit the ward as a result of such placement, and a determination that such placement will provide appropriate treatment in the least restrictive available treatment and residential program. For purposes of this subsection, the interdisciplinary evaluation report may be one performed within two (2) months prior to the placement for purposes of determining whether such placement is necessary and appropriate, or may be an evaluation and assessment provided by the residential facility immediately after placement. Notice to the court shall not be required where the ward is transferred from one licensed residential facility to another.
- (2) To make provision for the ward's care, comfort, and maintenance and arrange for such educational, social, vocational, and rehabilitation services as are appropriate and as will assist the ward in the development of maximum self-reliance and independence.
- (3) To give any necessary consent or approval to enable the ward to receive medical or other professional care, counsel, treatment or service, except that a guardian may not consent on behalf of a ward to an abortion, sterilization, psychosurgery, removal of a bodily organ, or amputation of a limb unless the procedure is first approved by order of the court or is necessary, in an emergency situation, to preserve the life or prevent serious impairment of the physical health of the ward.
- (4) To act with respect to the ward in a manner which limits the deprivation of civil rights and restricts his personal freedom only to the extent necessary to provide needed care and services to him. . . .

LOUISIANA LA. CIV. CODE ANN. art. 392 (2010);
LA. CODE CIV. PROC. ANN. art. 4566 (2012)

§ 392. Curators

The court shall appoint a curator to represent the interdict in juridical acts and to care for the person or affairs of the interdict, or any aspect of either. The duties

and powers of a curator commence upon his qualification. In discharging his duties, a curator shall exercise reasonable care, diligence, and prudence and shall act in the best interest of the interdict.

The court shall confer upon a curator of a limited interdict only those powers required to protect the interests of the interdict. . . .

§ 4566. Management of affairs of the interdict

A. Except as otherwise provided by law, the relationship between interdict and curator is the same as that between minor and tutor. The rules provided by Articles 4261 through 4269, 4270 through 4274, 4301 through 4342, and 4371 apply to curatorship of interdicts. Nevertheless, provisions establishing special rules for natural tutors and parents shall not apply in the context of interdiction.

. . .

G. A curator may not consent to an abortion or sterilization of the interdict without prior court authorization.

H. Neither a curator nor a court shall admit or commit an interdict to a mental health treatment facility except in accordance with the provisions of R.S. 28:50 through 64.

I. A curator appointed in an order of temporary interdiction shall have no authority to admit the defendant to a residential or long- term care facility in the absence of good cause shown at a contradictory hearing.

MAINE.....ME. REV. STAT. tit. 18A, § 5-312 (2011)

§5-312 General powers and duties of guardian

(a) A guardian of an incapacitated person has the same powers, rights and duties respecting his ward that a parent has respecting his unemancipated minor child, except that a guardian is not legally obligated to provide from his own funds for the ward and is not liable to 3rd persons for acts of the ward solely by reason of the parental relationship. In particular, and without qualifying the foregoing, a guardian has the following powers and duties, except as modified by order of the court:

(1) To the extent that it is consistent with the terms of any order by a court of competent jurisdiction relating to detention or commitment of the ward, he is entitled to custody of the person of his ward and may establish the ward's place of abode within or without this State, and may place the ward in any hospital or other institution for care in the same manner as otherwise provided by law.

(2) If entitled to custody of his ward he shall make provision for the care, comfort and maintenance of his ward and, whenever appropriate, arrange for his training and education. . . .

(3) A guardian may give or withhold consents or approvals related to medical or other professional care, counsel, treatment or service for the ward.

Except as authorized by a court of competent jurisdiction, a guardian shall make a health-care decision in accordance with the ward's individual instructions, if any, and other wishes expressed while the ward had capacity to the extent known to the guardian. Otherwise, the guardian shall make the decision in accordance with the guardian's determination of the ward's best interest. In determining the ward's best interest, the guardian shall consider the ward's personal values to the extent known to the guardian. A decision of a guardian to withhold or withdraw life-sustaining treatment is effective without court approval unless the guardian's decision is made against the advice of the ward's primary physician and in the absence of instructions from the ward made while the ward had capacity.

MARYLAND.....MD. CODE ANN., Est. & Trusts
§§ 13-708, 13-712, 13-713 (LexisNexis 2011 Supp.)

§ 13-708. Rights, duties and powers of guardian.

(a) In general.—

- (1) The court may grant to a guardian of a person only those powers necessary to provide for the demonstrated need of the disabled person.
- (2) The court may appoint a guardian of the person of a disabled person for the limited purpose of making one or more decisions related to the health care of that person.

(b) Nonexclusive enumeration of permissible powers.— Subject to subsection (a) of this section, the rights, duties, and powers which the court may order include, but are not limited to:

- (1) The same rights, powers, and duties that a parent has with respect to an unemancipated minor child, except that the guardian is not liable solely by reason of the guardianship to third persons for any act of the disabled person;
- (2) The right to custody of the disabled person and to establish his place of abode within and without the State, provided there is court authorization for any change in the classification of abode, except that no one may be committed to a mental facility without an involuntary commitment proceeding as provided by law;
- (3) The duty to provide for care, comfort, and maintenance, including social, recreational, and friendship requirements, and, if appropriate, for training and education of the disabled person; . . .
- (8) The power to give necessary consent or approval for:
 - (i) Medical or other professional care, counsel, treatment, or service, including admission to a hospital or nursing home or transfer from one medical facility to another;
 - (ii) Withholding medical or other professional care, counsel, treatment, or service; and

(iii) Withdrawing medical or other professional care, counsel, treatment, or service.

(c) Medical procedures.—

(1) Notwithstanding the powers conferred to a guardian under subsection (b)(8) of this section, and except as provided in paragraph (2) of this subsection, where a medical procedure involves, or would involve, a substantial risk to the life of a disabled person, the court must authorize a guardian's consent or approval for:

- (i) The medical procedure;
- (ii) Withholding the medical procedure; or
- (iii) Withdrawing the medical procedure that involves, or would involve, a substantial risk to the life of the disabled person.

(2) The court may, upon such conditions as the court considers appropriate, authorize a guardian to make a decision regarding medical procedures that involve a substantial risk to life without further court authorization, if:

- (i) The disabled person has executed an advance directive in accordance with Title 5, Subtitle 6 of the Health - General Article that authorizes the guardian to consent to the provision, withholding or withdrawal of a medical procedure that involves a substantial risk to life but does not appoint a health care agent; or
- (ii) The guardian is:

- 1. Within a class of individuals specified in § 5-605(a)(2) of the Health - General Article as authorized to make health care decisions for the disabled person; and
- 2. Determined by the court to be familiar with the personal beliefs, values, and medical situation of the disabled person.

(3) A petition seeking the authorization of a court that a life-sustaining procedure be withheld or withdrawn is subject to the provisions of §§ 13-711 through 13-713 of this subtitle.

(d) Services provided directly to the disabled person by the guardian of the person.—

(1) Notwithstanding subsection (a) of this section, and in addition to the rights, duties, and powers which the court may order under subsection (b) of this section, the court may order the relief provided under this subsection. . . .

(3) To implement the provisions of this subsection, the court may: . . .

- (iii) Order any act necessary for the best interests of the disabled person.

§ 13-712. Substituted judgment; evidence.

(a) In general.— The court may approve a request for the withholding or withdrawal of a life-sustaining procedure from a disabled person on the basis of a substituted judgment.

- (b) Clear and convincing evidence required.— The court may make a substituted judgment under subsection (a) of this section only on the basis of clear and convincing evidence that the disabled person would, if competent, decide to withhold or withdraw a life-sustaining procedure under the circumstances.
- (c) Admissibility of evidence.— Evidence of the intentions or wishes of the disabled person regarding the withholding or withdrawal of a life-sustaining procedure that might otherwise be inadmissible may be admitted, in the discretion of the court, if it is:
 - (1) Material and probative; and
 - (2) The best evidence available.

§ 13-713. Best interest of a disabled person.

- (a) In general.— If the court is unable to make a substituted judgment under § 13-712 of this subtitle, the court may approve a request for the withholding or withdrawal of a life-sustaining procedure from the disabled person if the court determines, on the basis of clear and convincing evidence, that the withholding or withdrawal is in the best interest of the disabled person.
- (b) Considerations precluded.— The decision of whether life-sustaining procedures should be provided, withheld, or withdrawn shall not be based, in whole or in part, on either a patient's preexisting, long-term mental or physical disability, or a patient's economic disadvantage.

MASSACHUSETTS..... MASS. GEN. LAWS ch. 190B, §5-309 (2010)

§5-309 Powers, Duties, Rights and Immunities of Guardians, Limitations.

- (a) Except as limited pursuant to section 5-306(c), a guardian of an incapacitated person shall make decisions regarding the incapacitated person's support, care, education, health and welfare, but a guardian is not personally liable for the incapacitated person's expenses and is not liable to third persons by reason of that relationship for acts of the incapacitated person. A guardian shall exercise authority only as necessitated by the incapacitated person's mental and adaptive limitations, and, to the extent possible, shall encourage the incapacitated person to participate in decisions, to act on his own behalf, and to develop or regain the capacity to manage personal affairs. A guardian, to the extent known, shall consider the expressed desires and personal values of the incapacitated person when making decisions, and shall otherwise act in the incapacitated person's best interest and exercise reasonable care, diligence, and prudence. A guardian shall immediately notify the court if the incapacitated person's condition has changed so that he or she is capable of exercising rights previously limited. In addition, a guardian has the duties, powers and responsibilities of a guardian of a minor as described in section 5-209(b), (c), (d) and (e).
- (b) A guardian shall report in writing the condition of the incapacitated person and account for funds and other assets subject to the guardian's possession or

control within 60 days following appointment, at least annually thereafter, and when otherwise ordered by the court. A report shall briefly state:

- (1) the current mental, physical and social condition of the incapacitated person;
 - (2) the living arrangements for all addresses of the incapacitated person during the reporting period;
 - (3) the medical, educational, vocational and other services provided to the incapacitated person and the guardian's opinion as to the adequacy of the incapacitated person's care;
 - (4) a summary of the guardian's visits with and activities on the incapacitated person's behalf and the extent to which the incapacitated person participated in decision-making;
 - (5) if the incapacitated person is institutionalized, whether the guardian considers the current treatment or habilitation plan to be in the incapacitated person's best interests;
 - (6) plans regarding future care; and
 - (7) a recommendation as to the need for continued guardianship and any recommended changes in the scope of the guardianship.
- (c) The court shall establish a system for monitoring guardianships, including the filing and review of annual reports.
- (d) The court may appoint a guardian ad litem pursuant to section 1-404 to review a report, to interview the incapacitated person or guardian, and to make such other investigation as the court may direct.
- (e) A guardian, without authorization of the court, may not revoke a health care proxy of which the incapacitated person is the principal. If a health care proxy is in effect, absent an order of the court to the contrary, a health-care decision of the agent takes precedence over that of a guardian.
- (f) No guardian shall be given the authority under this chapter to admit or commit an incapacitated person to a mental health facility or a mental retardation facility as defined in the regulations of the department of mental health.
- (g) No guardian shall have the authority to admit an incapacitated person to a nursing facility except upon a specific finding by the court that such admission is in the incapacitated person's best interest.

MICHIGAN.....MICH. COMP. LAWS § 700.5314 (2011)

§ 700.5314 Powers and duties of guardian.

Sec. 5314. Whenever meaningful communication is possible, a legally incapacitated individual's guardian shall consult with the legally incapacitated individual before making a major decision affecting the legally incapacitated individual. Except as limited under section 5306, a legally incapacitated individual's guardian is responsible for the ward's care, custody, and control, but is not liable to third persons by reason of that responsibility for the ward's acts. In

particular and without qualifying the previous sentences, a guardian has all of the following powers and duties, except as modified by court order: . . .

- (b) If entitled to custody of the ward, the guardian must make provision for the ward's care, comfort, and maintenance and, when appropriate, arrange for the ward's training and education. The guardian shall secure services to restore the ward to the best possible state of mental and physical well-being so that the ward can return to self-management at the earliest possible time. . . .
- (c) A guardian may give the consent or approval that is necessary to enable the ward to receive medical or other professional care, counsel, treatment, or service. . . .
- (e) The guardian shall report the condition of the ward and the ward's estate that is subject to the guardian's possession or control, as required by the court, but not less often than annually. The guardian shall also serve the report required under this subdivision on the ward and interested persons as specified in the Michigan court rules. A report under this subdivision must contain all of the following:
 - (i) The ward's current mental, physical, and social condition.
 - (ii) Improvement or deterioration in the ward's mental, physical, and social condition that occurred during the past year.
 - (iii) The ward's present living arrangement and changes in his or her living arrangement that occurred during the past year.
 - (iv) Whether the guardian recommends a more suitable living arrangement for the ward.
 - (v) Medical treatment received by the ward.
 - (vi) Services received by the ward.
 - (vii) A list of the guardian's visits with, and activities on behalf of, the ward.
 - (viii) A recommendation as to the need for continued guardianship. . . .

MINNESOTA MINN. STAT. § 524.5-313 (2010)

524.5-313 Powers and duties of guardian.

- (a) A guardian shall be subject to the control and direction of the court at all times and in all things.
- (b) The court shall grant to a guardian only those powers necessary to provide for the demonstrated needs of the ward.
- (c) The court may appoint a guardian if it determines that all the powers and duties listed in this section are needed to provide for the needs of the incapacitated person. The court may also appoint a guardian if it determines that a guardian is needed to provide for the needs of the incapacitated person through the exercise of some, but not all, of the powers and duties listed in this section. The duties and powers of a guardian or those which the court may grant to a guardian include, but are not limited to:

- (1) the power to have custody of the ward and the power to establish a place of abode within or outside the state, except as otherwise provided in this clause. The ward or any interested person may petition the court to prevent or to initiate a change in abode. A ward may not be admitted to a regional treatment center by the guardian except:
 - (i) after a hearing under chapter 253B;
 - (ii) for outpatient services; or
 - (iii) for the purpose of receiving temporary care for a specific period of time not to exceed 90 days in any calendar year;
- (2) the duty to provide for the ward's care, comfort, and maintenance needs, including food, clothing, shelter, health care, social and recreational requirements, and, whenever appropriate, training, education, and habilitation or rehabilitation. The guardian has no duty to pay for these requirements out of personal funds. . . .
 - (4)(i) the power to give any necessary consent to enable the ward to receive necessary medical or other professional care, counsel, treatment, or service, except that no guardian may give consent for psychosurgery, electroshock, sterilization, or experimental treatment of any kind unless the procedure is first approved by order of the court as provided in this clause. The guardian shall not consent to any medical care for the ward which violates the known conscientious, religious, or moral belief of the ward;
 - (ii) a guardian who believes a procedure described in item (i) requiring prior court approval to be necessary for the proper care of the ward, shall petition the court for an order and, in the case of a public guardianship under chapter 252A, obtain the written recommendation of the commissioner of human services. The court shall fix the time and place for the hearing and shall give notice to the ward in such manner as specified in section 524.5-308 and to interested persons. The court shall appoint an attorney to represent the ward who is not represented by counsel, provided that such appointment shall expire upon the expiration of the appeal time for the order issued by the court under this section or the order dismissing a petition, or upon such other time or event as the court may direct. In every case the court shall determine if the procedure is in the best interest of the ward. In making its determination, the court shall consider a written medical report which specifically considers the medical risks of the procedure, whether alternative, less restrictive methods of treatment could be used to protect the best interest of the ward, and any recommendation of the commissioner of human services for a public ward. The standard of proof is that of clear and convincing evidence;
 - (iii) in the case of a petition for sterilization of a developmentally disabled ward, the court shall appoint a licensed physician, a

psychologist who is qualified in the diagnosis and treatment of developmental disability, and a social worker who is familiar with the ward's social history and adjustment or the case manager for the ward to examine or evaluate the ward and to provide written reports to the court. The reports shall indicate why sterilization is being proposed, whether sterilization is necessary and is the least intrusive method for alleviating the problem presented, and whether it is in the best interest of the ward. The medical report shall specifically consider the medical risks of sterilization, the consequences of not performing the sterilization, and whether alternative methods of contraception could be used to protect the best interest of the ward;

- (iv) any ward whose right to consent to a sterilization has not been restricted under this section or section 252A.101 may be sterilized only if the ward consents in writing or there is a sworn acknowledgment by an interested person of a nonwritten consent by the ward. The consent must certify that the ward has received a full explanation from a physician or registered nurse of the nature and irreversible consequences of the sterilization;
- (v) a guardian or the public guardian's designee who acts within the scope of authority conferred by letters of guardianship under section 252A.101, subdivision 7, and according to the standards established in this chapter or in chapter 252A shall not be civilly or criminally liable for the provision of any necessary medical care, including, but not limited to, the administration of psychotropic medication or the implementation of aversive and deprivation procedures to which the guardian or the public guardian's designee has consented; . . .

MISSISSIPPI MISS. CODE ANN. §§ 93-13-38, 93-13-111, 93-13-121 (2007)

§ 93-13-38. General duties and powers of guardians

- (1) All the provisions of the law on the subject of executors and administrators, relating to settlement or disposition of property limitations, notice to creditors, probate and registration of claims, proceedings to insolvency and distribution of assets of insolvent estates, shall, as far as applicable and not otherwise provided, be observed and enforced in all guardianships.
- (2) It shall be the duty of the guardian of wards as defined by Section 1-3-58, Mississippi Code of 1972, to improve the estate committed to his charge, and to apply so much of the income, profit or body thereof as may be necessary for the comfortable maintenance and support of the ward and of his family, if he have any, after obtaining an order of the court fixing the amount. And such guardian may be authorized by the court or chancellor to purchase on behalf of and in the name of the ward with any funds of such ward's estate sufficient and appropriate property for a home for such ward or his family on five (5) days' notice to a member of said family, or the necessary funds may be borrowed and

the property purchased given as security. The guardian is empowered to collect and sue for and recover all debts due his said ward, and shall make payment of his debts out of the personal estate as executors and administrators discharge debts out of the estate of decedents, but the exempt property of the ward shall not be liable for debts, and no debts against such estate shall be payable by such guardian unless first probated and registered, as required of claims against the estate of decedent.

- (3) The word "family" shall be taken for the purpose of this section to mean husband or wife and children; if there be no husband, wife or children, the father and mother; and if there be no father or mother, then the grandfather and grandmother, sisters and brothers of said ward.
 - (4) (a) On application of the guardian or any interested party, and after notice to all interested persons and to such other persons as the court may direct, and on a showing that the ward will probably remain incompetent during his lifetime, the court may, after hearing and by order, authorize the guardian to apply such principal or income of the ward's estate as is not required for the support of the ward during his lifetime or of his family towards the establishment of an estate plan for the purpose of minimizing income, estate, inheritance, or other taxes payable out of the ward's estate. The court may authorize the guardian to make gifts of the ward's personal property or real estate, outright or in trust, on behalf of the ward, to or for the benefit of (i) organizations to which charitable contributions may be made under the Internal Revenue Code and in which it is shown the ward would reasonably have an interest, (ii) the ward's heirs at law who are identifiable at the time of the order, (iii) devisees under the ward's last validly executed will, if there be such a will, and (iv) a person serving as guardian of the ward provided he is eligible under either category (ii) or (iii) above.
 - (b) The person making application to the court shall outline the proposed estate plan, setting forth all the benefits to be derived therefrom. The application shall also indicate that the planned disposition is consistent with the intentions of the ward insofar as they can be ascertained. If the ward's intentions cannot be ascertained, the ward will be presumed to favor reduction in the incidence of the various forms of taxation and the partial distribution of his estate as herein provided.
 - (c) The court:
 - (i) Shall appoint a guardian ad litem for the ward; and
 - (ii) May appoint a guardian ad litem for any interested party at any stage of the proceedings, if deemed advisable for the protection of the interested party.
 - (d) Subsequent modifications of an approved plan may be made by similar application to the court.
 - (e) Before signing an order to effectuate the provisions of this subsection (4), the chancellor shall review the ward's will, if the will is known or can be

produced, to determine that a gift made under this subsection (4) is consistent with the will.

§ 93-13-111. Appointment of guardians of person and estate, or either, for persons in need of mental treatment

The chancellor may appoint guardians of the person and estate, or either, of persons found to be in need of mental treatment as defined in Section 41-21-61 et seq. and incapable of taking care of his person and property, upon the motion of the chancellor or clerk of the chancery court, or upon the application of relatives or friends of such persons or upon the application of any other interested party. Such proceeding may be instituted by any relative or friend of such person or any other interested party by the filing of a sworn petition in the chancery court of the county of the residence of such person, setting forth that such person is in need of mental treatment and incapable of taking care of his person and estate, or either. Upon the filing of such petition, the chancellor of said court shall, by order, fix the day, time and place for the hearing thereof, either in term-time or in vacation, and the person who is alleged to be in need of mental treatment and incapable of taking care of his person or property shall be summoned to be and appear before said court at the time and place fixed, which said summons shall be served upon such person not less than five (5) days prior to the date fixed for such hearing. At such hearing all interested parties may appear and present evidence as to the truth and correctness of the allegations of the said petition. If the chancellor should find from the evidence that such person is in need of mental treatment and incapable of taking care of his estate and person, or either, the chancellor shall appoint a guardian of such person's estate and person, or either, as the case may be. In such cases, the costs and expenses of the proceedings shall be paid out of the estate of such person if a guardian is appointed. If a guardian is appointed and such person has no estate, or if no guardian is appointed, then such costs and expenses shall be paid by the person instituting the proceedings.

§ 93-13-121. Incompetent adult; appointment of guardian

In any case where a guardian has been appointed for an adult person by a court of competent jurisdiction of any state, and the adult thereafter, at the time of filing the petition provided for in this section, is a resident of this state and is incompetent to manage his or her estate, the chancery court of the county of the domicile of the adult shall have jurisdiction and authority to appoint a guardian for the incompetent adult upon the conditions specified in this section; however, infirmities of old age shall not be considered elements of infirmities.

The petition for the appointment of a guardian under the provisions of this section shall be filed by the incompetent person or his guardian in the office of the clerk of the chancery court in the county of the residence of the incompetent person and

process shall be served as provided in Section 93-13-281, unless joined in by that person or those persons prescribed in that section.

Upon the return day of the process, the chancellor, if in vacation, or the court, if in termtime, shall cause the applicant to appear in person and then and there examine the applicant and all interested parties, and if, after the examination, the chancellor in vacation or the court in termtime is of the opinion that the applicant is incompetent to manage his or her estate, then it shall be the duty of the court to appoint a guardian of the estate of the applicant; however, in no instance shall the court have authority to appoint a guardian under the provisions of this section unless it examines the applicant in person and finds after the examination that the applicant is incompetent to manage his or her estate.

A guardian appointed under the provisions of this section shall be required to make and file annual accounts of his acts and doings as in case of guardians for persons with mental illness.

MISSOURI.....MO. REV. STAT. § 475.120 (2000)

§ 475.120 General powers and duties of guardian of the person—social service agency acting on behalf of ward, requirements

1. The guardian of the person of a minor shall be entitled to the custody and control of the ward and shall provide for the ward's education, support and maintenance.
2. A guardian or limited guardian of an incapacitated person shall act in the best interest of the ward. A limited guardian of an incapacitated person shall have the powers and duties enumerated by the court in the adjudication order or any later modifying order.
3. The general powers and duties of a guardian of an incapacitated person shall be to take charge of the person of the ward and to provide for the ward's care, treatment, habilitation, education, support and maintenance; and the powers and duties shall include, but not be limited to, the following:
 - (1) Assure that the ward resides in the best and least restrictive setting reasonably available;
 - (2) Assure that the ward receives medical care and other services that are needed;
 - (3) Promote and protect the care, comfort, safety, health, and welfare of the ward;
 - (4) Provide required consents on behalf of the ward;
 - (5) To exercise all powers and discharge all duties necessary or proper to implement the provisions of this section. . . .
5. No guardian of the person shall have authority to seek admission of the guardian's ward to a mental health or mental retardation facility for more than

thirty days for any purpose without court order except as otherwise provided by law. . . .

MONTANA.....MONT. CODE ANN. § 72-5-321 (2009)

§ 72-5-321. Powers and duties of guardian of incapacitated person.

- (1) The powers and duties of a limited guardian are those specified in the order appointing the guardian. The limited guardian is required to report the condition of the incapacitated person and of the estate that has been subject to the guardian's possession and control, as required by the court or by court rule.
- (2) A full guardian of an incapacitated person has the same powers, rights, and duties respecting the ward that a parent has respecting an unemancipated minor child, except that a guardian is not liable to third persons for acts of the ward solely by reason of the parental relationship. In particular and without qualifying the foregoing, a full guardian has the following powers and duties, except as limited by order of the court:
 - (a) To the extent that it is consistent with the terms of any order by a court of competent jurisdiction relating to detention or commitment of the ward, the full guardian is entitled to custody of the person of the ward and may establish the ward's place of residence within or outside of this state.
 - (b) If entitled to custody of the ward, the full guardian shall make provision for the care, comfort, and maintenance of the ward and whenever appropriate arrange for the ward's training and education. . . .
 - (c) A full guardian may give any consents or approvals that may be necessary to enable the ward to receive medical or other professional care, counsel, treatment, or service. This subsection (2)(c) does not authorize a full guardian to consent to the withholding or withdrawal of life-sustaining treatment or to a do not resuscitate order if the full guardian does not have authority to consent pursuant to the Montana Rights of the Terminally Ill Act, Title 50, chapter 9, or to the do not resuscitate provisions of Title 50, chapter 10. A full guardian may petition the court for authority to consent to the withholding or withdrawal of life-sustaining treatment or to a do not resuscitate order. The court may not grant that authority if it conflicts with the ward's wishes to the extent that those wishes can be determined. To determine the ward's wishes, the court shall determine by a preponderance of evidence if the ward's substituted judgment, as applied to the ward's current circumstances, conflicts with the withholding or withdrawal of life-sustaining treatment or a do not resuscitate order. . . .
- (5) A full guardian or limited guardian may not involuntarily commit for mental health treatment or for treatment of a developmental disability or for observation or evaluation a ward who is unwilling or unable to give informed consent to commitment, except as provided in 72-5-322, unless the procedures for involuntary commitment set forth in Title 53, chapters 20 and 21, are

followed. This chapter does not abrogate any of the rights of mentally disabled persons provided for in Title 53, chapters 20 and 21.

- (6) Upon the death of a full guardian's or limited guardian's ward, the full guardian or limited guardian, upon an order of the court and if there is no personal representative authorized to do so, may make necessary arrangements for the removal, transportation, and final disposition of the ward's physical remains, including burial, entombment, or cremation, and for the receipt and disposition of the ward's clothing, furniture, and other personal effects that may be in the possession of the person in charge of the ward's care, comfort, and maintenance at the time of the ward's death.

NEBRASKA NEB. REV. STAT. § 30-2628 (Supp. 2012)

§ 30-2628. General powers, rights, and duties of guardian; inventory

- (a) Except as limited by section 30-2620, a guardian of an incapacitated person has the same powers, rights, and duties respecting the guardian's ward that a parent has respecting the parent's unemancipated minor child, except that a guardian is not liable to third persons for acts of the ward solely by reason of the parental relationship. In particular, and without qualifying the foregoing, a guardian has the following powers and duties, except as may be specified by order of the court:

- (1) To the extent that it is consistent with the terms of any order by a court of competent jurisdiction relating to detention or commitment of the ward, a guardian is entitled to custody of the person of his or her ward and may establish the ward's place of abode within this state or, with court permission, outside of this state. When establishing the ward's place of abode, a guardian shall make every reasonable effort to ensure that the placement is the least restrictive alternative. A guardian shall authorize a placement to a more restrictive environment only after careful evaluation of the need for such placement. The guardian may obtain a professional evaluation or assessment that such placement is in the best interest of the ward.
- (2) If entitled to custody of his or her ward, a guardian shall make provision for the care, comfort, and maintenance of his or her ward and, whenever appropriate, arrange for the ward's training and education. . . .
- (3) A guardian may give any consents or approvals that may be necessary to enable the ward to receive medical, psychiatric, psychological, or other professional care, counsel, treatment, or service. When making such medical or psychiatric decisions, the guardian shall consider and carry out the intent of the ward expressed prior to incompetency to the extent allowable by law. Notwithstanding this provision or any other provision of the Nebraska Probate Code, the ward may authorize the release of financial, medical, and other confidential records pursuant to sections 20-161 to 20-166.

....

- (c) Nothing in subdivision (a)(3) of this section or in any other part of this section shall be construed to alter the decisionmaking authority of an attorney in fact designated and authorized under sections 30-3401 to 30-3432 to make health care decisions pursuant to a power of attorney for health care.

NEVADA..... NEV. REV. STAT. § 159.079 (Supp. 2011)

§ 159.079. General functions of guardian of person; establishment or change of ward’s residence by guardian

- 1. Except as otherwise ordered by the court, a guardian of the person has the care, custody and control of the person of the ward, and has the authority and, subject to subsection 2, shall perform the duties necessary for the proper care, maintenance, education and support of the ward, including, without limitation, the following:
 - (a) Supplying the ward with food, clothing, shelter and all incidental necessities, including locating an appropriate residence for the ward.
 - (b) Authorizing medical, surgical, dental, psychiatric, psychological, hygienic or other remedial care and treatment for the ward.
 - (c) Seeing that the ward is properly trained and educated and that the ward has the opportunity to learn a trade, occupation or profession. . . .

NEW HAMPSHIRE.....N.H. REV. STAT. § 464-A:25 (Supp. 2012)

§ 464-A:25 General Powers and Duties of Guardian of the Person.

- (a) To the extent that it is consistent with the terms of any order by a court of competent jurisdiction relating to detention or commitment of the ward, the guardian shall be entitled to custody of the ward and may establish the ward’s place of abode within or without this state. Admission to a state institution shall be in accordance with the following:
 - (1) A guardian may admit a ward to a state institution with prior approval of the probate court if, following notice and hearing, the court finds beyond a reasonable doubt that the placement is in the ward’s best interest and is the least restrictive placement available. Authorization for such admission shall not be time limited unless the court so orders. Authority to admit a ward to a state institution with prior approval under this subparagraph shall not be subject to the limitations contained in RSA 464-A:25, I(a)(2) through (7).
 - (2) A guardian may admit a ward to a state institution without prior approval of the probate court upon written certification by a physician licensed in the state of New Hampshire, or, in the case of placement in New Hampshire hospital, by a psychiatrist licensed in the state of New Hampshire, that the placement is in the ward’s best interest and is the least

restrictive placement available. Within 36 hours, excluding days when the court is closed, of such an admission of a ward to a state institution, the guardian shall submit to the Merrimack county probate court notice of the admission and the reasons therefor, together with a copy of the certificate by the physician or psychiatrist.

....

(6) A guardian may not admit a ward to a state institution for more than 60 days for any single admission or more than 90 days in any 12-month period upon certification of a physician or psychiatrist without filing a petition requesting approval of the probate court.

....

(b) If entitled to custody of the ward, a guardian shall make provision for the care, comfort and maintenance of the ward, and, whenever appropriate, arrange for the ward's training, education or rehabilitation. . . .

....

(d) A guardian of the person may give any necessary consent or approval to enable the ward to receive medical or other professional care, counsel, treatment, or service or may withhold consent for a specific treatment, provided, that the court has previously authorized the guardian to have this authority, which authority shall be reviewed by the court as part of its review of the guardian's annual report. No guardian may give consent for psychosurgery, electroconvulsive therapy, sterilization, or experimental treatment of any kind unless the procedure is first approved by order of the probate court.

(e) If a ward has previously executed a valid living will, under RSA 137-J, a guardian shall be bound by the terms of such document, provided that the court may hold a hearing to interpret any ambiguity in such document. If a ward has previously executed a valid durable power of attorney for health care, RSA 137-J shall apply.

....

(g) A guardian may authorize a health care provider to restrain or forcibly administer treatment, or both, to the ward, subject to any limitations imposed by the court. . . .

NEW JERSEY..... N.J. STAT. ANN. §§ 3B:12-56 to -57 (West 2007)

§ 3B:12-56. Powers, rights and duties of a guardian of the person of a ward generally

- b. A guardian of the person of a ward is not liable to a third person for acts of the ward solely by reason of the relationship and is not liable for injury to the ward resulting from the wrongful conduct of a third person providing medical or other care, treatment or service for the ward except to the extent that the guardian of the ward failed to exercise reasonable care in choosing the provider.
- c. If a ward has previously executed a valid power of attorney for health care or advance directive under P.L.1991, c.201 (C.26:2H-53 et seq.), or revocation

pursuant to section 5 of P.L.1991, c.201 (C.26:2H-57), a guardian of the ward shall act consistent with the terms of such document unless revoked or altered by the court.

- d. To the extent specifically ordered by the court for good cause shown, the guardian of the person of the ward may initiate the voluntary admission, as defined in section 2 of P.L.1987, c.116 (C.30:4-27.2), of a ward to a State psychiatric facility, as defined in section 2 of P.L.1987, c.116 (C.30:4-27.2), or a private psychiatric facility. A ward so admitted shall be entitled to all of the rights of a voluntarily admitted patient, which rights shall be exercised on behalf of the ward by the guardian. The guardian of the ward shall exercise the ward's rights in a manner consistent with the wishes of the ward except to the extent that compliance with those wishes would create a significant risk to the health or safety of the ward. If the wishes of the ward are not ascertainable with reasonable efforts, the guardian of the ward shall exercise the ward's rights in a manner consistent with the best interests of the ward. Notwithstanding the provisions of this section to the contrary, if the ward objects to the initiation of voluntary admission for psychiatric treatment or to the continuation of that voluntary admission, the State's procedures for involuntary commitment pursuant to P.L.1987, c.116 (C.30:4-27.1 et seq.) shall apply. If the ward objects to any other decision of the guardian of the ward pursuant to this section, this objection shall be brought to the attention of the Superior Court, Chancery Division, Probate Part, which may, in its discretion, appoint an attorney or guardian ad litem for the ward, hold a hearing or enter such orders as may be appropriate in the circumstances.

§ 3B:12-57. Powers and duties of a guardian of the person of a ward.

- f. In accordance with Section 12 of P.L.2005, c.304 (C.3B:12-24.1), a guardian of the person of a ward shall exercise authority over matters relating to the rights and best interest of the ward's personal needs, only to the extent adjudicated by a court of competent jurisdiction. In taking or forbearing from any action affecting the personal needs of a ward, a guardian shall give due regard to the preferences of the ward, if known to the guardian or otherwise ascertainable upon reasonable inquiry. To the extent that it is consistent with the terms of any order by a court of competent jurisdiction, the guardian shall:

....

- (3) provide for the care, comfort and maintenance and, whenever appropriate, the education and training of the ward;
- (4) subject to the provisions of subsection c. of N.J.S.3B:12-56, give or withhold any consents or approvals that may be necessary to enable the ward to receive medical or other professional care, counsel, treatment or service;

....

- (7) develop a plan of supportive services for the needs of the ward and a plan to obtain the supportive services;

-
- g. In the exercise of the foregoing powers, the guardian shall encourage the ward to participate with the guardian in the decision-making process to the maximum extent of the ward's ability in order to encourage the ward to act on his own behalf whenever he is able to do so, and to develop or regain higher capacity to make decisions in those areas in which he is in need of guardianship services, to the maximum extent possible.

NEW MEXICO..... N.M. STAT. ANN. § 45-5-312 (2011)

§ 45-5-312. General powers and duties of the limited guardian and guardian

- A. If the court enters judgment pursuant to Subsection C of Section 45-5-304 NMSA 1978, it shall appoint a limited guardian if it determines that the incapacitated person is able to manage some but not all aspects of personal care. The court shall specify those powers that the limited guardian shall have and may further restrict each power so as to permit the incapacitated person to care for the incapacitated person's own self commensurate with the incapacitated person's ability to do so. A person for whom a limited guardian has been appointed retains all legal and civil rights except those that have been specifically granted to the limited guardian by the court. The limited guardian shall exercise supervisory powers over the incapacitated person in a manner that is the least restrictive form of intervention consistent with the order of the court.
- B. A guardian of an incapacitated person has the same powers, rights and duties respecting the incapacitated person that a parent has respecting an unemancipated minor child, except that a guardian is not legally obligated to provide from the guardian's own funds for the incapacitated person and is not liable to third persons for acts of the incapacitated person solely by reason of the guardianship. In particular and without qualifying the foregoing, a guardian or the guardian's replacement has the following powers and duties, except as modified by order of the court:

-
- (2) if entitled to custody of the incapacitated person, a guardian shall make provision for the care, comfort and maintenance of the incapacitated person and, whenever appropriate, arrange for training and education. . . .
- (3) if no agent is entitled to make health-care decisions for the incapacitated person under the provisions of the Uniform Health-Care Decisions Act [24-7A-17 NMSA 1978], then the guardian shall make health-care decisions for the incapacitated person in accordance with the provisions of that act. In exercising health-care powers, a guardian may consent or withhold consent that may be necessary to enable the incapacitated person to receive or refuse medical or other professional care, counsel, treatment or service. That decision shall be made in accordance with the values of the incapacitated person, if known, or the best interests of the incapacitated person if the values are not known;

....

- (5) the guardian shall exercise the guardian's supervisory powers over the incapacitated person in a manner that is least restrictive of the incapacitated person's personal freedom and consistent with the need for supervision. . . .

NEW YORK.....N.Y. MENTAL HYG. LAW §§ 81.20, 22
(McKinney 2006 & Supp. 2012)

§ 81.20 Duties of guardian.

- (a) Duties of guardian generally. 1. a guardian shall exercise only those powers that the guardian is authorized to exercise by court order; 2. a guardian shall exercise the utmost care and diligence when acting on behalf of the incapacitated person; 3. a guardian shall exhibit the utmost degree of trust, loyalty and fidelity in relation to the incapacitated person; 4. a guardian shall file an initial and annual reports in accordance with sections 81.30 and 81.31 of this article; 5. a guardian shall visit the incapacitated person not less than four times a year or more frequently as specified in the court order; . . . 7. a guardian who is given authority relating to the personal needs of the incapacitated person shall afford the incapacitated person the greatest amount of independence and self-determination with respect to personal needs in light of that person's functional level, understanding and appreciation of that person's functional limitations, and personal wishes, preferences and desires with regard to managing the activities of daily living.

§ 81.22 Powers of guardian; personal needs.

- (a) Consistent with the functional limitations of the incapacitated person, that person's understanding and appreciation of the harm that he or she is likely to suffer as the result of the inability to provide for personal needs, and that person's personal wishes, preferences, and desires with regard to managing the activities of daily living, and the least restrictive form of intervention, the court may grant to the guardian powers necessary and sufficient to provide for the personal needs of the incapacitated person. Those powers which may be granted include, but are not limited to, the power to: 1. determine who shall provide personal care or assistance; . . . 8. (i) for decisions in hospitals as defined by subdivision eighteen of section twenty-nine hundred ninety-four-a of the public health law, act as the patient's surrogate pursuant to and subject to article twenty-nine-CC of the public health law, and (ii) in all other circumstances, to consent to or refuse generally accepted routine or major medical or dental treatment, subject to the decision-making standard in subdivision four of section twenty-nine hundred ninety-four-d of the public health law; 9. choose the place of abode; the choice of abode must be consistent with the findings under section 81.15 of this article, the existence of and availability of family, friends and

social services in the community, the care, comfort and maintenance, and where appropriate, rehabilitation of the incapacitated person, the needs of those with whom the incapacitated person resides; placement of the incapacitated person in a nursing home or residential care facility as those terms are defined in section two thousand eight hundred one of the public health law, or other similar facility shall not be authorized without the consent of the incapacitated person so long as it is reasonable under the circumstances to maintain the incapacitated person in the community, preferably in the home of the incapacitated person.

- (b) No guardian may: 1. consent to the voluntary formal or informal admission of the incapacitated person to a mental hygiene facility under article nine or fifteen of this chapter or to a chemical dependence facility under article twenty-two of this chapter; 2. revoke any appointment or delegation made by the incapacitated person pursuant to sections 5-1501, 5-1601 and 5-1602 of the general obligations law, sections two thousand nine hundred sixty-five and two thousand nine hundred eighty-one of the public health law, or any living will.

NORTH CAROLINAN.C. GEN. STAT. § 35-A-1241 (2011)

§ 35A 1241. Powers and duties of guardian of the person.

- (a) To the extent that it is not inconsistent with the terms of any order of the clerk or any other court of competent jurisdiction, a guardian of the person has the following powers and duties:
- (1) The guardian of the person is entitled to custody of the person of the guardian's ward and shall make provision for the ward's care, comfort, and maintenance, and shall, as appropriate to the ward's needs, arrange for the ward's training, education, employment, rehabilitation or habilitation.
 - (2) The guardian of the person may establish the ward's place of abode within or without this State. In arranging for a place of abode, the guardian of the person shall give preference to places within this State over places not in this State if in State and out of State places are substantially equivalent. The guardian also shall give preference to places that are not treatment facilities. If the only available and appropriate places of domicile are treatment facilities, the guardian shall give preference to community based treatment facilities, such as group homes or nursing homes, over treatment facilities that are not community based.
 - (3) The guardian of the person may give any consent or approval that may be necessary to enable the ward to receive medical, legal, psychological, or other professional care, counsel, treatment, or service; provided that, if the patient has a health care agent appointed pursuant to a valid health care power of attorney, the health care agent shall have the right to exercise the authority granted in the health care power of attorney unless the Clerk has suspended the authority of that health care agent in accordance with G.S. 35A 1208. The guardian shall not, however, consent to the sterilization of a mentally ill or mentally retarded ward unless the guardian obtains an

order from the clerk in accordance with G.S. 35A 1245. The guardian of the person may give any other consent or approval on the ward’s behalf that may be required or in the ward’s best interest. The guardian may petition the clerk for the clerk’s concurrence in the consent or approval.

....

- (c) A guardian of the person, if he has acted within the limits imposed on him by this Article or the order of appointment or both, shall not be liable for damages to the ward or the ward’s estate, merely by reason of the guardian’s:
 - (1) Authorizing or giving any consent or approval necessary to enable the ward to receive legal, psychological, or other professional care, counsel, treatment, or service, in a situation where the damages result from the negligence or other acts of a third person; or
 - (2) Authorizing medical treatment or surgery for his ward, if the guardian acted in good faith and was not negligent.

NORTH DAKOTAN.D. CENT. CODE § 30.1-28-12 (2010)

§ 30.1-28-12. General powers and duties of guardian.

- 1. A guardian of an incapacitated person has only the powers and duties specified by the court.
- 2. To the extent that it is consistent with the terms of an order by a court of competent jurisdiction, the guardian is entitled to custody of the person of the ward and may establish the ward’s place of residence within or without this state. However, no guardian may voluntarily admit a ward to a mental health facility or state institution for a period of more than forty-five days without a mental health commitment proceeding or other court order. Notwithstanding the other provisions of this subsection, the guardian may readmit a ward to a mental health facility or a state institution within sixty days of discharge from that institution, if the original admission to the facility or institution had been authorized by the court.
- 3. If entitled to custody of the ward, the guardian should make provision for the care, comfort, and maintenance of the ward and, whenever appropriate, arrange for the ward’s training, education, or rehabilitative services. . . .
- 4. Notwithstanding general or limited authority to make medical decisions on behalf of the ward, no guardian may consent to psychosurgery, abortion, sterilization, or experimental treatment of any kind unless the procedure is first approved by order of the court.
- 5. When exercising the authority granted by the court, the guardian shall safeguard the civil rights and personal autonomy of the ward to the fullest extent possible by:
 - a. Involving the ward as fully as is practicable in making decisions with respect to the ward’s living arrangements, health care, and other aspects of the ward’s care; and

- b. Ensuring the ward’s maximum personal freedom by using the least restrictive forms of intervention and only as necessary for the safety of the ward or others. . . .

OHIOOHIO REV. CODE ANN. § 2111.13 (West Supp. 2011)

§ 2111.13 Duties of guardian of person

(A) When a guardian is appointed to have the custody and maintenance of a ward, and to have charge of the education of the ward if the ward is a minor, the guardian’s duties are as follows:

- (1) To protect and control the person of the ward;

....

(C) A guardian of the person may authorize or approve the provision to the ward of medical, health, or other professional care, counsel, treatment, or services unless the ward or an interested party files objections with the probate court, or the court, by rule or order, provides otherwise. . . .

OKLAHOMA.....OKLA. STAT. tit. 30, §§ 30-1-119, -120 (2011)

§ 30-1-119. Powers of guardian

A guardian has only those powers over the person or the property of the ward, or both such person and property, as ordered by the court pursuant to this title.

§ 30-1-120. Power of guardian of the person--Report of change of ward’s abode--Power of limited guardians

A. A guardian, including a special guardian, of the person is charged with the custody of the ward, and must look to the support, health and education of the ward. Except as provided by Section 3-113 of this title, he may fix the place of abode of the ward at any place within the county, but not elsewhere, without permission of the court and any change in the place of abode of a ward within the county shall be reported to the court.

B. Limited guardians of partially incapacitated persons shall not have custody of the person of the ward and shall have only those powers or controls over the person of the ward specifically ordered in a dispositional order or other order of the court.

OREGONOR. REV. STAT. § 125.315 (2011)

§ 125.315. General powers and duties of guardian.

(1) A guardian has the following powers and duties:

....

- (b) The guardian shall provide for the care, comfort and maintenance of the protected person and, whenever appropriate, shall arrange for training and education of the protected person. . . .
- (c) Subject to the provisions of ORS 127.505 to 127.660 and subsection (3) of this section, the guardian may consent, refuse consent or withhold or withdraw consent to health care, as defined in ORS 127.505, for the protected person. A guardian is not liable solely by reason of consent under this paragraph for any injury to the protected person resulting from the negligence or acts of third persons.
- (d) The guardian may:
 - (A) Make advance funeral and burial arrangements;
 - (B) Subject to the provisions of ORS 97.130 [right to control disposition of remains], control the disposition of the remains of the protected person; and
 - (C) Subject to the provisions of ORS 97.965 [persons authorized to make anatomical gift of body or body part of decedent], make an anatomical gift of all or any part of the body of the protected person.

....

(3) A guardian may consent to the withholding or withdrawing of artificially administered nutrition and hydration for a protected person only under the circumstances described in ORS 127.580 [presumption of consent to artificially administered nutrition and hydration] (1)(a), (b), (d), (e) or (f) and, if the protected person has a medical condition specified in ORS 127.580 [presumption of consent to artificially administered nutrition and hydration] (1)(b), (d), (e) or (f), the condition has been medically confirmed.

PENNSYLVANIA..... 20 PA. CONS. STAT. ANN. §§ 5456, 5460 (West Supp. 2011)

§ 5456. Authority of health care agent

- (a) Extent of authority.—Except as expressly provided otherwise in a health care power of attorney and subject to subsection (b) and section 5460 (relating to relation of health care agent to court-appointed guardian and other agents), a health care agent shall have the authority to make any health care decision and to exercise any right and power regarding the principal's care, custody and health care treatment that the principal could have made and exercised. The health care agent's authority may extend beyond the principal's death to make anatomical gifts, dispose of the remains and consent to autopsies.
- (b) Life-sustaining treatment decisions.—A life-sustaining treatment decision made by a health care agent is subject to this section and sections 5429 (relating to pregnancy), 5454 (relating to when health care power of attorney operative) and 5462(a) (relating to duties of attending physician and health care provider).
- (c) Health care decisions.—

- (1) The health care agent shall gather information on the principal's prognosis and acceptable medical alternatives regarding diagnosis, treatments and supportive care.
- (2) In the case of procedures for which informed consent is required under section 504 of the act of March 20, 2002 (P.L.154, No.13) [40 P.S. § 1303.504], known as the Medical Care Availability and Reduction of Error (Mcare) Act, the information shall include the information required to be disclosed under that act.
- (3) In the case of health care decisions regarding end of life of a patient with an end-stage medical condition, the information shall distinguish between curative alternatives, palliative alternatives and alternatives which will merely serve to prolong the process of dying. The information shall also distinguish between the principal's end-stage medical condition and any other concurrent disease, illness or physical, mental, cognitive or intellectual condition that predated the principal's end-stage medical condition.
- (4) After consultation with health care providers and consideration of the information obtained in accordance with paragraphs (1), (2) and (3), the health care agent shall make health care decisions in accordance with the health care agent's understanding and interpretation of the instructions given by the principal at a time when the principal had the capacity to understand, make and communicate health care decisions. Instructions include an advance health care directive made by the principal and any clear written or verbal directions that cover the situation presented.
- (5) (i) In the absence of instruction, the health care agent shall make health care decisions that conform to the health care agent's assessment of the principal's preferences and values, including religious and moral beliefs.
 - (ii) If the health care agent does not know enough about the principal's instructions, preferences and values to decide accordingly, the health care agent shall take into account what the agent knows of the principal's instructions, preferences and values, including religious and moral beliefs, and the health care agent's assessment of the principal's best interests, taking into consideration the following goals and considerations:
 - (A) The preservation of life.
 - (B) The relief from suffering.
 - (C) The preservation or restoration of functioning, taking into account any concurrent disease, illness or physical, mental, cognitive or intellectual condition that may have predated the principal's end-stage medical condition.
 - (iii) (A) In the absence of a specific, written authorization or direction by a principal to withhold or withdraw nutrition and hydration administered by gastric tube or intravenously or by other artificial or invasive means, a health care agent shall presume that the principal would not want nutrition and hydration withheld or withdrawn.

- (B) The presumption may be overcome by previously clearly expressed wishes of the principal to the contrary. In the absence of such clearly expressed wishes, the presumption may be overcome if the health care agent considers the values and preferences of the principal and assesses the factors set forth in subparagraphs (i) and (ii) and determines it is clear that the principal would not wish for artificial nutrition and hydration to be initiated or continued.
- (6) The Department of Health shall ensure as part of the licensure process that health care providers under its jurisdiction have policies and procedures in place to implement this subsection.
- (d) Health care information.—
- (1) Unless specifically provided otherwise in a health care power of attorney, a health care agent has the same rights and limitations as the principal to request, examine, copy and consent or refuse to consent to the disclosure of medical or other health care information.
- (2) Disclosure of medical or other health care information to a health care agent does not constitute a waiver of any evidentiary privilege or of a right to assert confidentiality. A health care provider that discloses such information to a health care agent in good faith shall not be liable for the disclosure. A health care agent may not disclose health care information regarding the principal except as is reasonably necessary to perform the agent's obligations to the principal or as otherwise required by law.

§ 5460. Relation of health care agent to court-appointed guardian and other agents

- (a) Accountability of health care agent.— If a principal who has executed a health care power of attorney is later adjudicated an incapacitated person and a guardian of the person to make health care decisions is appointed by a court, the health care agent is accountable to the guardian as well as to the principal. The guardian shall have the same power to revoke or amend the appointment of a health care agent that the principal would have if the principal were not incapacitated but may not revoke or amend other instructions in an advance health directive absent judicial authorization.
- (b) Nomination of guardian of person.— In a health care power of attorney, a principal may nominate a guardian of the person for the principal for consideration by a court if incapacity proceedings for the principal's person are thereafter commenced. If a court determines that the appointment of a guardian is necessary, the court shall appoint a guardian in accordance with the principal's most recent nomination except for good cause or disqualification.
- (c) Reasonable expenses.— In fulfilling the health care needs for a principal, a health care agent may incur reasonable expenses, including the purchase of health care insurance, to the extent the expenses are not otherwise covered by insurance or other similar benefits. Payment for the expenses or reimbursement

to the health care agent for the expenses from the principal's funds shall be made by either of the following:

- (1) A guardian of the estate of the principal.
- (2) An agent acting on behalf of the principal under a power of attorney if the agent has the power to disburse the funds of the principal.

PUERTO RICO..... P.R. LAWS ANN. tit. 31,
§§ 561, 562, 661, 662, 665 (1993 & Supp. 2006)

§ 561. Support defined

Support is understood to be all that is indispensable for maintenance, housing, clothing and medical attention, according to the social position of the family. . . .

§ 562. Persons obliged to support each other

The following are obliged to support each other within the full meaning of the preceding section:

- (1) Husband and wife.
- (2) Legitimate ascendants and descendants
- (3) The adopter and the person adopted and their descendants.

Brothers and sisters also owe their legitimate brothers and sisters, even when only on the mother's or the father's side, the aid necessary to maintain their existence, when, through a physical or mental defect or for any other cause not the fault of the person requiring support, the said person cannot provide for himself. With such support are included the expenses necessary for the elementary education and teaching of a profession, art or trade.

§ 661. Object of tutorship

The object of tutorship is the custody of the person and property, or of only the property, of such persons who, not subject to patria potestas, are incapable of governing themselves.

§ 662. Persons subject to guardianship

The following are subject to guardianship:

- (1) Minors not lawfully emancipated.
- (2) Demented or insane persons, although they may have lucid moments, and deaf-mutes who cannot understand or communicate effectively by any means
- (3) Prodigals or habitual drunkards declared [as] such by final judgment.
-
- (5) Those who, upon firm and final judgment, have been declared drug addicts.

§ 665. Care of person and property by attorneys or district attorneys.

The attorney of the family Relations Court or the District Attorney in districts where there is no Family Relations Court, of the place in which persons subject to tutorship reside, shall provide for the care of such persons and their personal property until a tutor shall be appointed, when there are no other persons lawfully under such obligation.

RHODE ISLANDR.I. GEN. LAWS § 33-15-29 (2011)

§ 33-15-29 General duties of limited guardians or guardians with respect to person and estate

Every limited guardian or guardian with authority to make decisions with respect to the person of his or her ward shall exercise authority in the best interest of his or her ward. . . .

SOUTH CAROLINA.....S.C. CODE ANN. § 62-5-312 (2009)

§ 62-5-312. General powers and duties of guardian.

(a) A guardian of an incapacitated person has the same powers, rights, and duties respecting his ward that a parent has respecting his unemancipated minor child except that a guardian is not liable to third persons for acts of the ward solely by reason of the parental relationship. In particular, and without qualifying the foregoing, a guardian has the following powers and duties, except as modified by order of the court:

. . . .

(2) If entitled to custody of his ward he shall make provision for the care, comfort, and maintenance of his ward and, whenever appropriate, arrange for his training and education. . . .

(3) A guardian may give any consents or approvals that may be necessary to enable the ward to receive medical or other professional care, counsel, treatment, or service. . . .

SOUTH DAKOTA.....S.D. CODIFIED LAWS § 29A-5-402 (2004)

§ 29A-5-402. Responsibility of guardian of protected person

A guardian of a protected person shall make decisions regarding the protected person's support, care, health, habilitation, therapeutic treatment, and, if not inconsistent with an order of commitment or custody, shall determine the protected person's residence. A guardian shall maintain sufficient contact with the protected person to know of the protected person's capabilities, limitations, needs, and opportunities.

....

A guardian shall exercise authority only to the extent necessitated by the protected person’s limitations, and if feasible, shall encourage the protected person to participate in decisions, to act on his own behalf, and to develop or regain the capacity to manage personal affairs. A guardian shall, to the extent known, consider the express desires and personal values of the protected person when making decisions, and shall otherwise act in the protected person’s best interests and exercise reasonable care, diligence, and prudence.

TENNESSEETENN. CODE ANN. § 34-7-104 (2001)

§ 34-7-104. Powers and duties of district public guardian.

- (a) The duties and powers of the district public guardian are as follows:
 - (1) To serve as conservator for disabled persons who are sixty (60) years of age or older who have no family members or other person, bank or corporation willing and able to serve as conservator;
 - (2) The district public guardian does not have any power or authority beyond that set forth for a conservator in chapters 1, 2 and 3 of this title; and
 - (3) To provide for the least intrusive alternatives, the district public guardian may accept power of attorney.
- (b) The district public guardian may employ sufficient staff to carry out the duties of the office.
- (c) The district public guardian may delegate to staff members the powers and duties of the office of district public guardian except as otherwise limited by law. The district public guardian retains ultimate responsibility for the discharge of required duties and responsibilities.

....

(d)(2) The commission on aging, in consultation with the departments of human services and health, may develop and implement a statewide program to recruit, train, assign, supervise and evaluate volunteer persons to assist district public guardians in maintaining the independence and dignity of their elderly wards. In developing and implementing this statewide program, the commission on aging shall solicit input and resources from interested organizations, including, but not necessarily limited to, community senior citizen centers, churches and synagogues having senior projects and programs under the auspices of the American Association of Retired Persons. Each volunteer shall possess demonstrated personal characteristics of honesty, integrity, compassion and caring for the elderly. The background of each volunteer shall be subject to appropriate inquiry and investigation. Volunteers shall receive no salary but may be reimbursed by the commission on aging for travel and other expenses incurred directly as a result of the performance of volunteer services.

....

- (l) The district public guardian shall adhere to all state laws that are applicable to conservatorship. . . .

TEXASTEX. PROB. CODE ANN. §§ 767, 770, 770A (West Supp. 2011)

§ 767. Powers and Duties of Guardians of the Person

- (a) The guardian of the person is entitled to take charge of the person of the ward, and the duties of the guardian correspond with the rights of the guardian. A guardian of the person has:
- (1) the right to have physical possession of the ward and to establish the ward's legal domicile;
 - (2) the duty to provide care, supervision, and protection for the ward;
 - (3) the duty to provide the ward with clothing, food, medical care, and shelter;
 - (4) the power to consent to medical, psychiatric, and surgical treatment other than the in-patient psychiatric commitment of the ward; . . .
- (b) Notwithstanding Subsection (a)(4) of this section, a guardian of the person of a ward has the power to personally transport the ward or to direct the ward's transport by emergency medical services or other means to an inpatient mental health facility for a preliminary examination in accordance with Subchapters A and C, Chapter 573, Health and Safety Code.

§ 770. Care of Ward; Commitment

- (a) The guardian of an adult may expend funds of the guardianship as provided by court order to care for and maintain the incapacitated person. The guardian may apply for residential care and services provided by a public or private facility on behalf of an incapacitated person who has decision-making ability if the person agrees to be placed in the facility. The guardian shall report the condition of the person to the court at regular intervals at least annually, unless the court orders more frequent reports. If the person is receiving residential care in a public or private residential care facility, the guardian shall include in any report to the court a statement as to the necessity for continued care in the facility.
- (b) Except as provided by Subsection (c) or (d) of this section, a guardian may not voluntarily admit an incapacitated person to a public or private in-patient psychiatric facility or to a residential facility operated by the Texas Department of Mental Health and Mental Retardation for care and treatment. If care and treatment in a psychiatric or a residential facility are necessary, the person or the person's guardian may:
- (1) apply for services under Section 593.027 or 593.028, Health and Safety Code;
 - (2) apply to a court to commit the person under Subtitle D, Title 7, Health and Safety Code (Persons with Mental Retardation Act), Subtitle C, Title 7, Health and Safety Code (Texas Mental Health Code), or Chapter 462, Health and Safety Code; or

- (3) transport the ward to an inpatient mental health facility for a preliminary examination in accordance with Subchapters A and C, Chapter 573, Health and Safety Code.
- (c) A guardian of a person younger than 18 years of age may voluntarily admit the ward to a public or private inpatient psychiatric facility for care and treatment.
- (d) A guardian of a person may voluntarily admit an incapacitated person to a residential care facility for emergency care or respite care under Section 593.027 or 593.028, Health and Safety Code. (footnotes omitted).

§ 770A. Administration of Medication

- (a) In this section, “psychoactive medication” has the meaning assigned by Section 574.101, Health and Safety Code.
- (b) If a person under a protective custody order as provided by Subchapter B, Chapter 574, Health and Safety Code, is a ward who is not a minor, the guardian of the person of the ward may consent to the administration of psychoactive medication as prescribed by the ward’s treating physician regardless of the ward’s expressed preferences regarding treatment with psychoactive medication.

UTAH..... UTAH CODE ANN. § 75-5-312 (2004)

§ 75-5-312. General powers and duties of guardian -- Penalties.

- (1) A guardian of an incapacitated person has only the powers, rights, and duties respecting the ward granted in the order of appointment under Section 75-5-304.
- (2) Absent a specific limitation on the guardian’s power in the order of appointment, the guardian has the same powers, rights, and duties respecting the ward that a parent has respecting the parent’s unemancipated minor child except that a guardian is not liable to third persons for acts of the ward solely by reason of the parental relationship. In particular, and without qualifying the foregoing, a guardian has the following powers and duties, except as modified by order of the court:
 - (a) To the extent that it is consistent with the terms of any order by a court of competent jurisdiction relating to detention or commitment of the ward, the guardian is entitled to custody of the person of the ward and may establish the ward’s place of abode within or without this state.
 - (b) If entitled to custody of the ward the guardian shall provide for the care, comfort, and maintenance of the ward and, whenever appropriate, arrange for the ward’s training and education. . . .
 - (c) A guardian may give any consents or approvals that may be necessary to enable the ward to receive medical or other professional care, counsel, treatment, or service.

- (d) If no conservator for the estate of the ward has been appointed, the guardian may:
- (i) institute proceedings to compel any person under a duty to support the ward or to pay sums for the welfare of the ward to perform that duty; or
 - (ii) receive money and tangible property deliverable to the ward and apply the money and property for support, care, and education of the ward; but the guardian may not use funds from the ward's estate for room and board which the guardian, the guardian's spouse, parent, or child have furnished the ward unless a charge for the service is approved by order of the court made upon notice to at least one adult relative in the nearest degree of kinship to the ward in which there is an adult. The guardian must exercise care to conserve any excess for the ward's needs. . . .

VERMONT..... VT. STAT. ANN. tit. 14, § 3069 (Supp. 2012)

§ 3069. Powers of a guardian

- (a) If the court enters judgment pursuant to subsection 3068(f) of this title, it may appoint a guardian if it determines that the respondent is unable to manage, without the supervision of a guardian, any or all aspects of his or her personal care and financial affairs.
- (b) When the person under guardianship has an advance directive, the authority of the agent and the instructions contained therein shall remain in effect unless the probate division of the superior court expressly orders otherwise in a petition for review of the advance directive under 18 V.S.A. § 9718.
- (c) The court shall grant powers to the guardian in the least restrictive manner appropriate to the circumstances of the respondent and consistent with any advance directive. Guardianship powers shall be ordered only to the extent required by the respondent's actual mental and adaptive limitations. The court shall specify which of the following powers the guardian shall have and may further restrict each power so as to preserve the respondent's authority to make decisions commensurate with respondent's ability to do so:
 - (1) the power to exercise general supervision over the person under guardianship. This includes care, habilitation, education, and employment of the person under guardianship and choosing or changing the residence, subject to the requirements of sections 2691, 3073, and 3074 of this title;
 - (2) the power to seek, obtain, and give or withhold consent to the initiation or continuation of medical or dental treatment, subject to the provisions of section 3075 of this title and any constitutional right of the person under guardianship to refuse treatment, provided that the court in its discretion may place limitations on the guardian's powers under this subdivision if appropriate under the circumstances, including requiring prior court approval for specific surgeries, procedures, or treatments;

-
- (d) (1) When a guardian has been granted some but not all guardianship powers, the guardianship shall be identified as a “limited guardianship” and the guardian identified as a “limited guardian.”
- (2) A person for whom limited guardianship has been granted retains all the powers identified in subsection (c) of this section except those which have been specifically granted to the limited guardian.
- (e) The guardian shall exercise supervisory powers in a manner which is least restrictive of the personal freedom of the person under guardianship consistent with the need for supervision.
- (f) The guardian shall encourage the person under guardianship to participate in decisions, to act on his or her own behalf when practicable, and to develop or regain the capacity to manage his or her own personal affairs to the maximum extent possible. The wishes, values, beliefs, and preferences of the person under guardianship shall be respected to the greatest possible extent in the exercise of all guardianship powers.

VIRGINIA..... VA. CODE ANN. § 37.2-1020 (2011)

§ 37.2-1020. Duties and powers of guardian

- A. A guardian stands in a fiduciary relationship to the incapacitated person for whom he was appointed guardian and may be held personally liable for a breach of any fiduciary duty to the incapacitated person. . . .
- B. A guardian’s duties and authority shall not extend to decisions addressed in a valid advance directive or durable power of attorney previously executed by the incapacitated person. A guardian may seek court authorization to revoke, suspend, or otherwise modify a durable power of attorney, as provided by the Uniform Power of Attorney Act (§ 26-72 et seq.). Notwithstanding the provisions of the Health Care Decisions Act (§ 54.1-2981 et seq.) and in accordance with the procedures of § 37.2-1012, a guardian may seek court authorization to modify the designation of an agent under an advance directive, but the modification shall not in any way affect the incapacitated person’s directives concerning the provision or refusal of specific medical treatments or procedures.
- C. A guardian shall maintain sufficient contact with the incapacitated person to know of his capabilities, limitations, needs, and opportunities. The guardian shall visit the incapacitated person as often as necessary.
- D. A guardian shall be required to seek prior court authorization to change the incapacitated person’s residence to another state, to terminate or consent to a termination of the person’s parental rights, or to initiate a change in the person’s marital status.
- E. A guardian shall, to the extent feasible, encourage the incapacitated person to participate in decisions, to act on his own behalf, and to develop or regain the capacity to manage personal affairs. A guardian, in making decisions, shall

consider the expressed desires and personal values of the incapacitated person to the extent known and shall otherwise act in the incapacitated person's best interest and exercise reasonable care, diligence, and prudence.

WASHINGTON WASH. REV. CODE § 11.92.043 (2006)

§ 11.92.043 Additional duties.

It shall be the duty of the guardian or limited guardian of the person:

- (1) To file within three months after appointment a personal care plan for the incapacitated person which shall include (a) an assessment of the incapacitated person's physical, mental, and emotional needs and of such person's ability to perform or assist in activities of daily living, and (b) the guardian's specific plan for meeting the identified and emerging personal care needs of the incapacitated person.
- (2) To file annually or, where a guardian of the estate has been appointed, at the time an account is required to be filed under RCW 11.92.040, a report on the status of the incapacitated person, which shall include:
 -
 - (b) The services or programs which the incapacitated person receives;
 - (c) The medical status of the incapacitated person;
 - (d) The mental status of the incapacitated person;
 - (e) Changes in the functional abilities of the incapacitated person;
 - (f) Activities of the guardian for the period;
 - (g) Any recommended changes in the scope of the authority of the guardian;
 - (h) The identity of any professionals who have assisted the incapacitated person during the period;
- (3) To report to the court within thirty days any substantial change in the incapacitated person's condition, or any changes in residence of the incapacitated person.
- (4) Consistent with the powers granted by the court, to care for and maintain the incapacitated person in the setting least restrictive to the incapacitated person's freedom and appropriate to the incapacitated person's personal care needs, assert the incapacitated person's rights and best interests, and if the incapacitated person is a minor or where otherwise appropriate, to see that the incapacitated person receives appropriate training and education and that the incapacitated person has the opportunity to learn a trade, occupation, or profession.
- (5) Consistent with RCW 7.70.065, to provide timely, informed consent for health care of the incapacitated person, except in the case of a limited guardian where such power is not expressly provided for in the order of appointment or subsequent modifying order as provided in RCW 11.88.125 as now or hereafter amended, the standby guardian or standby limited guardian may provide timely, informed consent to necessary medical procedures if the guardian or limited guardian cannot be located within four hours after the need for such consent

arises. No guardian, limited guardian, or standby guardian may involuntarily commit for mental health treatment, observation, or evaluation an alleged incapacitated person who is unable or unwilling to give informed consent to such commitment unless the procedures for involuntary commitment set forth in chapter 71.05 or 72.23 RCW are followed. Nothing in this section shall be construed to allow a guardian, limited guardian, or standby guardian to consent to:

- (a) Therapy or other procedure which induces convulsion;
- (b) Surgery solely for the purpose of psychosurgery;
- (c) Other psychiatric or mental health procedures that restrict physical freedom of movement, or the rights set forth in RCW 71.05.370 [recodified as RCW 71.05.217]. A guardian, limited guardian, or standby guardian who believes these procedures are necessary for the proper care and maintenance of the incapacitated person shall petition the court for an order unless the court has previously approved the procedure within the past thirty days. The court may order the procedure only after an attorney is appointed in accordance with RCW 11.88.045 if no attorney has previously appeared, notice is given, and a hearing is held in accordance with RCW 11.88.040.

WEST VIRGINIA W. VA. CODE § 44A-3-1 (Supp. 2011)

§ 44A-3-1. Duties of guardian of protected person

- (a) The guardian of a protected person owes a fiduciary duty to the protected person and is responsible for obtaining provision for and making decisions with respect to the protected person's support, care, health, habilitation, education, therapeutic treatment, social interactions with friends and family, and, if not inconsistent with an order of commitment or custody, to determine the protected person's residence.
- (b) A guardian shall maintain sufficient contact of not less than once very six months with the protected person to know of the protected person's capabilities, limitations, needs, and opportunities.
- (c) A guardian shall be required to seek prior court authorization to change the protected person's residence to another state, to terminate or consent to a termination of the protected person's parental rights, to initiate a change in the protected person's marital status, to deviate from a protected person's living will or medical power of attorney, or to revoke or amend a durable power of attorney executed by the protected person.
- (d) A guardian shall exercise authority only to the extent necessitated by the protected person's limitations, and, where feasible, shall encourage the protected person to participate in decisions, to act on his or her own behalf, and to develop or regain the capacity to manage personal affairs.
- (e) A guardian shall, to the extent known, consider the express desires and personal values of the protected person when making decisions, and shall otherwise act

in the protected person's best interests and exercise reasonable care, diligence, and prudence.

- (f) Upon the petition of an interested party or upon its own motion, the court or Mental Hygiene Commissioner may order the guardian to take appropriate action to address the needs and best interests of the protected person as required by this section.

WISCONSIN

WIS. STAT. ANN. § 54.25 (Supp. 2009)

§ 54.25 Duties and powers of guardian of the person

- (1) Duties. A guardian of the person shall do all of the following:

- (a) Make an annual report on the condition of the ward to the court that ordered the guardianship and to the county department designated under s. 55.02(2). That county department shall develop reporting requirements for the guardian of the person. The report shall include the location of the ward, the health condition of the ward, any recommendations regarding the ward, and a statement as to whether or not the ward is living in the least restrictive environment consistent with the needs of the ward.
- (b) Endeavor to secure any necessary care or services for the ward that are in the ward's best interests, based on all of the following:
 1. Regular inspection, in person, of the ward's condition, surroundings, and treatment.
 2. Examination of the ward's patient health care records and treatment records and authorization for redisclosure as appropriate.
 3. Attendance and participation in staff meetings of any facility in which the ward resides or is a patient, if the meeting includes a discussion of the ward's treatment and care.
 4. Inquiry into the risks and benefits of, and alternatives to, treatment for the ward, particularly if drastic or restrictive treatment is proposed.
 5. Specific consultation with providers of health care and social services in making all necessary treatment decisions.

- (2) Powers.

- (a) Rights and powers of a guardian of the person. A guardian of the person has only those rights and powers that the guardian is specifically authorized to exercise by statute, rule, or court order. Any other right or power is retained by the ward, unless the ward has been declared incompetent to exercise the right under par. (c) or the power has been transferred to the guardian under par. (d).
- (b) Rights retained by individuals determined incompetent. An individual determined incompetent retains the power to exercise all of the following rights, without consent of the guardian:

....

3. To have access to and communicate privately with representatives of the protection and advocacy agency under s. 51.62 and the board on aging and long-term care.
4. To protest a residential placement made under s. 55.055, and to be discharged from a residential placement unless the individual is protectively placed under ch. 55 or the requirements of s. 55.135(1) are met.
5. To petition for court review of guardianship, protective services, protective placement, or commitment orders.
6. To give or withhold a consent reserved to the individual under ch. 51.
7. To exercise any other rights specifically reserved to the individual by statute or the constitutions of the state or the United States, including the rights to free speech, freedom of association, and the free exercise of religious expression.

(c) Declaration of incompetence to exercise certain rights.

1. The court may, as part of a proceeding under s. 54.44 in which an individual is found incompetent and a guardian is appointed, declare that the individual has incapacity to exercise one or more of the following rights:

....

- e. The right to consent to sterilization, if the court finds that the individual is incapable of understanding the nature, risk, and benefits of sterilization, after the nature, risk, and benefits have been presented in a form that the individual is most likely to understand.
- f. The right to consent to organ, tissue, or bone marrow donation.

....

2. Any finding under subd. 1. that an individual lacks evaluative capacity to exercise a right must be based on clear and convincing evidence. In the absence of such a finding, the right is retained by the individual.
3. If an individual is declared not competent to exercise a right under subd. 1. or 4., a guardian may not exercise the right or provide consent for exercise of the right on behalf of the individual. If the court finds with respect to a right listed under subd. 1. a., d., e., or f. that the individual is competent to exercise the right under some but not all circumstances, the court may order that the individual retains the right to exercise the right only with consent of the guardian of the person.

....

- (d) Guardian authority to exercise certain powers. 1. A court may authorize a guardian of the person to exercise all or part of any of the powers specified in subd. 2. only if it finds, by clear and convincing evidence, that the individual lacks evaluative capacity to exercise the power. The court shall

authorize the guardian of the person to exercise only those powers that are necessary to provide for the individual's personal needs, safety, and rights and to exercise the powers in a manner that is appropriate to the individual and that constitutes the least restrictive form of intervention. The court may limit the authority of the guardian of the person with respect to any power to allow the individual to retain power to make decisions about which the individual is able effectively to receive and evaluate information and communicate decisions. When a court appoints a guardian for a minor, the guardian shall be granted care, custody, and control of the person of the minor.

2. All of the following are powers subject to subd. 1.:

- ab. Except as provided under subd. 2. b., c., and d., and except for consent to psychiatric treatment and medication under ch. 51, and subject to any limitation under s. 54.46 (2) (b), the power to give an informed consent to the voluntary receipt by the guardian's ward of a medical examination, medication, including any appropriate psychotropic medication, and medical treatment that is in the ward's best interest, if the guardian has first made a good-faith attempt to discuss with the ward the voluntary receipt of the examination, medication, or treatment and if the ward does not protest. For purposes of this subd. 2. ab., "protest" means, with respect to the voluntary receipt of a medical examination, medication, including appropriate psychotropic medication, or medical treatment, make more than one discernible negative response, other than mere silence, to the offer of, recommendation for, or other proffering of voluntary receipt of the medical examination, medication, or medical treatment. "Protest" does not mean a discernible negative response to a proposed method of administration of the medical examination, medication, or medical treatment. In determining whether a medical examination, medication, or medical treatment is in the ward's best interest, the guardian shall consider the invasiveness of the medical examination, medication, or treatment and the likely benefits and side effects of the medical examination, medication, or treatment.
- ac. Except as provided under subd. 2. b., c., and d., and except for consent to psychiatric treatment and medication under ch. 51, and subject to any limitation under s. 54.46 (2)(b), the power to give informed consent, if in the ward's best interests, to the involuntary administration of a medical examination, medication

other than psychotropic medication, and medical treatment that is in the ward's best interest. A guardian may consent to the involuntary administration of psychotropic medication only under a court order under s. 55.14. In determining whether involuntary administration of a medical examination, medication other than psychotropic medication, or medical treatment is in the ward's best interest, the guardian shall consider the invasiveness of the medical examination, medication, or treatment and the likely benefits and side effects of the medical examination, medication, or treatment.

- b. Unless it can be shown by clear and convincing evidence that the ward would never have consented to research participation, the power to authorize the ward's participation in an accredited or certified research project if the research might help the ward; or if the research might not help the ward but might help others, and the research involves no more than minimal risk of harm to the ward.
- c. The power to authorize the ward's participation in research that might not help the ward but might help others even if the research involves greater than minimal risk of harm to the ward if the guardian can establish by clear and convincing evidence that the ward would have elected to participate in such research; and the proposed research was reviewed and approved by the research and human rights committee of the institution conducting the research. The committee shall have determined that the research complies with the principles of the statement on the use of human subjects for research adopted by the American Association on Mental Deficiency, and with the federal regulations for research involving human subjects for federally supported projects.
- d. Unless it can be shown by clear and convincing evidence that the ward would never have consented to any experimental treatment, the power to consent to experimental treatment if the court finds that the ward's mental or physical status presents a life-threatening condition; the proposed experimental treatment may be a life saving remedy; all other reasonable traditional alternatives have been exhausted; 2 examining physicians have recommended the treatment; and, in the court's judgment, the proposed experimental treatment is in the ward's best interests.
. . . .
- f. The power to give informed consent to release of confidential records other than court, treatment, and patient health care records and to redisclosure as appropriate.

-
- i. The power to choose providers of medical, social, and supported living services. . . .

WYOMING.....WYO. STAT. ANN. §§ 3-2-201 to -202 (2011)

§ 3-2-201. Powers and duties of guardian.

(a) The guardian shall:

- (i) Determine and facilitate the least restrictive and most appropriate and available residence for the ward;

....

- (iii) Subject to the restrictions of W.S. 3-2-202, authorize or expressly withhold authorization of medical or other professional care, treatment or advice;

....

(c) The guardian is not liable for injury to the ward resulting from the negligence or acts of third persons performed by authority given by the guardian for medical or other professional care, treatment or advice, unless it would have been negligent for a parent to have given that authority. . . .

§ 3-2-202. Powers of the guardian subject to approval of the court.

(a) Upon order of the court, after notice and hearing and appointment of a guardian ad litem, the guardian may:

- (i) Commit the ward to a mental health hospital or other mental health facility;

(ii) Consent to the following treatments for the ward:

- (A) Electroshock therapy;
- (B) Psychosurgery;
- (C) Sterilization;
- (D) Other long-term or permanent contraception.

....

- (iv) Execute any appropriate advance medical directives, including durable power of attorney for health care under W.S. 35-22-403(b) and an individual instruction under W.S. 35-22-403(a).