

Guardianship: A Review

Guardianship: A Medicolegal Review for Clinicians

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Kahli Zietlow MD,^{1,2} Leslie Dubin MSW,³ Alethia Battles JD, MSW,^{3,4} Caroline Vitale MD^{1,2}

¹Division of Geriatric and Palliative Medicine, Department of Internal Medicine, University of Michigan, Ann Arbor, MI.

²Geriatric Research Education and Clinical Center, VA Ann Arbor Healthcare System, Ann Arbor, MI.

³School of Social Work, University of Michigan, Ann Arbor, MI.

⁴Assistant General Counsel, Office of the Vice President and General Counsel, University of Michigan, Ann Arbor, MI.

Corresponding Author: Kahli Zietlow, 1500 E Medical Center Dr, Ann Arbor, MI 48109. Email: Kaheliza@med.umich.edu. Phone: 734-936-2519 Fax: 734-647-8535. Twitter: @KahliGoBlue.

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Key Points:

- Guardianship grants a legally appointed guardian broad powers over the incapacitated person (ward), resulting in significant loss of autonomy. It should be pursued as a mechanism of last resort after all other viable options for surrogate decision-making have been explored.
- Guardians should be encouraged to practice “substituted decision-making” based on their wards’ previously expressed values and preferences where possible, rather than paternalistic decision-making.
- There is a paucity of data regarding guardianship and its impact on patient care.

Why Does This Paper Matter?

Persons with dementia or other disabilities that impair rational thinking may lose their ability to participate in medical decision-making as the condition progresses, and often require a surrogate decision-maker. Guardianship is one option for incapacitated patients who do not have a previously designated power of attorney or another viable decision-maker. Guardianship is meant to serve as a mechanism of protection for vulnerable individuals. However, a guardian's power to engage in decision-making on behalf of the incapacitated individual (ward) is usually all-encompassing and a major threat to individual autonomy. Several high-profile cases have illustrated how guardianship may lead to exploitation and abuse. Furthermore, the guardianship process takes place outside of the clinical realm and in the probate court system, leading to uncertainty surrounding the process for many clinicians. As guardianship policies are regulated at the state level, practices vary widely, and there is no centralized database of guardians or wards to allow systematic study of how guardianship may impact an individual's care or quality of life. Most medical professionals receive little, if any, training on the topic of guardianship. This paper highlights both the strengths and limitations of guardianship, delineates the process of assigning a guardian, and summarizes viable alternatives to full guardianship. This paper fills an educational gap for clinicians and serves as a call to action to advocate for guardianship reform.

Abstract

Guardianship may pose an ethical dilemma for physicians, who must balance protecting vulnerable patients from potential safety concerns with respecting their autonomy. Older adults with dementia are particularly susceptible to loss of independence and ability to participate in medical-decision making. To have capacity for medical decision making, individuals must understand relevant information, appreciate their circumstances, demonstrate reasoning, and express a consistent choice free from coercion. Although capacity assessments are usually task-specific, geriatricians and other specialists may be asked to comment on capacity more globally. These determinations may be used to support a Petition for the Appointment of a Guardian of a Legally Incapacitated Adult, the legal process of pursuing guardianship in probate court. Assigned guardians may be known to the incapacitated individual (e.g., a family member or friend) or may be professional guardians with no prior relationship to the ward. Guardians are encouraged to use substituted decision-making, taking into account the ward's previously expressed values and preferences. Although a number of viable alternatives to guardianship exist, numerous systemic barriers may prevent these from being fully explored. The ongoing need for guardianship should be periodically revisited and reassessed. Data about guardians and wards is shockingly sparse, as there are no centralized databases. Laws and regulations for guardianships vary significantly between states. Physicians can serve as important allies and advocates for patients with cognitive impairment at risk of incapacity, can help preserve their autonomy for as long as possible, and ensure appropriate protections are in place if the patient does lose their decision-making ability.

Case Report

Mr. S is a 70-year-old male found down in a parking lot and brought to the emergency department. On arrival, he could state his name and the date, but was not oriented to location or situation. He appeared non-toxic but was confused and fatigued. His SpO₂ was 88% on room air and improved to 92% on 2L oxygen; other vital signs were stable. He had dry crackles on pulmonary exam; cardiac, abdominal, and neurologic exams were otherwise unremarkable. Chest X-ray demonstrated bilateral multifocal airspace opacities, and SARS-CoV-2 RT-PCR via nasopharyngeal swab returned positive.

His past medical history includes hypertension, polyarthritis, active alcohol and tobacco use, and opioid abuse disorder in remission, on methadone maintenance. Mr. S lived with his brother, was independent in all activities of daily living (ADLs), and reportedly independent in his instrumental activities of daily living (IADLs), however his brother provided significant support. Mr. S graduated high school and worked various odd jobs, but had not worked for the past several years. The patient lost his license 20 years ago due to a driving under the influence (DUI) charge, so his brother provided transportation. He received a monthly social security stipend, which was deposited into a bank account he and his brother could both access. His brother managed the household finances. The patient did not have a durable power of attorney (DPOA). When attempts were made to contact the patient's brother, the team discovered that his brother was hospitalized and critically ill with COVID-19 at another institution. The patient had an adult son who indicated that he was estranged from his father and declined to be involved.

The patient's clinical course was uncomplicated; he improved over one week with supportive measures. Unfortunately, the patient's brother passed away from complications of COVID-19. The patient's mental status improved, but his medical team noted several lapses in his judgement. He did not exhibit a strong grief response to the passing of his brother. He seemed fixated on getting out of the hospital, without much thought about his self-care or

financial arrangements. He was not forthcoming about his substance use and was evasive about intent to continue using. Occupational therapy performed a Montreal Cognitive Assessment (MoCA)¹ and the patient scored 13/30, with significant deficits in executive function, attention, and short-term memory.

Given concerns about the patient's limited social support and probable underlying cognitive impairment, social work made extensive efforts to identify other persons who could support Mr. S and assist with medical-decision making. Although several acquaintances were contacted, none were willing or able provide additional support. The primary team requested a geriatrics consult to further assess the patient's capacity for medical decision-making and ability to live independently.

Capacity Assessment

When the geriatrics team first met Mr. S, he understood that he was no longer receiving treatment for COVID-19 and was confused about the reason for his ongoing hospitalization. He was not delirious according to the confusion assessment method (CAM) criteria.² When asked, the patient could not state his past medical history. Although he was taking several medications, he could only name alprazolam. The patient correctly stated the amount of money deposited into his bank account monthly and had a mobile banking device on his smart phone that showed the balance in good standing. He had a single debit card tied to the account, and was not aware of any other accounts or debt. However, he did not know whether his brother owned or rented their shared residence, nor could he name their utility providers.

The geriatrician asked several questions related to judgement and home-safety, and found the quality of the patients' answers variable. Some examples:

Q: How will you run errands if you can't drive?

A: I can still drive. I borrow friends' cars. I lost my license because of a DUI...I just have to go to court to clear it all up. [The patient affirmed he lived within walking distance of his pharmacy, methadone clinic, and a grocery store].

Q: When did you lose your license?

A: About 20 years ago.

Q: Can you think of any risks or problems of driving without a license?

A: No, I can still drive, like I said, I just have to get the license thing cleared up.

Q: What would you do if you ran out of money?

A: It wouldn't happen. It's never happened before.

Q: What if something changed and you did run out of money?

A: I'd ask my friends to get me food until my next check...I could hunt. I'd be fine.

Q: What would you do if you were at home and smelled gas?

A: I'd turn off the gas.

Q: Anything else?

A: Call the utility company.

Q: What about if you smelled smoke?

A: I'd figure out where it's coming from.

Q: Anything else?

A: No.

After this initial assessment, the geriatrics team felt unable to make a definitive decision regarding capacity. Many of his answers showed a logical thought process, although he demonstrated deficits in judgement, as illustrated by his impression that he could re-instate his license with ease, despite having lost it more than 20 years ago. There were also concerns that he was unable to name his medications or past medical history (despite coaching from the assessors). During the course of the interview, the patient perseverated on wanting to discharge and abruptly ended the interview when he realized he would not go home that day.

Notably, the next day the patient did not remember meeting with geriatrics, despite a prolonged and highly emotional interview. The geriatrician again asked the patient to summarize his clinical course; he stated that he was admitted with COVID-19 but was “no longer sick.” Despite significant prompting, he again was unable to name his medical conditions or medications, nor was he able to identify any risks of returning home independently. Ultimately, the patients’ profound cognitive impairment, short-term memory deficits, and his inability to reason led geriatrics to determine that the patient lacked capacity to participate in discharge planning and recommend the hospital pursue temporary guardianship appointment.

Introduction

Assigning a guardian for incapacitated patients creates tension between principles of autonomy and protecting patients from harm. Recent high-profile cases, such as the conservatorship of popular culture icon Casey Kasem, have brought to light the potential for abuse of vulnerable wards. This tension is often augmented by knowledge deficits regarding the guardianship process. Following a determination of incapacity, if it is determined that a patient requires a surrogate decision maker, and the patient has not already assigned a DPOA, the process of guardianship is often entertained. This process is a legal one that takes place in probate courts, outside of the clinical sphere. Patients assigned a guardian may be lost to follow-up, particularly if they enter long-term care or move to be closer to their newly assigned guardians.

Alternatively, geriatricians may make capacity determinations as consultants during moments of crises, and thus have no longitudinal relationship with the patient, further miring the process in ambiguity.

Additionally, the majority of physicians receive little, if any, formal education about guardianship. Education on guardianship is not a required competency per the Accreditation Council for Graduate Medical Education (ACGME) in either family (FM) or internal medicine (IM), even though many such physicians care for patients under guardianship and/or participate

in capacity hearings. One small survey showed trainees in FM, IM, and emergency medicine demonstrated uncertainty and misconceptions regarding guardianship.³ Although the training requirements of some medical specialties, e.g., geriatric medicine and psychiatry, do require attaining knowledge about ethical and legal issues surrounding capacity assessments and surrogate decision-making, we are not aware of any published medical education curricula on guardianship.

Medical professionals need formal training on guardianship, including ways to mitigate the need for guardianship through advance care planning, alternatives to guardianship, and the process of revocation. Additionally, the process of guardianship itself is dynamic, and many legal and advocacy societies have recognized the need for reform. This article provides a review of the guardianship process relevant for clinicians and summarizes how providers can advocate for vulnerable wards.

Capacity Evaluations

Capacity for medical decision-making consists of four components; (1) understanding relevant information, (2) appreciation of one's circumstances, (3) ability to reason or manipulate information in a logical way, and (4) ability to express a choice that is consistent and free from coercion.⁴ There are a number of tools that can guide structured capacity determinations.^{5,6} Capacity can also be assessed via an informal patient-provider interview, so long as the provider is able to assess the patient across all four domains.

Capacity for medical-decision making is generally task-specific, e.g., to consent for an upcoming surgery. Capacity is dynamic; a patient may lack capacity at a given point in time due to delirium, psychosis, or another acute condition, but this should have no bearing on future capacity assessments. Furthermore, patients may lack capacity to make a complex decision,

but retain capacity to make more straight-forward decisions, such as assigning a durable power of attorney for healthcare (DPOA).

There is significant confusion regarding relevant terminology. Global incapacity has historically been called incompetence, but this term has fallen out of favor in both legal and clinical realms. In general, global incapacity, also called “legal incapacity” is a designation made within the court system, while clinical incapacity, as determined by clinicians, remains task-specific. However, physician evaluations are critical to determinations of legal incapacity. The American Bar Association and American Psychological Association Handbook provides greater detail on capacity assessments and relevant terminology. In particular, geriatricians, psychiatrists, and other specialists may be asked to evaluate a patient’s global capacity for medical-decision making. In such cases, the principles of domain-based capacity assessment still apply. Capacity assessments can be framed around next steps in care or a patient’s ability to live independently. These assessments should include input from a multidisciplinary team, including social workers and physical and occupational therapists, who can speak to ability to manage self-care and optimize support structures.⁷ The Making and Executing Decisions for Safe and Independent Living (MED-SAIL) provides a semi-structured interview that assesses patients’ ability to remain safely in their home.⁸ Additionally, specialized tools can assess patients’ abilities to perform individual tasks, such as managing medications or finances.^{9,10}

If a patient lacks capacity, all efforts should be made to correct reversible factors, such as addressing polypharmacy, treating contributing mood disorders, etc. Particularly in patients with cognitive impairment, use of supplementary educational tools such as memory or organizational aids may enhance decision-making.¹¹ Providers should determine which diagnoses are contributing to incapacity and whether these medical conditions are reasonably expected to improve or can be further optimized. If psychiatric disease is playing a role in

potential incapacity, it is essential that patients undergo evaluation by a psychiatrist and contributing disorders are evaluated and addressed.

Patients who lack capacity for medical-decision making may need a surrogate decision-maker, especially if clinical decisions at hand require patient input and consent. In high acuity, emergency situations in which it is not practical to contact next of kin, e.g., emergency surgery to stabilize an unresponsive trauma patient, physicians can generally act as surrogate decision-makers to provide stabilizing care, although providers should be familiar with their institution-specific policies. In a case of incapacity that is expected to improve within a relatively short time frame, e.g., delirium, it may be appropriate for the legal next of kin or another appropriate individual to serve as a temporary decision-maker, depending on hospital policy or state health-care decisions law.¹² However, in more protracted cases of incapacity, a more long term solution is usually needed. Previously authored advance directives (e.g. “living wills”) can provide clinicians guidance on the incapacitated individuals’ values and preferences, but are variably recognized across institutions and regions, and may not be specific enough to address the medical situation at hand. If the patient has designated a durable power of attorney for health care, it can be activated, which may or may not require a formal activation process, depending on state-specific laws. If the patient does not have a DPOA, then assignment of a guardian to serve as their medical-decision maker may be in the best interest of the patient, in the absence of alternatives to guardianship, which are described below.

Defining Guardianship

Guardianship is the legal process in which one individual takes over the decision-making for another when it has been determined that the individual in question lacks decision-making capacity. Full guardianship entails decision-making in the realms of legality, finances, and

healthcare. Conservatorship is sometimes used synonymously with guardianship, or more commonly refers to a guardian who exclusively oversees finances. Broadly, guardians are encouraged to utilize the principle of “substituted judgement,” or making decisions based on the individuals’ known preferences and values, rather than utilizing the more paternalistic model of making decisions in the “best-interest” of the patient, which may be at odds with previously expressed wishes.¹³ Ideally, a guardian is someone known to the individual, with whom they have a trusting relationship, such that the guardian can comfortably make decisions on their behalf. However, reality is often at odds with such idealized circumstances. Over 40% of the US population has never discussed their wishes for end of life care with loved ones,¹⁴ while only one third of adults have completed an advance directive.¹⁵ Thus, even guardians with close relationships to the incapacitated individual may not be familiar with their wishes. Additionally, familial conflict, secondary interests, and poor financial and health literacy may all negatively impact decision-making of both professional and non-professional guardians.

Appointing a Guardian

The legal standard for appointing a guardian is that there be clear and convincing evidence presented to a Probate Court that the individual in question is: (1) incapacitated and (2) that the appointment of a guardian is necessary as a means of providing continuing care and supervision of the individual. Anyone with concerns about an individual’s well-being may file a Petition for the Appointment of a Guardianship, which begins the process. The person who completes the Petition is called the Petitioner. Prior to filing, the Petitioner must identify and nominate a proposed guardian. Once guardianship is established, the individual becomes the ward of the appointed guardian. A guardian may be known to the ward (e.g., a friend or family member). If there is no acquaintance (e.g., family member, close friend) available or willing to

accept the appointment of guardian, or if a proposed guardian is deemed inappropriate by a judge, then an individual may be assigned a professional guardian.

The guardianship process often takes several weeks, as there are many steps, some of which have statutory requirements that allow days or weeks to complete. These steps include selecting the proper jurisdiction, nominating a potential guardian, filing the Petition, paying the filing fee, notifying all interested parties (including the proposed ward), assigning guardian ad litem (GAL), submitting the GAL report and recommendation, and conducting the hearing. A GAL is a person who protects the interests of the ward for the duration of the hearing. Any patient, regardless of their capacity, has the legal right to contest the Petition. If the individual indicates to the GAL that they do not desire a guardian, the Court must appoint an attorney for that individual and set a date for an evidentiary hearing. Guardianship hearings are heard in probate courts, which generally have jurisdiction over a single county. Thus, there may be differences in how guardianship cases are approached not just state by state, but across individual counties. Judges and individuals serving as GAL also introduce subjectivity, as they are influenced by their own expertise, approach, and biases.

Treating physicians may be asked to provide documentation in support of the Petition. Such documentation provides objective evidence by a trained medical professional about the individual's capacity. A sample letter advocating for guardianship is included in the supplemental materials. Clinicians who provide letters of support may be later called upon to provide testimony at evidentiary hearings.

A temporary guardianship request may be granted and heard by the Court in instances of urgent medical decisions that need to be made when there is no suitable decision-maker available to provide informed consent. In these rare instances, the Court may relax some statutory provisions outlined above and appoint a temporary guardian with specific authority to address the urgent decision at hand. The law requires a full hearing at a later date (typically

within 30-60 days), although laws do vary from state to state. As of 2014, Maryland, Mississippi, and Virginia do not have statutes regarding temporary guardianship.¹⁶ The term “temporary guardian” is sometimes used interchangeably with “emergency guardian.”

Limitations of Guardianship

Guardianship is regulated at the state level, so there is significant variation in the laws, regulation, and scope of guardianship among states.¹⁷ Guardianship processes often also vary among counties within each state. Guardians may lack authority to make certain medical decisions. For instance, many states do not allow guardians to change a patient’s code status to “do not attempt resuscitation” or consent to the withdrawal of life-sustaining treatments without a court order, unless in line with previously documented advanced directives.¹⁸ Requirements and minimum standards for guardians are also widely variable. As of 2020, only 9 states require prospective guardians to submit a credit report, and 2 states (Arkansas and Louisiana) do not require background checks on prospective guardians.¹⁹

Educational requirements for guardians are also inconsistent. The national guardianship association (NGA) is an advocacy group that allies with and endorses the Center for Guardianship Certification (CGC) to establish standardized educational content and certification of guardians. However, only ten states currently require guardians to complete the CGC, while an additional four states require state-sponsored training (<https://guardianshipcert.org/>). Although guardians are often asked to serve as fiduciary, healthcare advocate, and property manager, among other roles, they may have minimal or no training to support them.

The state-specific nature of guardianship significantly impedes data collection and interpretation of current practices. There is no centralized database capturing the number of guardians, individuals under guardianship, or data about the profession, experience, education,

or other descriptors of existing guardians. Many states do not maintain databases of active guardianship cases. In 2011, the National Center for State Courts estimated 1.5 million individuals were under guardianship, but due to scant data, the number could be anywhere between 1 and 3 million.²⁰

Given the lack of centralized data, little is known about how guardianship impacts care. One retrospective study examined outcomes in end-of-life care in veterans with dementia with and without guardians, demonstrating similar rates of ICU admissions and other life-sustaining measures.²¹ While the results are reassuring that end-of-life care did not significantly differ for veterans with and without guardians, one limitation is that there was high utilization of aggressive care at the end of life in both groups. In 2018, the bipartisan US Senate Special Committee on Aging recognized and advocated for enhanced, centralized data collection during a special session on guardianship reform.²²

Alternatives to Guardianship

In assigning an incapacitated individual a guardian, the individual loses the right to dictate virtually all aspects of their lives, including where to live, whether to marry, and even simple everyday decisions about household purchases or maintenance healthcare. The loss of autonomy can be all-encompassing, and the potential for exploitation is real. Pursuing guardianship for patients who lack capacity for medical-decision making should be considered a mechanism of last resort.

A number of viable alternatives to full guardianship exist and are summarized in **Table 1**. While most state policies advocate for alternatives to full guardianship, pursuing such measures can be cumbersome and may require mobilization of support, navigating familial conflicts, or incorporating protections that lack the full force of the law, leaving individuals vulnerable to

exploitation.¹³ Thus, full guardianship may in reality be pursued before all other reasonable options have been exhausted. Additionally, certain system policies and practices may unwittingly steer healthcare teams towards guardianship. For example, post-acute and longterm care facilities may decide not to accept patients without a legally appointed decision-maker, creating pressure to assign a guardian in equivocal cases. Furthermore, there is almost no data describing how often or under which circumstances full guardianship versus alternatives are pursued. While clinicians are not expected to make such determinations, being aware of alternatives allows clinicians to provide education, engage proactively in advance care planning discussions, and serve as advocates for patients with cognitive impairment or other disabilities who are vulnerable to loss of capacity.

Oversight and Reversal of Guardianship

Unlike psychiatric disease or oversight of a minor, many older adults are assigned guardianship due to dementia, which is almost always progressive and non-reversible. However, exceptions exist. Older adults may have cognitive impairment or disability from reversible factors, such as delirium, acute illness, or substance use. Even adults with mild dementia may modestly improve if confounding factors are addressed and optimized. Thus, it is essential that the need for ongoing guardianship is periodically revisited. Clinicians should also advocate for wards to live in the least restrictive environment possible. This may mean re-evaluating the need for continued nursing home care for those wards who are initially placed in long term care but show improvement once their care has been optimized.

Revocation of guardianship is a legal process that is similar to assigning a guardian, and requires the filing of a petition and subsequent hearing in the probate court. As with other aspects of guardianship, requirements to review the ongoing necessity of guardianship are

variable and at times incompletely followed. There are state-specific statutes regarding the oversight of guardianship. Generally, guardians are required to submit periodic written updates (typically annual reports) that are monitored by the probate court that appointed the guardian.²³

In practice, the data suggests that re-evaluation of the need for guardianship is rarely done.²⁴

Incapacitated older adults may have limited means to advocate for themselves, contact an attorney, and/or access funds to mobilize new court proceedings.²⁵ Physicians providing care for older adults under guardianship can support these individuals by periodically reassessing cognition and capacity for medical-decision-making. If the clinician feels that the ward may no longer require guardianship, they can reach out to the guardian to initiate a discussion.

Alternatively, they can place a referral to social work, who can help the ward communicate with the probate court or provide information about local legal resources. **Table 2** provides examples of some local and national legal resources available for vulnerable older adults.

A Path Forward

Figure 1 summarizes how physicians can partner with guardians to create therapeutic alliances, while providing wards person-centered care. When caring for incapacitated wards, clinicians should understand the diagnosis and rationale that led to a determination of incapacity, and evaluate whether contributing medical conditions are being appropriately managed. As with all older adults, it is appropriate to periodically assess cognition, and it may be appropriate to reassess capacity for medical-decision making, particularly if patients have experienced interval improvements in cognition or undergone significant changes to their clinical status (e.g., moving to a facility, weaning off problematic medications).

Clinicians should seek to form a relationship with the guardian of the ward and facilitate bidirectional communication. This may be particularly important in the cases of professional

guardians not previously known to their wards. To the extent possible, both the clinician and guardian should seek to involve the ward in shared clinical decision making and honor the principle of substituted judgement, to ensure that care aligns with the patient's previously expressed wishes and values. Although guardianship is meant to serve as a means of protection, cases of abuse and exploitation do unfortunately happen. Nearly half of patients with dementia experience some form of elder abuse.²⁶ Those under guardianship are not immune, and clinicians should continue to perform periodic screening for elder abuse and exploitation. If concern for elder abuse arises, a referral to Adult Protective Services (APS) is appropriate. Healthcare providers are mandated reporters of suspected abuse of vulnerable adults in 49 states, excluding Pennsylvania.²⁷

Understanding the state-specific roles and limitations of guardians can improve the relationship between physicians and guardians, which is in the best interest of patients. Furthermore, by understanding viable alternatives, including engaging in proactive advance care planning in patients with mild cognitive impairment or mild dementia, physicians can educate and advocate for patients and families and possibly mitigate the need for future guardianship.

In addition to providing excellent care on an individual provider level, health professional students and trainees should receive education regarding guardianship and alternatives. Physicians can also advocate for much needed guardianship reform, including centralized databases to allow us to study and understand guardianship at the level of both the guardian and wards. The data is so sparse and poorly centralized that we cannot even confidently state how many guardianship cases are open in the United States! Physicians can serve as important allies and advocates for patients with cognitive impairment at risk of incapacity, to help preserve their autonomy for as long as possible, and ensure appropriate protections are in place if the patient does lose decision-making abilities.

Case Resolution

Mr. S was assigned a temporary guardian, who helped facilitate transfer to subacute rehabilitation at a skilled nursing facility after his admission. His guardian then arranged transfer to a group home. During this time, he re-established care with a primary care physician and was weaned off his benzodiazepines. His other chronic health conditions were also addressed and he remained abstinent from alcohol. Thirty days after his temporary guardianship was assigned, he underwent a hearing for appointment of a full (permanent) guardian. The judge appointed a guardian, but recommended reassessment in 6 months. At that time, his MoCA score had improved to 22/30. At the 6-month review hearing, the court determined that he no longer required full guardianship, but that he would benefit from supported decision makers to help him manage his affairs. Two of the patient's friends were willing to assist. Now abstinent from alcohol, Mr. S reopened a relationship with his estranged son, who eventually became his father's DPOA for healthcare and finances. Mr. S elected to remain in the group home for ongoing social support.

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Figure Legends

Figure 1. A synopsis of how physicians can ally with guardians to form therapeutic alliances to promote patient-centered care for incapacitated individuals. Physicians can also advocate for individuals under guardianship by periodically reassessing the patient's cognition and capacity, while also screening at regular intervals for elder abuse.

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	Description	Potential Drawbacks
Advance Directives	Documents such as a living will or Portable Medical Orders (POLST). Written by individuals to provide guidance on their future care preferences. Health care providers or surrogate decision makers may use these documents as a reflection of one's previously stated wishes.	<ul style="list-style-type: none"> • May require witness signatures and/or notarization in some states. • Variable content included; may be insufficient for specific medical decisions that arise. • Forms are variably recognized and honored geographically and across healthcare systems.
Supported Decision Making	Identifying and mobilizing trusted friends and family members who can help individuals with dementia or other disabilities make decisions. The individual retains decisional capacity.	<ul style="list-style-type: none"> • Potential for undue influence of support person(s). • Lack of formal legal recognition of the support person(s).
Durable* Medical Power of Attorney**	While a person maintains decision making abilities, they appoint a surrogate decision maker to make medical decisions at a point of future incapacity. (Also called "health care proxy" in some states).	<ul style="list-style-type: none"> • Requires witness signatures and/or notarization in some states. • Requires written physician activation in certain states. • Revokable by the individual at any time they have decisional capacity. • Can be overridden if the named POA is unavailable, unwilling to serve, or not acting in incapacitated individual's best interest.
Mediation	Private process in which an objective third party arbitrates disputes. In the context of potential guardianship, can be used to define roles, assign healthcare proxies, and/or identify less restrictive options.	<ul style="list-style-type: none"> • Not available or legally recognized in all fifty states. • May be impractical in the case of interfamilial conflict.
Limited (Partial) Guardianship	Guardianship is granted only over the domains for which the individual lacks capacity for rational decision making, (e.g., finances, properties, place of residence). The individual otherwise retains the right to make decisions and manage affairs on their own behalf.	<ul style="list-style-type: none"> • Requires nuanced evaluation by expert assessor to demonstrate domain-specific capacity assessments. • Loss of patient autonomy in relevant domains.
Temporary Guardianship	Guardianship is granted for the identified domains for which the individual lacks capacity for rational decision making but is time-limited due to the possibility their condition could improve (e.g., prolonged delirium, post-stroke).	<ul style="list-style-type: none"> • Loss of patient autonomy. • Requires serial court appearances to reassess ongoing need for guardianship.

Table 1. Alternatives to Full Guardianship

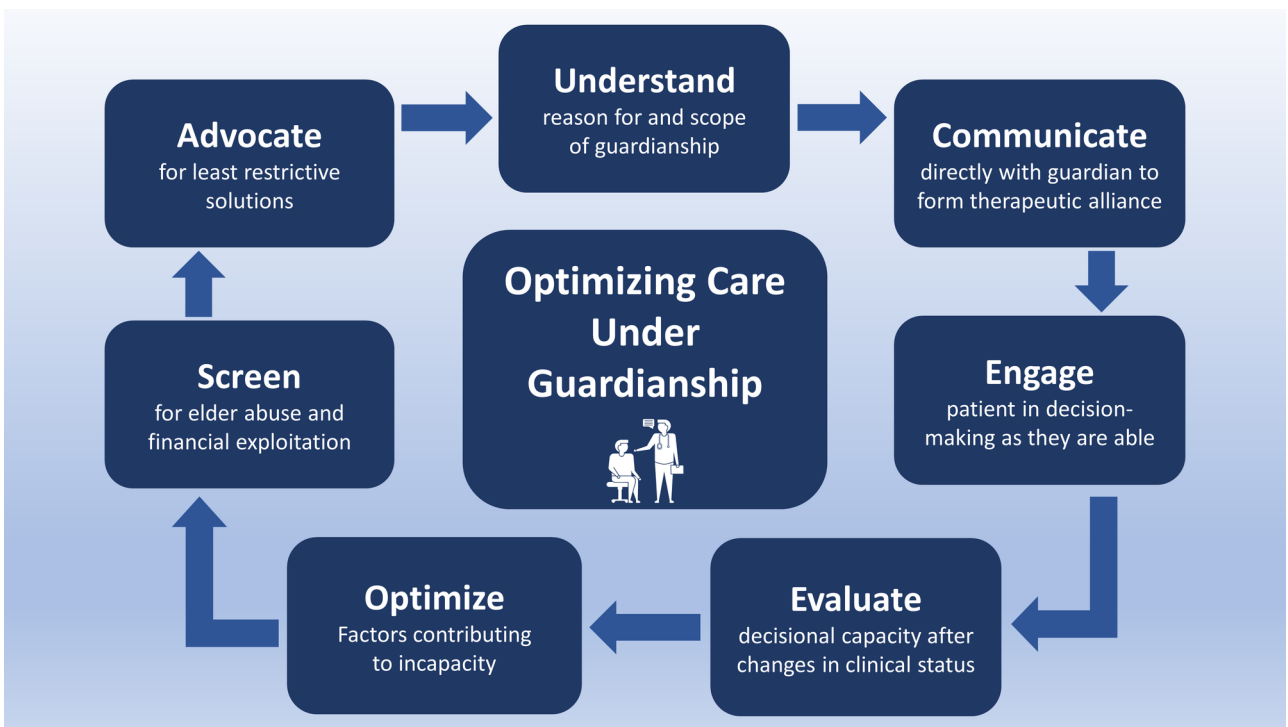
*A Durable Power of Attorney allows the agent to assume their role as soon as the document is activated. A Springing Power of Attorney is inactive until certain conditions are met (e.g., once the patient becomes incapacitated).

**A Financial Power of Attorney is similar, but refers specifically to financial matters. A General Power of Attorney grants broad powers to the assigned agent, encompassing financial, medical, and legal decisions.

Guardianship: A Review

Resource	Description	Website
Adult Protective Services	Agency that investigates allegations of abuse, exploitation, or neglect (including self-neglect), regulated at the state-level.	https://www.napsa-now.org/
American Bar Association	A voluntary association of lawyers that provides free referrals to attorneys and houses a compendium on low-cost resources for older adults.	https://www.americanbar.org
Area Agency on Aging	Federally-funded agencies, regulated at the county level, committed to helping older adults remain in the community. AAA may be able to provide referrals to local legal resources.	https://www.usaging.org/
Center for At-Risk Elders	A non-profit legal center providing compassionate guardianship services for vulnerable older adults, serving Indiana.	https://indianacare.org
Medical Legal Partnerships	An integrated healthcare model in which lawyer expertise is available to patients of the clinic. This is a novel but growing care model.	https://medical-legalpartnership.org
Michigan's Elder Justice Initiative	An advocacy and educational organization to empower and protect low income, vulnerable older adults. Serving Michigan.	https://meji.org/
Ursuline Support Services	A non-profit legal and advocacy center, provides guardianship services for vulnerable older adults, serving Southwestern Pennsylvania.	http://ursulinesupportservices.org

Table 2. Examples of national and local resources providing legal-aid and advocacy for at-risk older adults



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