LEGACY ETHICS EDUCATION RESOURCE

This Guardianship Ethics Curriculum is a legacy, case-based educational resource developed through a 2006 collaborative project involving the Florida State Guardianship Association (FSGA), the Florida Bioethics Network (FBN), the University of Miami Ethics Programs, and the Institute for Bioethics and Health Policy (IBHP), with original grant support to FSGA from the Statewide Public Guardianship Office.

The curriculum is being made available as part of IBHP's stewardship of legacy educational resources and to support continued engagement around guardianship ethics education. It remains valuable for ethics discussion and teaching and should be read in light of developments in guardianship law, ethics, and practice since it was first developed.

For questions about reuse, reposting, modification, or incorporation into other resources, please contact IBHP.

IBHP gratefully acknowledges the longstanding contributions of FSGA, FBN, and other partners to guardianship ethics education.

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Guardianship and Ethics

Few professions raise issues as interesting, complex and ethically challenging as guardianship. The task of making major decisions for others – often with no or only the slenderest threads of information – can be daunting. Yet in an aging and increasingly disconnected society, the number of people requiring the services of guardians is increasing. It should be uncontroversial to regard people who have been determined to be incompetent as vulnerable. Indeed, wards are arguably as vulnerable as individuals in any group.

Moreover, given the high stakes of many guardianship decisions, and in light of the challenging ethical questions they pose, it is not a little surprising there are so few resources to guide guardians when they must address these questions. This is unfortunate in light of the increasing number of guardianship cases that make their way to institutional ethics committees ... and because there are vastly many more cases for which there is no ethics committee to turn to.

For these reasons, the Florida Guardianship Ethics Project has been created as a collaboration among the Florida Bioethics Network, the Florida State Guardianship Association and the University of Miami Ethics Programs. The project has three overarching goals:

- Design of an ethics curriculum for guardians, lawyers, family members, judges and others.
- Establishment of a statewide guardianship ethics consultation service.
- Fostering a mechanism to review and create institutional and other policies related to guardianship and surrogate decision making.

This document represents a first approximation of one component of the first goal. Ethics curricula in the health and other professions have for decades thrived and relied on case studies to illustrate issues, identify best practices and suggest ethically optimized solutions in challenging cases.

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Hence, *Case Studies in Ethics and Guardianship* constitutes an initial effort to provide preliminary curricular tools. The document should be regarded as a work in progress. Curriculum components are available on the menu bar at left.

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NOTES

All cases in this collection are actual and bona fide; that is, no cases have been invented. Names and initials of individuals are used only when the designations are in the public record; in other cases, if a name is used it is fictitious to protect privacy.

While cases included here come from around the country, the material in this document/Website was prepared in Florida and is therefore to some extent shaped by Florida law. Users in other states should not assume that terms (e.g., "proxy" and "surrogate") are used the same or have the same meaning in all states and jurisdictions.

While many of the cases and comments involve legal as well as ethical issues, nothing in this document should be understood to be providing or suggesting legal advice. Those with legal issues or questions should seek competent legal counsel.

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The cases and questions for discussion are intended to be pedagogic tools and not vehicles for expressing opinions or advancing any particular view. Nevertheless, any views that might be inferred from the material herein should be attributed exclusively to the authors and not to the Statewide Public Guardianship Office, the Florida State Guardianship Association, the University of Miami or St. Thomas University.

This effort was supported by a grant in 2006 to the Florida State Guardianship Association from the Statewide Public Guardianship Office in Florida's Department of Elder Affairs, under the good offices of Michelle R. Hollister, Esq., Executive Director.

Comments, questions and suggestions, including suggestions for additional cases, may be sent to the University of Miami Ethics Programs at ethics@miami.edu (mailto:ethics@miami.edu).

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Module 1 - Medicine

Case Studies:

A. End-of-life Care

- Deciding for an Infant
- A Never-Competent Adult
- The Terri Schiavo Case
- Removal of Life-Sustaining Treatment

B. Amputation

- Authority to Amputate

C. Reproductive Issues

- Abortion Ordered for Rape Victim
- Guardian for a Fetus
- Mother Seeks Sterilization of Son
- Sterilization of the Disabled
- Brain Dead and Pregnant

A. End-of-life Care

Deciding for an Infant

Baby Boy W. was born after an emergency Cesarean section was performed on his mother, who died of a seizure just before the procedure.

Severe encephalopathy, or a diffuse disease of the brain, left him with mental retardation. After one month, he had non-reactive pupils, no gag reflex, could not swallow and was posturing with pain and gasping respirations of 5-13 breaths per minute. He was on a ventilator and had a feeding tube.

The boy's maternal grandmother petitioned the court for the appointment of a temporary guardian with authority to make medical decisions. His deceased mother's husband denied paternity and a default was entered against him in the guardianship proceeding as a result of his failure to respond to a court citation. The grandmother is seeking appointment as guardian and permission to withdraw the artificial life support.

The undisputed testimony of two physicians, one of whom was the director of the neonatal intensive care unit at the hospital for 15 years, revealed that Baby Boy W.'s condition was terminal and irreversible, and that the treatment being provided was an extraordinary burden to the baby. One of the physicians further testified that the treatments to keep the baby alive were painful.

The petitioner, a registered nurse who had worked in hospitals' obstetrics-gynecology and pediatrics units, also gave undisputed testimony that, based upon her observations and experience, the baby was suffering. What was in the baby's best interest? "I love him enough to let him go," the nurse told the court.

The report of the court-appointed guardian ad litem recommended the immediate appointment of the petitioner as temporary guardian with full powers that would be granted to a permanent guardian, including the authority to withhold or withdraw life sustaining treatment.

The court granted the petition and appointed the grandmother as temporary guardian, with powers to make health care decisions, including withholding or withdrawal of life sustaining treatment. The boy died not too long afterward.

Source

- *Matter of Baby Boy W.* (https://www.leagle.com/decision/20046593misc3d6561573), 773 N.Y.S.2d 255 (N.Y. Misc. 2004).

Questions for Discussion

1. Is the "best interest" standard appropriate when, in the case of an infant, person with mental retardation or person who never had capacity, substituted judgment cannot be achieved?

2. Would a "reasonable person" standard be more appropriate under the circumstances? Why? Does it make sense to apply a "reasonableness" standard to infants?

3. What steps should guardians take to try to ensure that wards are not in pain? More broadly, what are standards for pain management and palliative care?

A Never-Competent Adult

John Storar was a 52-year-old man with profound mental retardation who was also suffering from irreversible bladder cancer. The cancer had spread to his lungs and perhaps other organs. The cancer was reckoned to be untreatable, but Mr. Storar was being given blood transfusions to manage a related loss of blood.

Mr. Storar had never been competent; he had the mental capacity of an infant. The hospital in which he was being cared for refused to administer treatment without the consent of a legal guardian, so Mr. Storar's mother, his closest relative, applied for and was appointed guardian over his person and property. The guardian initially consented to the blood transfusions.

Mr. Storar had received the transfusions for some time, but was expressing resistance to the treatment. His guardian instructed the hospital to discontinue the treatment. The hospital refused to follow the guardian's instructions and, instead, petitioned the court for authority to continue the transfusions, claiming that without them death would occur within weeks. With treatment, the hospital said, Mr. Storar's life-span was estimated to be between three and six months.

The trial court denied the hospital's petition and an appellate court affirmed that decision. On a second appeal, however, to the New York Court of Appeals, the court reversed these decisions. Mr. Storar continued to receive treatment while the appeals were pending, but he died before the New York Court of Appeals' decision was issued.

Source

- *Matter of Storar* *(https://www.casebriefs.com/blog/law/health-law/health-law-keyed-to-furrow/life-and-death-decisions/in-re-storar/)* , 420 N.E.2d 64 (N.Y. 1981).

Questions for Discussion

1. If a person has never been competent, he cannot be said to have had his own wishes or preferences. If that is the case, under what circumstances is it ethical to withdraw or remove treatment? Substituted judgment does not apply, leaving the best interests and reasonable person standards to carry the burden. Explain why either standard can be used to support the withdrawal or withholding of medical treatment.

2. Compare Storar to Baby Boy W. Should it make a difference that Storar was a 52-year-old man whereas Baby Boy W. was one-month old?

3. What resources does a guardian have when confronted with decisions in unfamiliar or difficult ethical cases? Hint: Hospitals and nursing homes are supposed to have committees to help.

The Terri Schiavo Case

In February 1990, at age 27, Theresa Marie Schiavo suffered a cardiac arrest, apparently as a result of a potassium imbalance. She was not resuscitated in time to prevent devastating brain damage, and she was eventually diagnosed as being in a permanent vegetative state.

For more than 10 years after the heart attack, Ms. Schiavo lived in nursing homes, receiving constant care. She received nutrition and hydration by way of a percutaneous endoscopic gastrostomy (PEG) tube to provide nutrition and hydration. During that 10-year period, Ms. Schiavo's brain further deteriorated. Within six years of the heart attack, CT scans of her brain showed a severely abnormal structure, with much of her cerebral cortex destroyed and replaced by cerebrospinal fluid.

This meant that Ms. Schiavo could never be cured by medical treatment. She would never be able to see, hear, feel or communicate anything.

Ms. Schiavo's husband and court-appointed guardian, Michael Schiavo, continued to care for and visit her. He never divorced her and he became a physical therapist working in a local hospital. As guardian, friends said, he always attempted to provide optimum treatment for her, and zealously advocated for her care. Theresa's parents, Robert and Mary Schindler also visited her often, and were strong advocates for her care. Mr. Schiavo's detractors alleged he was not caring at all, and made much of a subsequent romantic relationship with another woman.

A lawsuit for medical malpractice had been filed on her behalf shortly after her heart attack. That lawsuit ultimately resulted in a significant award of money.

In May 1998, after Mr. Schiavo and the Schindlers could not agree on whether to withdraw the PEG tube and because the inheritance issue created the appearance of conflict, Mr. Schiavo petitioned the court for an order authorizing the withdrawal of artificial hydration and nutrition; by this means, the court would serve as the surrogate decision-maker rather than him. The Schindlers opposed the petition. The trial court found, by clear and convincing evidence, that Ms. Schiavo was in a persistent vegetative state and that she would not want to continue to be sustained by artificial life support under the circumstances. The court granted the petition. An appellate court, finding sufficient evidence in the record to support the trial court's findings, affirmed the trial court's decision.

Extraordinary and probably unprecedented series of executive orders, state and federal appeals and legislation – and protests – continued until March 2005. The PEG tube was withdrawn on March 18, and Ms. Schiavo died on March 31.

Source

- Cerminara KL, Goodman KW. *Key events in the case of Theresa Marie Schiavo* (https://bioethics.miami.edu/clinical-and-research-ethics/terri-schiavo-project/timeline-of-key-events/part-1/index.html) ; and several of the references linked to therein, especially:
- *In re Guardianship of Theresa Maria Schiavo* (https://www.floridasupremecourt.org/content/download/363273/3167029/03-1242_JurisAns.pdf) , 780 So.2d 176 (Fla. 2d DCA 2001).

Questions for Discussion

1. The Schiavo case is arguably the most interesting – and perhaps the most important – guardianship case ever. Distinctively, the guardian in this case was a spouse who had a falling out with his ward's parents. What could have been done to prevent (or reduce the possibility of) the collapse of this relationship?

2. In addition to a spouse as court-appointed guardian, two guardians ad litem were appointed at various points. Read their reports at the online resource cited above. What do they say, if anything, that bears on questions of substituted judgment or best interests.

3. Several courts accepted and ruled based on Michael Schiavo's reports that Ms. Schiavo would not want to remain on artificial hydration and nutrition. But in the absence of a written advance directive, it can be difficult indeed to determine a ward's end-of-life preferences. In the absence of any explicit evidence of a ward's preferences, what should guardians recommend when faced with a permanent vegetative state? Would any reasonable person really want to perpetuate such a state? If not, can a reasonable person standard be of use?

Removal of Life-Sustaining Treatment

Michael Martin suffered extensive injuries, including a severe head injury, in an automobile accident. He was unable to walk or talk, and had a gastrotomy tube to provide artificial hydration and nutrition. His wife was appointed his legal guardian. She was unsure whether to continue the treatment, and sought advice from a hospital ethics committee, which said both that withdrawal of the nutrition support was medically and ethically appropriate and that a court order was needed to effect the withdrawal.

The guardian petitioned a probate court seeking approval to terminate the treatment, but Mr. Martin's mother and sister objected, requesting that Ms. Martin be removed as guardian. During subsequent legal proceedings, it was reported that before his accident, Mr. Martin had expressed the opinion that he would not want to "be dependent on people and machines."

The trial court determined that there was clear and convincing evidence that, before his injuries, the ward expressed a medical preference to decline life-sustaining medical treatment under the circumstances, and the appellate court affirmed. The case eventually reached the Michigan Supreme Court, which considered whether life-sustaining treatment in the form of a gastrostomy tube that provides nutritive support should be removed from a conscious ward who is not terminally ill or in a persistent vegetative state, but who suffers from a mixture of cognitive functions and communication impairments that make it impossible to evaluate the extent of his cognitive deficits.

The Michigan Supreme Court reversed, concluding that there was *not* clear and convincing proof that the ward "made a firm and deliberate decision, while competent, to decline medical treatment in these circumstances." The court noted:

As we begin our analysis, we are mindful that the paramount goal of our decision is to honor, respect, and fulfill the decisions of the patient, regardless of whether the patient is currently competent. The decision to accept or reject life-sustaining treatment has no equal. We enter this arena humbly acknowledging that neither law, medicine nor philosophy can provide a wholly satisfactory answer to this question.

Source

- (https://pdfs.semanticscholar.org/7afa/ac04b907924afa1a4727fbf92b126dd77d44.pdf)
  In re Michael Martin (https://heinonline.org/HOL/LandingPage?handle=hein.journals/ilmed12&div=35&id=&page=), 538 N.W.2d 399 (Mich. 1995).

Questions for Discussion

1. How should guardians interpret and present evidence of a ward's past values regarding future incapacity?

2. The Michigan Supreme Court wrote "...we must err in preserving life." While this sounds reasonable enough, what exactly does it mean? Is it really always better to prolong life, or might it be morally permissible to err, say, in "preserving dignity and freedom," or "honoring shared or basic values" ...?

3. Why do you think the hospital's ethics committee wanted a court order to support its findings? What could a court add to the committee's deliberations?

B. Amputation

Authority to Amputate

Bob Warren, a 78-year-old diabetic, collapsed on the street. He was taken by ambulance to a VA Hospital over his wife's objections, but with the approval of the physician. Mr. Warren was diagnosed as having had "dry" gangrene in his right foot for more than a month. Dry gangrene may lead to "wet" gangrene which involves infected, dead, non-viable tissue and has harmful effects on the cardiovascular and nervous systems. It can make diabetes medically uncontrollable. Warren's condition developed into "wet" gangrene in two of the toes on his right foot. Moreover, Mr. Warren's mental condition had deteriorated, and he was semi-conscious and unable to communicate.

Mr. Warren therefore lacked capacity to consent to or refuse medical treatment. Accordingly, the hospital staff advised Warren's wife that amputation of Warren's right foot to remove the infection was needed to improve his condition. Mrs. Warren, however, refused to consent to the amputation.

Mr. Warren's condition deteriorated, and he was admitted to the ICU. He was put on a ventilator, given a pulmonary artery catheter, received a radial arterial IV, underwent a stomach decompression and was administered broad-spectrum antibiotics.

The hospital notified Ms. Warren about her husband's worsening condition, and again requested her consent for the amputation because without it her husband's death was imminent. She again refused to consent to the amputation. Thereafter, hospital authorities asked the United States Attorney to apply for a court order appointing a hospital administrator as guardian for Mr. Warren to consent to the surgical procedure to amputate his foot. Over Ms. Warren's objection, the court appointed the hospital administrator as guardian for the limited purpose of consenting to surgery and any related treatment.

Trial testimony revealed that without surgery, Warren's vital organs would continue to fail and he would certainly die. Surgery would give Mr. Warren a chance to survive; delaying the surgery would reduce that chance.

Mr. Warren's wife was a registered nurse who had worked at Harlem Hospital for 30 years. She had been caring for her husband at home. She refused to consent to the amputation because, she said, the physician interns had a morbid desire to cut and had little to occupy their time. She also

contended that her husband would refuse to consent to this surgery because he would rather die than not have his foot. She said her view was based on past conversations with her husband about his sister, who died after diabetes-related complications after she refused to consent to surgery.

The court found Ms. Warren's testimony insufficient to establish clear and convincing evidence that Mr. Warren, before becoming incompetent, had expressed a wish that in the face of imminent death, no amputation should be allowed. While acknowledging Ms. Warren's genuine care for her husband, the court found her testimony questionable in strength and reliability in light of her intractable conviction that her husband was not suffering from a dangerous gangrenous condition despite medical evidence to the contrary. The court was also troubled by Ms. Warren's hostility toward the medical staff at the hospital, and found that her strongly held convictions impeded her objectivity in reporting the true state of her husband's intention under the circumstances.

Source

- *Petition of Dept. of Veteran's Affairs Medical Center* (https://law.justia.com/cases/federal/district-courts/FSupp/749/495/1616582/), 749 F. Supp. 495 (S.D.N.Y. 1990).

Questions for Discussion

1. Is it appropriate for a hospital administrator to be appointed guardian of a patient in the administrator's own hospital? Why or why not? Is it significant that the administrator was appointed guardian for the limited purpose of consenting to surgery and any related treatment?

2. Mr. Warren is not in a persistent vegetative state; nor does he have a condition from which he is unable to recover. Should this fact have any bearing on his right to refuse treatment through a surrogate? Why or why not?

3. Should a guardian be permitted to refuse to consent to an amputation when the refusal would result in a ward's death? If so, how is refusing to consent to a life-saving amputation different than refusal of any other life-prolonging treatment?

C. Reproductive Issues

Abortion Ordered for Rape Victim

28-year-old woman who was deaf and had the cognitive skills of a 4-year-old was raped and became pregnant. Her guardian sought approval from the court to terminate the pregnancy.

The ward had a shunt in her brain to drain excess fluid and her neurologist testified that the pregnancy had been painful and resulted in the ward becoming "violently ill" when the shunt was under too much pressure. He maintained that continuing pregnancy full term would be dangerous for the ward. Though essentially unable to communicate, the ward was able to utter the words "My baby no more."

The ward was believed to have been raped, likely more than once, according to police. Accordingly, the judge authorized an abortion, a tubal ligation to prevent future pregnancies, and the collection of a DNA sample from the fetus so that police could identify the rapist. The orders were carried out.

A source for a newspaper reporter was quoted as saying, "This is as close to Solomon as you're going to get."

Source

- The Associated Press, *Abortion Averted, group says* *(https://www.heraldtribune.com/story/news/2003/05/30/abortion-averted-group-says/28751594007/)* . Herald Tribune, May 24, 2003.

Questions for Discussion

1. Florida's guardianship statute (FS744) requires a court order to approve abortion, sterilization or psychosurgery. But the law does not provide guidance for judges in making such determinations, meaning that ethics – and not law – must inform these rulings. What ethical rules or principles ought a judge use in deciding such cases? Hence,

2. Should the judge have ordered the abortion? Why or why not? Should the judge have ordered the sterilization? Why or why not?

3. Should the woman's statement, "My baby no more" be taken to mean she wants an abortion? Given that the woman needed a guardian to make decisions for her, how much weight should a guardian give to her own opinions and decisions? If someone is adjudicated incompetent, how should a guardian then interpret the ward's statements regarding care?

Guardian for a Fetus

JDS, a 22-year-old woman with severe mental retardation, cerebral palsy, autism, and seizure disorder, was raped and became pregnant. The Florida Department of Children and Families (DCF) petitioned a court for an order authorizing emergency adult protective services and appointment of a guardian. DCF intended to seek a guardian for the fetus after it was born.

Florida Gov. Jeb Bush then intervened in the case by asking DCF lawyers to ask the court to appoint a guardian for the fetus itself, that is, not waiting for it to be born.

DCF then tried to make the fetal guardianship case by arguing that JDS was taking numerous medications which would be detrimental to the fetus. The Department also argued that JDS's interests and needs, as expressed by her guardian, were potentially adverse to those of the fetus. DCF also contended that JDS's guardian was required to avoid conflicts of interest, and that such a conflict was likely because JDS's medications could harm the fetus.

Jennifer Wixtrom applied to be appointed as guardian for the fetus, alleging that the appointment was essential because JDS lacked capacity to provide proper prenatal care and make necessary decisions for the protection and enhancement of the fetus. She further contended that JDS's guardian might elect to have an abortion or fail to consider her medications would have an adverse effect on the fetus. The trial court denied Ms. Wixtrom's petition and her subsequent motion for rehearing, and entered an order stating that JDS's guardian had created a plan which stated that an abortion would not be performed.

The court denied the appointment of guardian for the fetus, and this ruling was appealed.

While the appeal was pending, JDS delivered her baby. Although the birth of the child rendered the appeal moot, the appellate court decided the case on the merits because the issue was considered one of great public importance, and capable of recurring. The appellate court affirmed the trial court's denial of Ms. Wixtrom's petition, finding that Florida guardianship law does not extend to fetuses.

Addressing Ms. Wixtrom's concern that JDS might have elected an abortion, the appellate court pointed out that Florida law requires a guardian to obtain specific authority from a court before consenting to an abortion for a ward, and that before the court can grant such authority, it must appoint an attorney to represent the ward, receive independent evidence from experts, and find by clear and convincing evidence that the incapacitated person cannot make the decision and that the requested procedure is in the best interest of the ward. The court could also appoint a monitor to conduct an investigation, collect evidence, and report its findings to the court.

The appellate court upheld the trial court's refusal to appoint a guardian for a fetus.

Source

- *Guardianship of J.D.S* (https://www.courtlistener.com/opinion/1827917/in-re-guardianship-of-jds/)., 864 So.2d 534 (Fla. 5th DCA 2004).

Questions for Discussion

1. The case was politically charged, and received international attention. If fetuses have rights that include the protections of guardianship, it would mean that fetuses are persons. How does this question bear on the debate about abortion?

2. Should fetuses have guardians? Answer this question in the context of the many cases of what obstetricians call "maternal-fetal conflict."

3. JDS already had a guardian committed to protecting her interests. What could be the consequences of a fetal guardian duty-bound to protect the interests of a fetus in cases when the two guardians disagreed? How could such disputes be resolved?

Mother Seeks Sterilization of Son

A 63-year-old woman from South London, who has a son with Down's Syndrome, petitioned the court to have her son sterilized. She said she can no longer keep him under strict supervision and any pregnancies he causes would have serious consequences for both the mother and child. The mother is worried that when she can no longer provide for him her son will have to go into residential care. She fears that being in residential care would make her son even more vulnerable than he is now – if he is not sterilized. In residential care, she said, there will be more opportunities for her son to form relationships with women.

The mother said she believes that sterilization is in her son's best interest, and had experts testify that her son's quality of life would improve with the procedure. However, this is disputed. The mother says her son has sexual awareness, but is unable to connect the act of sex with pregnancy. She said the operation would give her son the chance to have relationships without the risk of being responsible for a pregnancy.

The family court division president said that so long as the mother continued to care for her son, then he would be closely supervised.

The sterilization was eventually rejected by the court.

Source

- Robert Verkaik, *Mother loses fight to have son sterilized* (https://www.independent.co.uk/news/mother-loses-fight-to-have-son-sterilised-1133890.html), The Independent (London), Dec. 21, 1999.

Questions for Discussion

1. Should a ward be sterilized to eliminate the risk of another's pregnancy? Would it matter if the ward were a woman and the sterilization would prevent her pregnancy? How so or how not? (Hint: Is the sterilization procedure reversible?)

2. If sterilization is not to be allowed, how can the mother prevent her son from impregnating a female, when he is unable to understand the link between sex and pregnancy and when he himself will be unable to support or care for a child? What are some ethical solutions to prevent an unwanted pregnancy?

3. In such cases, should a potential child's quality of life be taken into account? Suppose the young man's mother were afraid she would acquire responsibility for raising her grandchild – what weight, if any, should be given to that concern?

Sterilization of the Disabled

Consider these two scenarios:

1. Alice's daughter, Jane, is 21 years old and was born with Down's Syndrome. When her brother brought home a new baby, Jane also wanted one. It is unclear whether Jane understands how a woman becomes pregnant. Her mother does not believe that she has ever had sex and kissing is still an unusual experience. If Jane were to become pregnant, Alice knows that Jane would be unable to care for her child and it would become Alice's responsibility. So far, Alice has not chosen to have her daughter sterilized, but she also does not want her daughter to have children.

2. A single mother living with her 15-year-old daughter wants a court to permit her daughter's tubal ligation. The daughter was born with an unusually small head and suffers from cerebral palsy. She frequently has seizures. Her IQ is in the 40s, which puts into question whether she can understand such a procedure and its consequences. The girl does not know her phone number or address. She does know her name, but is unable to spell it. The mother's lawyer said the girl has no concept of life and death. The lawyer said the daughter suffers from daily seizures and that if she were pregnant, "the seizures themselves could cause complications for the fetus. The hormonal effects of a pregnancy could have fatal effects on her because of its effects on her seizure disorder. Seizures during pregnancy can be very dangerous."

Source

- David Olinger, *The Rights of the Retarded* (https://www.tampabay.com/archive/1990/11/18/the-rights-of-the-retarded/) . Tampa Bay Times. November 18, 1990 .

Questions for Discussion

1. What are key distinctions between these scenarios? Is the medical risk to the fetus in the second scenario significant?

2. If a child with mental retardation did get pregnant, and if, as the child's guardian, a parent may seek an abortion, can sterilization be seen as a preventive measure to avoid such difficult future decisions?

3. A parent or guardian cannot watch over a ward at all times, so sterilization can allow the guardian to prevent unwanted pregnancies and hence the possibility that a child will be conceived and delivered to parents who are unable to care for it. Is it morally permissible for a guardian who might have to help care for a child who is the result of an unwanted pregnancy to prevent the possibility of such a pregnancy in the first place?

4. Why is the systematic sterilization of those with mental retardation universally regarded as abhorrent?

Brain Dead and Pregnant

Susan Torres, 26, was pregnant when aggressive melanoma spread to her brain and she lost consciousness from a stroke. The stroke caused severe brain damage, and she was eventually diagnosed as brain dead. Because Ms. Torres was pregnant, her family decided to keep her on "life support"[1] machines until her fetus was viable. Torres's family believed that she would want to be maintained in such a state for the sake of her future child.

As a result, Ms. Torres was kept on machines for three months, or until her fetus reached the point where it could survive outside the womb. There was the chance that Torres's cancer could spread into the placenta and harm her fetus; however, the hospital carefully monitored this possibility.

After the delivery of the baby, the family removed Torres from the machines.

Source

- Melinda Smith, *US Doctors Use Sophisticated Technology to Care for Fragile Babies* (https://www.voanews.com/a/a-13-2005-07-29-voa41/396487.html)

, Voice of America, July 29, 2005.

Questions for Discussion

1. What standard for surrogate decision making should be followed in such a case: substituted judgment, best interest or reasonable person?

2. Family members all agreed that Ms. Torres would have wanted to be kept on machines until her baby could safely be born. But what could be the evidence for such a report? Did Ms. Torres actually contemplate being pregnant and brain dead? What kind of beliefs about others' values can be used in making such decisions?

3. There was a small chance that Ms. Torres's fetus could acquire the spreading cancer. If the chance of the cancer spreading to the placenta were great, should this matter in trying to decide whether to save the fetus' life?

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[1]The phrase "life support" appears in quotation marks because it makes no sense, precisely speaking, to say a brain dead patient is on life support. That is, brain dead patients are dead, according to ethical consensus and 50 different state laws, and there therefore is no life to support. But the phrase is almost impossible to avoid in cases such as this.

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Module 2 - Behavioral Health

Case Studies:

A. Psychotropic Drugs

- Involuntary Medication (i)
- Involuntary Medication (ii)

B. Other Issues

- Ward Refuses Medical Treatment
- Quality of Life and Family Connections
- Organ Donation for Research

A. Psychotropic Drugs

Involuntary Medication (i)

Jackson's parents sought guardianship of their son and authorization to treat him with antipsychotic medication. At a temporary hearing, Jackson was adjudicated mentally ill. From that hearing until trial, Jackson's condition showed great improvement, but his parents contended that the improvement was not enough to render him competent to make his own psychiatric treatment decisions.

Jackson said he is not mentally ill, but two psychiatrists testified that he suffers from paranoid schizophrenia, and because of this illness he was not competent to make his own decisions about medication. Jackson called in another psychiatrist who could not testify that Jackson was not mentally ill, but who offered a possible alternative diagnosis: bipolar disorder. Jackson's family contended that this psychiatrist did not review records other than those of a recent hospitalization, did not get a family history, did not speak with the physicians who had examined or treated Jackson, and admitted that he did not have enough information about the patient to reach a definitive diagnosis. Further, the family said, Jackson's chosen psychiatrist examined Jackson during a time when Jackson had improved.

At trial, Jackson testified about his activities and reaction to the medication. He said he hadn't taken his medication for a while because of its side effects. The judge found that Jackson was more relaxed and happy since his hospitalization. Jackson had been hospitalized with an order for involuntary medication after the initial hearing on temporary guardianship. Jackson had been involved in classes at a university, had taught at a hockey clinic, and was involved with a religious group. He was also living with his girlfriend and serving as a music minister.

The judge concluded that while Jackson had been incompetent by reason of mental illness at times in his life, his parents did not meet their burden of showing that he was incompetent at the time of trial. Additionally, applying principals of substituted judgment, the judge denied the petition seeking involuntary treatment.

Source

- *In re Guardianship of Jackson* (https://www.jstor.org/stable/20786559?seq=1), 814 N.E.2d 393 (Mass. App. Ct. 2004).

Questions for Discussion

1. What does it mean in behavioral health cases when patients' capacity waxes and wanes? How should this be taken into account in making treatment decisions for psychiatric patients?

2. How competent ought one be to enjoy the right to refuse treatment?

3. Even in cases of complete incapacity, it is sometimes possible for a person to communicate care preferences. How valid are these expressions?

Involuntary Medication (ii)

The ward had a long history of mental illness before the establishment of this guardianship, and had been institutionalized. During his second institutionalization, this guardianship was established after the ward attacked another patient for no apparent reason and had to be restrained by hospital attendants. He was diagnosed with schizophrenia paranoid type, and the hospital recommended that he be treated with antipsychotic medication.

The ward refused all drugs, as he had done on many previous occasions, and also refused psychotherapy. His refusal was based on his prior experiences with illicit drugs which, among other things, caused him to be in a car accident. His guardian ad litem further argued that another factor in the ward's refusal was the ward's acceptance of certain tenets of the Christian Science faith. Over the objections of the guardian ad litem, the court decided that the guardian (who was at the time a temporary guardian) had the authority to consent to forcible administration of antipsychotic drugs for the ward because the ward was institutionalized.

After the ward's discharge from the institution, the guardian ad litem successfully sought to prohibit the continued forcible administration of the anti-psychotic medications. The appellate court held that in the absence of an emergency, the guardian of a mentally ill ward does not have inherent authority to consent to forcible administration of antipsychotic drugs of a non-institutionalized ward. Only a court can authorize the forcible administration of psychotropic medications on a non-institutionalized ward. The substituted judgment determination under these circumstances cannot be delegated to the guardian. Instead, a judicial determination of substituted judgment is required.

In undertaking substituted judgment, the judge is required to consider, among other relevant factors, the following: the ward's expressed preferences regarding treatment; his religious beliefs; the impact upon the ward's family; the probability of adverse side effects; the consequences if treatment is refused; and the prognosis with treatment. If the judge determines that the ward, if competent, would accept the medication, he is required to order its administration. If the judge determines that the ward's substituted judgment would be to refuse the treatment, then the judge must balance that judgment against any State interests.

Included among State interests that may outweigh the right to refuse treatment are the preservation of life, the protection of the interests of innocent third parties, the prevention of suicide, and maintaining the moral integrity of the medical profession. If the judge determines that the State interests outweigh the right to refuse treatment, the court must then make an "extended substituted judgment" determination to choose from among all acceptable, available and least intrusive means of satisfying the State interest. A substituted judgment determination limited to a decision between involuntary commitment or involuntary medication must be made.

Source

- *Matter of Guardianship of Roe* (https://www.courtlistener.com/opinion/2230457/guardianship-of-roe/), 421 N.E.2d 40 (Mass. 1981).

Questions for Discussion

1. Is a substituted judgment determination a legal fiction when used in cases of wards with long histories of mental illness? Compare this to never-competent persons.

2. Why not use a best interest or reasonable person standard in such cases?

3. What kinds of "interests of innocent third parties" should be able to constitute a state interest strong enough to justify forced medication?

B: Other Issues

Ward Refuses Medical Treatment

Mrs. W., 92, is a legally incompetent woman who has a mass in her bladder. Although her doctors are considering aggressive procedures to determine the nature of the mass, Mrs. W. is expressing a desire not to endure any diagnostic procedures or surgical procedures. Her guardian, Ms. G., has been appointed to make medical decisions on her behalf. Ms. G. is now faced with the question whether to override Mrs. W.'s wishes and authorize a full diagnostic workup.

In making her determination, Ms. G. discussed treatment options with Mrs. W.'s physician. According to her physician, the procedure contemplated (a transvaginal probe and biopsy) would cause discomfort and afford no certain benefit. In addition, it presents a number of nontrivial risks. Because of her refusal, Ms W. might need to be restrained (physically and/or chemically) – a potentially violent measure that would damage or destroy any therapeutic relationship with the health professionals involved.

Ms. G. also discussed the situation with Mrs. W., who very clearly expressed her desire to refuse any invasive workup or surgical intervention. Throughout her life, Mrs. W. sought medical care when necessary, but, in part because of a number of bad experiences, has since refused and expressed disdain for surgery in general; this opinion long predates her incapacity. Her decision to refuse the procedure presently at issue is consistent with a longstanding belief. She also expressed her conviction that she regards the transvaginal procedure being contemplated as a violation of her personal dignity. She has lived a long and full life, and seems to have a sense of the consequences of her refusal – which might include death.

Ms. G. made the decision to refuse the diagnostic workup and any surgical intervention. Her reasoning was that forcing an unwanted surgical procedure would cause unreasonable distress and there were grounds for believing that Mrs. W. considered the treatment unnecessary. Adequate pain management and palliative care were recommended in case her malady worsened because of the refusal.

It is widely accepted that capacity is not a binary value such that people are either completely capacitated or completely incapacitated; and that this is true even for people who have guardians assigned them. Mrs. W.'s refusal would be completely uncontroversial and unremarkable in a person who had not been declared incompetent by a court.

Source

- Anonymous

Questions for Discussion

1. Does and should a legally incompetent person have the right to refuse potentially life-sustaining treatment? What criteria should be used?

2. Should a refusal of treatment be disregarded because a person is determined to be incompetent?

3. How should values held before incapacity be understood to apply after incapacity?

Quality of Life and Family Connections

John is a 68-year-old legally incompetent male who has had a diagnosis of schizophrenia since his early 20's. John's father died in the early 1970's. His mother died in 2002. John lived with his mother at her house until late 1996. His mother was his guardian for most of his adult life, and John's niece, Judy, became his legal guardian when his mother's declining health forced her to resign.

John suffers from many medical problems, including chronic hypertension. Approximately 15 months ago he was diagnosed with bladder cancer which was treated with surgery and chemotherapy. Most recently, he has developed heart problems. The doctors have recommended open-heart surgery involving the use of a heart/lung bypass machine, with surgery to repair or replace his mitral valve. Post-operative recuperation would require the patient's cooperation in rehabilitation therapy.

Judy needed to decide whether to treat John's heart disorder aggressively. In consultation with a cardiologist, the guardian decided against surgery but, instead, elected to keep the ward as comfortable as possible. Options included a pacemaker or an angioplasty that would result in opening the blood vessels sufficiently to increase blood flow and more efficient heart pump action.

When discussing the choices with the cardiologist, Judy had already been through the bladder cancer recovery period with John and knew that he was very uncooperative with treatment. John has a very low level of functioning and either is not able to understand what is necessary or is unwilling to take the necessary steps to recover after surgery. Throughout his cancer treatment, John experienced paranoia and was defiant and resistant to treatment. At times he was still exhibiting those symptoms, in addition to periodic bouts of confusion and depression.

The guardian's decision not to approve surgery was based primarily on a determination to preserve John's quality of life. She believed that John would not have a clear understanding of his medical condition and would not cooperate with treatment. She also believed that major surgery would only serve to aggravate his mental health and would not improve his medical condition significantly.

Note that the guardian had been very close to her grandmother – the mother of the ward – and that the guardian's mother – the ward's sister – is very emotional about the possibility that the family could lose both her mother and her brother in a short time. The guardian had promised grandmother that John would always be taken care of and protected even after grandmother died.

Source

- Anonymous

Questions for Discussion

1. How should quality of life be balanced against life itself?

2. How should mental disability be included in assessing quality of life?

3. How should guardians-as-family-members weigh family pressures and the concerns of loved ones in making decisions for wards?

Organ Donation for Research

A ward needs final arrangements to be made, and his guardian has been approached by the teaching hospital at a local university about donating his brain for analysis after death. The ward is being treated there for his Alzheimer's disease, and his physician is nationally respected for his work in the field.

The ward is not able to participate in this decision and has left nothing of his personal history for the guardian to review. Little is known about his life before his incapacity. He was probably a blue collar laborer. He was abandoned by someone, possibly a stepson, in an apartment. There is no known family.

The guardian, a volunteer, is seeking advice. Should the guardian allow the ward's brain to be used for research after he dies?

Source

- E-mail from Julia Nack, Volunteer Guardian Director, Central Ohio Area Agency on Aging, to nga-list@guardianship.org (mailto:nga-list@guardianship.org), *Brain Donation – Ethics Situation* (December 23, 2003)

Questions for Discussion

1. Which surrogate decision making sandard – substituted judgment, best interest or reasonable person – should be applied? Why?

2. Should "benefit to society" be included in the guardian's decision process? If so, under what circumstances?

UNIVERSITY OF MIAMI

Module 3 - Residential and Social Decisions

Case Studies:

A. Family Issues and Conflicts

- Daughter Impedes Mother's Care

B. Placement

- Ward's Wishes vs. Risk of Injury
- Conflict of Interest in Placement Decision
- Guardian as Advocate

A. Family Issues and Conflicts

Daughter Impedes Mother's Care

Ms. R. is a legally incompetent 95-year-old woman with a diagnosis of dementia. She has a 75-year-old daughter, Ms. D., with whom she has been living. Ms. D., a paranoid schizophrenic, doesn't take the medication prescribed for her psychiatric illness and has been interfering with Ms. R.'s care. Ms. R.'s guardian is seriously concerned about the living situation and the effect it is having on her ward.

The guardian arranged for care management services (personal attendants) to ensure that medication was administered to Ms. R., that the house was clean and that Ms. R. was receiving the appropriate and necessary daily care. Ms. D., however, does not permit the attendants to enter the home.

As a result, Ms. R. is no longer receiving an appropriate level of care. Ms. D. selectively medicates her mother, and the living conditions in the house have become unsanitary. In addition, Ms. D. is alienating Ms. R. from the rest of the family and restricting visitation.

Ms. R. does not wish to be separated from her daughter.

Source

- Anonymous

Questions for Discussion

1. Should the guardian consider seeking a separation of mother and daughter? Why or why not?
2. Should a guardian be sought for the daughter? If so, how should the two guardians communicate and collaborate to protect their respective wards?
3. What other information is required, if only, do you want before making a decision in this case?

B. Placement

Ward's Wishes vs Risk of Injury

The ward is a 22-year-old developmentally disabled female. She lived with her mother until 2 years ago when her mother died. The whereabouts of the ward's father are unknown.

A professional guardian was appointed over the ward's person and the right to determine residence was delegated to the guardian. After an evaluation of the home setting, after considering the available alternatives – residence with the ward's willing 24-year-old sister and the sister's 26-year-old boyfriend, or residence in a group home – and after consultation with the ward whose preference it is to reside with her sister, the guardian determined that the ward would reside with her sister.

The ward has been in that residence for the past two years, is doing well and is emotionally attached to her sister, her sister's boyfriend and their new child (the ward's niece). Recently, the sister's boyfriend was arrested and charged with leaving the scene of an accident and driving under the influence of alcohol. The sister's boyfriend occasionally provides transportation for the ward. Should the guardian consider changing the ward's residence?

Source

- Anonymous

Questions for Discussion

1. Does the sister's boyfriend put the ward at risk? In what ways, and to what extent?
2. How should the guardian's obligation to protect her ward be balanced against the ward's desire to reside with family members?
3. Can the guardian seek to impose restrictions on family members that would minimize risk to the ward?

Conflict of Interest in Placement Decision

Ward lived independently in his own apartment. He had a job, a dog and a bicycle that he rode frequently. He was well known and liked in the community. He had no family in the area, but had become active in his church.

His guardian decided that he wasn't safe in the community and relocated the ward to a long-term care facility. The guardian, it develops, had a financial interest in that facility.

Older residents at the facility eventually reported the appearance of new residents with no apparent need for nursing care. It was subsequently alleged that this placement was part of a larger scheme to fill empty nursing home beds.

Source

- Mary Johnson, *Getting states to implement the Supreme Court's integration ruling means fighting for dollars that nursing home operators see as rightfully theirs – by law* (http://www.raggededgemagazine.com/0500/a0500cov.htm), Ragged Edge Online, May/June 2000.

Questions for Discussion

1. This case clearly is about a conflict of interest. Identify at least three ways a guardian might be in a conflict of interest situation.

2. Suppose the ward really was in need of nursing care. What should a guardian-investor do in such a case?

3. Identify a larger strategy for dealing with such issues. Consider, for instance, whether guardians should have *any* investments in businesses or industries related to ward placement.

Guardian as Advocate

The ward, Camilla, lived in a state-run group home where she received medically necessary 24-hour nursing and attendant care. Camilla has significant cognitive deficiencies. Additionally, she suffers from seizure disorder, often becomes frightened at night and screams often.

Under great pressure to serve those with more severe care needs than Camilla, the state-run group home is considering transferring Camilla to a community-based home, where the level of care, due to insufficient funding, was substantially less. For instance, the community-based home did not have access to the specialized bathing devise used to irrigate Camilla's external lesions, nor was it equipped to provide 24-hour nursing and attendant care that she required.

The guardian threatened legal action, and was able to keep Camilla in the state-run group home.

Source

- Anonymous

Questions for Discussion

1. How far should a guardian go to advocate for a ward's needs? Under what circumstances should a guardian threaten legal action?

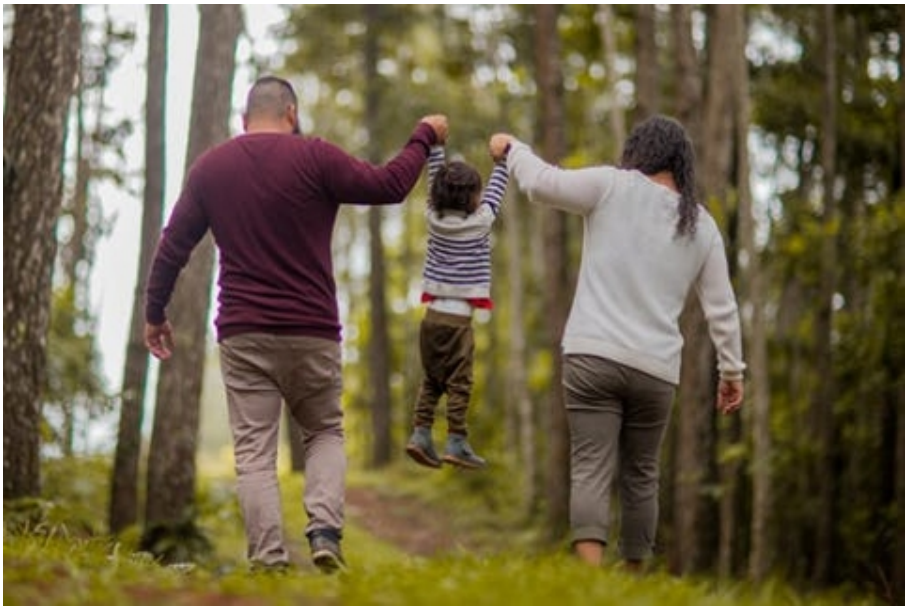
2. What moral responsibility – if any – does society have to provide adequate care for wards?

3. Which social institutions bear that responsibility?

4. Should public funding be increased to support care of this vulnerable population?

5. Should taxes be increased to support such care? Would *you* agree to pay higher taxes if the increased revenue were used to support the state's wards? Why or why not?

Module 4 - Property



Case Studies:

- Transfer of Assets to Guardian/Spouse
- Gifting to Ward's Intended Heirs (i)
- Gifting to Ward's Intended Heirs (ii)
- Management of Dysfunctional Family
- Liquidating Assets

Transfer of Assets to Guardian/Spouse

Myrna Labis wanted to be appointed guardian for her husband, Manuel, who was left mentally incompetent after a stroke permanently damaged his brain. Myrna also wanted the authority to undertake Medicaid estate planning for Manuel's benefit. Manuel is bedridden and paralyzed on the right side. He is unable to swallow, communicate, follow directions, or answer questions. Myrna, if appointed his guardian, wanted an interspousal transfer of his interest in their home as part of Medicaid planning.

Manuel and Myrna purchased their home together and have jointly maintained it. The couple also jointly paid for the education of their two now-adult children. Myrna continues to work full-time, while Manuel receives a Social Security disability pension and a small early retirement pension. Both Manuel and Myra have reciprocal wills with the surviving spouse receiving all the assets and, thereafter, equal allocations to their children.

The Law Division judge appointed Myrna as Manuel's guardian but denied the interspousal transfer of their home, citing a public interest. The judge believed that the Labis family should preserve some assets to repay a portion of the public expense of supporting Manuel.

The court rules that, "It is not fair to the public to transfer the home to her sole name during the joint lives of the parties free of any interest of the incompetent (and the public). Such a transfer might result in a situation in which she predeceases the incompetent and leaves the house to the parties' adult children free of the claims of the public."

Source

- *In the Matter of Labis* *(https://www.courtlistener.com/opinion/2399470/matter-of-labis/)* , 714 A.2d 335 (N.J. Super Ct. App. Div. 1998).

Questions for Discussion

1. The Medicaid planning proposed here would partially benefit Myrna, the guardian, by decreasing the amount she would have to pay for her husband's health care. Was the judge correct in forbidding it? Were his reasons sound?

2. What if Myrna did not do Medicaid planning for her husband – but then exhausted their finances, to the extent they needed public assistance?

3. Is it a conflict of interest for Myrna, as Manuel's guardian and wife, to perform Medicaid planning?

Gifting to Ward's Intended Heirs (i)

Mildred Keri, a nursing home resident, had irriversible dementia and was unable to care for herself. Ms. Keri's two sons helped cared for her. They would visit her on alternating days and made sure she was well cared for in their absence.

Ms. Keri's residence comprised the bulk of her estate; it was valued at $170,000. Her other assets ranged from $17,000 to $40,000, and her monthly income, from Social Security, was $1,575.

Ms. Keri's will divided her estate equally between her two sons. One son, Richard, was her agent by a general power of attorney. This power allowed him to apply for Medicaid benefits for his mother. However, it did not explicitly authorize him to make gifts on her behalf for any reason, so Richard petitioned for guardianship of his mother.

As his mother's guardian, Richard wanted to give some of his mother's assets to himself and his brother. He would leave Ms. Keri with enough assets to pay the nursing home during the period of ineligibility. This plan would allow Richard to give away his mother's assets to qualify for Medicaid instead of having to spend those assets on his mother's nursing home care until she became eligible for Medicaid.

The trial court granted the guardianship, authorized the sale of the home, but did not authorize the Medicaid plan. The interim appellate court affirmed in part and reversed in part, and certification to the Supreme Court of New Jersey was granted. The New Jersey Supreme Court held that when certain criteria are met, Medicaid planning is permissible in order to render a decision the ward would have made if competent, and that the Medicaid plan proposed in this case met such criteria, namely:

- It is not possible to restore the ward to capacity;
- The assets of the estate remaining after the consummation of the proposed gifts are such that, in light of the ward's life expectancy and present condition of health, they are more than adequate to meet all of the ward's needs in the style and comfort in which the ward is currently (and since the onset of incapacity has been) maintained, giving due consideration to all normal contingencies;
- The recipients of the money must constitute the natural objects of the bounty of the ward;
- The transfer will benefit and advantage the estate of the ward; and
- There is no "substantial evidence" that the ward would not have disapproved the plan.

Source

- *Matter of Mildred Keri*
(https://www.courtlistener.com/opinion/1980847/in-re-keri/)
853 A.2s 909 (N.J. 2004)

Questions for Discussion (see next case)

Gifting to Ward's Intended Heirs (ii)

A Florida appellate court reversed a trial court's denial of a guardian's petition to implement Medicaid planning on behalf of a ward, based upon the trial court's failure to conduct an evidentiary hearing to determine whether or not, after the proposed transfer of assets, there would be a period of ineligibility imposed before the ward could qualify for Medicaid benefits and, if so, whether there would be sufficient funds to pay for the ward's nursing home care during any period of ineligibility.

At the time the petition was brought, the ward was 86 years of age and living in a skilled nursing facility. When the guardianship was established, the ward's assets were about $78,725, she had a monthly income of $980.97, and a monthly deficit of $4,377.78. The petition alleged that the ward's life expectancy was 6.2 more years, and that the ward's assets would be depleted in 10.64 months unless the ward qualified for and obtained Medicaid benefits. The proposed Medicaid plan consisted of gifting the sum of $3,000 per month to the ward's only daughter, the sole beneficiary named in the ward's will.

By the date of the hearing on the petition, the guardian had already spent $32,000 on the ward's care. The court would not conduct an evidentiary hearing but did accept proffers of testimony that the ward and his daughter had a close personal relationship and, from an elder law specialist, that "Medicaid planning is a common tool used to preserve the estate of a ward for intended beneficiaries, as well as a tool for estate and income tax planning."

The elder law specialist also said that Medicaid planning was legal and that the proposed plan would not result in any penalty to the ward. Despite the proffers, the court found that it was not in the best interest of the ward to allow Medicaid planning. The petition was denied. The appellate court reversed and remanded, holding that the trial court was required to conduct an evidentiary hearing to determining whether after the proposed transfer of the ward's assets there would be a period of ineligibility before the ward could qualify for Medicaid and, if so, whether there would be sufficient funds to pay for the ward's nursing care during that period of ineligibility. The appellate court also held that the appropriate standard to be applied in considering the petition is substituted judgment.

Source

- *Rainey v. Guardianship of Mackey* (https://www.courtlistener.com/opinion/1704548/rainey-v-guardianship-of-mackey/), *773 So. 2d 118 (Fla. 4th DCA 2000).*

Questions for Discussion

1. Does it constitute a conflict of interest for heirs to make gifts to themselves in order to qualify wards for Medicaid?

2. In general, should one be able to preserve a ward's estate through gifts rather than "spending down" the estate?

3. What are key differences between these two cases? Does it matter that in the second case, the guardian was depleting her own financial reserves?

4. Medicaid planning is a common, albeit sometimes controversial, way to preserve estates. In cases such as the two here, is there an argument to be made that society itself should assume greater responsibility for the care of those determined by courts to be incompetent? What factors should be considered in assessing the ethics of Medicaid planning?

Management of Dystunctional Family

This case involves a guardianship of the property of a minor who sustained a brain injury in an accident as a young child. There was a large personal injury settlement, which was used to purchase an annuity with a sizable, long-term monthly payout.

The minor ward remains in the custody of his parents and natural guardians, but they were not appointed guardian of the property because of concerns they would mismanage such a large amount of money, invest it inappropriately, and/or use it for their sole benefit and not in the best interest of the child.

As time passes and the guardian becomes familiar with the case, the guardian realizes that the ward's progressively dangerous behavior is not so much the result of brain injury as it is the result of very poor parenting. No one in the family has attempted to get any services that are appropriate for a brain-injured child. In fact, his parents have been uncooperative with the guardian's suggestions to do so. Both parents have records of alcohol and drug abuse, his father apparently has a criminal record and only sporadically supports the family, and there is evidence of emotional and physical abuse.

All in all, the ward is in a very bad environment. His behaviors include violent temper tantrums, dropping out of school, flirting with drugs, running away from home, and credit card fraud. His parents then divorced and he was kicked out of his father's home, his mother's home, the grandmother's home and the home of a family friend. He has run out of people to live with and so is currently staying alone, at age 16, in a vacant home purchased with money from the personal injury settlement. This home is the property of the guardianship and the guardian has been advised by her attorney to sell it due to all the usual liability issues surrounding maintaining it and keeping it safe.

The guardian has experience working with dysfunctional families and knows this child needs some stability and structure. The guardian also knows what community resources are available to get the ward back on the path of growth and productivity, and keep him out of what increasingly appears inevitable: jail. The guardian wants to help, but is uncertain of the extent of her authority as guardian of the property under circumstances in which the ward's parents are the ward's natural guardians.

Source

- Anonymous

Questions for Discussion

1. Special challenges are faced in dealing with dysfunctional families. What approaches should a guardian consider in cases such as this?

2. Is there any way to incorporate evidence that children are generally better off in the presence of parents?

3. It is difficult and can be frustrating when a family member retains guardianship of the person and a guardian assumes control over property. At what point, if any, in this case should the guardian in this case seek plenary powers?

Liquidating Assets

Ms. Z, a legally incompetent adult, has assets of about $20 million. One of her many real estate acquisitions includes a parcel of land that she purchased in 1950 for $10,00; it is now worth approximately $3 million.

She regularly receives offers to buy the property, which is much sought after because of its prime location. Ms. Z. doesn't have any financial need to sell the property. But the property, a vacant lot, is something of a liability for her because many youths use it as a track to ride dirt bikes.

On the other hand, if Ms. Z. were to sell the property, she would be responsible for paying a significant capital gains tax. There are several named heirs, who eventually will inherit the property.

Ms. Z.'s guardian is a close personal friend of the real estate agent, who will make several hundred thousand dollars in commissions, and who is pressuring her to sell.

Source

- Anonymous

Questions for Discussion

1. Where should guardians turn for advice in making ethically optimized investment and liquidation decisions? What special precautions are necessary when very large sums of money are involved?

2. If you were this guardian, how would you deal with the real estate agent who is pressuring you to sell? What issues are raised by the fact that the agent is a close friend?

Module 5 - Voting

Case Studies:

Ward's Capacity to Vote

Following a full-blown incapacity hearing and relying upon the reports of the examining committee, parts of which conflicted with parts of others, the court entered an order determining limited capacity of the ward and removing the following rights:

- Marry
- Personally apply for government benefits
- Have a driver's license
- Travel
- Seek or retain employment
- Contract, sue and defend lawsuits
- Manage property or make any gift or disposition of property
- Determine residence

- Consent to medical and mental health treatment.

The court permitted the ward to retain the right to vote. The right to vote is not a delegable right.

Source

- Shanker Verdantam, *Dementia and the Voter: Research Raises Ethical, Constitutional Questions.* (http://www.washingtonpost.com/wp-dyn/articles/A18916-2004Sep13.html) Washingtonpost.com. September 14, 2004.

Questions for Discussion

1. What obligation, if any, does the guardian have to facilitate the ward's right to vote? If the ward is unable, for whatever reason, to express how he wishes to vote, should the guardian attempt to apply principles of substituted judgment, best interests or reasonable person, and assist him in completing an absentee ballot or in voting at the polls?

2. What if during the ward's full capacity he always voted along Democratic lines, and now, after he's been determined to have limited capacity, expresses wishes to vote for a Republican presidential candidate?

3. If a guardian has the right to make life-or-death medical decisions for an individual, should voting also be something s/he can do for a ward?

4. What if the ward has been a passionate advocate for one political party throughout his or her life and always voted the party line? Should one's guardian be able to continue to vote the party line for the ward? What should guardians do during primary elections?

5. If the right to vote is not assignable and only the ward may exercise that vote, how does one reconcile the fact that the ward may be easily influenced by family, friends, political activists and perhaps not voting on his beliefs?

6. If one believes a ward should be disenfranchised based on his dementia, does that constitute discrimination against the disabled? We do not require other voters to demonstrate competency to vote; and, in fact, voters may vote based on any number of factors, some of which are irrational.

7. Should a competency test be administered to those declared incompetent? Can administering tests to determine voting capacity be objective? Who would be required to take such a test? Would such a test be discriminatory?

Module 6 - Religion

Case Studies:

- Refusal of Blood Products (i)
- Refusal of Blood Products (ii)

Refusal of Blood Products (i)

The mother of two teenage children, Maria Duran is a Jehovah's Witness and her beliefs commanded her to abstain from blood products and blood transfusions. She is the only Jehovah's Witness in her family. When Ms. Duran needed a liver transplant she sought out the University of Pittsburgh Medical Center because she had been told that it had performed liver transplants on Jehovah's Witnesses without the need for blood transfusions.

Ms. Duran discussed her religious beliefs and her desire to not be given any blood products or transfusions with the medical staff. She even executed a durable power of attorney for medical care. In the document, Ms. Duran specifically stated that she would refuse any blood, no matter what her medical condition. She stated that even if a blood transfusion were the only therapy required to

preserve her life or health, she would still refuse. Further, she stated that her family, relatives, or friends may disagree with her beliefs and wishes, but that is legally and ethically irrelevant. In her durable power of attorney, Ms. Duran appointed Larry M. Johnson as her health-care agent.

Before the liver transplant, Ms. Duran left New York, where she had been living, and moved near Pittsburgh with her health-care agent and his wife. Before the transplant, she again discussed her wishes with her husband and family. Maria also provided her Doctors with copies of her durable power of attorney and again told them she would not consent to blood transfusions.

After her transplant, Ms. Duran's body rejected the liver. Her health-care agent consented to a second transplant, along with kidney dialysis and a biopsy. The second liver was rejected as well, and Ms. Duran's declining condition left her comatose. Doctors believed she would die within 24 hours if she were not given a transfusion.

Her husband, Lionel, petitioned the court to be appointed her emergency limited guardian for the purpose of consenting to a blood transfusion. Her health-care agent was not given notice of the hearing and the court granted Mr. Duran's petition. He then consented to the transfusion. She nevertheless died shortly thereafter.

The health care agent appealed and the appellate court held (1) that the appeal was cognizable despite its technical mootness, (2) that Ms. Duran's self-determination to refuse blood transfusion therapy is protected by common law, (3) that the trial court abrogated Ms. Duran's right when it appointed the emergency limited guardian, and (4) that the health care agent was entitled to notice of the hearing.

Source

- *In re Maria Isabel Duran* (https://caselaw.findlaw.com/pa-superior-court/1159125.html), 769 A.2d 497 (Pa. Super. Ct. 2001).

Questions for Discussion

1. Ms. Duran's rights of self-determination and religious freedom were, at court, outweighed by the appointment of a guardian with the authority to consent to the transfusion. Did the court do the right thing?

2. Does the fact that Ms. Duran had two minor children affect whether her rights should have given way to the consent of her husband/emergency guardian?

3. Ms. Duran specifically selected Mr. Johnson as her health-care agent because he would honor her beliefs and wishes. She believed her husband, as a non-Jehovah's Witness, would contradict her wishes. Guardians are supposed to use the substituted judgment standard for decision making, when possible. Was it appropriate for her husband to consent to a treatment that he knew she did not want? What justification could be give in acting as he did?

Refusal of Blood Products (ii)

Delores Heston, a 22 year old, unmarried woman, was severely injured in a car accident. Upon entry to the hospital, it was determined that she would not survive without surgery for her ruptured spleen. She also required a blood transfusion.

Ms. Heston and her parents are Jehovah's Witnesses, a religion which forbids blood transfusions. Ms. Heston later contended that she refused a transfusion, but the hospital's documentation shows she was in shock when she got there. The attending physicians believed that she was disoriented and incoherent.

Ms. Heston's mother also opposed the transfusion and signed a release of liability for the hospital and its personnel. Ms. Heston herself was unable to sign the release.

The hospital then made an emergency application to a judge for the appointment of a guardian, with directions to consent to the transfusion, arguing that Ms. Heston's death was imminent without the transfusion.

The court appointed the guardian with permission to consent to the transfusion.

The appellate court affirmed, holding that the interest of the hospital and its staff, as well as the state's interest in life, warranted transfusion. The court stated:

"The question is whether the State may authorize force to prevent death or may tolerate the use of force by others to that end. Indeed, the issue is not solely between the State and Miss Heston, for the controversy is also between Miss Heston and a hospital and staff who did not seek her out and upon whom the dictates of her faith will fall as a burden.

"Hospitals exist to aid the sick and the injured. The medical and nursing professions are consecrated to preserving life. That is their professional creed. To them, a failure to use a simple, established procedure in the circumstances of this case would be malpractice, however the law may characterize that failure because of the patient's private convictions. A surgeon should not be asked to operate under the strain of knowing that a transfusion may not be administered even though

medically required to save his patient. The hospital and its staff should not be required to decide whether the patient is or continues to be competent to make a judgment upon the subject, or whether the release tendered by the patient or a member of his family will protect them from civil responsibility. The hospital could hardly avoid the problem by compelling the removal of a dying patient, and Miss Heston's family made no effort to take her elsewhere.

"When the hospital and staff are thus involuntary hosts and their interests are pitted against the belief of the patient, we think it reasonable to resolve the problem by permitting the hospital and its staff to pursue their functions according to their professional standards. The solution sides with life, the conservation of which is, we think, a matter of State interest. A prior application to a court is appropriate if time permits it, although in the nature of the emergency the only question that can be explored satisfactorily is whether death will probably ensue if medical procedures are not followed. If a court finds, as the trial court did, that death will likely follow unless a transfusion is administered, the hospital and the physician should be permitted to follow that medical procedure."

This decision was, however, subsequently overruled by a later opinion from the same court.

Sources

- *John F. Kennedy Memorial Hospital v. Heston* (https://law.justia.com/cases/new-jersey/supreme-court/1971/58-n-j-576-0.html), 279 A.2d 670 (N.J. 1971).
- *Matter of Conroy* (https://www.courtlistener.com/opinion/2203106/matter-of-conroy/), 486 A.2d 1209 (N.J. 1985).

Questions for Discussion

1. The Court authorized a transfusion to save Ms. Heston's life, but such a decision directly conflicts with her religious views. Should the Court be allowed to take away her right to refuse to consent here because her religious views will result in her death?

2. How should health care personnel deal with a person who enters their facility disoriented, incoherent, or in shock, and who refuses to consent to a procedure to save his or her life, a procedure that an ordinary, reasonable person would authorize?

3. How should the state interest of preserving life be weighed against the individual's autonomy? Should the state even have an interest in these cases?

4. How do health care professionals assess the strength of individuals' religious convictions? *Should* they do so?

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Module 7 - In the Professions

Case Studies:

A. Guardianship Attorneys

- Representing Client's Guardian
- Prior Representation of the Ward
- Disclosure of Fee Petition
- Duty to Disclose Misconduct
- Attorney-In-Fact as Guardian
- Attorney Selected, Employed by Insurer

B. Guardians

- HIPAA and a Failure to Communicate

C. Judges

- Competing Petitions for Appointment

A. Guardianship Attorneys

Representing Client's Guardian

Attorney Jane Brown has represented William Morriston, partly in estate planning, for more than 30 years. Recently, Mr. Morriston's daughter, Melissa, contacted Ms. Brown with her concern that her father is becoming incapacitated. Ms. Morriston also believes that Mr. Morriston's friend and caretaker, Judy, is exerting undue influence over him. Ms. Morriston wants Ms. Brown's help in protecting her father as his capacity lessens and as Judy's influence potentially grows.

Ms. Morriston wants Ms. Brown, if necessary, to have her appointed as her father's guardian. This would require Ms. Brown to represent Ms. Morriston, while Mr. Morriston is still her client.

Shortly after this conversation with Ms. Morriston, Ms. Brown received a letter from an attorney. The letter included a form discharging her from her duties as Mr. Morriston attorney and was signed by Mr. Morriston himself. The new attorney, Don Carting, told Ms. Brown to turn over Mr. Morriston files and not to contact him.

Source

- Linda G. Bauer, *Ethical Issues for Elder Law Attorneys.* (https://bbopublic.blob.core.windows.net/web/f/elder.pdf)

Questions for Discussion

1. What constitutes a conflict of interest or commitment is of great interest to scholars of legal professionalism. Relationships are often complex, and vague cases are as common as clear-cut cases. Are Ms. Brown's relationships with Ms. and Mr. Morriston inappropriate?

2. As a matter of fact, can Ms. Brown adequately fulfill her roles as father's guardian and daughter's attorney? Why or why not?

3. Do Bar rules say anything about such relationships?

Prior Representation of the Ward

An attorney had previously represented an elder in a number of minor legal matters. As the client became less able to handle her affairs, the attorney, representing a daughter of the client as petitioner, petitioned to establish a guardianship naming a bank as guardian of the property and an individual as guardian of the person.

The guardianship was established and the attorney represented both guardians. All parties were aware of the attorney's representation of the ward before guardianship, as well as his representation of both guardians.

The same daughter later retained other counsel and petitioned for the removal of the guardian of the person, alleging that he was unfit to serve in that capacity. The guardianship attorney was uncertain as to whether or not he should continue representation of the guardian of the person in light of the circumstances. The opinion of the ethics advisory committee was that the guardianship attorney should discontinue representation at this time.

Source

- *Neb. Ethics Advisory Op. 71-5 (1971).*
(https://supremecourt.nebraska.gov/sites/default/files/ethics-opinions/Lawyer/71-5_0.pdf)

Questions for Discussion

1. How does this case differ from the previous case?

2. In the absence of clear rules – or even clear intuitions – about the best way to proceed, what do you think about the ethical advice always to err on the side of caution? In this case, such advice would lead to the discontinuation of representation for one or both clients. If only one were discontinued, which should it be?

Disclosure of Fee Petition

Ward was an abrasive person who, before his incapacity, alienated those with whom he had relationships. He had no friends or adult family members, with the exception of one adult daughter who reluctantly sought and obtained guardianship. The daughter's reluctance was presumably a result of the ward's behavior and the fact that she and the ward were estranged.

As guardian, the daughter experienced much difficulty providing care for his person and managing his property. For example, the ward was been aggressive, mean, non-compliant and verbally abusive to the guardian and to caregivers arranged for by the guardian. Moreover, he refused to permit the guardian to sell a custom motorcycle despite the need to obtain funds to pay for his health care. In providing for the ward's needs, the guardian had to miss time from work and suffered a significant drop in income.

The daughter was being reimbursed from the ward's assets for reasonable expenses – but not without argument; the ward would, for instance, accuse his guardian-daughter of committing "highway robbery." Because of her drop in income, the guardian recently petitioned for an award of guardian's fees in addition to reimbursement of expenses.

The guardian is at the end of her rope and cannot cope with the ward accusing her of "evil motivations" in the guardianship, particularly since she is working hard and missing time from work and her own children.

The ward lacks capacity to understand and manage his finances, but the attorney for the ward is confident that the ward will throw a fit and "fire additional abuse" at the guardian if he learns of the petition for guardian fees. The ward's attorney is certain that disclosure of the fee petition to the

ward will cause a battle and leave the "high-maintenance, low-asset ward to public guardianship, which will likely fall short of his needs." The disclosure could also have the effect of driving the guardian away, thus cutting him off from contact with his only family member.

Source

- Anonymous.

Questions for Discussion

1. Does the ward's attorney have a legal or moral duty to disclose the fee petition to the ward? What if the ward has been declared totally incapacitated? How about if only the ward's right to manage his finances has been removed?

2. Should the attorney's concern for the ward's physical and mental wellbeing outweigh any obligation he might have to disclose the fee petition to the client? What arguments could be offered in support of each position?

Duty to Disclose Misconduct

The attorney for the guardian assisted the guardian in the preparation of a court-required initial inventory. This inventory indicated that the ward's property was in disarray and disrepair and that considerable additional work was required to restore the estate to an orderly condition. The court was asked to approve expenditure of funds for the rehabilitation effort as well as the payment of a monthly salary to the guardian. Although the court did not enter an order affirming the initial inventory (or apparently approving the proposed expenditure and salary request), the attorney believed that the court had given its tacit approval to the inventory and on that basis advised the guardian that she could proceed with the rehabilitation effort.

Upon examination of records, the attorney determined that the guardian had misappropriated a significant amount of money from the ward. The court thereafter requested that the attorney make a full disclosure of all property transactions made by the guardian. The attorney disclosed this information to the court, and the court turned the information over to the State Attorney's Office.

The Bar ethics committee opined that full disclosure to the court was appropriate and permissible because the disclosure was necessary to address the guardian's misconduct.

Source

- St. B. of S.D. Ethics Op. 92-13 (1992); *see also*, Fla. Atty. Gen. Op. 96-94 (November 20, 1996). (https://www.myfloridalegal.com/ago.nsf/Opinions/EC4BB94C5106D5B5852563F60052F39A)

Questions for Discussion

1. Attorney-client privilege is a cornerstone of our legal system. Exceptions must always be carefully justified. Was the court correct in requesting the disclosure? Why or why not?

2. Was the attorney correct in obeying the order? Why or why not?

3. Attorneys for guardians have a complex relationship to guardians' wards. How should such dual agency – and the duties which follow from it – be managed in cases in which the interests of guardian and ward diverge?

Attorney-In-Fact as Guardian

An attorney who had been named attorney-in-fact in his client's durable power of attorney and who later determined that his client was no longer competent to handle his affairs sought an advisory ethics opinion to determine whether or not he could petition for appointment as guardian. The attorney also inquired as to whether he could represent himself in the proceeding in which a court authorizes payment of attorneys' fees from guardianship assets.

The New York State Bar Association's Committee on Professional Ethics concluded that the attorney should not petition for appointment of guardian without the client's consent unless the attorney determined that the client is incapacitated, that there is no practical alternative through use of the power of attorney or otherwise to protect the client's best interest, and that no one else is available to serve as petitioner.

The committee further concluded that subject to conflict of interest restrictions, the attorney may represent himself in the proceeding as long as the client does not oppose the petition and the attorney will not be a witness.

Source

- *N.Y. St. B. Assn. Comm. On Prof. Ethics, Ethics Op. 746 (2001).* (https://nysba.org/opinion-746/)

Questions for Discussion

1. Attorney-in-fact … holding durable power of attorney … petitioning for guardianship … and representing himself. Sorting out such roles is difficult. Yet because the relationships are complex, it is not clear precisely where a conflict of interest might lie. What do you think – is there a conflict of interest?

2. What alternatives does the attorney have if he wants to extricate himself from this tangle of relationships with a single person?

Attorney Selected, Employed by Insurer

An insurance company negotiated a settlement with the natural guardian of a minor who had been injured by a client of the insurance company. With the consent of the natural guardian, the insurance company selected and employed an attorney to represent the guardian in commencing the guardianship proceedings and obtaining court approval of the settlement. The attorney disclosed to the court his relationship to the insurance company, and the court denied the right of the attorney to appear on behalf of the guardian.

A bar association ethics committee concluded that the attorney violated a rule prohibiting attorneys from representing conflicting interests. The committee further concluded that while an exception exists to permit an attorney to represent conflicting interests if they all consent to the arrangement after full disclosure, such an exception cannot be invoked to permit an attorney to represent both the plaintiff and the defendant in an adversary proceeding, nor could it permit an attorney to represent a fiduciary when the fiduciary's acceptance of the conflicting interest would constitute a breach of the fiduciary's duty.

Despite its conclusions, the committee stated that it would not be improper for the insurance company to agree to reimburse the guardian for legal fees incurred by the guardian in connection with the proceeding when the selection and employment of the attorney is entirely within the discretion of the guardian.

Source

- *Colo. B. Assn. Formal Ethics Op. 23 (1962; addendum issued 1995).*
(https://www.cobar.org/Portals/COBAR/repository/ethicsOpinions/FormalEthicsOpinion_23_2011.pdf)

Questions for Discussion

1. In this conflict of interest case, an ethics advisory board appears prepared to permit a dual relationship as long as competing parties agree to it. Is such consent adequate to prevent or mitigate a conflict?

2. One can imagine that the insurance company might contend it is being helpful, if not magnanimous. Under what circumstances might competing parties agree to an arrangement of the sort described here?

B. Guardians

HIPAA and a Failure to Communicate

An emergency temporary guardian was appointed for a gravely ill patient in a critical care unit. A copy of the letters of emergency temporary guardianship was placed in the patient's chart and with the hospital's risk management department. Letters of plenary guardianship were later issued and faxed to the hospital.

While on her way to a Family Court "status conference," the guardian called the hospital to inquire about the ward's status. The first ICU nurse whom the guardian spoke with told the guardian that the ward was in critical condition. When the guardian asked if the ward was in a coma, the nurse said that she could not disclose any more information by phone.

The guardian then spoke with the charge nurse and advised the nurse that she had been appointed plenary guardian and needed to report shortly to a judge. The charge nurse said that she could not disclose any information over the phone and, moreover, refused to speak with the judge.

The guardian asked if the refusal to communicate was motivated by an interpretation of the HIPAA Privacy Rule, and the charge nurse said it was.

Source

- Anonymous

Questions for Discussion

1. What level of caller authentication should be required before disclosing information on the phone? How can the failure to communicate described in this case have been prevented?

2. Does HIPAA actually prevent disclosure of "protected health information" in such cases?

3. Many hospital staffers are ignorant of the duties and powers of guardians. What can be done to help nurses, physicians and administrators have a better understanding of the challenges faced by guardians?

C. Judges

Competing Petitions for Appointment

Cynthia Schmidt was in a car accident in which she suffered a severe head trauma. Her brother petitioned for their sister, Sheryl Strack, to be appointed her guardian. Ms. Schmidt's husband, Thomas Schmidt, filed a counter-petition to be appointed his wife's guardian.

The trial court found Ms. Schmidt to be disabled and appointed her husband as her plenary guardian. The court ordered that her family be notified 72 hours in advance of any private decision to withdraw life-sustaining treatment. The court also ordered that Ms. Strack be given reasonable access to her sister's medical records, but it did not give her authority to make medical decisions for her sister.

Mr. Schmidt contended it was in his wife's best interest that her medical records stay confidential, but he allowed his sister-in-law, a nursing student, to see the records. Mr. Schmidt also said his wife would not wish to be kept alive by artificial means and that she would not want to live in a vegetative state.

Ms. Schmidt's mother said her daughter would want everyone to care for her and continue the care she was getting, but that she would not want to live on life support. She based this on conversations she had with her daughter. Ms. Schmidt's aunt and a woman she had a close relationship with, said Ms. Schmidt had once said she would not like to live if unable to speak or otherwise communicate. Several of Ms. Schmidt's family members had asked her to communicate with them by closing or blinking her eyes. Ms. Strack, the sister and proposed guardian, said Mr. Schmidt was trying to end his wife's life prematurely.

Each side relied on different medical reports regarding Ms. Schmidt's condition. One physician advised that she was in a severe vegetative state and that he did not anticipate recovery, whereas another doctor gave a more optimistic view, which Ms. Schmidt's siblings relied on. However, while that doctor said Ms. Schmidt might improve, her failure to do so after two weeks would be a strong indication she would not recover.

Mr. Schmidt argued that his wife's close relatives prefer her sister, Ms. Strack as guardian; only Ms. Schmidt's minor daughter and her husband supported the appointment of Mr. Schmidt.

The trial court appointed Mr. Schmidt as guardian of his wife's person and estate. The appellate court affirmed.

Source

- *In re Cynthia Schmidt* (https://www.courtlistener.com/opinion/2048846/in-re-schmidt/), 699 N.E.2d 1123 (Ill. App. Ct. 1998).

Questions for Discussion

1. What is the best way to resolve conflicting views on an incompetent person's medical condition?

2. When a family is divided over health care decision making for a loved one, whose view should be given the most weight? (Compare the order of proxies in most state statutes.)

3. Here, the court gave Ms. Schmidt's husband and sister access to her medical records. Medical records are very private documents. Should both parties have been allowed such access? If not, which should have access to the records?

4. What should be done when family members believe a court-appointed guardian/family member does not know the ward's beliefs or will not follow them? How can the requirements of substituted judgment be met when those best positioned to meet those requirements are in disagreement?

5. Should the number of family members supporting one guardian over another matter? Should the "closeness" of the family members to the ward matter?

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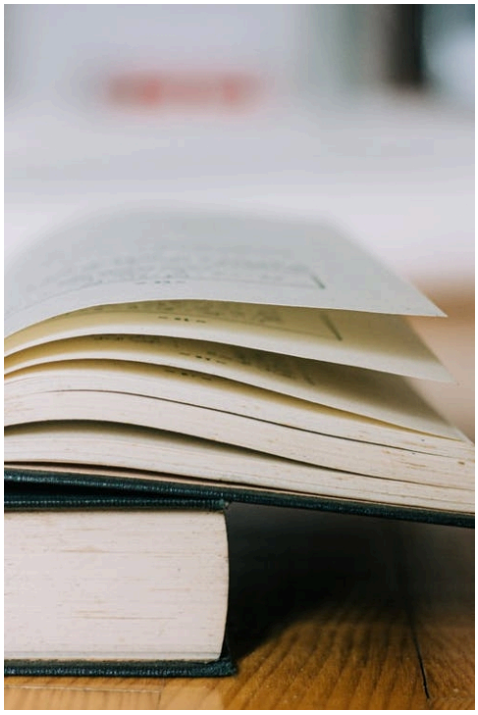
Guardianship and Elder Law Bibliography



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- Community-State Partnerships to Improve End-of-Life Care (https://www.reliasmedia.com/articles/45599-community-state-partnership-to-improve-end-of-life-care-program-curriculum), a former Robert Wood Johnson Foundation-supported project, issued a periodical, *State Initiatives in End-Of-Life Care,* the March 2002 issue of which featured a number of articles on guardianship.

OTHER RESOURCES

- American Bar Association Commission on Law and Aging (https://www.americanbar.org/groups/law_aging/resources/guardianship_law_practice.html)
  Includes a guardianship state legislative update and summary and the document "Health Care Decision-Making Authority: Health Care Agents vs. Court Appointed Guardians."

- California Law Revision Commission (http://www.clrc.ca.gov/)
  Recommendation: Health Care Decisions for Adults Without Decisionmaking Capacity. Important policy document leading to changes in California law.

- Florida Courts, 17th Judicial Circuit, Broward County (http://www.17th.flcourts.org/probate/)
  Offers a handbook for guardians and access to local guardianship procedures and forms.

- The Florida Senate (http://www.flsenate.gov/statutes/)
  This site provides access to all Florida Statutes. Those of particularly relevance to guardianship and surrogate decision making are Chapter 744 and Chapter 765.

- Florida State Guardianship Association (http://www.floridaguardians.com/)

Contains information concerning the nature and various types of guardianships. Membership applications and a schedule of conferences and events are also available.

- Florida State University Center for Innovative Collaboration in Medicine and Law
(http://mediaproduction.med.fsu.edu/mdjd/playmodule/story_html5.html)

  The Center has developed a free online educational module relating to interprofessional collaboration between physicians and attorneys on behalf of their older patients/clients.

- Illinois Office of State Guardian
(https://www2.illinois.gov/sites/gac/OSG/Pages/service-profile.aspx)

  Provides an intake telephone number where information can be obtained concerning many aspects of guardianship, including one module titled “Ethics and guardianship: how do I know how and when to do the right thing?”

- National Guardianship Association
(http://www.guardianship.org/)

  The National Guardianship Association is a national organization for guardians that provides a wide range of resources. This site includes access to “a model code of ethics for guardians” and a “Standards of Practice” document.

- National Center for Ethics in Health Care
(http://www.ethics.va.gov/)

  This Veterans Health Administration site gives policy guidance on the question whether, under HIPAA, clinicians may disclose health information to surrogates. (Answer: Yes, they may.)

- Stetson University Center for Excellence in Elder Law
(https://www.stetson.edu/law/wings/)

  The Center "has adopted WINGS [Working Interdisciplinary Network of Guardianship Stakeholders], a national guardianship [education] program incubated by Florida’s courts ..." Focus is on lawyers.

- University of Miami Miller School of Medicine Institute for Bioethics and Health Policy
(https://bioethics.miami.edu/index.html)

  Includes resources dealing with various ethical issues in health care and business, including an ethics and geriatrics curriculum and a timeline and other material on the Terri Schiavo case.

Please send recommended additions to ethics@miami.edu (mailto:ethics@miami.edu).