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# Legal guardianship and other alternatives in the care of elders with Alzheimer's disease

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## Abstract

*This paper discusses planned instructional and proxy interventions for incapacity, legal guardianship, and supplements to care for people with Alzheimer's disease (AD). Service providers are encouraged to identify and initiate care decisions that are consistent with the client's care preferences. Case examples are discussed. Practitioners are encouraged to educate clients, particularly those in the early stages of Alzheimer's disease, to create evidence for care preferences through planning. Service providers' concerns for liability are briefly discussed.*

*Key words: advance directives, Alzheimer's disease, durable power of attorney, guardianship, health care proxy, instructional directives*

## Introduction

In general, adults are presumed to be capable and competent to make choices and decisions in their own best interests. Our legal system is supported with this assumption. An individual's capacity or competency to make choices and decisions is legally presumed unless the courts have declared otherwise.<sup>1,2</sup> Courts have the responsibility and power to make far-reaching decisions with far-reaching consequences about an individual's capacity or competency to make choices and decisions in their own best interest. Even at first glance, capacity and competency do not appear as incontestable concepts. In fact, capacity is complicated and multifaceted because of the various meanings attached to the content and process by which it is determined. These various meanings can become a tense dialogue for legal, judicial, health, mental health, and social service professionals as well as the individual upon whom the process is focused. Questions of

capacity arise regularly for professionals as they provide service to elders with Alzheimer's disease (AD).

From a legal perspective, capacity is a construct that is treated as fact because of its utility.<sup>3</sup> Thus, the constructs of capacity and incompetence provide a threshold mechanism by which the state may justify direct intervention in an individual's life. Because of the belief that the state has a responsibility to care for its citizens and ensure their safety, these constructs legitimize autonomy-limiting interventions such as guardianship.<sup>4</sup>

Clinical professionals clearly understand that the determination of competency or incompetence is a prerogative of the state. Yet, from that clinical perspective, these professionals would also suggest that they could recognize competence and incompetence when necessary in their delivery of services to specific individuals. However, there remains disagreement among clinical professionals over the meaning of competence and incompetence, how they are defined, and the manner in which they are measured as well as the validity of measurement tools and criteria. Over the years, various standards have been adopted to evaluate capacity. Because of the status and authority of physicians, many judicial decisions regarding the capacity of an individual have been based solely on a psychiatric or medical diagnosis.<sup>5</sup> Currently, legal and clinical professionals have perceived that a capacity decision based on a diagnostic label is a simplistic and unreliable approach to a multidimensional issue.<sup>5-7</sup> Most clinical professionals argue that the assessment of an individual's capacity should incorporate the evaluation of functional behavior as well as cognitive functioning.<sup>5-7</sup> Some judicial, legal, and legislative professionals advocate that an assessment of an individual's capacity should include not only cognitive and functional assessments, but an assessment that determines the individual's absolute need for the intervention of the judicial system.<sup>3</sup> Agreement over the elements in a competency assessment is no less challenging than providing precise criteria for the condition.<sup>1,8</sup>

To further compound issues, terminology, language

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preferences, and their attached meanings have become complicated arenas. Various disciplines favor specific terminology based on discipline-specific perceptions, beliefs, and values. Although this may work well in intradisciplinary settings, it becomes problematic when speaking across professional lines. As an example, capacity and incapacity are currently favored among legislators over competency and incompetency.<sup>3,9</sup> Those advocating the use of this set of terms over others suggest that other terms have stigmatizing historical meanings.<sup>1,9</sup> For the purposes of this paper, however, competency and capacity will be used interchangeably.

## Autonomy

The possibility of a judicial decision of incapacity is a volatile legal and individual issue because of its link to the legitimate termination of personal autonomy. Autonomy is the freedom to choose.<sup>10</sup> If, in the abstract, these constructs are provocative, they become even more so when applied in individual situations. The result of capacity proceedings may be the loss of an individual's autonomy. Put simply, one human being may receive the legal duty to make all decisions and choices for another human being.

While autonomy may be one of the most important rights in many Western societies, the value of an individual's autonomy is questionable when there is associated danger or risk. Do individuals always have the right to make choices, even when those choices are not in their own best interest? Do individuals have the right to make choices and decisions that are dangerous or harmful to self or others? Do individuals have the right to make choices and decisions when their ability to understand the consequences of those choices and decisions is questionable? Do individuals have the right to make choices and decisions when their behaviors fall outside the range of action that is generally considered appropriate and reasonable? Legislative, judicial, health, mental health, and social service professionals will all suggest answers to those questions. Some will note that, since great variation exists among people, variation will exist in the exercise of autonomy. After all, the right to self-determine allows individuals to make "good" or "bad" choices. Yet most will suggest there are limits in the exercise of autonomy. There may not be consensus among these professional groups as they view various individual cases. While most professionals will arrive at their conclusions through discipline-specific training using discipline-specific values, consensus among the various professionals will surface only in certain specific cases. Where there is this general agreement regarding the need to limit an individual's ability to choose, the consequences of these "bad"

choices are so overwhelmingly profound that there is an undeniable need for intervention. In this convergence of agreement, there is an implicit understanding of the principles of nonmaleficence (*i.e.*, preventing harm) and beneficence (*i.e.*, doing good). All disciplines embrace these principles.<sup>11</sup>

The principles of nonmaleficence and beneficence appear noble. Yet, when professionals appeal to these principles, it is usually to justify unsolicited or unwanted intervention in another person's life. In this way, the well intentioned professional is able to protect a reluctant or unwilling client from harm and to provide that which the professional deems the "good" intervention. The client's resistance to the intervention can be countered because the professional appeals to a superior and beneficent expertise. Because the professional appeals to nonmaleficence and beneficence, the professional promotes the "good" of the clients and prevents her or him from making a "bad" choice or one "not in her or his best interest." These beneficent professional interventions may be evaluated by others, including peers or professionals of other disciplines, as appropriate or inappropriate, depending on individual preferences and discipline-specific values and training. However, seen from another perspective, these noble principles are the underpinnings of paternalism.<sup>8,12</sup>

While an ethical conundrum to some, most professionals would prefer to be accused of paternalism rather than incompetence, malpractice, or liability, all of which may result if professionals do not act within the prescribed standard of care. Clearly, in cases of harmful consequences or the need for immediate rescue, paternalistic or beneficent intervention is justified.<sup>13</sup> Most professionals would argue that in these cases the need for intervention is of critical importance to prevent harm or ensure safety. The concern over an individual's being in danger of harm or in need of rescue justifies the interference in an individual's autonomy.<sup>12,14</sup> While it is easy to articulate these seemingly simple principles, application in individual situations is not always so neat, clear, incontestable, or feasible. Sabatino sums up the concerns of all the players in questions of capacity, beneficence, and paternalism: "In the real world, autonomy is messy."<sup>3</sup>

## Autonomy, beneficence, and the elder with Alzheimer's disease

In a culture that values youth, the "old" are often perceived as less valuable. Even among various professional groups, research indicates that attitudes and perceptions toward older people fall somewhere, at best, in the neutral area of the attitude continuum.<sup>15-18</sup> Ageism insidiously pervades much of contemporary society, including

service delivery options and environments.<sup>19,20</sup> Studies show that relatively few individuals choose to pursue a professional career in service of older people,<sup>21</sup> particularly people with Alzheimer's disease.<sup>18</sup> A common ageist misperception is attributing memory impairment to most older adults and significantly overestimating the incidence of AD within the general population. Some researchers have identified this as a new and subtle form of ageism.<sup>19</sup>

In spite of public and professional attitudes and perceptions, determining capacity for individuals with Alzheimer's disease is not a clear-cut issue. As noted previously, criteria for determining capacity vary by geographic location, time, discipline-specific assessment, legislative intent, and judicial opinion.<sup>1,5-7</sup> Because the disease process itself is uneven and unpredictable, great individual variation exists among those affected.<sup>22</sup> Capacity is not an all-or-nothing condition, but rather a continuum, incorporating wide variations between total capacity and total incapacity. With this variation in capacity comes a range of possibilities for each individual elder with AD, and her or his ability to make well reasoned and rational decisions.

The need for beneficent intervention in the autonomy of an elder with AD is undoubtedly indicated when harmful consequences will result or immediate rescue is needed.<sup>13,14</sup> Most professionals are able to recount situations in which memory impaired elders were in need of beneficent intervention "in their own best interest." Local evening news broadcasts regularly inform of a memory impaired elder living in filth amid stacks of newspapers and garbage, with weeks-old spoiled food in the refrigerator. Newspapers tell tales of elders with AD wandering away from home, becoming lost, and then being found in risk of dying from exposure to cold or drowning. In these extraordinary cases, there is a convergence of professional opinion that beneficent intervention is justifiable and even required.

As certain as the need for beneficent intervention is in the above examples, there are also cases in which the motivation for the intervention is suspect and questionable. Some have noted that capacity concerns are less likely to be referred for legal determination when clients concur with service providers than when they do not concur or are noncompliant.<sup>23,24</sup> Older patients appear more likely to undergo psychiatric evaluation when they refuse medical intervention than when they agree to service.<sup>25</sup> When individuals lack the skills to articulate their preferences, the decisions of family members and professionals may prevail.<sup>26</sup> Clearly, the motivation of the individual initiating an intervention must be scrutinized. Although the motivation for individuals initiating intervention may vary, two primary motivations have been

documented in the literature: (1) altruism, or beneficent desires for the good and safety of the individual with AD; and (2) the self-interests and desires of other parties who will benefit as a result of the intervention.<sup>1</sup> In the latter instance, service providers, family members, agencies, or institutions initiate the intervention legitimately to benefit themselves with or without a concern for the best interest of the elder with AD. In these cases, service providers may be attempting to provide a service that meets a prescribed standard of care, agencies may be worried about reimbursement, family members may be seeking control of assets, or health care facilities may be seeking to obtain consent for the provision of reimbursable services.<sup>1</sup> Although beneficial to the party initiating the intervention, these interventions may not necessarily prove beneficial to the elder with AD.

While guardianship may be the most visible means of limiting individual autonomy, it is not the only intervention available to prevent harm, ensure safety, or rescue individuals with Alzheimer's disease. Some intervention strategies may be prearranged or planned prior to any compromise in an individual's capacity. Planned strategies help to ensure that any necessary intervention approximates an individual's care preferences. These planned interventions may be instructional in nature or involve substitute judgment. The following sections will discuss various options that may be initiated, particularly with individuals in the early stages of AD, as well as feasible options for individuals in more advanced stages of memory impairment.

## Planned interventions for incapacity

All people, particularly those forewarned that they will face the challenges of memory impairment, should plan their future care preferences. Many people have considered, deliberately or accidentally, which care options are palatable to them and consistent with their beliefs and values. These deliberations are often brief and a result of exposure to friends and relatives who receive "hi-tech," life-prolonging intervention. Not infrequently, questions arise as to the acceptability, value, and appropriateness of these interventions. Individuals in very early stages of AD and other types of memory impairment are generally capable of making decisions regarding their future care. These decisions allow individuals to advocate for future care that is consistent with their individual "value histories."<sup>27</sup> Based on personal values and beliefs, value histories provide information on care preferences that seem reasonable, acceptable, and desirable for an individual. Obviously, an individual's value history must be known to various professionals in order to be acknowledged and executed. Individuals must

ensure that care preferences are known by professional care providers as well as those who would be called to act in the form of substituted judgement (*e.g.*, guardians, proxies, surrogates, or agents). Among various ethnocultural groups, family members may be an extremely valuable source of support and information about the elder with AD.<sup>28</sup> In essence, this process attempts to “create as much evidence as possible regarding preferences, by specifying choices and expressing relevant opinions.”<sup>29</sup> To create evidence in these cases may involve both instructional and proxy directives.

### *Instructional directives*

There are four common types of instructional directives that may inform professional care providers of clients’ value histories: inferred communication, oral communication, personal written instructions, and living wills.<sup>29</sup> Each is briefly reviewed.

Inferred communication is instruction deduced from an individual’s personal values and beliefs as well as the ideologies of various organizations of which the individual is a member. Frequently, these inferences are based on the individual’s association with religious, philosophical, political, or social organizations. As an example, the use of bloodless medical interventions might be inferred for members of specific religious groups.

Oral communication, prior to capacity concerns, may provide valuable information on care preferences. These communications may take the form of informal reflections (“It’s a shame the way my brother has all those tubes and wires in him...I’d rather just die!”) or formal oral directives (“Promise that you will not let them put me on a machine when they know there isn’t much hope of getting back to my old self.”). These communications may be made to health, mental health, religious, or legal professionals as well as family and friends. These oral communications provide valuable insight into the individual’s value history<sup>27</sup> and merit compliance.

Personal written instructions possess greater reliability than do inferred or oral communications.<sup>29</sup> Individuals in the early stages of AD may be encouraged to write detailed instructions regarding their future care. These written instructions may provide evidence of capacity if future care options are challenged by others. Further, these written instructions help ensure that an individual’s care preferences are observed.<sup>30</sup>

Living wills are written documents that identify care preferences and come into play when individuals are no longer capable of making decisions about life-sustaining medical treatment.<sup>1</sup> Originally, the living will was conceived as a statement that affirmed the right of an individual with a terminal illness to die without the use of

artificial and heroic measures.<sup>1</sup> Living wills are generally standardized and somewhat vague documents, which provide little detailed information on care preferences for specific situations. Instead, they provide general information on care preferences applicable in a variety of settings and for a number of health concerns. Living wills have several limitations as a result of their ambiguous nature. Health care professionals may be unaware of the existence of a patient’s living will.<sup>1</sup> In the event of a health care emergency where a provider is unaware of care preferences outlined in a living will, these care preferences probably will not be observed. Health care providers may also subvert the intentions documented in the living will by refusing to acknowledge clinically the presence of a terminal illness, a precondition for the activation of most living wills.<sup>1,31</sup> Additionally, requirements for living wills vary from location to location. Individuals who have executed living wills should understand that they frequently rely on the willingness of health professionals to respect a document that has limited coercive weight.<sup>32</sup> Clearly, a living will documents care choices for selective situations, which may not be honored by the health care provider.

### *Proxy directives*

Proxy directives include power of attorney, durable power of attorney, and health care surrogate. (A discussion of guardianship follows later in this article.) Each is briefly reviewed.

A power of attorney is a document in which one person (the “principal”) gives another person (the “agent”) the legal authority to act on her or his behalf. Agents are generally individuals well known to the principal, such as trusted family members, professional associates, advisors, or friends.<sup>1</sup> The document is time-limited, and may include activities such as signing checks, managing assets, etc. These documents are useful when a person is away for an extended period of time or feels unable to manage specific tasks without assistance. A power of attorney becomes ineffective when an individual becomes incapacitated. Thus, when the elder with AD presents with questionable competency, the power of attorney becomes ineffective.

Similar to the power of attorney is the durable power of attorney. The durable power of attorney is a document that remains effective, even when an elder with AD becomes incapacitated. The standard durable power of attorney becomes effective immediately upon execution. Another type of durable power of attorney, referred to as a “springing” durable power of attorney, may not come into effect until some condition is met, such as a serious illness or incapacity of the principal. A durable power of

attorney remains in effect until it is competently revoked or the death of the principal. Based on the powers and duties outlined in the durable power of attorney, agents may be responsible for an elder's financial, legal, and personal matters.<sup>33</sup> Most states have legislation that identifies the requirements for durable powers of attorney responsible for another person's legal, financial and personal matters.<sup>1</sup> Additionally, most states have legislation that identifies the requirements for health care durable powers of attorney or health care proxies.<sup>1</sup> Legal requirements for these two types of durable powers of attorney may be different. Health care surrogates act as agents when the principal becomes incapacitated and medical decisions are required. Powers of attorney and durable powers of attorney should be prepared by a lawyer, as the specific duties and powers attached to these documents must be specifically outlined and in compliance with state requirements.

*Case example.* Mrs. P, a widow of many years, has become increasingly frail and demonstrating some evidence of memory impairment. Her daughter lives in the same city and speaks with or visits Mrs. P daily. Over the years, Mrs. P has repeatedly told her daughter that she regrets allowing her husband to die in the hospital, "filled with tubes and surrounded by those machines." Mrs. P has orally communicated portions of her value history at these times. At her Ladies Society meeting at church two years ago, a member of a law firm had spoken on advance directives. Mrs. P had completed a living will the previous year, but was encouraged by this presentation to appoint a health care proxy to make health care decisions should she become incapacitated. Mrs. P identified her daughter in the document as her choice and she agreed to perform this task. At her daughter's request, Mrs. P discussed many of her health care preferences with her daughter to make sure that she understood her wishes. Since Mrs. P has been very active in her church, she shared much of the same information with several members of her congregation and her priest. Several weeks later and because of a substantial number of assets in the estate, Mrs. P also opted to draft a springing durable power of attorney, which outlined all the responsibilities she would like her daughter to assume should she become incapacitated and unable to perform these tasks. At this point, Mrs. P has planned for her future care and established a value history.

## Guardianship

Guardianship is based on the legal doctrine of *parens patriae*, *i.e.*, the belief that the state has the right and duty to protect individuals and their property when they are unable to care for themselves.<sup>1,3,8,34</sup> This doctrine is not a

recent development. English law of the 14th century proposed that the sovereign (*i.e.*, the state) care for the estate and property of "idiots" and "lunatics," who were unable to care for themselves.<sup>3,4</sup> Since these laws only involved the propertied class of individuals, the sovereign's motivation and involvement was to ensure economic stability and prevent disorder.<sup>1,3</sup>

Currently, all states have guardianship provisions, which allow the courts to appoint a substitute decision-maker for a mentally incompetent ward.<sup>1</sup> Substitute decision-makers have the power to make financial, personal, legal, and health care choices for their ward, depending on the type of guardianship the court imposes. Various states identify several types of guardianship. Commonly, courts appoint guardians of property, sometimes called conservators, and plenary guardians. Guardians of property are responsible for the financial assets of the ward, whereas plenary guardians are responsible for assets and every other aspect of the ward.<sup>1</sup>

Although most states recognize partial or limited guardianship, few courts appoint limited guardians.<sup>1,6,7,24,35,36</sup> This is difficult to understand in light of the United States Supreme Court's interpretation of due process, which suggests that government interference into individual freedom is to be delivered at the least restrictive level possible.<sup>1</sup> Limited guardianships, when appropriate, may allow wards to retain various civil rights and articulate care preferences, based on their value histories. Along the competency continuum,<sup>12</sup> it is not uncommon for elders with AD to retain capacity for some decisions.<sup>8,12</sup> Limited guardianships may well offer the required support and structure for a memory impaired individual, while allowing the individual to maintain some autonomy. If further reducing autonomy becomes necessary at a later time, the guardian must return to court. Although this would require a greater commitment of time and energy from the courts, court evaluators, and limited guardians, it would also support the individual in maintaining her or his civil rights as long as possible.

Clearly, plenary guardianship is the most restrictive and autonomy-limiting intervention, as it suspends an individual's civil rights.<sup>7</sup> Wards may be denied their right to vote, marry, travel, drive, be employed, enter contracts, manage property, consent to medical treatment, chose a residence, or even pursue a social life.<sup>37</sup>

The process for establishing guardianship can be cumbersome and expensive,<sup>29</sup> and is specific to each state.<sup>1,8</sup> To determine that individuals are incapable of caring for themselves due to mental incapacity is not a clearly defined procedure. State-specific legislation establishes the legal requirements for guardianship. According to most state statutes, establishing incapacity or incompetence is more than simply having a physician

provide a medical or psychiatric diagnosis. Among the criteria regarded in various states to distinguish capacity from incapacity are tests for functional behavior, cognitive functioning, disabling conditions, and measuring the ability to meet essential needs and avoid endangerment.<sup>3</sup> None of these alone is a sufficient test to establish incapacity requiring guardianship. Some argue that if an individual is cognitively impaired but in no danger of harm or loss, a guardianship is not necessary. This argument holds that capacity assessment requires a test of cognitive functioning and must incorporate a “consequential behavior element.”<sup>3</sup> Thus, it must be demonstrated to the court that the individual is in danger of harm or loss due to the impairment. If this cannot be established, less restrictive interventions should be considered.<sup>3</sup>

Although sometimes the only available option, abuse of guardianship is abundantly documented. Most states do not determine how capacity is to be assessed.<sup>1,3,8</sup> Court records repeatedly indicate that guardianships have been established based on a diagnosis alone.<sup>1,5</sup> Much appears left to the courts’ discretion.<sup>1,3</sup> Those who are in the greatest risk of being declared a guardian’s ward appear to be single females with assets.<sup>1,5</sup> Finally, most guardianships appear to be plenary guardianships with no proof that limited guardianships would not have met the need.<sup>1,6,7,24,35,36</sup>

Guardianship may be the only option in cases where there is an issue of danger of harm or loss, and there are no relatives, friends, close advisors, or business partners to offer alternative solutions. In situations where there is no advance directive or family and the elder with AD is in danger of harm or loss, few options other than guardianship may be feasible. In these cases, if there are sufficient assets, professional guardianship services may assume the duties of guardian. Where there are few or no assets, public guardianship may be the only available option.

Some have suggested that courts rarely need to be involved in the care of elders with AD and other types of dementia.<sup>26</sup> Clearly, if an individual is not in danger of harm or loss due to cognitive impairment, less restrictive interventions should be considered. These interventions may include care management, adult protective services, and representative payee services.

*Case example.* Mr. J has been found many times wandering around the city, inappropriately dressed for the season, confused, and unkempt. He appears thin and frail, and is disoriented to time, place, and person. Police have taken him to his home several times, but he is generally found again wandering through the city a few days later. He frequently tells the police officer that he is searching for his brother, who was lost in World War II. He is widowed and has no children. One niece lives about 200 miles away. The last time the police found Mr. J wandering the streets looking for his

brother, they were concerned about his emaciated appearance and took him to the local emergency room. The physician requested a psychiatric consult and discharge planning when he insisted on being discharged. Following these assessments, members of Mr. J’s family were contacted. Mr. J stated he wanted to continue to search for his brother. His niece agreed to care for him, but, because of his recurrent wandering behavior and self-neglect, initiated guardianship proceedings. Mr. J was declared incompetent due to his confusion, memory impairment, and inability to care for himself. Because of current and future danger to self, his niece was appointed plenary guardian.

## Supplements to care

Not all elders with Alzheimer’s disease require a legal guardian. Many are not in danger of harm or loss. Regularly, informal caregiving by family members precludes the necessity of guardianship. Various beliefs regarding responsible care of family elders with AD are important among various ethnocultural groups.<sup>28</sup>

For a proactive individual, viable alternatives to guardianship exist and can be exercised. Of particular importance are those discussed earlier, including instructional directives and proxy directives. In guardianship and other fiduciary relationships, an agent is trusted and empowered to act for the benefit of another person.<sup>42</sup> Other options, not based on a fiduciary relationship, may supplement care. These may include care management, adult protective services, and money management or representative payee services.<sup>11</sup> Many of these options can be used by guardians, health care proxies, and durable powers of attorney. Each of these is briefly reviewed.

### *Care management*

Through assessment, development, and coordination of a comprehensive care plan, care managers identify and provide for a client’s medical, psychosocial, and financial needs. Care management services may be obtained through state and federally subsidized care management programs, nonprofit agencies, and for-profit care management agencies.<sup>11</sup> These services may provide an effective means to delay, or even to prevent, guardianship in some cases.

Additionally, care managers may provide services at the request of guardians, durable powers of attorney, and health care surrogates. In the process, care managers may allow clients to express their value histories and assist in determining care preferences.

### *Adult protective services*

Adult protective services (APS) normally are accessed

when individuals are no longer able to care for themselves (self-neglect) or are being abused. In these cases, service recommendations may be enforced. Under APS authority, elders may be removed from their homes if they are deemed to be in danger of harm or loss. Rarely are APS services voluntarily sought. Nonetheless, APS may engage in preventive, supportive, and surrogate services.<sup>11</sup> APS may recommend court-appointed surrogates in some situations. Frequently, APS has limited resources, expanding case loads, and may choose to intervene only in crisis situations.

### *Representative payee services and money management*

Two critically important tasks that are regularly evaluated in capacity proceedings are: (a) an individual's ability to take medications as prescribed, and (b) an individual's ability to manage personal finances.<sup>38,39</sup> Many organizations, both for-profit and nonprofit, currently offer money management services. The Social Security Administration (SSA) has encouraged agencies to assume the responsibility of representative payee for elderly clients.<sup>40</sup> These services may be provided at no cost to the client, on a sliding fee schedule, or on a fee-for-service basis. There is great diversity among this group of service providers, their credentials, and their abilities. In some cases, these professionals work closely with elders and attend to care preferences and value histories. For elders with family support, joint bank accounts may be similarly effective. The use of these strategies may delay, if not prevent, guardianship.

### *Liability and risk concerns*

Few doubt that we live in a litigious society. Most health, mental health, and social service providers have been schooled in risk-management strategies and quality-assurance techniques, and they have malpractice and liability insurance. In dealing with elders and autonomy, particularly elders with memory impairment, the concern arises: "Can I be sued?" Legal supervision by an attorney is necessary and professionally beneficial.<sup>41,42</sup> Nonetheless, service providers appear to experience anxiety surrounding professional liability and are unable to articulate specific legal fears.<sup>11</sup> Some service providers, with sound reasons, appear to be more concerned about the possibility of negative publicity associated with an allegation or accusation than liability itself.<sup>11</sup> Risk-management strategies developed within accepted standards of care and informed by expert legal advice appreciably reduce liability concerns. Additionally, attentiveness to care preferences informed by value histories assist in risk management.

Service providers must obtain informed consent prior to service delivery. Informed consent presumes that the recipient of services is voluntarily accepting them, has received complete information in order to make a reasonable decision, and is competent to understand the information.<sup>8</sup> When an individual is unable to contract for services due to competency issues, surrogate decision-makers may provide consent. In cases where a guardian or formal surrogate has been authorized to make these decisions, service providers may accept the consent of surrogates who possess formal authority. In situations in which there is no legally authorized surrogate decision maker, service providers have been known to accept consent from family members. However, greater restraint must be exercised in cases where there is no formal surrogate decision-maker and there is disagreement among family members. In these cases, there may be no other option than seeking a court-appointed surrogate decision-maker prior to service delivery.

### *Resistance to care alternatives*

While various care alternatives seem appealing to many professionals, these same professionals may view these alternatives as malpractice and liability risks. To some extent, they may be. Some practitioners would prefer that all interventions be directed through court-approved proxies. This belief is based on the notion that guardianship and other forms of substituted judgement reduce liability concerns. However, practitioners would do well to remember that the risk of litigation increases when care is substandard, providers commit acts of fraud, or disregard the well-being of their clients.<sup>11,43</sup> At present, litigation against providers of care alternatives appears rare.<sup>11</sup>

In addition to fear of liability, various care alternatives have met with provider reluctance due to inadequate funding.<sup>11</sup> Currently, there are few reliably funded services available to elders who need care at various points along the capacity continuum. Professionals frequently do not choose to use alternative approaches to care because of reimbursement concerns, misunderstanding of these alternatives, or liability issues.<sup>44</sup>

### *Conclusion*

This article has reviewed capacity issues in providing services to elders with memory impairment, particularly the interplay of autonomy, beneficence, and paternalism. Planned instructional and proxy directives, guardianship, and care alternatives have been reviewed. Practitioners are encouraged to be respectful of care preferences, as established by the client's value history,

if possible. Finally, the profoundly restrictive aspects of guardianship have been discussed along with strategies to determine when less restrictive alternatives may be appropriate.

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