

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 402
(A-24)

Introduced by: Medical Student Section

Subject: Guardianship and Conservatorship Reform

Referred to: Reference Committee D

1 Whereas, 1.3 million people (including their \$50 billion in assets) are in court-appointed
2 guardianships or conservatorships, the vast majority of which are permanent guardianships, the
3 most restrictive form and the most difficult and expensive to amend¹; and
4

5 Whereas, due to wide state variation, data on guardian abuse is limited, but reports indicate
6 hundreds of cases of physical and financial abuse¹⁻⁴; and
7

8 Whereas, a Senate Committee on Aging report noted the harm of our guardianship system on
9 older and disabled patients, and emphasized the need for less restrictive alternatives¹; and
10

11 Whereas, the elderly American population is projected to nearly double by 2060 and comprise
12 over 20% of the total population^{1,5-6}; and
13

14 Whereas, physicians play a major role in determining guardianships by providing medical
15 evidence and expertise⁷; and
16

17 Whereas, individuals with intellectual and developmental disabilities (IDD) face barriers to
18 adequate capacity determinations that increase their risk of overly restrictive guardianships⁸;
19 and
20

21 Whereas, supported decision making (SDM) is a less restrictive alternative to guardianships
22 already adopted by 12 states and several other countries that demonstrates preservation of
23 decision-making capacity, cognitive function, and social support⁹⁻¹¹; therefore be it
24

25 RESOLVED, that our American Medical Association support federal and state efforts to collect
26 anonymized data on guardianships and conservatorships to assess the effects on medical
27 decision making and rates of abuse (New HOD Policy); and be it further
28

29 RESOLVED, that our AMA study the impact of less restrictive alternatives to guardianships and
30 conservatorships including supported decision making on medical decision making, health
31 outcomes, and quality of life. (Directive to Take Action)
32

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 03/28/2024

REFERENCES

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3. Margaret "Jenny" Hatch, Samantha Alexandra Crane, Jonathan G. Martinis; Unjustified Isolation Is Discrimination: The *Olmstead* Case Against Overbroad and Undue Organizational and Public Guardianship. *Inclusion* 1 June 2015; 3 (2): 65–74. doi: <https://doi.org/10.1352/2326-6988-3.2.65>
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10. Peterson, Andrew et al. "Supported Decision Making With People at the Margins of Autonomy." *The American journal of bioethics : AJOB* vol. 21,11 (2021): 4-18. doi:10.1080/15265161.2020.1863507
11. National Resource Center for Supported Decision-Making, In Your State, accessed March 10, 2022. <http://www.supporteddecisionmaking.org/states>

RELEVANT AMA POLICY

H-140.845 Encouraging the Use of Advance Directives and Health Care Powers of Attorney

Our AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives. [CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 9, I-15; Reaffirmed: Res. 517, A-16; Reaffirmed: BOT Rep. 05, I-16; Reaffirmed in lieu of: Res. 121, A-17]

Code of Medical Ethics Opinion 2.1.2 Decisions for Adult Patients Who Lack Capacity

Respect for patient autonomy is central to professional ethics and physicians should involve patients in health care decisions commensurate with the patient's decision-making capacity. Even when a medical condition or disorder impairs a patient's decision-making capacity, the patient may still be able to participate in some aspects of decision making. Physicians should engage patients whose capacity is impaired in decisions involving their own care to the greatest extent possible, including when the patient has previously designated a surrogate to make decisions on his or her behalf.

When a patient lacks decision-making capacity, the physician has an ethical responsibility to:

- (a) Identify an appropriate surrogate to make decisions on the patient's behalf:
 - (i) the person the patient designated as surrogate through a durable power of attorney for health care or other mechanism; or
 - (ii) a family member or other intimate associate, in keeping with applicable law and policy if the patient has not previously designated a surrogate.
- (b) Recognize that the patient's surrogate is entitled to the same respect as the patient.
- (c) Provide advice, guidance, and support to the surrogate.
- (d) Assist the surrogate to make decisions in keeping with the standard of substituted judgment, basing decisions on:
 - (i) the patient's preferences (if any) as expressed in an advance directive or as documented in the medical record;
 - (ii) the patient's views about life and how it should be lived;
 - (iii) how the patient constructed his or her life story; and
 - (iv) the patient's attitudes toward sickness, suffering, and certain medical procedures.
- (e) Assist the surrogate to make decisions in keeping with the best interest standard when the patient's preferences and values are not known and cannot reasonably be inferred, such as when the patient has not previously expressed preferences or has never had decision-making capacity. Best interest decisions should be based on:
 - (i) the pain and suffering associated with the intervention;
 - (ii) the degree of and potential for benefit;
 - (iii) impairments that may result from the intervention;
 - (iv) quality of life as experienced by the patient.
- (f) Consult an ethics committee or other institutional resource when:
 - (i) no surrogate is available or there is ongoing disagreement about who is the appropriate surrogate;
 - (ii) ongoing disagreement about a treatment decision cannot be resolved; or
 - (iii) the physician judges that the surrogate's decision:
 - a. is clearly not what the patient would have decided when the patient's preferences are known or can be inferred;
 - b. could not reasonably be judged to be in the patient's best interest; or
 - c. primarily serves the interests of the surrogate or other third party rather than the patient.

AMA Principles of Medical Ethics: I,III,VIII; Issued: 2016