

## *Elder Abuse*

### **Legal Issues Related to Bank Reporting of Suspected Elder Financial Abuse<sup>1</sup>**

By Sandra L. Hughes, J.D.<sup>2</sup>

#### **Introduction**

Since the 1990s, adult protective services (APS) workers and advocates for elder abuse victims have promoted the idea that bank personnel can prevent elder financial abuse by recognizing it and reporting their suspicions to APS and law enforcement authorities. Some states have developed “bank reporting projects” to train bank personnel to recognize and report suspected elder financial abuse (the most well known projects are in Massachusetts and Oregon). Other states are attempting to implement similar programs. Banks and other depository institutions,<sup>3</sup> however, have traditionally resisted enactment of statutes requiring or encouraging reporting and participation in both voluntary and mandatory reporting programs, expressing concern that disclosure of confidential information regarding a customer may result in liability.

This article will help APS workers and advocates for elder abuse victims understand the legal issues that banks may raise. It examines the perceived legal obstacles to participation by banks in reporting programs and concludes that although minor amendments to state law may, in some cases, be necessary, there are no significant legal reasons why bank personnel cannot report suspected elder abuse.

#### **Mandatory Reporting Provisions in APS Statutes**

States that do not already either list banks as mandatory reporters or have universal mandatory reporting (*i.e.*, require “any person” to report suspected elder abuse) may consider amending their APS statutes to add banks as mandatory reporters as the first step in implementing a bank reporting

*Continued on page 2*

## *Guardianship*

### **Health Care Decision-Making: A Guardian’s Authority**

By Sarah B. Richardson<sup>1</sup>

A guardian of the person (“guardian”)<sup>2</sup> is a court-appointed decision-maker selected for individuals who lack capacity to manage their own personal care and physical well-being.<sup>3</sup> Courts appoint guardians after a screening procedure that considers evidence submitted by the alleged incapacitated person’s physicians and other interested persons. The court then writes an order describing the duration and scope of the guardian’s powers. The guardianship order is the starting point for analysis of a guardian’s authority, and it may be expanded or restricted throughout the guardian’s appointment. Together with the guardianship order, a state’s statutes and case law provide the legal framework for reviewing and monitoring a guardian’s performance.

This article provides a national comparison of statutes establishing a guardian’s health care decision-making authority, restrictions, and standards.<sup>4</sup> A close look is also given to statutes that clarify the ultimate decision-making authority between a guardian and an agent under a medical power of attorney. Case law is not considered here, nor are variations that may appear in individual guardianship orders.

Most state statutes award guardians health care decision-making powers in broad-brush fashion. Twenty-five states

*Continued on page 5*

## **Inside**

**Winners of the 2003 Law and Aging Student Essay Competition (page 14)**

**GrandDriver Steers Public to Aging’s Effects on Driving (page 14)**

**State Bar Updates: Maryland’s Elder Law Section Wins Best Project Award; California Publishes Consumer Legal Guide for Seniors (pages 14 & 15)**

**Register Now for NALC! (see back page)**

## Bank Reporting of Suspected Elder Financial Abuse

*Continued from page 1*

program. However, the states that have attempted to do so have typically encountered considerable resistance from the banking industry and have not been successful.<sup>4</sup> In Massachusetts and Oregon the state bankers associations strongly opposed a proposal for mandatory reporting. Both states decided to compromise on the issue, thus securing the industry's cooperation in developing a voluntary program. As a result, both states now have very successful reporting programs, as do several other voluntary reporting states.

To address the problem of elder abuse, the legislatures of all 50 states and the District of Columbia enacted laws that establish APS programs and criteria for those services. Recognizing that elder abuse is a hidden problem, the legislature created either mandatory or voluntary reporting schemes. As of the end of 2001, all but six jurisdictions had

some form of mandatory reporting requirement in their APS laws. The other six states (Colorado, New Jersey, New York, North Dakota, South Dakota, and Wisconsin) authorize voluntary reporting.

In the 45 jurisdictions that mandate reporting, the categories of persons who are required to report suspected elder abuse vary considerably from state to state. Bank personnel are mandatory reporters in three states: Florida, Georgia, and Mississippi. Fifteen other states have universal mandatory reporting laws; in these states, banks are also obligated to report abuse. These states are: Delaware, Indiana, Kentucky, Louisiana, Missouri, New Hampshire, New Mexico, North Carolina, Oklahoma, Rhode Island, South Carolina,<sup>5</sup> Tennessee, Texas, Utah, and Wyoming. Banks are voluntary reporters in all other states.

States that have mandatory reporting schemes have found that such a law can help prod the banking industry to support a reporting project. This has been the experience in Utah, where the APS statute requires reporting by "any person" who suspects abuse, including financial exploitation.

## Federal Bank Privacy Laws

Banks often cite concerns about the possibility of being charged with a violation of the federal statutes that govern the disclosure of private financial records as a barrier to participation in reporting programs. However, the two federal laws most frequently cited do not prohibit reporting to APS.

The first law, the Right to Financial Privacy Act ("RFPA"), provides that in most circumstances, a customer must be given prior notice and an opportunity to challenge the government's action in court before the government can obtain customer information from a financial institution. However, the RFPA applies only to the federal government and it therefore places no restrictions on the action of state and local agencies in obtaining financial records and information.<sup>6</sup> Therefore, a bank can reveal customer financial information to APS or to state or local law enforcement as part of a voluntary or mandatory report of suspected financial abuse without risking prosecution for a violation of the RFPA. (The same analysis applies to a response to a request for bank records in connection with an APS investigation.)

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Correction: The article "Reaching Out to Homebound Elderly" that appeared in the Vol. 24, No. 3, Spring 2003 issue was written by Mary H. Quigley, Director of the Special Projects Unit of Legal Services of Eastern Missouri.

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The second law, the Financial Services Modernization Act of 1999 (popularly known as the Gramm-Leach-Bliley Act), does contain extensive privacy provisions that apply both to the federal government and to state and local governments. There are several exceptions to the Act, however, that permit the disclosure of “nonpublic personal information.” Some of these exemptions apply to mandatory reporting, voluntary reporting, or both. Subsection (e)(3)(B) permits disclosure “to protect against or to prevent actual or potential fraud, unauthorized transactions, claims, or other liability.”<sup>7</sup> Subsection (e)(5) permits disclosure “to the extent specifically permitted or required under other provisions of law... to law enforcement agencies... or for an investigation on a matter related to public safety.”<sup>8</sup> In addition, Subsection (e)(8), which permits disclosure “to comply with federal, state, or local laws, rules, and other applicable legal requirements,” would allow disclosures in connection with an APS investigation.<sup>9</sup>

In an opinion letter regarding the legality of Michigan’s bank reporting procedures, the seven federal regulatory agencies responsible for enforcement of the Gramm-Leach-Bliley Act stated that reporting suspected financial abuse falls within the exceptions to the Act that were discussed above.<sup>10</sup> However, the opinion letter indicated the importance of Michigan’s investigation and reporting protocols as a factor in formulating the opinion, and it is uncertain whether the same result would have been reached if these protocols did not exist.

APS agencies in other states may, if appropriate, want to consider developing or revising their protocols to address reporting by bank personnel. APS agencies may also want to request a similar opinion letter about their state’s law and procedures. Agency directors, state banking officials, and other government officials may request an opinion letter from the federal agencies, or they may ask their Congressional representatives to request such a letter. Regardless of what entity solicits the opinion letter, in order to expedite the response, any request should include copies of pertinent statutes, regulations, and protocols. Agencies that do not currently have protocols may want to submit bank training and other pertinent materials in addition to their state statute(s) and regulation(s).

## State Bank Privacy Laws

Most states have statutory law, case law, or both that protects the privacy of financial institution records and specifies the circumstances under which banks can lawfully disclose customer information. Statutory provisions regarding disclosure of financial records vary greatly from state to state, making it impossible to generalize about whether disclosure as part of

a report to APS may violate a state’s financial privacy rules. In some states, the law clearly permits disclosure to APS. For example, Nevada law provides that a financial institution may “in its discretion” initiate contact with and disclose “the financial records of a customer to appropriate governmental agencies concerning a suspected violation of the law.”<sup>11</sup> Such a law would protect banks from liability for disclosure whether they are located in a mandatory or a voluntary reporting state.

In other states, the financial privacy law does not permit disclosure to APS. In these states, statutory amendments may be needed to make it clear that disclosure to APS by banks is lawful. For example, the state of Maryland recently amended its provision on “allowable financial disclosures by fiduciary institutions” to specify that disclosure to APS is an allowable disclosure:

Notwithstanding any other provision of law, a fiduciary institution or an officer, employee, agent, or director of a fiduciary institution may disclose financial records and any other information relating to a customer of the fiduciary institution if the fiduciary institution...:

- (1) Believes that the customer has been subjected to financial exploitation; and
- (2) Makes the disclosure in a report to the adult protective services program in a local department of social services.<sup>12</sup>

## Immunity Provisions in APS Statutes

Banks also frequently express concern that a customer will sue for damages in connection with a report to APS and the disclosure of the customer’s private account information. With one exception,<sup>13</sup> the state APS laws provide immunity from civil or both civil and criminal liability to reporters of abuse who act in good faith.<sup>14</sup> If a bank falls within the scope of the immunity provision, the bank should be protected both from liability to the customer for alleged damages and from liability for violation of the state’s financial privacy law, if it is applicable.

Some immunity statutes may not provide adequate protection to banks, however. The typical state immunity provision gives immunity to “any person” or “anyone” who makes a report of financial abuse. This raises the question of whether the immunity provision protects both the employee who makes the report and the bank or financial institution that employs the reporting employee (which is almost surely the intention of the statute) or whether only the employee is

*Continued on page 4*

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## Bank Reporting of Suspected Elder Financial Abuse

*Continued from page 3*

protected. The answer turns on whether the term “any person” or “anyone” refers only to individual people or whether it also includes corporations, associations, and similar entities. In many states, the term “person” is interpreted broadly to include corporations and other entities. For example, a District of Columbia court stated: “Statutory use of the word persons to include corporations is so general that to hold corporations are not included requires clear proof of legislative intent to exclude them.”<sup>15</sup> In some other states, there is a statutory provision that defines the term “person” for all state laws. To illustrate, the law in Washington, which is typical, provides that the “term ‘person’ may be construed to include ... any public or private corporation or limited liability company, as well as an individual.”<sup>16</sup>

In states where the immunity provision is ambiguous or limited in its scope, leaving banks uncertain about whether they are fully protected, statutory amendments may be needed to clarify and expand its scope. In Texas, which has been attempting to implement a bank reporting program modeled on the Massachusetts and Oregon projects, the APS statute’s immunity provision was amended last year to reassure the banking community. The statute now specifically provides that an “employer whose employee [makes a report of elder abuse] is immune from civil or criminal liability on account of an employee’s report, testimony, or participation in any judicial proceedings arising from a petition, report, or investigation.”<sup>17</sup> Similarly, the Georgia APS law provides that:

Any financial institution..., that is an employer of anyone who makes a report pursuant to this chapter in his or her capacity as an employee, or who testifies in any judicial proceeding arising from a report made in his or her capacity as an employee, or participates in a required investigation under the provisions of this chapter in his or her capacity as an employee, shall be immune from any civil or criminal liability on account of such report or testimony or participation of its employee....<sup>18</sup>

### Conclusion

APS workers and advocates for elder abuse victims who wish to develop bank reporting programs will benefit from understanding that federal law poses no barrier to bank reporting projects. There may be legal impediments resulting from state bank privacy laws or APS statute immunity provisions,

however. These problems can be resolved through minor amendments to state law(s) to protect banks from law suits by customers or potential liability under state financial privacy law.

### Notes

1. This document was developed for the National Center on Elder Abuse and supported, in part, by a grant, No. 90-AP-2144, from the Administration on Aging, Department of Health and Human Services. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration on Aging policy.

The partner organizations comprising the National Center on Elder Abuse include the National Association of State Units on Aging, the ABA Commission on Law and Aging, the Clearinghouse on Abuse and Neglect at the University of Delaware, the National Association of Adult Protective Services Administrators, the National Committee for the Prevention of Elder Abuse, and the San Francisco Consortium for Elder Abuse Prevention, Institute on Aging. For more information about the National Center on Elder Abuse, visit [www.elderabuse-center.org](http://www.elderabuse-center.org).

2. Consultant, ABA Commission on Law and Aging. The views expressed herein have not been approved by the House of Delegates or the Board of Governors of the American Bar Association except where otherwise indicated, and, accordingly, should not be construed as representing the policy of the American Bar Association.

This report has benefited greatly from the expert advice of Lori Stiegel, J.D., Associate Staff Director of the ABA Commission on Law and Aging, and of John Pickering and Ricardo Delfin of Wilmer, Cutler & Pickering in Washington, D.C., who reviewed the discussion of federal bank privacy law. Commission intern Beverly Blackwell conducted the essential preliminary research for the report. The remaining research was done in late 2001 and early 2002. Thus, information in this report regarding the status of both the law and of bank reporting projects is current as of that date.

3. Throughout this report, the term “banks” is used to refer collectively to banks, savings associations, and credit unions.
4. Virginia, New Hampshire, and California are examples.

5. South Carolina mandates reporting only by any person “who has actual knowledge” of abuse. SC ST §43-35-25(A).
6. See 12 U.S.C. §3401(3), defining “government authority” as “any agency or department of the United States, or any officer, employee or agent thereof.”
7. 15 U.S.C. §6802(e)(3)(B).
8. 15 U.S.C. §6802(e)(5).
9. 15 U.S.C. §6802(e)(8).
10. The seven agencies are Board of Governors of the Federal Reserve System, the Federal Deposit Insurance Corporation, the National Credit Union Administration, the Office of the Comptroller of the Currency, the Office of Thrift Supervision, the Securities and Exchange Commission, and the Federal Trade Commission. The text of the letter is available on the Web sites of the National Center for Elder Abuse, and of the ABA Commission on Law and Aging, .  
The opinion letter was issued on July 3, 2002, in response to a request from U.S. Senator Debbie Stabenow (D-MI).
11. NV ST §239A.070(3).
12. MD FIN INST §1-306(b).
13. The South Dakota APS statute provides immunity only to institutions and “any employee, agent, or member of a medical or dental staff thereof.” SD ST §22-46-6.
14. Maine, Maryland, Michigan, New York, and Oregon provide only civil immunity. ME ST T. 22 §3479-A; MD FAMILY §14.309; MI ST 400.11c(1); NY SOC SERV §473-b; and OR ST §124.075.
15. *Central Amusement Co. v. District of Columbia*, 121 A.2d 865, 866 (D.C. App. 1956).
16. WA ST §1.16.080.
17. TX HUM RES §48.054(d).
18. GA ST §30-5-4(c).

**A** considerably longer version of this article, which also discusses the experience in the states with both bank reporting projects and attempts to amend mandatory reporting laws to include financial institutions, is available on the Web sites of the ABA Commission on Law and Aging ([www.abanet.org/aging](http://www.abanet.org/aging)) and the National Center for Elder Abuse ([www.ncea.org](http://www.ncea.org)).

Printed copies can also be ordered for a fee from the ABA Commission by calling (202) 662-8690 or emailing [abaaging@abanet.org](mailto:abaaging@abanet.org).

## A Guardian's Authority

*Continued from page 1*

list among the guardian's powers and duties a responsibility to provide for the “care, comfort, and maintenance” or “support, care, education, health, and welfare”<sup>5</sup> of the ward.<sup>6</sup> In slightly more specific terms, 36 states (including some of the 25) authorize the guardian to give consent for “health care,” “medical treatment,” or “medical or other professional care, counsel, treatment, or service.”<sup>7</sup> Beyond these general powers, a guardian's authority is typically restricted by requirements to return to court and seek approval for specified matters. Guardians are also bound to follow specific decision-making standards laid out by statute.

## Whether a Guardian Decides

Although most states have fostered advance health care planning through the passage of living will and medical power of attorney statutes, these laws do not always dovetail with state guardianship laws. Confusion over health care decision-making authority may arise in the small number of cases where an incapacitated person has both a health care agent and a court-appointed guardian of the person.<sup>8</sup> Often, health care providers and attorneys incorrectly assume that a guardian's decision-making powers supercede those of a health care agent.<sup>9</sup> In fact, this is rarely the case. Only six states favor the guardian over the agent in health care decisions.<sup>10</sup> The majority, 29 states, provide clear language safeguarding a patient's originally designated choice.<sup>11</sup> The remaining 16 states are silent.<sup>12</sup>

Who ultimately makes health care decisions for a patient makes a difference. First, endowing a guardian with these powers over the designated health care agent undermines patient autonomy and may discourage advance planning. Second, involving a guardian in health care decisions exacts a greater cost. For example, decisions that would not ordinarily require court approval if made by a health care agent may require review if made instead by a guardian.<sup>13</sup> The review process involves the expenditure of judicial resources and time, as well as the intrusion into a patient's private affairs.<sup>14</sup> Finally, the legal and ethical standards by which health care decisions are made and the resources available to the ultimate decision-maker may vary.

Because the guardianship petitioning process is intended to be comprehensive, instances where a patient has both a designated agent and a guardian should be rare. Courts are often required to consider the existence of a health care agent

*Continued on page 6*

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## A Guardian's Authority

*Continued from page 5*

as a factor in determining the necessity of a guardian.<sup>15</sup> In such a case, the court may find appointing a guardian unnecessary or be required to limit the guardian's powers.<sup>16</sup> Some states treat the patient's health care agent as a *de facto* nomination for guardian;<sup>17</sup> others treat the agent as the preferred nominee.<sup>18</sup> Where a court does appoint a guardian alongside an agent, this decision may be based in a finding that the agent's authority, as laid out in the patient's health care instructions, is not broad enough or specific enough to reach the scenario in question. In other cases, there may be evidence of abuse or neglect, or the agent's existence or whereabouts may be unknown to the court.<sup>19</sup> This analysis targets situations where a patient has both a designated agent and a guardian. No study has tracked the frequency of such conflicts, but they are believed to be uncommon.

States need clear guidelines that define the roles and designated realms of decision-making for the health care agent and guardian for patients with both. Both the Uniform Guardianship and Protective Proceedings Act and the Uniform Health-Care Decisions Act give preference to decisions by the health care agent, absent a court order to the contrary.<sup>20</sup> This policy is favored by 29 states,<sup>21</sup> compared to six<sup>22</sup> who prefer the court-appointed guardian. Of the latter group of states, three place the guardian in the shoes of the ward and authorize the guardian to revoke or amend a power of attorney.<sup>23</sup> Some states, including one clearly favoring the agent, direct the health care agent to "account to" or "report to" the guardian.<sup>24</sup> Another state, Kansas, gives the guardian discretion to decide whether the health care agent may continue to act.<sup>25</sup> In another variation, Colorado splits health care decision types into "medical treatment" and "personal care" choices, giving the guardian authority to revoke a power of attorney only on matters of personal care.<sup>26</sup> Finally, some states grant guardians a specific right to request judicial review of the ward's advance directive or power of attorney,<sup>27</sup> although as a practical matter, a guardian could request such review in every state.

### What a Guardians Decides

State laws generally grant guardians broad health care decision-making powers, limited by situation-specific restrictions. While nine states lack specific restrictions on the health care decision-making authority of guardians,<sup>28</sup> most either set outright restrictions or require additional layers of judicial review. In particular, a guardian's authority to place the ward in an institution for the mentally ill<sup>29</sup> is singled out

for review by 26 states.<sup>30</sup> This restriction is also the recommended protocol of the Uniform Guardianship and Protective Proceedings Act.<sup>31</sup> Decisions involving highly invasive procedures—including abortion, sterilization, psychosurgery, and removal of bodily organs—are also often set apart. Nineteen states require court review of such procedures.<sup>32</sup> Similarly, two states expressly list amputation as a decision requiring approval.<sup>33</sup> Amputation, especially of a lower extremity, is of particular concern to elderly wards who may suffer from poor circulation from chronic conditions. Poor circulation problems, combined with immobility, can lead to pressure sores and decubitus ulcers and, ultimately, gangrenous symptoms that mandate amputation. States may also restrict decisions regarding elective or non-emergency surgery.<sup>34</sup>

In some states, guardians face restrictions on health care decisions affecting the ward's emotional and mental functioning. Three states specifically require court approval be obtained before treating a ward with anti-psychotic or psychotropic medication.<sup>35</sup> Seven states<sup>36</sup> require court approval for electro-convulsive therapy (ECT), a therapy sometimes used to treat severe depression.<sup>37</sup> These restrictions may particularly impact quality of life for elderly wards who experience high incidences of Alzheimer's disease<sup>38</sup> and depression.<sup>39</sup>

As new treatments for Alzheimer's disease,<sup>40</sup> dementia, and other conditions emerge, access to these treatments by incapacitated persons—via their guardians—may be restricted in some jurisdictions. Federal regulations on human subject research require "the legally effective informed consent of the subject or the subject's legally authorized representative."<sup>41</sup> For a potential subject with a guardian, the interested researcher would be obliged to seek the consent of that guardian.<sup>42</sup> Eleven states require, in turn, that the guardian seek court approval before providing informed consent to a ward's exposure to experimental medications or medical procedures.<sup>43</sup> Some states require a court determination whether the experimental treatment is in the ward's "best interests."<sup>44</sup>

Finally, nine states restrict decisions by guardians to withhold or withdraw life-supporting treatments.<sup>45</sup> In these nine states, court review and approval must be obtained first. Three states require "clear and convincing evidence" of the ward's wishes;<sup>46</sup> two additional states require only that it appear the ward would have wanted to withhold treatment.<sup>47</sup>

### How a Guardian Decides

The Uniform Health Care Decisions Act authorizes a guardian to make health care decisions "without judicial

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approval,” provided the guardian complies with the ward’s individual instructions.<sup>48</sup> Similarly, twenty states require guardians to comply with the standards or instructions for health care decisions set by the ward in an advance directive or “expressed” in some other way, presumably while the ward was competent.<sup>49</sup> Other states, including many of the twenty, require consideration of the ward’s “wishes” or “intent,” in some cases as implied by the ward’s behavior.<sup>50</sup> Altogether, twenty-two states require a guardian to look to a ward’s express and/or implied health care instructions.<sup>51</sup>

Because most wards will not have an advance directive, nor discuss or even imply what the ward’s wishes might be in various health care scenarios, some states require extra steps to maximize patient autonomy and personalize health care decisions. For example, a state may require guardians to attempt to involve their wards in decision-making<sup>52</sup> or to determine their philosophical, religious, and ethical values.<sup>53</sup>

The two standards most commonly cited are “best interest” and “substituted judgment.” The “best interest” standard typically involves the weighing of the burdens and benefits of a medical treatment from an objective point of view. Most states, however, require guardians first to exercise “substituted judgment,” a subjective standard designed to approximate the ward’s own, individualized judgment, values, and wishes. One instruction common to nine states directs the guardian to decide “as closely as possible to what the patient would have done or intended under the circumstances.”<sup>54</sup>

Where substituted judgment is not possible because information about the ward is lacking, states may authorize guardians to decide based on the ward’s “best interest,” by weighing the benefits against the burdens to the individual as a result of the treatment.<sup>55</sup> Sixteen jurisdictions reserve such best interest judgments as the alternative to substituted judgment.<sup>56</sup> Another six states establish best interest as either the sole standard or a constant, all-inclusive standard under which guardians exercise health care decision-making authority.<sup>57</sup>

Some states provide the guardian a number of factors to weigh in making a decision. These factors are sometimes listed under both the state’s substituted judgment and best interest definitions. Sixteen states instruct the guardian to consider the ward’s “values and beliefs.”<sup>58</sup> The views of family and friends are given consideration by two states.<sup>59</sup> Three states forbid a guardian from allowing financial considerations to taint the decision-making process.<sup>60</sup>

The outcome and results of a medical procedure may also be factored in. Four states list the likelihood of regaining capacity or recovery as a factor;<sup>61</sup> three weigh the risks to physical, emotional, or cognitive functions, and risk of pain.<sup>62</sup> New York, whose guardianship laws on end-of-life decision-making cover only decisions for the mentally

retarded and developmentally disabled, cautions a guardian against undervaluing a retarded person’s quality of life and instructs a guardian to treat the ward with the same respect and dignity afforded a person without such disabilities.<sup>63</sup> Finally, two states weigh the likelihood of death or the effect of the treatment on life expectancy.<sup>64</sup>

A surprising number of states (twenty) provide no specific standards for measuring a guardian’s health care decision-making.<sup>65</sup> Of these, sixteen states provide boundaries by requiring court approval for some decisions, while the remaining four<sup>66</sup> provide scarce protective language—varying from an assertion that the court may limit the guardian’s powers at any time<sup>67</sup> to an assurance that a guardian may be removed if in the ward’s best interests.<sup>68</sup> These provisions are common to most guardianship statutes and reflect underlying equitable principles governing guardianship.

## Conclusion

Questions surrounding a guardian’s authority can be expected to grow in the coming years.<sup>69</sup> No study has scientifically documented the number of adults under guardianship, although a 1987 Associated Press estimate placed that figure between 300,000 and 400,000.<sup>70</sup> Recently, the number of guardianship petitions filed has risen, and this trend is likely to accelerate given increasing life expectancies and a concomitant rise in persons with cognitive impairment.<sup>71</sup> Even now, older adults are disproportionately represented as wards under guardianship.<sup>72</sup> With these trends and general increased mobility of the U.S. population, clarity and uniformity of the law are essential to individuals and their families, as well as to policy makers, as they plan for various health care decision-making scenarios.

The highly respected Uniform Guardianship and Protective Proceedings Act<sup>73</sup> and Uniform Health-Care Decisions Act,<sup>74</sup> provide a useful framework for discussing state law on guardians’ health care decision-making authority. The Acts promote personal autonomy by favoring a ward’s designated health care agent over a later, court-appointed guardian. They also direct the guardian to follow the ward’s instructions and restrict the guardian from revoking a health care power of attorney.<sup>75</sup> Apart from this limitation, both Acts authorize broad guardianship powers. Only the UGPPA carves out a second restriction—that a guardian complies with the state’s involuntary civil commitment procedures.<sup>76</sup> The UHCDA makes health care decisions by a guardian “effective without judicial approval.”<sup>77</sup>

State adoption of these Uniform Act features varies. Most states reflect the Acts’ aim to advance individual auton-

*Continued on page 8*

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## A Guardian's Authority

*Continued from page 7*

omy through statutes that favor the designated health care agent over a guardian. Furthermore, nearly half specifically require the guardian to follow the ward's health care wishes as expressed in an advance directive or implied. On the other hand, where the ward's wishes are unclear and the decision at hand is highly invasive or presents an irreversible outcome, states depart from the Acts' minimalist approach to court involvement. Many states have moved beyond restrictions requiring guardians to follow state commitment proceedings, as in the UGPPA. These states also require court approval for decisions ranging from withdrawing life-sustaining treatment to authorizing anti-psychotic medications. It is here, in the area of restricted decisions, that state statutes reveal the greatest variability. If nothing else, this survey demonstrates the difficulty in reaching consensus on how much flexibility and direction a guardian needs to achieve the best protection for vulnerable persons.

For more information, including specific statutory language and comparative charts on guardians' health care decision-making authority, see the Legislative Updates section on the ABA Commission on Law and Aging's Web site at <http://www.abanet.org/aging>. For general information on guardianship, see the ABA Commission on Law and Aging's list of guardianship publications at <http://www.abanet.org/aging/orderingpage.html#alternatives>.

### Notes

1. Sarah B. Richardson was the Borchard Fellow for Summer 2003 at the ABA Commission on Law and Aging. Richardson is a graduate of the University of Virginia (Class of '93) and is in her third year at the University of Maryland's School of Law. She was the law school's 2003 recipient of the Geriatrics & Gerontology Education and Research Award for her commitment to serving senior citizens.
2. Guardianship terminology varies by state; for uniformity within this article, "guardian" is used for a guardian of the person. States can also appoint individuals to manage a person's property. For a contemporary look at "guardians of the property" and suggestions for reform of the probate courts and their procedures, see PAULA A. MONOPOLI, *AMERICAN PROBATE: PROTECTING THE PUBLIC, IMPROVING THE PROCESS* (Northeastern University Press 2003). See also, Wingspan—The Second National Guardianship Conference, *Recommendations*, adopted Dec. 2, 2001, available at <http://www.naela.org/PDFFiles/Recommendations.pdf>.
3. "Capacity" is a fluid term, specific to the complexity of the decision at hand. Knowing when to step in and how to evaluate a person's ability to live and make decisions independently is essential to helping a loved one with a dementing illness. That person may deny having problems and accuse others of interfering. Understanding what to expect and how to care for an individual with a dementing illnesses can provide great comfort to the caregiver. See generally NANCY L. MACE & PETER V. RABINS, *THE 36-HOUR DAY: A FAMILY GUIDE TO CARING FOR PERSONS WITH ALZHEIMER'S DISEASE, RELATED DEMENTING ILLNESSES, AND MEMORY LOSS IN LATER LIFE* (3d ed. 1999). Numerous instruments have been developed to assess a person's capacity across a broad spectrum of functions. For an evaluation of some of these as they relate to guardianship, see Jennifer Moye, *Guardianship and Conservatorship in Evaluating Competencies* 309 (T. Grisso ed., 2002).
4. Additionally, this article does not cover guardians' powers to move a ward across state lines unless this would involve a transfer to a restricted living environment. Nor does the article discuss "boilerplate" language typical to guardianship statutes, such as a guardian's duty to choose the "least restrictive" options for the ward. Furthermore, the article does not explore what features may be unique to public guardians. Finally, the standards of decision-making discussed are those assigned by guardianship statutes, which may or may not refer back to the standards used in health care consent laws.
5. See ALA. CODE § 26-2A-108 (2001); ALASKA STAT. § 13.26.150 (Michie 2000); ARIZ. REV. STAT. ANN. § 14-5312(A) (West 2003); ARK. CODE ANN. § 28-65-301 (Michie 2000); COLO. REV. STAT. ANN. § 15-14-314 (West 2001); CONN. GEN. STAT. ANN. § 45a-656 (West 2003); DEL. CODE ANN. tit. 12, § 3922 (2002); D.C. CODE ANN. § 21-2047 (2001); GA. CODE ANN. § 29-5-3 (2002); HAW. REV. STAT. § 560:5-312 (2002); IDAHO CODE § 15-5-312 (Michie 2000); 755 ILL. COMP. STAT. 5/11a-17 (2003); KAN. STAT. ANN. § 59-3075 (2002); MINN. STAT. ANN. § 525.56 Subd. 3 (West 2001); MO. ANN. STAT. § 475.120.3 (West 2003); NEV. REV. STAT. ANN. § 159.079 (Michie 2001); N.H. REV. STAT. ANN. § 464-A:25 (2001); N.D. CENT. CODE § 30.1-28-12 (5-312) (2001); OR. REV. STAT. § 125.315 (2001); S.C. CODE ANN. § 62-5-312 (Law. Co-op 2003); S.D. CODIFIED LAWS § 29A-5-402 (Michie 2001); TEX. PROB. CODE ANN. § 767 (Vernon 2001); UTAH CODE ANN. § 75-5-312 (2002); VA. CODE ANN. § 37.1-134.6 (Michie 2001); W. VA. CODE ANN. § 44A-3-1 (Michie 2001).
6. "Ward" is the legal term for the individual under a guardian's care. See ALA. CODE § 26-2A-108 (2001); ALASKA STAT. § 13.26.150 (Michie 2000); ARIZ. REV. STAT. ANN. § 14-5312(A) (West 2003); ARK. CODE ANN. § 28-65-301 (Michie 2000); COLO. REV. STAT. ANN. § 15-14-314 (West 2001); CONN. GEN. STAT. ANN. § 45a-656 (West 2003); DEL. CODE ANN. tit. 12, § 3922 (2002); D.C. CODE ANN. § 21-2047 (2001); GA. CODE ANN. § 29-5-3 (2002); HAW. REV. STAT. § 560:5-312 (2002); IDAHO CODE § 15-5-312 (Michie 2000); 755 ILL. COMP. STAT. 5/11a-17 (2003); KAN. STAT. ANN. § 59-3075 (2002); MINN. STAT. ANN. § 525.56 Subd. 3 (West 2001); MO. ANN. STAT. § 475.120.3 (West 2003); NEV. REV. STAT. ANN. § 159.079 (Michie 2001); N.H. REV. STAT. ANN. § 464-A:25 (2001); N.D. CENT. CODE § 30.1-28-12 (5-312) (2001); OR. REV. STAT. § 125.315 (2001); S.C. CODE

- ANN. § 62-5-312 (Law. Co-op 2003); S.D. CODIFIED LAWS § 29A-5-402 (Michie 2001); TEX. PROB. CODE ANN. § 767 (Vernon 2001); UTAH CODE ANN. § 75-5-312 (2002); VA. CODE ANN. § 37.1-134.6 (Michie 2001); W. VA. CODE ANN. § 44A-3-1 (Michie 2001).
7. See ALASKA STAT. § 13.26.150 (Michie 2000); ARIZ. REV. STAT. ANN. § 14-5312(A) (West 2003); CAL. PROB. CODE §§ 2353, 2355 (West 2003); COLO. REV. STAT. ANN. § 15-14-315 (West 2001); CONN. GEN. STAT. ANN. § 45a-656 (West 2003); DEL. CODE ANN. tit. 12, § 3922 (2002); D.C. CODE ANN. § 21-2047 (2001); FLA. STAT. ANN. § 744-363 (West 2003); GA. CODE ANN. § 29-5-3 (2002); HAW. REV. STAT. § 560:5-312(a) (2002); IDAHO CODE § 15-5-312(a) (Michie 2000); 755 ILL. COMP. STAT. 5/11a-17 (2003); IND. CODE ANN. § 29-3-8-2 (West 2001); IOWA CODE ANN. § 633-635-1 (West 2003); KAN. STAT. ANN. § 59-3075(b) (2002); KY. REV. STAT. ANN. § 59-3075 (Michie 2002); ME. REV. STAT. ANN. tit. 18-A, § 5-312 (2001); MD. CODE ANN. EST. & TRUSTS § 13-708 (2001); MICH. COMP. LAWS ANN. § 700.5314 (West 2001); MINN. STAT. ANN. § 525.56 Subd. 3 (West 2001); MO. ANN. STAT. § 475.120.3 (West 2003); MONT. CODE ANN. § 72-5-321 (2002); NEB. REV. STAT. ANN. § 30-2628 (2001); NEV. REV. STAT. ANN. § 159.079 (Michie 2001); N.J. STAT. ANN. § 3B:12-57 (West 2001); N.M. STAT. ANN. § 45-5-312 (Michie 2001); N.Y. MENTAL HYG. LAW § 81.22 (McKinney 2003); N.C. GEN. STAT. § 35A-1241 (2001); OHIO REV. CODE ANN. § 2111.13 (West 2001); OKLA. STAT. ANN. tit. 30, § 3-118.B.2 (West 2003); S.C. CODE ANN. § 62-5-312 (Law. Co-op 2002); TEX. PROB. CODE ANN. § 767 (Vernon 2001); UTAH CODE ANN. § 75-5-312 (2002); VT. STAT. ANN. tit. 14 § 3069 (2001); WASH. REV. CODE ANN. § 11.92.043 (West 2001); WYO. STAT. ANN. § 3-2-201 (Michie 2001).
  8. No studies have tracked the frequency of this type of conflict, but they are believed to be rare.
  9. Rebecca J. O'Neill, *Surrogate Health Care Decisions for Adults in Illinois—Answers to the Legal Questions that Health Care Providers Face on a Daily Basis*, 29 LOY. U. CHI. L. J. 411, 439 (Winter 1998). The author has also encountered situations where health care providers and attorneys recommend family members to seek guardianship over relatives who have already designated a health care agent. Other health care providers have even refused treatment under an agent's direction and wait until presented with a guardianship order. *Id.*
  10. See ALA. CODE § 26-1-2 (2001); ALASKA STAT. § 13.26.350 (Michie 2000); KAN. STAT. ANN. §§ 58-627 and 59-3075 (2002); N.C. GEN. STAT. § 32A-22 (2001); TEX. HEALTH & SAFETY CODE ANN. § 166.156(a) (Vernon 2003); WIS. STAT. ANN. § 155.60(2) (2003).
  11. See ARIZ. REV. STAT. ANN. § 13.26.350 (West 2003); CAL. PROB. CODE §§ 4672 (West 2003); COLO. REV. STAT. ANN. § 15-14-501 (West 2001); DEL. CODE ANN. tit. 16, § 2506 (2002); FLA. STAT. ANN. § 765.205 (West 2003); GA. CODE ANN. § 31-36-6 (2002); HAW. REV. STAT. § 327E-6 (2002); 755 ILL. COMP. STAT. 5/11a-17 (2003); IND. CODE ANN. § 30-5-3-4 (West 2001); IOWA CODE ANN. § 144B.6.1 (West 2003); KY. REV. STAT. ANN. § 311.6231 (Michie 2002); ME. REV. STAT. ANN. tit. 18-A, § 5-806 (2001); MASS. GEN. LAWS ANN. ch. 201D, § 5 (2001); MICH. COMP. LAWS ANN. § 700.5306 (West 2001); MISS. CODE ANN. § 41-41-213 (2002); NEB. REV. STAT. ANN. § 30-2628 (2001); N.H. REV. STAT. ANN. § 137-J:12 (2001); N.J. STAT. ANN. § 26:2H-61 (West 2001); N.M. STAT. ANN. § 24-7A-6.B (Michie 2001); N.Y. PUB. HEALTH LAW § 2892 (McKinney 2003); N.D. CENT. CODE § 32A-22 (2001); OR. REV. STAT. § 127.545.6 (2001); S.D. CODIFIED LAWS § 29A-5-118 (Michie 2001); TENN. CODE ANN. § 34-6-204 (2002); VT. STAT. ANN. tit. 14 § 3463 (2001); VA. CODE ANN. § 37.1-137.1 (Michie 2001); W. VA. CODE ANN. § 44A-3-1 (Michie 2001); WYO. STAT. ANN. § 3-5-204 (Michie 2001).  
See also S.C. CODE ANN. § 44-77-85 (Law. Co-op 2002)(*stating* "the authority of a person designated pursuant to [the Death with Dignity Act] is not affected by the subsequent appointment of a guardian"), but note potentially conflicting language in S.C. CODE ANN. § 62-5-501 (Law. Co-op 2002)(*stating* "appointment of a guardian terminates all or part of the power of attorney that relates to matter within the scope of the guardianship").
  12. The sixteen states without statutes that clarify the health care decision-making authority between a guardian and a health-care agent are: Arkansas, Connecticut, District of Columbia, Idaho, Louisiana, Maryland, Minnesota, Missouri, Montana, Nevada, Ohio, Oklahoma, Pennsylvania, Rhode Island, Utah, and Washington.
  13. See, e.g., DEL. CODE ANN. tit. 16, § 2503(g) (2002)(declaring "a health care decision made by an agent for a principal is effective without judicial approval").
  14. JOAN L. O'SULLIVAN & ANDREA I. SAAH, *THE MARYLAND GUARDIANSHIP BENCHBOOK* 63 (MICPEL 2001).
  15. See, e.g., CONN. GEN. STAT. ANN. § 45a-650 (West 2003).
  16. See, e.g., W. VA. CODE ANN. § 44A-1-3 (Michie 2002). Interestingly, one state, Texas, has created a statute that addresses decision-making authority during the initial guardianship hearing, as well as during the petition process by a guardian already appointed. The guardian is given sole authority to make health care decisions while the court considers whether to suspend or revoke the health care agent's powers. The statute directs the court to "consider the preferences of the principal as expressed in the medical power of attorney." TEX. HEALTH & SAFETY CODE ANN. § 166.156 (Vernon 2002).
  17. See, e.g., MINN. STAT. ANN. § 145B.03 (2003).
  18. See, e.g., W. VA. CODE ANN. § 44A-1-3 (Michie 2002).
  19. An agent may also be found to be "unavailable" where the court determines the agent is acting inappropriately. This article does not consider challenges to the agent's authority that recommend a guardian. See, e.g., *Application of Rochester General Hosp.*, 601 N.Y.S.2d 375 (1993). This article looks at the statutory landscape *after* the petitioning process, where a guardian has been appointed and a health care agent has been designated under a valid medical power of attorney, to determine which of these figures has the ultimate health care decision-making authority.
  20. UNIF. GUARDIANSHIP AND PROTECTIVE PROCEEDINGS ACT OF 1997 § 316(c), U.L.A. (2002) and UNIF. HEALTH CARE DECISIONS ACT OF 1993 § 6(c), U.L.A. (2002). Regardless of a statute's terms, a court always has power to remove a health care agent for cause (e.g., where the agent is not "reasonably available" or is acting in "bad faith").

*Continued on page 10*

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## A Guardian's Authority

Continued from page 9

21. See *supra* note 11.
22. See *supra* note 10.
23. See ALA. CODE § 26-1-2 (2001); ALASKA STAT. § 13.26.350 (Michie 2000); KAN. STAT. ANN. §§ 58-627.
24. Alabama and Alaska favor the guardian and require the attorney in fact, or health care agent, to account to the guardian. ALA. CODE § 26-1-2 (2001); ALASKA STAT. § 13.26.350 (Michie 2000). Florida, while giving the health care agent preference, provides that the court may direct the surrogate to report the principal's health care status to the guardian. FLA. STAT. ANN. § 765.205(3) (West 2003).
25. KAN. STAT. ANN. § 59-3075(e) (2002).
26. COL. REV. STAT. ANN. § 15-14-501(1) (West 2002).
27. See MASS. GEN. LAWS ANN. ch. 201D, § 17 (2001); OR. REV. STAT. § 127.550(3) (2001); VA. CODE ANN. § 37.1-137.1 (Michie 2001).
28. The nine states without specific statutory restrictions on the health care decision-making authority of guardians are: Alabama, Georgia, Idaho, Nebraska, New Jersey, Ohio, Rhode Island, South Carolina, and Utah.
29. Studies indicate over two-thirds of adult wards reside in institutional settings. See Kathleen H. Wilber, *Guardianship/Conservatorship* in, ENCYCLOPEDIA OF AGING 456 (George L. Maddox ed., 2001)(citing Reynolds, S.L. & Wilber, K.H., *Correlates of open- and locked-facility placement in a population of decisionally-impaired adults*, JOURNAL OF GERONTOLOGY: SOCIAL SCIENCES, 349, 355 (1999).
30. See ALASKA STAT. § 13.26.150(e) (Michie 2000); ARIZ. REV. STAT. ANN. § 14-5312.01 (West 2003); ARK. CODE ANN. § 28-65-303 (Michie 2000); CAL. PROB. CODE § 2356 (West 2003); COLO. REV. STAT. ANN. § 15-14-312 (West 2001); CONN. GEN. STAT. ANN. § 45a-656(b) (West 2003); DEL. CODE ANN. tit. 12, § 3922(b) (2002); D.C. CODE ANN. § 21-2047(c) (2001); FLA. STAT. ANN. § 744.704(7) (West 2003); 755 ILL. COMP. STAT. 5/11a-14.1 (2003); LA. CODE CIV. PROC. ANN. Art. 4566 (West 2003); MASS. GEN. LAWS ANN. ch. 201, § 6 (2001); MICH. COMP. LAWS ANN. § 700.5314 (West 2001); MO. ANN. STAT. § 475.120.5 (West 2003); N.H. REV. STAT. ANN. § 464-A:25 I (2001); N.Y. MENTAL HYG. LAW § 81.22 (McKinney 2003); N.D. CENT. CODE § 30.1-28-12 (5-312) (2001); OKLA. STAT. ANN. tit. 30, § 3-119 (West 2003); OR. REV. STAT. § 125.320 (2001); PA. STAT. ANN. tit. 20, § 5521 (West 2001); TEX. PROB. CODE ANN. § 770(b) (Vernon 2001); VT. STAT. ANN. tit. 14 § 3074 (2001); VA. CODE ANN. § 54.1-2986 (Michie 2001); WASH. REV. CODE ANN. § 11.92.043 (West 2001); WIS. STAT. ANN. § 880.38 (West 2001); WYO. STAT. ANN. § 3-2-202 (Michie 2001).
31. UNIF. GUARDIANSHIP AND PROTECTIVE PROCEEDINGS ACT OF 1997 § 316(d), U.L.A. (2002).
32. See ALASKA STAT. § 13.26.150(e) (Michie 2000); ARK. CODE ANN. § 28-65-302 (Michie 2000); CAL. PROB. CODE § 4652 (West 2003); D.C. CODE ANN. § 21-2047(c) (2001); HAW. REV. STAT. § 560:5-304 (2002); KAN. STAT. ANN. § 59-3075(e) (2002); KY. REV. STAT. ANN. § 387.660 (Michie 2002); LA. CODE CIV. PROC. ANN. Art. 4566 (West 2003); MINN. STAT. ANN. § 525.56 Subd. 3 (West 2001); NEV. REV. STAT. ANN. § 159.0805 (Michie 2001); N.H. REV. STAT. ANN. § 464-A:25 I (2001); N.C. GEN. STAT. § 35A-1241(a) (2001); N.D. CENT. CODE § 30.1-28-12 (5-312) (2001); OKLA. STAT. ANN. tit. 30, § 3-119 (West 2003); OR. REV. STAT. § 125.320 (2001); PA. STAT. ANN. tit. 20, § 5521 (West 2001); VA. CODE ANN. § 54.1-2986 (Michie 2001); WASH. REV. CODE ANN. § 11.92.043 (West 2001); WYO. STAT. ANN. § 3-2-202 (Michie 2001).
33. Kansas and Kentucky specifically list amputation as a restricted procedure requiring court review. KAN. STAT. ANN. § 59-3075(e) (2002); KY. REV. STAT. ANN. § 387.660 (Michie 2001).
34. See IOWA CODE ANN. § 633-635-2 (West 2003); VT. STAT. ANN. tit 14, § 3075(b) (2001).
35. See CAL. PROB. CODE § 2356.5(b) (West 2003); MASS. GEN. LAWS ANN. ch. 201, § 6 (2001); WIS. STAT. ANN. § 880.33 (West 2001).
36. See CAL. PROB. CODE § 2356 (West 2003); D.C. CODE ANN. § 21-2047(c) (2001); MINN. STAT. ANN. § 525.56 Subd. 3 (West 2001); N.H. REV. STAT. ANN. § 464-A:25 I (2001); PA. STAT. ANN. tit. 20, § 5521 (West 2001); WASH. REV. CODE ANN. § 11.92.043 (West 2001); WYO. STAT. ANN. § 3-2-202 (Michie 2001).
37. ECT, despite its negative public image, often produces dramatic improvement in individuals for whom medications have failed. Among older adults, this treatment must be prescribed with care since their health and memory problems may complicate therapy. In particular, those with recent severe cardiovascular problems are at an elevated risk since ECT may be accompanied by transient increases in blood pressure. See Dan. G. Blazer, *Depression* in, ENCYCLOPEDIA OF AGING 288 (George L. Maddox ed., 2001).
38. Ten percent of adults over age 65 and nearly 50 percent of those over 85 have Alzheimer's Disease. By comparison, a small percentage of persons in their 30s and 40s get the disease. See ALZHEIMER'S ASSOCIATION, STATISTICS: ABOUT ALZHEIMER'S DISEASE (2002), available at <http://www.alz.org/ResourceCenter/FactSheets/FSAlzheimerStats.pdf> (last visited Aug. 1, 2003).
39. Depression ranks among the most common complaints for older adults, but it is not easily diagnosed within this population. As the leading cause of suicide in late life, depression and depressive disorders should be a major concern to care providers. See Dan. G. Blazer, *Depression* in, ENCYCLOPEDIA OF AGING 287 (George L. Maddox ed., 2001). Depression occurs in about 20-40 percent of Alzheimer's patients. See ALZHEIMER'S ASSOCIATION, FACTS: ABOUT DEPRESSION AND ALZHEIMER'S DISEASE (2003), available at [http://www.alz.org/ResourceCenter/FactSheets/FS\\_Depression.pdf](http://www.alz.org/ResourceCenter/FactSheets/FS_Depression.pdf) (last visited Aug. 1, 2003). Almost no research has been done to evaluate the use of ECT for patients who suffer both dementia and severe depression. In a

Continued on page 12

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## Commission Welcomes Summer Law Interns

**Sarah Beth Richardson** joined the ABA Commission's staff for the summer to work with Assistant Director Charlie Sabatino and Associate Staff Director Erica Wood on a review of guardianship statutes across the 50 states. In particular, she examined statutory authority for guardians in making health care decisions (see article in this issue). She also conducted a brief review of recent case law on Medicaid planning.

Sarah is a 1993 graduate of the University of Virginia and is a rising third-year student at the University of Maryland's School of Law. She received a Geriatrics & Gerontology Education and Research (GGEAR) Award in 2003 for her commitment to serving senior citizens. Richardson is also involved in student leadership as the president of her school's chapter of Phi Delta Phi, a legal honor fraternity. Her chapter, the Paca Inn, received the "2003 International Inn of the Year Award."

**Jenette Turner** is a rising third-year law student at Washburn University School of Law in Topeka, Kansas. While at Washburn, Jenette has been involved in leadership of several student organizations and with the Washburn Children and Family Law Center.

During her internship, Jenette assisted ABA Commission Associate Staff Director Lori Stiegel with development of a civil and criminal elder abuse database, one of the Commission's tasks in its role as a partner in the National Center on Elder Abuse. She also wrote a paper for publication on trends identified in elder neglect cases.

Prior to attending law school, Jenette worked in Adult Protective Services for the state of Utah. Jenette will graduate in May 2004 and is seeking opportunities to practice in elder law and to advocate for the legal needs of elders.

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- ◆ Bar association elder law section or committee leader; or
- ◆ National law and aging advocate.

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## A Guardian's Authority

Continued from page 10

small sample of 31 charts of such patients, the results were encouraging. PETER V. RABINS, CONSTANTINE G. LYKET-SOS & CYNTHIA D. STEELE, *PRACTICAL DEMENTIA CARE* 226 (Oxford University Press 1999).

40. For numerous fact sheets on clinical trials, *see generally* <http://www.alz.org/ResourceCenter/ByTopic/ClinicalTrials.htm> (last visited Aug. 1, 2003). *See also* Gina Kolata, *Families Embracing An Alzheimer's Drug That Is Unapproved*, N.Y.TIMES, June 15, 2003, at A1.
41. 45 C.F.R. § 46.116 (2003). *See also* Declaration of Helsinki (1948), reprinted in Council for International Organizations of Medical Sciences, *International Ethical Guidelines for Biomedical Research Involving Human Beings* 47 (1993).
42. Even where a person had both a guardian and designated health care agent but the state favored the agent to make decisions, important concerns remain about obtaining fully informed consent. The very nature of an emerging technology and an experimental setting makes obtaining consent by the patient via the designated health care agent an impossibility. Health care instructions drafted by the patient in anticipation of participating in an experimental treatment after losing capacity are limited.
43. *See* ALASKA STAT. § 13.26.150(e) (Michie 2000); ARK. CODE ANN. § 28-65-302 (Michie 2000); CAL. PROB. CODE § 2356 (West 2003); D.C. CODE ANN. § 21-2047(c) (2001); KAN. STAT. ANN. § 59-3075(e) (2002); MINN. STAT. ANN. § 525.56 Subd. 3 (West 2001); NEV. REV. STAT. ANN. § 159.0805 (Michie 2001); N.H. REV. STAT. ANN. § 464-A:25 I (2001); N.D. CENT. CODE § 30.1-28-12 (5-312) (2001); OKLA. STAT. ANN. tit. 30, § 3-119 (West 2003); PA. STAT. ANN. tit. 20, § 5521 (West 2001).  
Many states require the court to find the experimental treatment in the ward's "best interests." *See* Diane E. Hoffmann & Jack Schwartz, *Proxy Consent to Participation of the Decisionally-Impaired in Medical Research-Maryland's Policy Initiative*, 1 J. HEALTH CARE L. & POL'Y 123, 125 (1998). *See also* ALZHEIMER'S ASSOCIATION, PROTECTION OF PARTICIPANTS IN RESEARCH, *available at* <http://www.alz.org/ResourceCenter/FactSheets/FSprotection.pdf> (last visited Aug. 1, 2003).
44. For example, Illinois forbids a guardian from consenting to the ward's participation in any "unusual, hazardous, or experimental services or psychosurgery" without approval by court and a determination that such services are in the "best interests" of the ward. 405 ILL. COMP. STAT. ANN. 5/2-100 (West 2003). *See generally* Diane E. Hoffmann & Jack Schwartz, *Proxy Consent to Participation of the Decisionally-Impaired in Medical Research-Maryland's Policy Initiative*, 1 J. HEALTH CARE L. & POL'Y 123, 126 (1998).
45. *See* ALASKA STAT. § 13.26.150(e) (Michie 2000); ARK. CODE ANN. § 28-65-302 (Michie 2000); D.C. CODE ANN. § 21-2047(c) (2001); 755 ILL. COMP. STAT. 5/11a-17(d) (2003); IOWA CODE ANN. § 633-635-2 (West 2003); KAN. STAT. ANN. § 59-3075(e)(7) (2002); MD. CODE ANN. EST. & TRUSTS § 13-708(c)(1) (2001); N.Y. SURR. CT. PRO. ACT §

1750-b (McKinney 2003); OKLA. STAT. ANN. tit. 30, § 3-119(1) (West 2003).

46. *See* ALA. CODE § 22-8A-11(c) (2001); FLA. STAT. ANN. § 765.401(West 2003); MD. CODE ANN. EST. & TRUSTS § 13-712(b) (2001).
47. *See* D.C. CODE ANN. § 21-2047(c)(3) (2001); IOWA CODE ANN. § 144A.7.1 (West 2003).
48. UNIF. HEALTH CARE DECISIONS ACT OF 1993 § 6, U.L.A. (2002). The UHCDA also requires the guardian to seek court approval to revoke a ward's advance health-care directive. The Uniform Guardianship and Protective Proceedings Act also restricts the guardian's power to revoke the ward's power of attorney for health care. UNIF. GUARDIANSHIP AND PROTECTIVE PROCEEDINGS ACT OF 1997 § 316(d), U.L.A. (2002).
49. *See* ARIZ. REV. STAT. ANN. § 36-3203C (West 2003); CAL. PROB. CODE §§ 2355(a) (West 2003); COLO. REV. STAT. ANN. § 2355(a) (West 2001); CONN. GEN. STAT. ANN. § 19A-570(a) (West 2003); DEL. CODE ANN. tit. 16, § 2507(b)(7) (2002); D.C. CODE ANN. § 21-2210 (2001); HAW. REV. STAT. § 327E-6 (2002); 755 ILL. COMP. STAT. 5/11a-17(e) (2003); IOWA CODE ANN. § 144A.7.1 (West 2003); KAN. STAT. ANN. § 59-26(a)(2) (2002); KY. REV. STAT. ANN. § 311.631(3) (Michie 2002); ME. REV. STAT. ANN. tit. 18-A, § 5-312(a)(3) (2001); MD. CODE ANN. EST. & TRUSTS § 13-708(c)(2) (2001)(where "the disabled person executed an advance directive...that authorizes the guardian to consent"; MISS. CODE ANN. § 41-41-213 (2002); NEB. REV. STAT. ANN. § 30-2628(a)(3) (2001); OHIO REV. CODE ANN. § 2133.08(D)(2) (West 2001)(regarding life-sustaining treatment); PA. STAT. ANN. tit. 20, § 5521(a) (West 2001); S.D. CODIFIED LAWS § 29A-5-402 (Michie 2001); VA. CODE ANN. § 37.1-137.1 (Michie 2001); W. VA. CODE ANN. § 44A-3-1 (Michie 2001).
50. *See* CONN. GEN. STAT. ANN. § 19a-570(a) (West 2003); DEL. CODE ANN. tit. 16, § 2507(b)(7) (2002); D.C. CODE ANN. § 21-2210 (2001); IOWA CODE ANN. § 144A.7.1 (West 2003); ME. REV. STAT. ANN. tit. 18-A, § 5-312(a)(3) (2001); MD. CODE ANN. EST. & TRUSTS § 13-711(d) (2001); NEB. REV. STAT. ANN. § 30-2628 (2001); N.Y. SURR. CT. PRO. ACT § 1750-b (McKinney 2003); OHIO REV. CODE ANN. § 2133.08(D)(3) (West 2001)(including inferences "from the lifestyle and character of the patient"); S.C. CODE ANN. § 44-66-30(F) (Law. Co-op 2002); W. VA. CODE ANN. § 16-30-9 (Michie 2001).
51. Altogether, these states are: Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, Mississippi, Nebraska, New York, Ohio, Pennsylvania, South Carolina, South Dakota, Virginia, West Virginia.
52. *See, e.g.*, VA. CODE ANN. § 37.1-137.1 (Michie 2001).
53. *See, e.g.*, DEL. CODE ANN. tit 16, § 2506 (2002).
54. *See* ALA. CODE § 22-8A-11(c) (2001); ARIZ. REV. STAT. ANN. § 36-3203.C (West 2003); DEL. CODE ANN. tit. 16, § 2507(b)(7) (2002); D.C. CODE ANN. § 21-2047(c)(3) (2001); FLA. STAT. ANN. § 765.401(West 2003); 755 ILL. COMP. STAT. 5/11a-17(e) (2003); N.D. CENT. CODE § 23-12-13.3 (2001); OHIO REV. CODE ANN. § 2133.08(D)(2) (West 2001); WASH. REV. CODE ANN. § 7.70.065 (West 2001).

55. See, e.g. MD. CODE ANN. HEALTH-GEN I. §§ 5-601(e) and 5-605(c) (2003).
56. ALA. CODE § 22-8A-11(c) (2001); ARIZ. REV. STAT. ANN. § 36-3203.C (West 2003); CAL. PROB. CODE §§ 2355(a) (West 2003); DEL. CODE ANN. tit. 16, § 2507(b)(7)(b) (2002); D.C. CODE ANN. § 21-2210(b) (2001); FLA. STAT. ANN. §765.404 (West 2003); 755 ILL. COMP. STAT. 5/11a-17(e) (2003); ME. REV. STAT. ANN. tit. 18-A, § 5-312(a)(3) (2001); MD. CODE ANN. HEALTH-GEN I. §§ 5-605(c)(1) (2003); N.M. STAT. ANN. § 45-5-312(B)(3) (Michie 2001); N.D. CENT. CODE § 23-12-13.3 (2001); S.C. CODE ANN. § 44-66-30(F) (Law. Co-op 2002); S.D. CODIFIED LAWS § 29A-5-402 (Michie 2001); VA. CODE ANN. § 37.1-137.1 (Michie 2001); WASH. REV. CODE ANN. § 7.70.065 (West 2001); W. VA. CODE ANN. § 44A-3-1 (Michie 2001).
57. See COLO. REV. STAT. ANN. § 15-14-314(1) (West 2001); IND. CODE ANN. § 16-36-1-5(d) (West 2001); KAN. STAT. ANN. § 59-3075(a)(2) (2002); KY. REV. STAT. ANN. § 311.631(3) (Michie 2002); N.Y. MENTAL HYG. LAW § 81.22(a)(8) (McKinney 2003); R.I. GEN. LAWS 33-15-29 (2001).
58. See ALA. CODE § 22-8A-11(c) (2001); ARIZ. REV. STAT. ANN. § 14-5312.A(11) (West 2003); CAL. PROB. CODE §§ 2355(a) (West 2003); COLO. REV. STAT. ANN. § 15-14-314(1) (West 2001); DEL. CODE ANN. tit. 12, § 3922(b)(3) (2002) and DEL. CODE ANN. tit. 16, § 2507(b)(7) (2002); 755 ILL. COMP. STAT. 5/11a-17(e) (2003); KAN. STAT. ANN. § 59-3075(a)(2) (2002); ME. REV. STAT. ANN. tit. 18-A, § 5-312(a)(3) (2001); MD. CODE ANN. EST. & TRUSTS § 13-711 (2001); MINN. STAT. ANN. § 525.56 Subd. 3 (West 2001); N.M. STAT. ANN. § 45-5-312(B)(3) (Michie 2001); N.Y. MENTAL HYG. LAW § 81.22(a)(8) (McKinney 2003) and N.Y. SURR. CT. PRO. ACT § 1750-b.2 (McKinney 2003); OHIO REV. CODE ANN. § 2133.08(D)(2) (West 2001); S.D. CODIFIED LAWS § 29A-5-402 (Michie 2001); VA. CODE ANN. §§ 37.1-137.1, 54.1-2986 (Michie 2001); W. VA. CODE ANN. §§ 44A-3-1, 16-30-9 (Michie 2001).
59. See 755 ILL. COMP. STAT. 5/11a-17(e) (2003); MD. CODE ANN. EST. & TRUSTS § 13-711(d)(8) (2001).
60. See ALA. CODE § 22-8A-11(c) (2001); MD. CODE ANN. EST. & TRUSTS § 13-713 (2001); N.Y. SURR. CT. PRO. ACT § 1750-b.2(c) (McKinney 2003).
61. See DEL. CODE ANN. tit 16, § 2506 (2002); FLA. STAT. ANN. §765.401 (West 2003); MD. CODE ANN. EST. & TRUSTS § 13-711 (2001); N.Y. PUB. HEALTH LAW § 81.22(a) (McKinney 2003).
62. See MD. CODE ANN. EST. & TRUSTS § 13-711 (2001); N.Y. PUB. HEALTH LAW § 81.22(a) (McKinney 2003); W. VA. CODE ANN. § 16-30-9. (Michie 2001).
63. N.Y. SURR. CT. PRO. ACT § 1750-b.2 (McKinney 2003).
64. See DEL. CODE ANN. tit 16, § 2507 (2002); MD. CODE ANN. EST. & TRUSTS § 13-711(b) and (d) (2001).
65. These states are: Alaska, Arkansas, Georgia, Idaho, Louisiana, Massachusetts, Michigan, Missouri, Montana, Nevada, New Hampshire, New Jersey, Oklahoma, Oregon, Tennessee, Texas, Utah, Vermont, Wisconsin, and Wyoming.  
This review of decision-making standards did not include traditional “least restrictive alternative” standards; instead research focused on factors relating to a ward’s medical condition and value system.
66. These states are: Georgia, Idaho, New Jersey, and Utah.
67. See, e.g., N.J. STAT. ANN. § 3B:12-37 (2003).
68. See, e.g., IDAHO CODE § 15-5-307(a) (2003).
69. For an overview of past and present accountability issues, see Sally Balche Hurme & Erica Wood, *Guardianship Accountability Then and Now: Tracing Tenets for an Active Courthouse*, 31 STETSON L. REV. 867 (Spring 2002). See also, Wingspan—The Second National Guardianship Conference, *Recommendations*, adopted Dec. 2, 2001, available at <http://www.naela.org/PDFFiles/Recommendations.pdf>.
70. *Guardians of the Elderly: An Ailing System, AP Special Report* (Sept. 1987), in *Abuses in Guardianship of the Elderly and Infirm: A National Disgrace*, H.R. Comm. Print 100-639 (Dec. 1987).
71. See Kathleen H. Wilber, *Guardianship/Conservatorship* in, ENCYCLOPEDIA OF AGING 457 (George L. Maddox ed., 2001) (citing KAPP, M.B., GERIATRICS AND THE LAW: UNDERSTANDING PATIENT RIGHTS AND PROFESSIONAL RESPONSIBILITIES (3d ed., 1999)(observing the rise in guardianship petitions).
72. *Id.*
73. UNIF. GUARDIANSHIP AND PROTECTIVE PROCEEDINGS ACT OF 1997, U.L.A. (2002).
74. UNIF. HEALTH CARE DECISIONS ACT OF 1993, U.L.A. (2002).
75. See *supra* note 20.
76. See *supra* note 30.
77. See *supra* note 48.

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## *Inside the Commission*

### Winners of the 2003 Law and Aging Student Essay Competition

The ABA Commission on Law and Aging and the FJC Foundation are pleased to announce the results of the 2003 Law and Aging Student Essay Competition.

The purpose of the competition was to stimulate, encourage, and reward innovative student research and original writing on important issues and topics concerning law and the aging population, as well as to promote recognition of the value of this type of legal work.

The competition was open to all law students enrolled in ABA-accredited law schools, as well as to those who graduated within the last year. Topics of the essays focused on public policy or practice issues in serving socially, economically, or physically vulnerable older persons.

The winner of the 2003 Law and Aging Student Essay Competition is **Laura Diane Seng**, of Valparaiso Law School, for her essay "Legal and Regulatory Barriers to Adequate Pain Control for Elders in Long-term Care Facilities."

The second place winner is **Lauren R. Strum**, of the University of Kansas School of Law, for her essay "Fair Housing Issues in Continuing Care Retirement Communities (CCRCs): Can Residents Be Transferred Without Their Consent Under Federal Law?"

The third place winner is **Anna D. Helechko**, of Duquesne University School of Law, for her essay "Viatical Settlements and the Elderly: Potential Advantages and Hidden Dangers."

There were also four honorable mentions: **Kathleen S. O'Leary** and **Geraldine Gunther**, of Brooklyn Law School, for their essay "Medicare Reimbursement for Durable Medical Equipment"; **Timothy McIntire**, of the University of Memphis-Cecil C. Humphrey School of Law, for his essay "Ouch! That Really Hurts. Pain Management in the Terminally Ill: Is This a Legal or a Medical Problem?"; **Stephanie Roark**, of the University of Illinois College of Law, for her essay "When the System Fails: What Notification Procedure Does Due Process Require in the Context of State Aid to the Elderly?"; and **Berne V. Kapili**, from Fordham Law School, for his essay entitled "Should Doctor Welby Help Kill Grandma?"

The winning essays and one of the honorable mentions will be published in the Fall 2003 issue of the New York City Law Review, which is published by the City University of New York School of Law.

## *Good to Know*

### GrandDriver Program Steers Public Awareness to Aging's Effects on Driving

While many seniors may be good drivers, the physical changes associated with aging can ultimately affect the ability to drive safely. In an effort to increase awareness about aging's effects on driving, the American Association of Motor Vehicle Administrators, the Administration on Aging, and their partners in the District of Columbia, Maryland, and Virginia have created a pilot program entitled "GrandDriver."

The program is urging the public, particularly drivers over 65 and their adult children, to learn more about the effects of aging on the ability to drive.

As part of its campaign, a Web site has been established to provide older drivers and their families with educational resources and links to important services, including:

- Driver Refresher Courses
- How to Find a Driver Rehabilitation Specialist
- Alternative Transportation Options
- Family Resources, and
- Older Driver Facts

The Internet address for the GrandDriver Web site is <http://www.GrandDriver.info>, or phone 1-888-Grand03 for more information.

## *State Bar Updates*

### Maryland's Elder Law Section Wins Best Project Award

The Maryland State Bar Association (MSBA) Elder Law Section has been selected by the MSBA Board of Governors to receive the Presidential Best Section Project Award for its consumer guide, *Assisted Living in Maryland: What You Need to Know*. This is the second year in a row for the section to receive such an honor. Last year, the section received the "Best Section Project Award" for its Long-Term Care Medicaid Project, a pro bono panel representing elders in Medicaid level of care appeals.

*Assisted Living in Maryland: What You Need to Know* includes chapters on choosing a facility, costs and how to pay for them, what to look for in a contract, resident's rights, and the complaint process. It also includes discussions of health and financial decisionmaking, alternatives to assisted living, and resources.

The guide was a cooperative effort of the Legal Aid Bureau, Inc.'s Assisted Living Project, the Attorney General's Office, the Department of Aging, the Department of Health and Mental Hygiene, the Maryland State Bar Association, and the University of Maryland School of Law's Law and Health Care Program. It is a companion to the highly successful *Nursing Homes: What You Need to Know*.

Single copies of the guide were distributed to consumers through state and local agencies and is available for bulk purchase by attorneys wishing to offer it as a service to clients. The guide is also available online in PDF format at <http://www.mdoa.state.md.us/Housing/ALGuide.pdf>.

The companion guide, entitled *Nursing Homes: What You Need to Know*, is available online at [www.oag.state.md.us/consumer/nurshome.htm](http://www.oag.state.md.us/consumer/nurshome.htm)

## California Publishes Consumer Legal Guide for Seniors

The State Bar of California has published a consumer information guide to help seniors understand their legal rights and the special services available to help them stay in charge of their lives. *Seniors & the Law: A Guide for Maturing Californians* is being distributed free of charge by the California Bar Journal and the State Bar of California's Office of Media and Information Services. The 16-page, tabloid-style guide covers a wide range of senior-specific

topics, most addressed in a question-and-answer format. For example, the section entitled "Making Ends Meet" tackles such questions as:

- What is Social Security?
- What is a representative payee?
- What is a reverse mortgage?
- Is there any special tax relief for seniors?
- Can I get help paying my gas and electric bills?
- What can I do if I can't afford to eat?
- Is there any financial assistance available for seniors who are immigrants?

In addition, there are a number of side-bar sections featuring information on "Where to Live"; "Obtaining Health Care Benefits"; "Dealing with Debt"; "Getting Around"; "Getting Divorced or Remarried"; "Raising Your Grandchildren"; "Finding a Caregiver or Nursing Home"; "Losing a Spouse or Parent"; "Types and Samples of Elder Abuse"; "Protecting Your Identity"; and "Hiring Help in the Home."

To request your copy, email [barcomm@calbar.ca.gov](mailto:barcomm@calbar.ca.gov) or write to: The State Bar of California, Attn: *Seniors & the Law*, 180 Howard St., San Francisco, CA 94105-1639. When ordering, include your name, complete mailing address (P.O. boxes are not acceptable), number of copies ordered, English or Spanish version, and a daytime phone number.

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**Mark Your Calendar!**

*Announcing the Fourth Annual*

# **National Aging and Law Conference**

*October 15 - 18, 2003, Hilton Crystal City, Arlington, Virginia*

- The pre-conference day on October 15 will include sessions on the “Nuts and Bolts” of key aging and law topics.
- On Friday, October 17, Robert Grey, president-elect of the American Bar Association, will deliver the luncheon keynote address.

**This year’s conference offers you the opportunity to share your expertise with colleagues!  
NALC 2003 will include workshops planned and conducted by advocates in the field.**

- **For a registration form, email [NALC@aarp.org](mailto:NALC@aarp.org) for a PDF version or to request a copy via regular mail. Register online at [www.aarp.org/ntp](http://www.aarp.org/ntp) and select the “register on-line today” option. An additional \$10.00 processing fee will be charged for using this special online service.**
- Registration Fee: \$300 legal services and aging advocates; \$350 private attorneys.
- Hotel Accommodations: Same rate as last year! \$125/night, single or double (ask for the AARP/NALC room rate).
- Added Benefit: Shuttle service available between Crystal City Metro Station and Hilton Crystal City Hotel.

Sponsored by the AARP Foundation, ABA Commission on Law and Aging, the National Senior Citizens Law Center, the Center for Social Gerontology, the Center for Medicare Advocacy, Inc., the National Academy of Elder Law Attorneys, the National Consumer Law Center, and National Association of State Units on Aging.

**See you at the conference!**

# **NALC 2003**

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Washington, DC 20005-1022

On the Web at <http://www.abanet.org/aging>