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Notes

Broadening Anachronistic Notions of "Family" in Proxy Decisionmaking for Unmarried Adults

by
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Preferential treatment of the traditional family unit pervades law and society. Usually this deference is innocuous. In certain situations, however, it discriminates against people who do not live in traditional family settings, but who instead have formed other types of primary relationships. The preference for the traditional family seems particularly unjust in medical decisionmaking for incapacitated adults involved in serious relationships outside the societal norm.

One case provides an especially poignant example. On November 13, 1983, a drunken driver slammed into Sharon Kowalski's car, leaving the twenty-seven-year-old woman "physically and mentally impaired."[1] Both her traditional family—father, mother, and sister—and her roommate and lover of four years—Karen Thompson—spent as much time as possible by Sharon's bedside as she lay in a coma for several weeks. As a result of Karen's devotion, Sharon's father, Donald Kowalski, began to feel uncomfortable about the nature of the relationship between the two women. Donald Kowalski told Karen Thompson "that friends weren't supposed to visit as often as [Karen] was visiting and if [she] didn't stop visiting so often, he would see to it [Karen] couldn't visit at all."[2]

After consulting with the hospital psychologist, Karen wrote a letter to Sharon's parents, Donald and Della Kowalski, explaining that she and Sharon were lovers and that Sharon would want Karen's continued involvement in Sharon's rehabilitation and life.[3] The parents did not answer, but when Sharon's sister responded to this letter by calling Karen

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1. *In re* Guardianship of Kowalski, 382 N.W.2d 861, 862-63 (Minn. Ct. App. 1986).

2. K. THOMPSON & J. ANDRZEJEWSKI, WHY CAN'T SHARON KOWALSKI COME HOME? 17 (1988).

3. *Id.* at 21-25.

"a sick, crazy person who has made up this whole story,"[4] Karen decided to sue for guardianship to protect her ability to see Sharon.[5] Donald Kowalski cross-petitioned for guardianship.[6]

Karen agreed to Donald Kowalski's appointment as guardian, avoiding a trial on the matter. In exchange for her acquiescence, Karen received equal access to Sharon's medical and financial records, equal visitation with Sharon, and an equal right to consult with medical and financial personnel. The probate court never ruled that Donald Kowalski was "the most suitable and best qualified among those available and willing" to serve as guardian.[7] The court recognized "that Karen Thompson and Donald and Della Kowalski each have a significant relationship with the Ward, Sharon Kowalski, and [found] each to be a suitable and qualified person to discharge the trust."[8]

Disagreements between the Kowalskis and Karen continued, however, and on October 31, 1984, Donald Kowalski moved to amend the original guardianship order to end Karen's visitation and access. In response, Karen moved for the removal of Donald Kowalski as guardian. Both motions were dismissed on December 12, 1984.[9] After renewed motions by both Donald Kowalski and Karen, however, on July 23, 1985, the district court confirmed Donald Kowalski as guardian of Sharon Kowalski, removing all limitations on his power as guardian.[10] The court admonished Donald Kowalski to "consider, regarding all visitation decisions, that the primary consideration is the best interest of the ward and any reliably expressed wishes of the ward, both of which may change from time to time."[11] Notwithstanding this judicial direction, the next day Donald Kowalski banned Karen Thompson from visiting Sharon Kowalski. From August 1985 until recently, Karen could not so much as see Sharon.[12]

This Note, considering statutes and cases typical of those in all the states, posits that the *Kowalski* case would have led to the same result in any jurisdiction in the United States. The Note examines the state of the law of guardianship and proxy medical decisionmaking and finds that the law fails to serve the goals of guardianship for people in positions similar to Karen and Sharon—unmarried adults in serious, quasi-marital rela-

4. *Id.* at 26.
5. *Id.* at 28.
6. *In re* Guardianship of Kowalski, 382 N.W.2d 861, 863 (Minn. Ct. App. 1986).
7. *Id.*
8. *Id.*
9. *Id.*
10. *Id.* at 864.
11. *Id.*
12. K. THOMPSON & J. ANDRZEJEWSKI, *supra* note 2, app. A, at 3. After a lengthy legal battle, Karen Thompson finally was allowed to resume visitation with Sharon Kowalski in February, 1989. The couple had not seen each other for nearly four years. N.Y. Times, Feb. 8, 1989, § D, at 25, col. 1.

tionships in which one partner unexpectedly becomes incapacitated. The goals of guardianship or proxy decisionmaking are to protect the best interests of the incompetent patient or to implement the patient's own self-determination through the decisions of another.[13] While other commentators have focused on the potential for abuse of unfettered guardianship power or the adjudication of incapacity, little attention has been given to the common-law and statutory preference for family members to act for the ward. This Note finds these presumptions inconsistent with the primary aims of guardianship and proxy decisionmaking.

Section I discusses the evolution of the law's preference for family members to serve as guardians and decisionmakers, from its common-law origins to its codification in some states. The section also discusses the development of the two goals of guardianship, serving the best interests of the patient and effectuating the ward's self-determination through the guardian's use of "substituted judgment" in making decisions for the ward. Sections II and III review the types of medical decisionmaking and guardianship statutes and significant cases in each area. Section IV critically analyzes the relevant cases and statutes and demonstrates that rote appointment of legal next of kin does not fulfill either the best interests or substituted judgment goals for a significant number of unmarried adult Americans who may become incapacitated. Section V discusses changes that have been attempted already, such as living wills and durable powers of attorney, and explains why such attempts do not provide enough protection for unmarried couples. Finally, section VI proposes ways that both the courts and the legislatures can best protect the rights of incapacitated single adults.

I. Development of the Law of Medical Proxy Decisionmaking and Guardianship

Legal standards concerning who may make decisions on behalf of incapacitated adults have been developing for centuries. Even in ancient times, blood relatives were thought the best proxies. Although this assumption remains largely unchallenged and unchanged, the goal of the law has evolved. Originally, the law in this area aimed paternalistically to do what was "best" for the patient. Now, the primary goal is to implement the patient's own will by standing in her shoes when making decisions.

A. Preference for Family Members

The preference for family members to act for mentally incompetent adults is deeply entrenched in Western civilization. For example, in 449 B.C., Roman law stated that a "fool" and his belongings should be pro-

13. *See infra* notes 29-32 and accompanying text.

tected by his family.[14] The family traditionally has played two different, yet pivotal roles in the medical arena: making decisions for relatives unable to consent to treatment and serving as legal guardians for incompetent relatives.

The role of the family as proxy decisionmakers has continued, strengthened in part because of concerns over medical liability. Doctors and hospitals can be held liable for battery, trespass, or, more likely now, negligence, unless the patient first gives informed consent to the proposed medical procedure.[15] When the patient herself is unable to consent, the physician's duty is satisfied and liability usually avoided if the doctor obtains consent from the patient's next of kin.[16] In fact, one commentator asserts that the tradition of seeking consent and advice from family members is "so well known in society at large that any individual who finds the prospect particularly odious has ample warning to make other arrangements better suited to protecting his own ends or interests."[17] Thus, the physician traditionally has abided by the wishes of family members of incompetent adult patients without any legal formalities or judicial oversight.[18] Indeed, the physician's most likely goal in deferring

14. AMERICAN BAR FOUNDATION, THE MENTALLY DISABLED AND THE LAW 1 (2d ed. 1971).

15. Natanson v. Kline, 186 Kan. 393, 410, 350 P.2d 1093, 1106 (1960), was the watershed case, holding doctors liable for breaking their obligation "to disclose and explain to the patient in language as simple as necessary the nature of the ailment, the nature of the proposed treatment, the probability of success or of alternatives, and perhaps the risks of unfortunate results and unforeseen conditions within the body." This respect for the autonomy of the individual can be traced to Justice Cardozo, who stated: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." Schloendorff v. Society of the N. Y. Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914) (overruled on other grounds in Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957)).

16. Canterbury v. Spence, 464 F.2d 772, 789 n.92 (D.C. Cir.) ("Where the complaint in suit is unauthorized treatment of a patient legally or factually incapable of giving consent, the established rule is that, absent an emergency, the physician must obtain the necessary authority from a relative."), *cert. denied,* 409 U.S. 1064 (1972) ; Grannum v. Berard, 70 Wash. 2d 304, 306, 422 P.2d 812, 814 (1967) ("[I]n surgical cases, consent to such procedure must be obtained from either the patient, or, if the patient is under some disability, from a near relative capable of giving consent."); *see also* PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 1 (1983) [hereinafter DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT].

17. Capron, *Informed Consent to Catastrophic Disease and Research Treatment,* 123 U. PA. L. REV. 340, 424-25 (1974). Others, however, argue that "[t]he problem with this suggestion is that it is not at all clear that any 'other arrangements' are legally binding upon the physician . . . ." Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking,* 1979 WIS. L. REV. 413, 475 n.203.

18. *See* Barber v. Superior Ct., 147 Cal. App. 3d 1006, 1020-21, 195 Cal. Rptr. 484, 492-93 (1983) (physicians properly consulted with wife for treatment decisions about incompetent

to family wishes is to stay as far away from court as possible. This somewhat casual means of obtaining proxy consent, albeit age-old tradition, is not immune, however, from challenge.[19]

By contrast, the appointment of a guardian to make decisions for an incompetent adult is formal and legalistic.[20] Guardianship also has a long history in English and American law.[21] The king was the guardian-protector of all his subjects, especially the young or the weak,[22] and the sovereign exercised his *parens patriae*[23] powers to enter the decisionmaking process for incompetent adults.[24] Even though the king was formally the guardian of adult incompetents, close relatives were usually responsible for the incompetent adult's actual care.[25] Eventually, the courts began to favor appointing the incompetent adult's next of kin as guardian of the incompetent.[26] Guardianship became part of a private, familial

husband); *In re* Storar, 52 N.Y.2d 363, 385, 420 N.E.2d 64, 75, 438 N.Y.S.2d 266, 277 (Jones, J., dissenting in part) (physicians and families in actuality have been making decisions about life-sustaining treatment for incompetent patients), *cert. denied,* 454 U.S. 858 (1981).

19. *See* Gauvey, Leviton, Shuger & Sykes, *Informed and Substitute Consent to Health Care Procedures: A Proposal for State Legislation,* 15 HARV. J. ON LEGIS. 431, 445 (1978) ("family members . . . are not legally entitled to give consent in the absence of any statutory authorization"). Cases supporting this view include Beck v. Lovell, 361 So. 2d 245, 250 (La. Ct. App.) (in absence of an emergency, spouse does not have authority to consent to surgery simply because of marriage relationship), *cert. denied,* 362 So. 2d 802 (La. 1978); Gravis v. Physicians & Surgeons Hosp. of Alice, 427 S.W.2d 310, 311 (Tex. 1968) ("[T]he relationship of husband and wife does not in itself make one spouse the agent of the other.").

20. *See infra* text accompanying notes 64-67.

21. 1 W. BLACKSTONE, COMMENTARIES *460.

22. *Id.* *303; *see also* N. KITTRIE, THE RIGHT TO BE DIFFERENT 59 (1971) (quoting 2 L. SHELFORD, A PRACTICAL TREATISE ON THE LAW CONCERNING LUNATICS, IDIOTS AND PERSONS OF UNSOUND MIND 6 (1833)) ("The King, as the political father and guardian of his kingdom, has the protection of all his subjects, and of their lands and goods; and he is bound, in a more peculiar manner to take care of those who, by reason of their imbecility and want of understanding, are incapable of taking care of themselves.").

23. "[L]iterally 'parent of the country,' refers traditionally to role of state as sovereign and guardian of persons under legal disability." BLACK'S LAW DICTIONARY 1003 (5th ed. 1979). For an early chancery decision enunciating *parens patriae,* see Eyre v. Shaftsbury, 2 P. Wms. 103, 24 Eng. Rep. 659 (1722).

24. For examples of modern courts exercising *parens patriae* powers, see *In re* W.S., 152 N.J. Super. 298, 377 A.2d 969 (1977); *In re* Doe, 104 A.D.2d 200, 481 N.Y.S.2d 932 (1984); *In re* Terwilliger, 304 Pa. Super. 553, 450 A.2d 1376 (1982).

25. Regan, *Protective Services for the Elderly: Commitment, Guardianship, and Alternatives,* 13 WM. & MARY L. REV. 569, 570-71 (1972).

26. *See generally* Sullivan v. Dunne, 198 Cal. 183, 194, 244 P. 343, 347 (1926) (stating that all other things being equal, the law prefers the adult children of the incompetent named as guardians over strangers to the incompetent's blood); *In re* Estate of Colvin, 3 Md. 278 (1851) (stating that, contrary to more primitive times, the law now considers consanguinity a suitable recommendation, and strong grounds must be shown before it will be disregarded); *In re* Williams' Comm., 252 A.D. 314, 315, 298 N.Y.S. 881, 883 (1937) (court recognized that the well-established practice is to appoint the choice of the incompetent's next of kin unless it is impossible to find within the family circle or their nominees a qualified guardian). Many of these older cases refer to appointing a "committee" over the incompetent rather than a guard-

sphere, but remained subject to regulation by the courts.[27] In fact, a tension that continues today developed between judicial intervention and decisionmaking, and the role and power of the family.[28] Yet, whether physicians rely on tradition and informally choose to consult with family members when an adult is unable to give consent to treatment, or whether the state adjudicates the matter and appoints a legal guardian, chances are that the decisions still will be made by the incompetent adult's closest relative.

B. Goals of Proxy Decisionmaking and Guardianship

Courts have held that the paramount consideration in appointing a guardian[29] is the welfare of the proposed ward.[30] To effectuate this goal, courts traditionally have used the "best interests" standard, requiring a guardian to do what is best, on an objective basis, for the ward.[31] Courts now often rely on a more subjective standard, the doctrine of "substituted judgment," especially in cases involving consent to or refusal of medical procedures.[32]

The doctrine of substituted judgment originated in an 1816 English case in which the court allowed an incompetent adult's destitute siblings

ian. The purpose and powers were the same, and the committee often consisted of only one person.

27. Frolik, *Plenary Guardianship: An Analysis, a Critique and a Proposal for Reform,* 23 ARIZ. L. REV. 599, 608-09 (1981).

28. For an interesting discussion of this issue, see generally Relman, *The Saikewicz Decision: Judges as Physicians,* 298 NEW ENG. J. MED. 508 (March 2, 1978) (arguing that physicians, patients, and families of patients alone should make treatment decisions); Baron, *Medical Paternalism and the Rule of Law: A Reply to Dr. Relman,* 4 AM. J. L. & MED. 337 (1978) (arguing that judicial intervention is the only way to guarantee the incompetent patient's right to due process); *see generally* Comment, *The Role of the Family in Medical Decisionmaking for Incompetent Adult Patients: A Historical Perspective and Case Analysis,* 48 U. PITT. L. REV. 539 (1987) (authored by Elaine B. Krasik) (advocating the rights of the families of incompetent patients).

29. There are generally three types of guardianship: guardians of the person, guardians of the estate, and plenary guardians (of both the estate and person). *See, e.g.,* CAL. PROB. CODE §§ 2350, 2400 (West 1981); N.J. STAT. ANN. §§ 3A:6-16.10(b) (West Supp. 1981). In this Note, the term "guardian" will be used only to refer to guardians of the person or plenary guardians. "Conservator" will be used to refer to guardians of the estate.

30. *E.g.,* Boylan v. Kohn, 172 Ala. 275, 55 So. 127 (1911); *In re* Andrews, 125 A.D. 457, 109 N.Y.S. 831, *rev'd on other grounds,* 192 N.Y. 514, 85 N.E. 699 (1908); *In re* Estate of Fox, 365 P.2d 1002 (Okla. 1961).

31. *In re* Guardianship of Eberhardy, 102 Wis. 2d 539, 567, 307 N.W.2d 881, 894 (1981).

32. *In re* Severns, 425 A.2d 156, 159 (Del. Ch. 1980); *In re* Spring, 380 Mass. 629, 634, 405 N.E.2d 115, 119 (1980); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 750-51, 370 N.E.2d 417, 430-31 (1977); *In re* Quinlan, 70 N.J. 10, 41-42, 355 A.2d 647, 664, *cert. denied,* 429 U.S. 922 (1976); *see also* DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 16, at 132-34 (stating that substituted judgment maximizes patient's self-determination because the surrogate decisionmaker attempts to reach the same decision that the incapacitated person would have made had the incapacitation not occurred).

to take gifts from his estate because the court believed that was what the patient would have done if he had been able.[33] A United States court first recognized substituted judgment in a similar case, refusing to award a stipend to the stepdaughter of an incompetent man because the court thought the man would not have given the money to his stepdaughter before his illness.[34] In 1969, a court for the first time applied the doctrine of substituted judgment to a medical controversy and decided to allow the transplant of a kidney from an incompetent child to his critically ill brother.[35]

Usually, the two standards produce the same result: decisions made by a surrogate using substituted judgment should be the same as those made in the incapacitated person's best interests, because most people can be assumed to act for their own good. The best interests standard and the doctrine of substituted judgment diverge, however, and may produce different results if the guardian decides to forego life-sustaining treatment. Such a decision may be what the incapacitated person would have chosen, yet objectively it may not be in the person's best interests to pass up life-sustaining treatment.[36]

The two standards also might vary in less extreme situations. Because the patient's best interests are determined objectively, they are, in effect, based on what the majority of society believes is best. If a particular patient's personal views differ from the majority, use of substituted judgment to implement her self-determination could conflict with what most people would think to be the best course to follow. For example, if the religious beliefs of an incapacitated patient in need of blood preclude transfusions, the use of substituted judgment would lead her proxy to reject transfusions. Most people would find transfusions to be in the patient's best interests, and, therefore, use of the best interests standard would require the proxy to ignore the patient's wishes and consent to transfusions.

The traditional tendency to prefer family members as proxy decisionmakers will not further the goal of implementing a patient's self-determination if the beliefs or views of the patient differ significantly from her family's. Thus, reliance on tradition, even though codified in many states, is misplaced. Tradition should not be allowed to undermine the

33. *Ex parte* Whitbread, 2 Meriv. 99, 35 Eng. Rep. 878 (1816). The court stated, "[I]t is not because the parties are next of kin of the Lunatic, or, as such, have any right to an allowance, but because the Court will not refuse to do, for the benefit of the Lunatic, that which it is probable the Lunatic himself would have done." *Id.* at 103, 35 Eng. Rep. at 879 (quoted in Annotation, *Power of Court or Guardian to Make Noncharitable Gifts or Allowances out of Funds of Incompetent Ward,* 24 A.L.R.3d 863, 873 n.8 (1969)).

34. *In re* Willoughby, 11 Paige Ch. 257, 260 (N.Y. Ch. 1844).

35. Strunk v. Strunk, 445 S.W.2d 145 (Ky. 1969).

36. *E.g.*, Note, *Substituted Judgment in Medical Decisionmaking for Incompetent Persons: In re Storar,* 1982 WIS. L. REV. 1173, 1177 n.24.

goal of the law of medical proxy decisionmaking. An examination of statutes and cases, however, indicates that tradition is indeed controlling, regardless of the relationship to self-determination.

II. Proxy Decisionmaking in the Absence of a Guardian

The term "proxy decisionmaker" can refer to anyone empowered to make decisions for another person. Selection of the proxy may be informally accomplished, as when a physician asks for consent to treatment from whomever is available at the time. Selection of a proxy may be made formally through procedures to appoint a guardian for an incapacitated person. Guardians are court-appointed proxies, imbued with specific powers. One could also choose her own proxy decisionmaker by naming someone to act on her behalf in a durable power of attorney executed before incapacity.

This Note uses the term "proxy decisionmaker" to refer to situations in which the court has not appointed a guardian and the incapacitated patient has not legally empowered a proxy. Many jurisdictions have statutes or case law that provide guidance to a physician as to whom the proxy should be. Because physicians can be sued for treatment performed without consent, they have strong incentive to seek consent from someone other than the patient if the patient is unable to consent. This incentive is even stronger in states that require informed consent.

A. Statutes Designating Proxy Decisionmakers

Only twenty-eight states have statutes dealing with informed consent.[37] Of these, twenty-two explicitly or implicitly provide for proxy decisionmaking when the patient herself is unable to give consent to medical treatment or procedures.[38] Most of these statutes explicitly

37. ALASKA STAT. § 9.55.556 (1983); ARIZ. REV. STAT. ANN. § 12-561 (Supp. 1982); ARK. STAT. ANN. § 16-114-206 (1987); DEL. CODE ANN. tit. 18, § 6852 (Supp. 1988); FLA. STAT. ANN. § 766.103 (West Supp. 1989); GA. CODE ANN. § 88-2906.1 (Harrison Supp. 1989); HAW. REV. STAT. § 671-3 (1985); IDAHO CODE § 39.4304 (1985); IOWA CODE ANN. § 147.137 (West 1989); KY. REV. STAT. ANN. § 304.40-320 (Michie/Bobbs-Merrill 1988); LA. REV. STAT. ANN. § 40:1299.40 (West 1977 & Supp. 1989); ME. REV. STAT. ANN. tit. 24, § 2905 (Supp. 1989); MINN. STAT. ANN. § 144.651 (West 1989 & Supp. 1990); MISS. CODE ANN. §§ 41-41-3 to -15 (Supp. 1989); MO. ANN. STAT. § 431.061 (Vernon Supp. 1990); NEB. REV. STAT. § 44-2816 (1988); NEV. REV. STAT. § 41A.110 (1979); N.Y. PUB. HEALTH LAW § 2805-d (McKinney Supp. 1990); N.C. GEN. STAT. § 90.21.13 (1985); OHIO REV. CODE ANN. § 2317.54 (Anderson Supp. 1988); OR. REV. STAT. § 677.097 (1983); PA. STAT. ANN. tit. 40, § 1301.103 (Purdon Supp. 1989); R.I. GEN. LAWS § 9-19-32 (1985); TENN. CODE ANN. § 29-26-118 (1980); TEX. REV. CIV. STAT. ANN. art. 4590i, §§ 6.01-6.07 (Vernon Supp. 1990); UTAH CODE ANN. § 78-14-5 (1977); VT. STAT. ANN. tit. 12, § 1909 (Supp. 1989); WASH. REV. CODE ANN. §§ 7.70.050, 7.70.060 (Supp. 1989).

38. ALASKA STAT. § 9.55.556(b)(3) (1983); ARK. STAT. ANN. § 16-114-206(b)(2)(A) - (B) (1987); DEL. CODE ANN. tit. 18, § 6852(a)(2) (Supp. 1988); FLA. STAT. ANN.

grant legal relatives, in declining levels of consanguinity, the power to act on behalf of the incompetent patient. Other statutes are less specific, adding little to the tradition of consulting family members, with which physicians are already familiar. None of these statutes suggests that a lover or close friend of the patient might, in some circumstances, be a better proxy decisionmaker than a legal relative. Nor do the statutes provide any guidelines beyond bloodlines for physicians or courts to follow in determining who is the best-suited proxy.

Some proxy decisionmaking statutes are painstakingly clear and forthright. For example, the Georgia statute provides that:

> any one of the following persons is authorized and empowered to consent, either orally or otherwise, to any surgical or medical treatment or procedure not prohibited by law which may be suggested, recommended, prescribed, or directed by a duly licensed physician: (1) Any adult, for himself; (2) Any parent, whether an adult or a minor, for his minor child; (3) Any married person, whether an adult or a minor, for himself and for his spouse; (4) Any person temporarily standing in loco parentis, whether formally serving or not, for the minor under his care; and any guardian, for his ward; . . . .[39]

Mississippi's statute is especially thorough and inclusive of different relatives:

> Who may consent to surgical or medical treatment or procedures. . . . (a) Any adult, for himself. . . . (b) Any parent . . . for his minor child or for his adult child of unsound mind . . . . (d) Any married person . . . for his spouse of unsound mind . . . . (j) Any adult, for his minor brother or sister or for his adult brother or sister of unsound mind.[40]

Unlike these two statutes, Idaho's statute does not delineate all the different blood relatives who may consent on behalf of an incompetent adult. Instead, Idaho's provision includes a blanket grant of proxy powers to cover every possible situation:

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§ 766.103(3)(a)(1), (4)(a) (West Supp. 1989); GA. CODE ANN. § 88-2906.1(b)(2), (e)(3) (Harrison Supp. 1989); HAW. REV. STAT. § 671-3(a) (1985); IDAHO CODE § 39-4303 (1985); IOWA CODE ANN. § 147.137(3) (West 1989); KY. REV. STAT. ANN. § 304.40-320 (Michie/Bobbs-Merrill 1988); LA. REV. STAT. ANN. §§ 40:1299.53, .55 (West 1977); ME. REV. STAT. ANN. tit. 24, § 2905(1) (Supp. 1989); MINN. STAT. ANN. § 144.651(9) (West 1989); MISS. CODE ANN. § 41-41-3 (Cum. Supp. 1989); MO. ANN. STAT. § 431.061 (Vernon Cum. Supp. 1990); NEB. REV. STAT. § 44-2808 (1988); NEV. REV. STAT. § 41A.120(2) (1979); N.C. GEN. STAT. § 90.21.13(a) (1985); OHIO REV. CODE ANN. § 2317.54(C) (Anderson Supp. 1988); TEX. REV. CIV. STAT. ANN. art. 4590i, §§ 6.03(a), 6.04(a), 6.05 (Vernon Supp. 1990); UTAH CODE ANN. § 78-14-5(4) (1977); VT. STAT. ANN. tit. 12, § 1909(c)(3) (Supp. 1989); WASH. REV. CODE ANN. §§ 7.70.050(4), 7.70.060 (Supp. 1989).

39. GA. CODE ANN. § 88-2904(a) (Harrison 1986).

40. MISS. CODE ANN. § 41-41-3 (Cum. Supp. 1989). The informed consent statutes of Louisiana and Utah also contain long lists of relatives empowered to give consent for the incapacitated adult. *See* LA. REV. STAT. ANN. § 40:1299.53 (West 1977); UTAH CODE ANN. § 78-14-5(4) (1977).

> Consent for the furnishing of . . . care . . . to any person who is not then capable of giving such consent . . . may be given or refused by any competent parent, spouse, or legal guardian . . . unless the patient is a competent adult who has refused to give such consent. . . . If no parent, spouse or legal guardian is readily available to do so, then *consent may be given by any competent relative* . . . .[41]

Other states' statutes are less clear, but they evince a strong preference for allowing next of kin to make medical decisions for an incapacitated adult. For example, North Carolina's statute, ostensibly addressing only medical liability provides: "No recovery shall be allowed against any health care provider upon the grounds that the health care treatment was rendered without the informed consent of . . . the patient's spouse, parent, guardian, nearest relative or other person authorized to give consent for the patient . . . ."[42] The statute only implies that next of kin are proper proxies. Protection from liability provides a powerful incentive, however, for physicians to seek consent from a relative of the patient, regardless of the nature and closeness of the relationship between the patient and her relative. Thus, in effect, the statute provides that physicians must obtain consent from relatives of the patient when the patient is unable to consent. The statute perpetuates a bias in favor of legal relatives without consideration of other factors that would better evaluate a proxy decisionmaker's qualifications.

Finally, several states have cryptic statutes that are equivocal about who should make decisions for incapacitated patients. For example, Minnesota's statutory reference to proxy decisionmaking provides: "In cases where it is medically inadvisable [to give the information to the patient] the information shall be given to the patient's guardian or other person designated by the patient as a representative."[43] Similarly, Ohio's statute provides that: "[I]f the patient . . . lacks legal capacity to consent, [consent may be given] by a person who has legal authority to consent on behalf of such patient. . . ."[44] Statutes such as these most likely mean either that the hospital personnel will look to tradition and, consequently, the patient's next of kin, or that a judge will make the final decision using common law, which usually favors blood relatives. While laudable for not specifically preferring legal relatives to the exclusion of other loved ones, the end result probably will be the same as if the stat-

41. IDAHO CODE § 39-4303(a), (b) (1985) (emphasis added).

42. N.C. GEN. STAT. § 90-21.13(a) (1985).

43. MINN. STAT. ANN. § 144.651(9) (West 1989).

44. OHIO REV. CODE ANN. § 2317.54(C) (Anderson Supp. 1988). Arkansas, Florida, Kentucky, Iowa, Nevada, Washington, and Vermont are similarly vague about exactly who is supposed to act for the incompetent patient. *See* ARK. CODE ANN. § 16-114-206(b)(2)(A), (B) (1987); FLA. STAT. ANN. § 766.103(3)(a)(1), (4)(a) (West Supp. 1989); IOWA CODE ANN. § 147.137(3) (West 1989); KY. REV. STAT. ANN. § 304.40-320(1) (Baldwin 1988); NEV. REV. STAT. § 41A-120(.2) (1979); VT. STAT. ANN. tit. 12, § 1909(c)(3) (Supp. 1989); WASH. REV. CODE ANN. § 7.70.060 (Supp. 1989).

utes did note such a preference. Indefinite statutes also result in confusion because no one can know in advance where she stands or what her rights, if any, are. Statutes giving a clear preference for parents and other legal relatives to act as the decisionmakers at least provide some warning to people who, if they became incapacitated, would prefer someone other than a legal relative to make decisions for them. The warning may allow them to try to make other arrangements.

No state explicitly includes close friends or lovers as appropriate surrogate decisionmakers, or suggests that they may be people who, because of their intimate relationships with the incompetent adult and their knowledge of the patient's preference regarding treatment, should be consulted about treatment procedures. There seems to be an assumption behind these statutes that only legal family members know the incompetent person's feelings and preferences about treatment, are able to make valid decisions on the patient's behalf, or truly have the patient's best interests at heart.

B. Proxy Decisionmaking Cases

The common law of many states refers, however obliquely,[45] to a doctor's duty to obtain consent from a legal relative when nonemergency medical decisions must be made for an incapacitated patient.[46] Some cases, like some statutes, merely acknowledge that a person can give necessary medical consent for an incompetent patient, without specifying who the person may be. For example, a Kansas decision states, "[I]f the patient is incompetent the consent must be obtained from someone legally authorized to give it for him."[47] This case leaves open the question of who that person might be, or how the proxy decisionmaker should be chosen. Other similar cases simply specify that a "near relative" should

45. *See, e.g.*, Patrick v. Sedwick, 391 P.2d 453, 458 (Alaska 1964) (Medical expert testified that he would "also speak to the family when in his judgment the patient's condition warranted.").

46. *See* Canterbury v. Spence, 464 F.2d 772, 789 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Campbell v. Oliva, 424 F.2d 1244, 1251 (6th Cir. 1970); Cobbs v. Grant, 8 Cal. 3d 229, 243-44, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972); Nishi v. Hartwell, 52 Haw. 188, 198-99, 473 P.2d 116, 122-23 (1970); Younts v. St. Francis Hosp. & School of Nursing, 205 Kan. 292, 298, 469 P.2d 330, 336 (1970); Wilson v. Lehman, 379 S.W.2d 478, 479-80 (Ky. 1964); Percle v. St. Paul Fire & Marine Ins. Co., 349 So. 2d 1289, 1300 (La. Ct. App. 1977); Cornfeldt v. Tongen, 262 N.W.2d 684, 701 n.14 (Minn. 1977); *In re* Nemser, 51 Misc. 2d 616, 623-34, 273 N.Y.S.2d 624, 630-31 (N. Y. Sup. Ct. 1966); Kennedy v. Parrott, 243 N.C. 355, 360, 90 S.E.2d 754, 758 (1956); Murray v. VanDevander, 522 P.2d 302, 304 (Okla. Ct. App. 1974); Grannum v. Berard, 70 Wash. 2d 304, 306, 422 P.2d 812, 814 (1967).

47. *Younts*, 205 Kan. at 298, 469 P.2d at 336; *see also* Dunham v. Wright, 302 F. Supp. 1108, 1109 (M.D. Pa. 1969) (doctor should get consent for treatment of incompetent patient from "someone legally authorized to give it for him"), *aff'd*, 423 F.2d 940 (3d Cir. 1970).

give consent if the patient is unable.[48] Thus, individual trial judges have great discretion to resolve disputes.

Some courts, however, stress that decisions about proxy consent to medical treatment should be made in the private familial sphere rather than in the courtroom. In one case, *In re Nemser,* [49] the court scolded the parties in holding that a judicial determination was unwarranted. The case involved a disagreement among three adult sons over the proposed amputation of their mother's foot. The court stated:

> Is the court to be made the arbiter in all family disputes as to the wisdom or necessity of medical treatment, or is that, in reality a medical problem to be resolved by the physician, his patient, where possible, and the family, if necessary? Certainly, the courtroom is not the proper forum . . . . If there is no . . . emergency or urgency, then the Court should not, in effect, be placed in the position of making what should be a private or family determination—a medical decision, obviously not a legal one.[50]

Many cases about who is to decide questions of medical treatment for an incompetent adult involve the discontinuance of life-sustaining treatment, certainly the most extreme example of proxy decisionmaking. In *In re L.H.R.,* [51] a case involving a terminally ill child, the court held that the fourth amendment of the United States Constitution gives adult patients the right to refuse treatment, and that this right is not lost because of youth or incompetency. The court concluded that because of the value society places on the family, "the decision whether to end the dying process is a personal decision for family members or those who bear a legal responsibility for the patient."[52] The court spontaneously took "this opportunity to extend our holding to . . . incompetent adult patient[s]. . . . [T]he family of the adult or the legal guardian may make the decision to terminate life-support systems without prior judicial approval or consultation of an ethics committee."[53] If courts believe that as

48. *Wilson,* 379 S.W.2d at 479-80; *see also Percle,* 349 So. 2d at 1300 (quoting *Canterbury,* 464 F.2d at 789) ("[D]isclosure [is required] to a close relative with a view to securing consent to the proposed treatment. . . ."); *Cornfeldt,* 262 N.W.2d at 701 n.14 ("In a situation in which nondisclosure is warranted, the physician should seek consent from a close relative."); *Grannum,* 70 Wash. 2d at 306, 422 P.2d at 814 ("[I]n surgical cases, consent to such procedure must be obtained from either the patient, or, if the patient is under some disability, from a near relative capable of giving consent.").

49. 51 Misc. 2d 616, 273 N.Y.S.2d 624 (N.Y. Sup. Ct. 1966).

50. *Id.* at 623-24, 273 N.Y.S.2d at 631.

51. 253 Ga. 439, 321 S.E.2d 716 (1984).

52. *Id.* at 446, 321 S.E.2d at 723.

53. *Id.* at 447, 321 S.E.2d at 723. See also John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921 (Fla. 1984), which states:

> We hold that the right of a patient, who is in an irreversibly comatose and essentially vegetative state to refuse extraordinary life-sustaining measures, may be exercised either by his or her close family members or by a guardian of the person of the patient appointed by the court. *If there are close family members such as the pa-*

weighty a decision as discontinuing life-support systems should be left to blood relatives without court intervention,[54] there is little question that courts also would leave less serious questions to the legal family to decide, without judicial oversight.

One case seems to stand for an increased judicial role in life and death decisions. In *In re Conservatorship of Torres,* [55] the court held that a judicial order was necessary to discontinue a man's life-support system, even though the man's only two known relatives and the hospital staff all agreed that withdrawal of the support was the best course. The holding suggests that the court believed adjudication was required to protect the incompetent patient's rights. Yet, in a footnote, the court added that it did not intend for this opinion to change the common situation of families, physicians, and hospitals making decisions to discontinue the life support of incapacitated adult patients.[56] Courts, however, seem to be best suited to determine who should make decisions for incapacitated adults on a long-term, nonemergency basis. The role of the courts is to sift objectively through facts and make just conclusions. Courts also traditionally have been charged with protecting the weakest elements in society, and incompetent adult patients surely are a group in need of judicial protection. Thus, instead of shying away from such situations, to protect the rights of patients, courts should enter the fray and make decisions that balance all the interests involved.

One reason courts may favor legal family members as proxy decisionmakers for incapacitated adults is the concern that these relatives will be held financially responsible for the care and treatment of the patient. Because the financial resources of these persons are at stake, the reasoning goes, they should be able to make the medical decisions. As

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tient's spouse, adult children, or parents, who are willing to exercise this right on behalf of the patient, there is no requirement that a guardian be judicially appointed. . . . The decision to terminate artificial life supports is a decision that normally should be made in the patient-doctor- family relationship. Doctors, in consultation with close family members are in the best position to make these decisions.

Id. at 926 (emphasis added).

54. A concurring justice in *Bludworth* suggested that a guardian still should be appointed for an incapacitated adult when the decision of terminating life-sustaining treatment is involved, because a guardian is required in order to make conveyances of the incompetent person's property, and ending life support should be treated as seriously. *Id.* at 927 (McDonald, J., concurring).

55. 357 N.W.2d 332 (Minn. 1984).

56. "[A]bout 10 life support systems are disconnected weekly in Minnesota. This follows consultation between the attending doctor and the family with the approval of the hospital ethics committee. It is not intended by this opinion that a court order is required in such situations." *Id.* at 341 n.4; *see also In re* Spring, 380 Mass. 629, 636, 639, 405 N.E.2d 115, 120, 122 (1980) (stating, somewhat confusingly, both that "our opinions should not be taken to establish any requirement of prior judicial approval that would not otherwise exist" and that "[w]hen a court is properly presented with the legal question, whether treatment may be withheld, it must decide that question and not delegate it to some private person or group").

one court blatantly expressed this financial consideration, "where an adult child is incompetent and has no legally appointed guardian, the right to consent to medical or surgical treatment resides in the parent who has the legal responsibility to maintain and support such child . . . ."[57] While in most jurisdictions parents indeed are held financially responsible for their incompetent adult offspring who are unable to pay for needed medical treatment,[58] parents should not receive corresponding control over treatment decisions unless they also fulfill the two main goals of proxy decisionmaking, effectuating the patient's own will through substituted judgment and serving the best interests of the patient.[59] Power to make decisions for an incompetent patient should not go hand in hand with control of the pursestrings. Financial liability of parents for adult offspring is meant to protect society from paying for the care and treatment of patients, a goal that has nothing to do with the goals of the law in guardianship and proxy decisionmaking. The law's utmost concern in this area should be with protecting the rights of the powerless, with doing what is best for the incompetent person.

The conflict between financial responsibility and the best interests of the ward is apparent in situations involving the spouses of incompetent adults. It is an open question whether a financially obligated parent has more authority to make treatment decisions than the spouse of an incompetent adult. If the spouse does not have enough money to pay for the care and treatment of the incapacitated person and the bills go to the patient's parents, the logic of the above decisions seems to favor giving the parents, not the spouse, control over the patient. It is also clear,

57. Ritz v. Florida Patient's Compensation Fund, 436 So. 2d 987, 989 (Fla. Dist. Ct. App. 1983), *rev. denied,* 450 So. 2d 488 (Fla. 1984). Others have echoed essentially the same concern that the one with control of the pocketbook also should control treatment decisions, but less directly. *See, e.g.,* Corbett v. D'Alessandro, 487 So. 2d 368, 371 n.1 (Fla. Dist. Ct. App. 1986) ("with the concurrence of those who have responsibility for the diagnosis and with the concurrence of *those who have responsibility for the care of the patient,* it is not unethical to discontinue all means of life-prolonging medical treatment") (citing AMERICAN MEDICAL ASSOCIATION'S COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, WITHHOLDING OR WITHDRAWING LIFE-PROLONGING MEDICAL TREATMENT (Mar. 15, 1986)); *In re* L.H.R., 253 Ga. 439, 446, 321 S.E.2d 716, 723 (1984) ("the decision whether to end the dying process is a personal decision for family members or *those who bear a legal responsibility* for the patient") (emphasis added).

58. See Moore, *Parents' Support Obligations to Their Adult Children,* 19 AKRON L. REV. 183, 184 (1985), for a summary of the cases and statutes providing for such parental obligation in 30 jurisdictions.

59. Unfortunately, unlike the guardianship cases, *supra* note 32, none of the informed consent cases inquire into the wishes of the incompetent patient when delegating the authority to make decisions for the patient. A patient currently cannot "prevent critical decisions from being made by a relative whom he considers unreliable" because such veto provisions are "absent from the statutes and common law precedents authorizing relatives to give substituted consent." Note, *Appointing an Agent to Make Medical Treatment Choices,* 84 COLUM. L. REV. 985, 1002 (1984) (authored by Mark Fowler) (emphasis and footnote omitted).

however, that "the courts customarily recognize the presumptive priority of the incapacitated [patient's spouse] as a substitute decisionmaker,"[60] apparently without regard to the spouse's financial strength. Thus, financial responsibility as a rationale for selecting proxy decisionmakers is unsatisfactory.

In sum, there are no clear judicial guidelines for determining who should make decisions for an incapacitated patient, perhaps because of the courts' favoritism toward family members. The cases announce that the decisionmaker should be a "near relative," without suggesting how to define that term, how to resolve disputes between relatives or between relatives and other concerned individuals, or how to ascertain and implement the wishes of the incapacitated patient herself. The case law does nothing but uphold the age-old custom of obtaining consent from legal family members, which hospitals continue to do largely without resorting to the courts.[61] Medical professionals are left to sort out disputes among family members and among the incapacitated patient's family members and significant others, without guidance and with virtually unlimited discretion. If an affected party or a doctor fearing liability does turn to the courts for resolution of the sensitive and important question of who should be the substitute decisionmaker, the courts may admonish them and declare that the question is not worthy of judicial consideration.[62]

III. Guardianship

Guardianship is a formalized method of appointing a proxy decisionmaker for an incapacitated person. While courts only become involved in other types of proxy decisionmaking if a dispute arises, no one can become a guardian without court approval. Although courts administer guardianship proceedings, the results almost always are identical to less formal proxy decisionmaking because guardianship statutes and cases also favor appointment of a legal relative.

60. Comment, *supra* note 28, at 560 (footnote omitted); *see also* Corbett v. D'Alessandro, 487 So. 2d 368, 370 (Fla. Dist. Ct. App. 1986) (in consultation with doctors, husband could have vegetative wife's nasogastric tube removed); Steele v. Woods, 327 S.W.2d 187, 199 (Mo. 1959) (doctor should have obtained consent from husband of patient for necessary post-operative treatment because the patient was too groggy to be treated as competent); Annotation, *Priority and Preference in Appointment of Conservator or Guardian for an Incompetent,* 65 A.L.R.3d 991, 1018 (1975) ("the spouse of an incompetent is generally preferred over others as guardian, whether of the person, or of the estate, or of both, of the incompetent"). Spouses also are usually the first statutorily suggested proxy decisionmakers. *See supra* text accompanying notes 39-42.

61. *See supra* note 18 and accompanying text.

62. *See In re* Nemser, 51 Misc. 2d 616, 623-24, 273 N.Y.S.2d 624, 631 (N.Y. Sup. Ct. 1966). *But see* John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921, 926 (Fla. 1984) (even though normally treatment decisions should be left to the family and doctors to make, "the courts . . . are always open to hear these matters if request is made by the family, guardian, physician, or hospital").

The question of who serves as guardian is even more critical, however, because guardians obtain greater power over the incapacitated adult's life than a proxy decisionmaker. Although a proxy decisionmaker can make the ultimate decision to discontinue life support,[63] his decisions are limited to medical questions. A guardian can make all of the same medical decisions, but also can decide how and where the ward lives, who the ward may see, and almost every other detail of the ward's life. For these reasons, guardianship of unmarried adults deserves close scrutiny.

A. Guardianship Statutes

Appointing a guardian is a formal, legalistic process begun when a petition is filed by any interested party.[64] Notice of a hearing is served personally on the proposed ward and other interested parties, such as the spouse and parents of the proposed ward.[65] The alleged incompetent person's personal autonomy and liberties are at stake in the proceeding as well as control over virtually all aspects of the ward's life.[66]

Every state has a statute authorizing the appointment of a guardian for incapacitated individuals.[67] The statutes vary from being very com-

63. *See supra* notes 51-56 and accompanying text.

64. *See, e.g.,* ALASKA STAT. § 13.26.105(a) (1985); CAL. PROB. CODE § 1820 (West 1981). This person can be almost anyone. *See, e.g.,* ALASKA STAT. § 13.26.105(a) ([a]ny person may petition . . . for . . . a guardian for oneself or for another person"); MINN. STAT. ANN. § 525.541 (West Supp. 1980) ("[a]ny person may petition for the appointment of a guardian or conservator or for a protective order for any other person believed to be subject to guardianship or conservatorship"); OKLA. STAT. ANN. tit. 58, § 851 (West Supp. 1990) ("any relative or friend" may petition for a guardianship for the incompetent person).

65. *See, e.g.,* UTAH CODE ANN. § 75-5-309(2) (1978).

66. As one author stated: "A decision that finds guardianship proper also empowers the guardian to make decisions concerning day-to-day matters, such as where the ward will live and with whom, what medical treatment the ward will have, and how the ward's money will be spent." Mitchell, *The Objects of Our Wisdom and Our Coercion: Involuntary Guardianship for Incompetents,* 52 S. CAL. L. REV. 1405, 1408 (1979).

67. *See* ALA. CODE § 26-2A-102 (Supp. 1989); ALASKA STAT. §§ 13.26.095, 13.26.165 (1985); ARIZ. REV. STAT. ANN. §§ 14-5301 to -5315, 36-547 (1975 & Supp. 1989); ARK. STAT. ANN. §§ 28-65-101 to -603 (1987 & Supp. 1989); CAL. PROB. CODE §§ 1500-1605 (West 1981 & Supp. 1989); COLO. REV. STAT. §§ 15-14-101 to -502 (1973 & Supp. 1979); CONN. GEN. STAT. ANN. §§ 45-70 to -77b (West 1958 & Supp. 1989); DEL. CODE ANN. tit. 12, § 3914 (1979); FLA. STAT. ANN. §§ 744.101 to .531 (West 1986 & Supp. 1989); GA. CODE ANN. §§ 49-601 to -613 (Supp. 1980); HAW. REV. STAT. §§ 560:5-101 to 5-502 (1985 & Supp. 1988); IDAHO CODE §§ 15-5-101 to -603 (1979 & Supp. 1988); ILL. ANN. STAT. ch. 110 1/2, 11a-1 to -23 (Smith-Hurd Supp. 1989); IND. CODE ANN. §§ 29-3-1 to -13 (Burns 1989); IOWA CODE ANN. §§ 633.552 to .561 (West 1964 & Supp. 1988); KAN. STAT. ANN. §§ 59-3001 to -3038 (1983 & Supp. 1988); KY. REV. STAT. ANN. §§ 387.500-.990 (Michie/Bobbs-Merrill 1984 & Cum. Supp. 1988); LA. CIV. CODE ANN. arts. 389-426 (West 1952 & Supp. 1989); ME. REV. STAT. ANN. tit. 18-A, §§ 5-301 to -313 (1981 & Supp. 1989); MD. EST. & TRUSTS CODE ANN. §§ 13-101 to -806 (1974 & Supp. 1989); MASS. GEN. L. ch. 201, §§ 6-15 (1981 & Supp. 1989); MICH. COMP. LAWS ANN. §§ 700.401 to .499, 700.8 (West 1980 & Supp. 1989); MINN.

plex to simply acknowledging that a guardian may be appointed for some people under some circumstances.

(1) The Uniform Probate Code Model

Several states base their guardianship statutes on the Uniform Probate Code (UPC), which gives family members the predominant role in guardianship. Most of the statutes that are not patterned after the model code agree on this role of the family as well. Several states[68] define incapacity using language from the UPC, which defines an incapacitated person as "any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, or other causes (except minority) to the extent that he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person."[69]

STAT. ANN. §§ 525.539 to .614 (West Supp. 1990); MISS. CODE ANN. §§ 93-13-121 to -151 (1972 & Supp. 1989); MO. ANN. STAT. §§ 475.010 to .370 (Vernon Supp. 1989); MONT. CODE ANN. §§ 72-5-101 to -502 (1989); NEB. REV. STAT. §§ 30-2601 to -2672 (1985); NEV. REV. STAT. ANN. §§ 159.013 to .215 (Michie 1986); N.H. REV. STAT. ANN. §§ 464-A:1 to :44 (1983 & Supp. 1988); N.J. STAT. ANN. §§ 3B:12-24 to -66 (West 1983); N.M. STAT. ANN. §§ 45-5-101 to 5-502 (1989); N.Y. MENTAL HYG. LAW 78.01 to .31 (McKinney 1988); N.C. GEN. STAT. §§ 35A-1101 to -1294 (1984); N.D. CENT. CODE §§ 30.1-26-01 to -30-05 (1976 & Supp. 1989); OHIO REV. CODE ANN. §§ 2111.01 to .48 (Anderson 1976 & Supp. 1988); OKLA. STAT. ANN. tit. 58, §§ 851 to 859 (West 1965 & Supp. 1989); OR. REV. STAT. §§ 126.003 to .227 (1983); 20 PA. CONS. STAT. ANN. §§ 5501 to 5525 (Purdon 1975 & Supp. 1989); R.I. GEN. LAWS §§ 33-15-1 to -45 (1984 & Supp. 1988); S.C. CODE §§ 44-23-710 to -820 (1985 & Supp. 1988); S.D. CODIFIED LAWS ANN. §§ 30-26-1 to -7 (1984); TENN. CODE ANN. §§ 34-1-101 to -7-105 (1984 & Supp. 1989); TEX. PROB. CODE ANN. §§ 108-127A (Vernon 1980 & Supp. 1990); UTAH CODE ANN. §§ 75-5-101 to -502 (1978 & Supp. 1986); VT. STAT. ANN. tit. 14, §§ 3060-3096 (1988); VA. CODE ANN. §§ 37.1-128.01 to 37.1-147 (1984 & Supp. 1989); WASH. REV. CODE ANN. §§ 11.88.005 to .150 (1987); W. VA. CODE §§ 27-11-1 to -11-5 (1986); WIS. STAT. ANN. §§ 880.01 to .39 (West Supp. 1988); WYO. STAT. §§ 3-2-101 to -201 (1985).

68. ARIZ. REV. STAT. ANN. § 14-5101(1) (Supp. 1989); COLO. REV. STAT. § 15-14-101 (1987); IDAHO CODE § 15-5-101(a) (Supp. 1988); MONT. REV. CODE ANN. § 72-5-101(1) (1989); NEB. REV. STAT. § 30-2601(1) (1985); N.M. STAT. ANN. § 45-5-101(F) (1989); N.D. CENT. CODE § 30.1-26-01(2) (Supp. 1989); UTAH CODE ANN. § 75-1-201(18) (Supp. 1986).

69. UNIF. PROB. CODE § 5-101(1) (1969). One author criticized the lack of guidelines in the model code, stating as follows:

> Indeed, under this formula, there is no requirement that an allegedly incapacited [sic] person perform any acts of incompetence. The standard instead indicates that one's status, as elderly, physically disabled, mentally ill, or socially deviant, is the key element. Whether an individual is incapable, lacks understanding, or is unable to make proper decisions will depend on the subjective interpretations of the decisionmaker.

Mitchell, *supra* note 66, at 1421. Similarly, another author noted of California's guardianship provision, "that guardians are, in fact, not appointed 'for almost any unsuccessful person' can be credited only to the restrained exercise of sound judicial discretion." Pickering, *Limitations on Individual Rights in California Incompetency Proceedings,* 7 U.C. DAVIS L. REV. 457, 484-85 (1974).

Fourteen states have adopted substantially the UPC definition of guardianship.[70] The UPC contains a section entitled, "Who May Be Guardian; Priorities," which provides:

> (a) Any competent person or a suitable institution may be appointed guardian of an incapacitated person.
>
> (b) Persons who are not disqualified have priority for appointment as guardian in the following order:
>
> (1) the spouse of the incapacitated person;
>
> (2) an adult child of the incapacitated person;
>
> (3) a parent of the incapacitated person, including a person nominated by will or other writing signed by a deceased parent;
>
> (4) any relative of the incapacitated person with whom he has resided for more than 6 months prior to the filing of the petition;
>
> (5) a person nominated by the person who is caring for him or paying benefits to him.[71]

Several states have enacted similar provisions for choosing a guardian, giving the same enumerated preference for those closely related to the incapacitated person. Some of these statutes use the UPC model only as a base and add other important provisions that consider the preferences of the ward herself. For example, Alabama adds a provision for preferential appointment of the nominee of the incapacitated person as long as the nomination was made in a durable power of attorney, and "[u]nless lack of qualification or other good cause dictates the contrary."[72] Alabama's statute also contains, after a UPC-like list of preferences, a clause giving the court discretion to choose the guardian if two candidates are of equal priority[73] on the list, or if appointment of someone of lower priority or even no priority is in the best interests of the ward.[74] Colorado adds as the second choice for guardian on the enumeration of preferences "[a] person nominated by the incapacitated person in writing prior to his incapacity."[75] This provision is a much less formal means of considering the incompetent person's preference than requiring that the wish be expressed in a durable power of attorney, as Alabama's statute requires. Neither statute, however, sufficiently furthers the pref-

70. ALA. CODE §§ 26-2-40, 26-2-1 (1975); ALASKA STAT. § 13.26.005(1) (1972); ARIZ. REV. STAT. ANN. § 14-5301 (1975); COLO. REV. STAT. § 15-14-304 (1987 & Supp. 1989); HAW. REV. STAT. § 560:5-101(2) (1976); IDAHO CODE § 15-5-101(a) (1979); ME. REV. STAT. ANN. tit. 18(a), § 1-201(16) (1981); MICH. COMP. LAWS ANN. § 700.443 (1980 & Supp. 1989); MONT. CODE ANN. § 91-5-101 (1983); NEB. REV. STAT. § 30-2601(1) (1979); N.M. STAT. ANN. § 32-5-101 (1978); N.D. CENT. CODE § 30.1-26-04 (1976); OR. REV. STAT. § 126.003 (1983); UTAH CODE ANN. § 75-1-201(18) (1978 & Supp. 1986).

71. UNIF. PROB. CODE § 5-311 (1969).

72. ALA. CODE § 26-2A-104(b) (Supp. 1989).

73. For example, if both parents or two siblings of a patient requested appointment as guardian, the court would have discretion to choose.

74. ALA. CODE § 26-2A-104(d) (Supp. 1989).

75. COLO. REV. STAT. § 15-14-311(b) (1987).

erences of the ward because few adults execute documents stating such preferences.

Both Alaska and Montana have incorporated significant deviations from the UPC model into their respective guardianship statutes. Alaska expresses a clear preference for abiding by the wishes of the incompetent person. One section of the statute provides: "If it is necessary to appoint a guardian, the court shall consider the ward's preference."[76] In its list of preferences for guardian, the Alaska statute includes, as the first choice, "[the nominee of] the incapacitated person, if at the time of the nomination the incapacitated person had the capacity to make a reasonably intelligent choice."[77] Finally, Alaska adds another choice to the list of potential guardians: "a relative or *friend who has demonstrated a sincere, longstanding interest in the welfare of the incapacitated person.*"[78] Unfortunately, this option is last on the prioritized list. Another section, however, adds that the priorities are not binding and that the court should select the best qualified individual.[79] Thus, one can hope that the court will exercise its discretion to follow the likely wishes of the ward.

(2) Non-Uniform Probate Code States

A number of states have guardianship statutes that are not based substantially upon the UPC. The only traits these statutes have in common are their diversity and lack of concern for the ward's preferences. The methods for choosing a guardian exemplify the variety, ranging from those providing no guidance to the courts to those spelling out a clear preference for appointing family members as guardians.

Many of these states do not enumerate any priorities for the court to follow in appointing a guardian. Some offer no guidance at all. For example, New Hampshire's statute provides that "[a]ny competent person who agrees to so serve may be appointed guardian of the person and estate, or the person, or the estate."[80] Missouri's statute is similar: "any adult person may be appointed" guardian.[81] Three states add one qualifi-

76. ALASKA STAT. § 13.26.113(g) (1985).

77. *Id.* § 13.26.145(d)(1). Montana's statute also adds, as first priority, the nominee of the incompetent person, "if the court specifically finds that at the time of the nomination the incapacitated person had the capacity to make a reasonably intelligent choice." MONT. CODE ANN. § 72-5-312(2)(a) (1989).

78. ALASKA STAT. § 13.26.145(d)(5) (1985) (emphasis added). Montana's statute uses identical language. MONT. CODE ANN. § 72-5-312(2)(f) (1989).

79. ALASKA STAT. § 13.26.145(e) (1985); *accord* MONT. CODE ANN. § 72-5-312(3) (1989).

80. N.H. REV. STAT. ANN. § 464-A:10 (Supp. 1988).

81. MO. ANN. STAT. § 475.055 1.(1) (Vernon Supp. 1989). Several other states express no statutory preferences for appointments of guardians: California (although CAL. PROB. CODE § 1812 does enumerate priorities to be used in appointing a conservator), Connecticut, Iowa, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Minnesota, New York, North Carolina, Ohio, Oklahoma, Rhode Island, Tennessee, and West Virginia.

cation to this broad grant of discretion to the court by requiring that the court consider the wishes of the incompetent person.[82]

Other states have enacted statutes that go considerably further in defining the court's options for appointing guardians for incapacitated persons. These statutes range from those merely stating that the court shall have due regard for "relationship by blood or marriage to the person for whom the guardianship is sought,"[83] to those specifying persons the court should consider appointing as guardian, and everything in between.

For example, some states' statutes only imply a predominant role for legal relatives to play in the guardianship proceedings. Ohio's statute provides that "[t]he application of the guardian of an incompetent shall contain . . . [the] [n]ame, *degree of kinship,* age, and *address of next of kin,*"[84] and that "notice shall be served . . . [u]pon the next of kin of the person for whom appointment is sought known to reside in the county in which application is made."[85] Thus, it seems evident that the state intends for the legal relatives of the incapacitated person to be involved in the guardianship proceedings, and presumably to serve as guardian, yet the statute never explicitly states such a preference.[86] Four other states treat the involvement of legal relatives in a similar, implicit fashion.[87]

On the other hand, several states specify who is to be appointed guardian for an incompetent adult. Florida's statute treats the wishes of the incompetent person and the interests of her family equally. The statute provides that any qualified person can serve as guardian "whether

82. ILL. ANN. STAT. ch. 110 1/2, Paras. 11a-12(d) (Smith-Hurd Supp. 1989); KY. REV. STAT. ANN. § 387.600(2) (Michie/Bobbs-Merrill 1984); VA. CODE ANN. § 37.1-128.1(A) (Supp. 1989). Kentucky further qualifies the court's discretion in a later section, stating that the court shall give preference to people with these qualifications: "(1) kinship to the [incapacitated person]; (2) [e]ducation and business experience of the applicant; [and] (3) [c]apability to handle financial affairs." KY. REV. STAT. ANN. § 387.605.

83. ARK. STAT. ANN. § 28-65-204(b)(4) (1987). For other similar provisions, see IND. CODE ANN. § 29-3-5-4(5) (Burns 1989) and NEV. REV. STAT. § 159.061.4 (1989).

84. OHIO REV. CODE ANN. § 2111.03(B) (Anderson 1976) (emphasis added).

85. *Id.* § 2111.04(B)(2).

86. Only once does the statute specifically state that a legal relative should serve as guardian, and even then it is in equivocal fashion rather than a mandate. OHIO REV. CODE ANN. § 2111.11 provides that the incompetent person's spouse may be appointed guardian "if it is made to appear to the satisfaction of the court that such spouse is competent to discharge the duties of such appointment."

87. Maine and West Virginia both provide that the incompetent person's spouse or adult next of kin receive notice of the guardianship hearing. *See* ME. REV. STAT. ANN. tit. 18-A, § 5-309(a) (1964 & Supp. 1989) (also providing for notice to "an adult friend" if no adult relatives are available); W. VA. CODE § 27-11-1(b) (1986). And Massachusetts' statute provides that a parent or two or more relatives or friends or agencies may file a petition for guardianship. MASS. GEN. L. ch. 201, § 6 (1981 & Supp. 1989). Oklahoma's provision is similar. "Any relative or friend may petition for guardianship" and then the "court shall cause notice to be given to the supposed insane or incompetent person and . . . to some known near relative." OKLA. STAT. ANN. tit. 58, § 851 (West Supp. 1990).

related to the ward or not,"[88] but that the court shall give consideration to both "next of kin"[89] and the incompetent person's "wishes."[90] Texas' statute also is detailed and implies that legal relatives possess a *right* to be named guardian for an incompetent family member. The statute provides:

> (1) If [the incompetent] has a spouse who is not disqualified, such spouse shall be *entitled* to the guardianship in preference to any other person.
> (2) If there be no qualified spouse, the nearest of kin to such person, who is not disqualified, or in case of refusal by such spouse or nearest of kin to serve, then any other qualified person shall be *entitled* to the guardianship.
> (3) Where two or more persons are equally entitled, [one shall be chosen according to the best interests of the ward].[91]

Maryland's code also strongly favors family members, listing many blood relatives as having priority. The code also includes the boilerplate "heirs if [the incapacitated person] were dead" to the list.[92] Arkansas' statute is a little less rigid in its preference for family members, stating only that the court shall have due regard for any requests from the spouse of the incapacitated person and for "[t]he relationship by blood or marriage to the person for whom guardianship is sought."[93] In addition, the statute adds that the "court shall take into consideration any request made by the incapacitated person concerning his preference regarding the person to be appointed guardian."[94]

Some statutes direct the court to consider more than just blood and legal ties when choosing a guardian. For example, Georgia's statute includes the following in the list of preferences for guardians:

> (6) A relative or *other person* who has provided care for the incapacitated person and with whom the incapacitated person has resided for a significant period prior to the time of application; and
> (7) Other persons, such as relatives; persons nominated by a spouse, adult child, parent, or guardian; or *private persons providing income or other care* to the incapacitated person.[95]

Two other states have statutes that seem concerned with respecting the autonomy of the incapacitated person. Kansas includes in its statute

88. FLA. STAT. ANN. § 744.312(1) (West 1986).

89. *Id.* § 744.312(2). Florida's guardianship statute also contains a provision that few other states attempted—it gives a definition of next of kin. " 'Next of kin' means those persons who would be heirs at law of the ward or alleged incompetent if such person were deceased and includes lineal descendants of such ward or alleged incompetent person." *Id.* § 744.102(16).

90. *Id.* § 744.312(3).

91. TEX. PROB. CODE ANN. § 109(c) (Vernon 1980) (emphasis added).

92. MD. EST. & TRUSTS CODE ANN. § 13-707(a)(6) (Supp. 1989).

93. ARK. STAT. ANN. § 28-65-204(b)(4) (1987).

94. *Id.* § 28-65-204(c).

95. GA. CODE ANN. § 49-602(c) (1989) (emphasis added).

a provision for appointing a guardian for an adherent to faith healing. The statute states that "the court shall consider, but not be limited to, the appointment of a person as guardian who is sympathetic to and will support such system of healing."[96] This consideration for the beliefs and choices of the ward should be expanded to encourage the preservation of other lifestyle choices. Minnesota evinces concern for the incapacitated person's wishes by specifying factors the court should consider to determine which guardian would best serve the interests of the incapacitated person. The statute directs the court to consider:

> (1) the reasonable preference of the ward or conservatee, if the court determines the ward or conservatee has sufficient capacity to express a preference;
>
> (2) the interaction between the proposed guardian or conservator and the ward or conservatee; and
>
> (3) the interest and commitment of the proposed guardian or conservator in promoting the welfare of the ward or conservatee and the proposed guardian's or conservator's ability to maintain a current understanding of the ward's or conservatee's physical and mental status and needs. . . .
>
> Kinship is not a conclusive factor in determining the best interests of the ward or conservatee but it should be considered to the extent that it is relevant to the other factors contained in this subdivision.[97]

Although this statute lists several important factors, it fails to consider the ward's preferences expressed before incapacity. Thus, the statute does not encourage courts to preserve the ward's lifestyle by using substituted judgment. The statute instead advocates a somewhat enlightened paternalism. The strong preference for family is the common thread running through most of the guardianship statutes, whether they are UPC-model statutes or not. There are also other similarities. For example, some of the guardianship codes seem to have a great interest in economics and financial matters. The UPC includes in the enumeration of preferred guardians, "a person nominated by the person who is caring for him or paying benefits to him."[98] Kentucky's statute states that in appointing a guardian the court shall consider "kinship" to the incapacitated person plus the "[e]ducation and business experience of the applicant" and his or her capability to handle financial affairs.[99] Delaware includes creditors and debtors in its list of people to be preferred as

96. KAN. STAT. ANN. § 59-3014(a)(2)(c) (Supp. 1987).

97. MINN. STAT. ANN. § 525.539(7) (West Supp. 1990).

98. UNIF. PROB. CODE § 5-311(5) (1969). The UPC-model states have incorporated this into their lists of preferences as well.

99. KY. REV. STAT. ANN. § 387.605 (Michie/Bobbs-Merrill 1984); *see also* IND. CODE ANN. § 29-3-5-4 (Burns 1989) (court shall have "due regard to . . . [t]he best interest of the incapacitated person . . . and the property of the incapacitated person.")

guardians, right after parents, siblings, spouses, adult children, and next of kin.[100]

Most guardianship statutes, whether based on the UPC or not, encourage courts to appoint a legal family member of the ward as guardian. Little attention is paid to the goal of guardianship law, preserving the self-determination of the ward. Incompetent adult wards are, for the most part, treated as minors totally dependent on legal family members. The statutes do not encourage examination of the necessity or propriety of family involvement, unquestioningly accepting the preferability of family. Unfortunately, the interests of incompetent adults have not fared any better at the hands of judges.

B. Guardianship Cases

Sometimes a dispute,[101] due process concerns, or fears of liability compel a doctor, family member, or other concerned individual to turn to the courts and file a petition for legal guardianship for the incompetent patient. This procedure is the legally valid route of proxy decisionmaking.[102] In fact, one court has assumed that only a court-appointed guardian can give valid consent for an incapacitated adult patient.[103]

Even when a legal guardian is appointed, chances are good that a member of the incompetent person's legal family still will make the decisions, just as if the less formal proxy appointment method had been used. This situation occurs because "[p]reference is given to family members"[104] to serve as legal guardians, and "consanguinity . . . will not be disregarded except upon strong grounds" when appointing a guardian.[105]

100. DEL. CODE ANN. tit. 12, § 3914(a) (1979).

101. *In re* Guardianship of Kowalski, 382 N.W.2d 861 (Minn. Ct. App. 1986), is an example. For a time just after Sharon's incapacitating accident, both her legal family and her partner, Karen, consulted with doctors and expressed opinions about treatments. Only after Sharon's parents and Karen began to disagree and Karen's right to see Sharon was threatened did anyone think of starting the legal guardianship process.

102. *See supra* note 19.

103. *In re* Yetter, 62 Pa. D. & C.2d 619, 624 (Northampton Cty. 1973). Another court defended the requirement of a court order before life support systems could be removed from a patient in a vegetative state, regardless of the fact that the patient's immediate legal family members all agreed to discontinue the systems. The court stated that "the court system provides the only mechanism which can protect the interest of the doctor, the hospital, the patient, the family and the state, which can objectively weigh the competing interests in an emotionally charged situation, and which can insulate the participants from civil and criminal liability." Estate of Leach v. Shapiro, 13 Ohio App. 3d 393, 396, 469 N.E.2d 1047, 1052 (1984).

104. *In re* Schiller, 148 N.J. Super. 168, 186, 372 A.2d 360, 370 (1977).

105. *In re* Guardianship of Hampson's Estate, 190 Or. 279, 285, 223 P.2d 1039, 1042 (1950); *see also In re* Weisman, 112 A.D.2d 871, 872, 493 N.Y.S.2d 151, 153 (N.Y. App. Div. 1985) (court must appoint family member or their nominee as guardian, unless they are unqualified).

Many guardianship cases reflect the deeply entrenched presumption[106] that next of kin is best suited to serve as guardian.[107] One case actually states that the nearest relative possesses a *right* to be appointed guardian.[108]

Another case particularly illustrates how far courts will go to have a relative appointed guardian to make decisions for a patient.[109] In this case, the physicians of an elderly patient petitioned the court for authorization of a life-saving amputation.[110] Although the patient had consented to the operation,[111] his doctors were concerned about the validity of this consent because they believed the patient incompetent to make health decisions and because he had previously told relatives that he did not want the operation.[112] The patient's only close relative, both in terms of consanguinity and personal relationship, was his sister, and she refused to consent to the operation.[113] The court then located a niece of the patient, and, over the telephone, appointed her guardian and obtained her consent to perform the amputation.[114] This case also illustrates the tension between substituted judgment and best interests standards. If the court had stood in the patient's position and done as he would have done, it probably would have refused permission for the operation. By following the doctor's recommendation, the court did what it must have thought was for the patient's own good, regardless of what he wanted. Thus, one can see how the best interests standard allows courts to contradict a person's expressed wishes. The result may be worse than paternalism, amounting instead to a patronizing abuse of power.

106. "It appears that kinship and familial ties are regarded by the courts with particular partiality when they find it necessary to select a guardian, whether of the person, or of the estate, or of both, for an incompetent, and that such will not be disregarded except upon strong grounds . . . ." Annotation, *supra* note 60, at 998; *see also supra* note 26.

107. *See* Rathbun v. Rimmerman, 6 Ill. App. 2d 101, 126 N.E.2d 856 (1955); *In re* Dietz, 247 A.D. 366, 287 N.Y.S. 392 (N.Y. App. Div. 1936); *In re* Guardianship of Hampson's Estate, 190 Or. 279, 223 P.2d 1039 (1950). Modern cases still demonstrate a preference for appointing legal family members. *See* Kicherer v. Kicherer, 400 A.2d 1097 (Md. 1979); *In re* Tepen, 599 S.W.2d 533 (Mo. Ct. App. 1980); Roots v. Reid, 555 S.W.2d 54 (Mo. Ct. App. 1977); *In re* Steinberg, 121 A.D.2d 872, 503 N.Y.S.2d 795 (N.Y. App. Div. 1986); *In re* Weisman, 112 A.D.2d 871, 493 N.Y.S.2d 151 (N.Y. App. Div. 1985).

108. "The nearest relative thus has an absolute right to the appointment [as guardian] if unobjectionable." Kelley v. Kelley, 129 Ga. App. 257, 259, 199 S.E.2d 399, 402 (1973) (citations omitted).

109. Long Island Jewish-Hillside Med. Center v. Levitt, 73 Misc. 2d 395, 342 N.Y.S.2d 356 (N.Y. Sup. Ct. 1973).

110. *Id.* at 397. 342 N.Y.S.2d at 359.

111. *Id.*

112. *Id.*

113. *Id.* at 396, 342 N.Y.S.2d at 358.

114. *Id.* at 399, 342 N.Y.S.2d at 360-61.

The quintessential guardianship case, *In re Quinlan,* [115] illustrates both the preference for family members to act as guardians and the vast powers a guardian possesses. In *Quinlan,* the court authorized the patient's father, as her guardian, to use substituted judgment—that is, to stand in her place, and decide whether she would have wanted her life-support system disconnected.[116] According to the court, the father's strong familial bond with his daughter qualified him to be the guardian and to make this decision.[117] The court also stated that treatment questions should be left to the doctors and the family of the patient.[118]

There are, however, exceptions to the common-law preference for appointing family members as guardians for incompetent patients. For one, courts often are required to follow the principle that the appointment must serve the best interests of the incompetent person,[119] and this consideration may require appointing someone who is not a blood relative.[120]

Courts sometimes pass over family members for an unrelated person when conflicts of interest or disagreements[121] between the incapacitated person and her relatives are apparent. One court declared that, while blood relatives are entitled to a favorable presumption, the appointment of someone outside the legal family "is in the best interests of the incompetent where the record discloses dissension in the family, the adverse interests of the relatives and the incompetent, the lack of business ability

115. 70 N.J. 10, 355 A.2d 647, *cert. denied,* 429 U.S. 922 (1976).

116. *Id.* at 41-42, 355 A.2d at 664.

117. *Id.* at 53, 355 A.2d at 664.

118. *Id.* at 50, 355 A.2d at 669.

119. Boylan v. Kohn, 172 Ala. 275, 278, 55 So. 127, 128 (1911); Guardianship of Brown, 16 Cal. 3d 326, 334-35, 546 P.2d 298, 303-04, 128 Cal. Rptr. 10, 15-16 (1976); *In re* Estate of Bennett, 122 Ill. App. 3d 756, 760, 461 N.E.2d 667, 670 (1984); *In re* Andrews, 125 A.D. 457, 465, 109 N.Y.S. 831, 837, *rev'd on other grounds,* 192 N.Y. 514, 85 N.E. 699 (1908).

120. *See, e.g.,* Patterson v. Cook, 288 S.C. 220, 221, 341 S.E.2d 782, 782 (1986), which stated:

> "[T]he selection of the committee rests largely in the discretion of the appointing court, the paramount consideration being the best interests of the incompetent. While close relatives should be carefully considered as potential appointees, they need not be appointed if, in its discretion, the court determines that the best interests of the incompetent require the appointment of someone else." (Citations omitted.)

121. Cases setting forth potential areas of conflict within a family include: Maben v. Rankin, 55 Cal. 2d 139, 142, 358 P.2d 681, 682, 10 Cal. Rptr. 353, 354 (1961) (husband's ulterior motives for committing wife); Foody v. Manchester Memorial Hosp., 40 Conn. Supp. 127, 133, 482 A.2d 713, 717 (Conn. Super. Ct. 1984) (financial concerns); *In re* Spring, 380 Mass. 629, 640 n.3, 405 N.E.2d 115, 122 n.3 (1980) (financial concerns); *In re* Conroy, 98 N.J. 321, 339, 486 A.2d 1209, 1218 (1985) (family members' concern with possible inheritance of incompetent person's estate). Certainly another potential area of conflict within a family is differing religious beliefs. "Consider the different attitudes toward medical care held by a Jehovah's Witness, a right-to-life advocate, and a euthanasiast. A patient might very well prefer to have his health care decision made by a nonrelative who shares these convictions, rather than by a spouse or next-of-kin who does not." Note, *supra* note 59, at 1002 n.115.

of the relative or any other reason whereby a stranger would best serve the interest of the incompetent."[122]

Several courts also have acknowledged that the choice of a "close" relative as guardian is in the best interests of the incapacitated person only when the word "close" refers to more than consanguinity. "[T]he ties of blood are important . . . only if they bind in love and service."[123] Another court appointed a neighbor and close friend as guardian of an incapacitated woman, rather than the woman's daughter, because "personal enmity" existed between the mother and daughter.[124]

In appointing the woman's neighbor rather than her daughter, the court also gave effect to the woman's wishes as to who should be her guardian.[125] Other courts have followed the wishes of the incapacitated person when appointing her guardian. One declared that "the wishes and desires of the protected person, while certainly not binding upon the court, should be accorded as much deference as possible."[126] In one case, the court refused to appoint a man's daughter as his guardian because she intended to move the man back to her home in Texas. The man had moved away because he disliked living conditions there, and the court acceded to his wishes and appointed someone else.[127] Some courts, however, have ignored the wishes of the incompetent person, citing that a court has full discretion to appoint whomever it deems best suited to be guardian,[128] and that the wishes of the incompetent person are not con-

122. *In re* West, 13 A.D.2d 599, 600, 212 N.Y.S.2d 832, 834 (N.Y. App. Div. 1961); *see also In re* Guardianship of Ward, 42 Haw. 60, 72 (1957) (when next of kin have adverse interests to those of the incompetent person, the relatives will not be appointed guardian); *In re* Scurlock, 90 A.D.2d 552, 455 N.Y.S.2d 131 (N.Y. App. Div. 1982) (feuding family led to appointment of nonrelative as guardian); *In re* Lyon, 52 A.D.2d 847, 382 N.Y.S.2d 833 (1976) (court justified in not naming son of incompetent patient as guardian because of the son's indifference to the patient), *aff'd*, 41 N.Y.2d 1056, 396 N.Y.S.2d 183 (1977); Driscoll v. Jewel, 37 Or. App. 529, 588 P.2d 49 (1978) (friend of incompetent patient was a more suitable guardian than the patient's daughter, because the relationship between the patient and his daughter had deteriorated).

123. *In re* Danzig, 23 Misc. 2d 591, 592, 196 N.Y.S.2d 211, 213 (N.Y. Sup. Ct. 1960); *see also In re* Guardianship of Mignerey, 11 Wash. 2d 42, 118 P.2d 440 (1941) (appointment of nonrelative proper because incompetent woman did not have a close relationship with her children).

124. *In re* Guardianship of Quindt, 396 So. 2d 1217 (Fla. Dist. Ct. App. 1981).

125. *Id.* at 1218.

126. *Driscoll*, 37 Or. App. at 533, 588 P.2d at 51. Another court stated: "A man may be insane so as to be a fit subject for guardianship, and yet have a sensible opinion and strong feeling upon the question who that guardian shall be. And that opinion and feeling it would be the duty as well as the pleasure of the court anxiously to consult, as the happiness of the ward and his restoration to health might depend upon it." Allis v. Morton, 70 Mass. (1 Gray) 63 (1855). Also, courts have revoked the appointment of a guardian because the incompetent person wanted another to serve as guardian. *See In re* Weissinger, 720 S.W.2d 430, 435 (Mo. Ct. App. 1986); *In re* Guardianship of Green, 125 Wash. 570, 572, 216 P. 843, 844 (1923).

127. Guardianship of Mosier, 246 Cal. App. 2d 164, 54 Cal. Rptr. 447 (1966).

128. *In re* Guardianship of Cassidy, 95 Cal. App. 641, 647, 273 P. 69, 72 (1928); Kutzner

trolling.[129] These results seem at odds with the goals of the law in proxy decisionmaking. The courts in such cases have abdicated their responsibility and sacrificed what was truly best for the incompetent patient, probably for the sake of judicial efficiency.

C. Broad Powers of Guardians

Once appointed, a guardian possesses a great deal of power over the adult ward, often the "same rights, powers, and duties that a parent has with respect to an unemancipated minor child" and the "right to custody of the . . . person and the right to establish his . . . abode."[130] The guardian can decide how and where the ward lives, whom the ward may see, what treatment the ward receives, and even whether the ward continues to receive life sustainment, such as food and water through a nasogastric tube. In one case,[131] a young woman's mother, serving as her legally appointed guardian, petitioned the court for permission to disconnect the woman's life-support systems, even though the woman herself had never expressed such a desire.[132] The court held that the guardian could halt life-sustaining treatment without a prior court order[133] because "these decisions are best left, wherever possible, to the incompetent patient's guardian, immediate family and physicians."[134] Instead of making the decision from the patient's point of view, the court held that the guardian should have used the best interests standard and done what she thought was best for the patient.[135] The court stated that the wishes of the patient, even if expressed while incompetent, "must be given strong consideration," but did not require the guardian to follow the patient's expressed preferences about such treatment.[136]

In a case illustrating the broad scope of a guardian's powers and how these powers can be misused, five sets of parents petitioned for ap-

v. Meyers, 182 Ind. 669, 674, 108 N.E. 115, 117 (1915); *see also In re* Guardianship of Hill, 196 N.E.2d 816, 818 (Ohio Prob. 1963) (incompetent's choice for guardian "shall be appointed if a suitable person").

129. *See, e.g.*, Ahlman v. Wolf, 413 So. 2d 787, 788 (Fla. Dist. Ct. App. 1982).

130. MD. EST. & TRUSTS CODE ANN. § 13-708(b) (Supp. 1989). For examples of other codes giving the guardian the power to decide where and how the incapacitated person will live, see UNIF. PROB. CODE § 5-312(a) (1972); GA. CODE ANN. § 49-603 (Supp. 1989); N.C. GEN. STAT. § 35A-1241 (1987).

131. *In re* Guardianship of Grant, 109 Wash. 2d 545, 747 P.2d 445 (1987).

132. *Id.* at 550, 747 P.2d at 448.

133. Often, however, the court does require adjudication in the life and death decisions before the guardian can order the support systems withdrawn or nutrition stopped. "[S]uch questions of life and death seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created." Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 759, 370 N.E.2d 417, 435 (1977).

134. *Grant*, 109 Wash. 2d at 566, 747 P.2d at 456.

135. *Id.* at 567, 747 P.2d at 457.

136. *Id.*

pointment as guardians of their adult children in order to take physical custody of their offspring, remove the adults from their respective homes, and have them "deprogrammed."[137] The parents were upset because their adult offspring had joined the Unification Church. The trial judge granted their petitions, with the surprising statement that he was "leaving it entirely up to the parents. . . . [T]hese are adults, but as I've said before, a child is a child even though the parent may be ninety and the child is sixty."[138] The court of appeals set aside the guardianship proceedings, holding that "fundamental rights are at stake,"[139] including the young adults' constitutional rights of freedom of association and, perhaps, of religion.[140]

Some states limit the guardian's power to establish the ward's abode and to have physical custody of the ward if the ward is married. Massachusetts law provides that the "care, custody and education" of a married ward ordinarily will be left to the ward's spouse rather than to the guardian.[141] Ohio goes even further, providing that "[t]he marriage of a ward shall determine the guardianship as to the person but not as to the estate of the ward."[142] Florida's statute provides the incapacitated person with the greatest amount of autonomy and respect for lifestyle, regardless of the ward's marital status. The statute provides:

> In case of an adult ward, the guardian shall honor the ward's preferences as to place and standard of living, either as had been expressed or demonstrated by the ward prior to the determination of his incompetency, or as currently expressed by the ward, insofar as such a request is reasonable.[143]

A guardian can continue to wield tremendous power and control over the ward even from the grave. In the UPC, many UPC-model codes, and several other state statutes, the parents or spouse of an incompetent person are empowered to make a testamentary appointment of a guardian for their incompetent relative.[144]

Naming a guardian thus is an enormously important decision deserving of careful judicial oversight. The court can restrict the power of a particular guardian in the order appointing the person, or, through precedent, can require court approval before the exercise of certain pow-

137. Katz v. Superior Court, 73 Cal. App. 3d 952, 956-57, 141 Cal. Rptr. 234, 235 (1977).

138. Trial Transcript at 50, *In re* Conservatorships of Katz, Underwood, Hovard, Brown, & Kaplan, Nos. 216-828, 217-040, 217-063 (San Francisco Super. Ct. filed March 24, 1977) (cited in Mitchell, *supra* note 66, at 1406).

139. *Katz,* 73 Cal. App. 3d at 968, 141 Cal. Rptr. at 243.

140. *Id.* at 988, 141 Cal. Rptr. at 256.

141. MASS. GEN. L. ch. 201, § 24 (1981).

142. OHIO REV. CODE ANN. § 2111.45 (Anderson 1976).

143. FLA. STAT. ANN. § 744.361(3) (West 1986).

144. *See, e.g.,* UNIF. PROB. CODE §§ 5-301, -311(3) (1972); HAW. REV. STAT. § 560:5-301 (1985); NEV. REV. STAT. § 159.062 (1979).

ers.[145] Another check is the ability to appeal the lower court's decisions of appointment or authorization of the guardian's actions. The standard of appellate review used, however, is whether or not the trial court abused its discretion.[146] This standard is very difficult to meet because the lower court has wide discretion in appointing guardians and reviewing the actions of guardians.[147]

As the cases illustrate, the law clings to the presumption that a legal relative is the proper guardian for an incapacitated adult. This presumption usually prevails even in cases in which the "closest" relative is distant in both consanguinity and relationship with the ward. Some courts have ignored the preference for family when the incapacitated adult clearly prefers someone else, or when conflict exists between the adult and her legal relatives. The trial court is vested with so much discretion to appoint a guardian that whether the court adheres to tradition or considers other relevant factors is largely a matter of chance, depending on the individual judge involved. Similarly, once the guardian is appointed, whether he arbitrarily lays down rules controlling every aspect of the ward's life or respects the ward's wishes and makes decisions judiciously is solely for the guardian to decide. The trial court usually leaves the extent of the guardian's power to the guardian, vesting the guardian with full discretion to act as he pleases.[148]

D. *In re Guardianship of Kowalski*

The decision in *In re Guardianship of Kowalski*[149] strongly affirmed the role of legal family members as guardians, with the power to control all aspects of the incompetent person's life in disregard of the expressed wishes of the incapacitated relative. The court did so by employing the best interests standard and ignoring the patient's choices and desires. In

145. *See, e.g., In re* Moe, 385 Mass. 555, 559, 432 N.E.2d 712, 716-17 (1982) (guardian does not have authority to have ward sterilized); Doe v. Doe, 377 Mass. 272, 277-78, 385 N.E.2d 995, 999 (1979) (guardian cannot admit ward to mental facility unless court finds such action is in the ward's best interests); *In re* Storar, 52 N.Y.2d 363, 380-81, 420 N.E.2d 64, 73, 438 N.Y.S.2d 266, 275 (guardian cannot terminate son's life-prolonging blood transfusions), *cert. denied,* 454 U.S. 858 (1981).

146. *See, e.g., In re* Guardianship of Kowalski, 382 N.W.2d 861, 864-65 (Minn. Ct. App. 1986) (citing *In re* Guardianship of Dahmen, 192 Minn. 407, 256 N.W. 891 (1934); Schimdt v. Hebeisen, 347 N.W.2d 62, 64 (Minn. Ct. App. 1984)).

147. *See, e.g., In re* Guardianship of Kowalski, 382 N.W.2d 861 (Minn. Ct. App. 1986); *supra* notes 128-29 and accompanying text.

148. Of course, this discretionary power usually is accompanied by the admonishment to act only in the best interests of the ward. The limitation is, however, largely illusory. The guardian can justify almost any action within these loose boundaries, and the trial court's review of whether the guardian exceeded the limitation, like appellate review of a trial court's appointment decision, is not stringent.

149. 382 N.W.2d 861 (Minn. Ct. App. 1986).

the process, the court precluded any involvement of other loved ones of Sharon Kowalski, including her lover of four years, Karen Thompson.

Before the court, Karen Thompson argued that as Sharon Kowalski's de facto spouse, she was best suited to fulfill the fiduciary role as Sharon's guardian. Thompson cited the prohibition against spousal testimony[150] and analogized that a quasi-spousal relationship is a strong, confidential relationship deserving of legal recognition and protection as is the bond between legally recognized spouses.

Sharon Kowalski's father countered by arguing that "unconditional parental love for his daughter" supported his appointment as guardian.[151] The court agreed with Donald Kowalski, stating, "Thompson fails to acknowledge the strong confidential relationship which exists between parent and child. That relationship is presumably even stronger when the child has been incapacitated to a four- to six-year-old mental ability."[152] The court cited the fact that testimonial prohibition also applies to *minor* children and their parents as proof of the existence of this confidential relationship equal to the spousal relationship.[153] The fact that Sharon is no longer a minor, however, undermines the court's analogy. The law does not protect communications between adult children and their parents, which implies that a relationship deserving of legal protection does not necessarily exist between them.

One could read the court's language to suggest not only that family members are preferable legal guardians, but that parents are better suited to serve as guardians than the spouse of the incapacitated person.[154] Parents apparently are preferred, especially when the incapacitated adult's mental capacity has been impaired to the level of a child's.

The court also rejected the substituted judgment standard, which would have given effect to Sharon Kowalski's choices as to both whom the guardian should be and what subsequent decisions the guardian could make about her life. Instead, the court utilized the best interests standard,[155] allowing the court to decide who is the "best" guardian for Sharon, regardless of whom she would have preferred, and leaving the guardian to decide what is "best" for Sharon in making subsequent deci-

150. *Id.* at 864-65.

151. *Id.* at 865.

152. *Id.*

153. *Id.*

154. This language flies in the face of legal precedent and statutory preferences, which usually hold the spouse as the preferred choice over the incapacitated person's parents, especially when it comes to custody of the ward. *See supra* notes 71, 91, 141, 142 and accompanying text.

155. The best interests standard requires use of an objective, reasonable person test for determining what is best for the ward. *See supra* text accompanying note 31. But the reasonable, ordinary person probably would not think awarding guardianship to parents of adults who live away from their parents' home is better than appointing someone the adult has chosen as a partner, lives with, and loves.

sions. Use of the best interests standard allows both the court and the guardian to justify following their views and ignoring the wishes of the incompetent patient.

Karen Thompson argued that not only did Sharon express her choice of Karen as guardian after the auto accident, but also that Sharon expressed the same choice prior to her incompetency by choosing to love and live with Karen.[156] The court acknowledged that "[p]reference of the ward is an important factor,"[157] but then ignored the argument that Sharon's choices made prior to the accident actually demonstrated Sharon's preferences. The court stated only that Sharon's current expression of her desires and preferences were "inconsistent and, at times, unreliable"[158] and thus could be discounted. The court added that "[e]ven if the ward could indicate her preference, the guardian is bound . . . to balance her wishes with her best interest. These factors may not be in agreement."[159]

The court upheld the appointment of Donald Kowalski as his daughter's guardian as being in Sharon's "best interests."[160] The only reason given for this determination was that medical testimony showed that Sharon "enters a detrimental, depressed state after Thompson's visits."[161] The court admitted that "[a] pattern has developed indicating Thompson's visits may produce significant responses from the ward," but concluded that termination of Karen Thompson's visits with Sharon was in Sharon's "best interest" because "the ward regularly experiences depression and moodiness *following* Thompson's visits."[162] Yet, it seems understandable that a patient confined to a hospital would be upset and depressed to see her lover's visits come to an end, knowing that she had to stay behind, while her lover returned to their home without her. Presumably, the patient also would get depressed and feel lonely between visits, especially when she was used to living with and seeing her lover every day. One can certainly imagine that legally married couples would feel much the same way if one spouse were confined to a hospital and

156. *Kowalski,* 382 N.W.2d at 865. Karen Thompson also could have argued that because she and Sharon had lived together on a day-to-day basis for four years, and since Sharon had not lived with her parents or seen or spoken to them on a daily basis for more than four years, that Karen was in a much better position than Sharon's parents to know Sharon's current beliefs and desires about lifestyle, medical treatment, and place of abode. Familarity with the ward's personal wishes is particularly important in the substituted judgment model, which compels the court and guardian to act in accordance with what the ward would have done if competent; but familarity with the patient and her wishes also should serve in determining the patient's best interests.

157. *Id.*

158. *Id.* at 867.

159. *Id.*

160. *Id.* at 865.

161. *Id.* at 864.

162. *Id.* at 866 (emphasis added).

would exhibit the same moodiness and depression following visits. Yet, this behavior in a married person surely would never be justification for terminating visitation from his or her spouse.

In Minnesota, whose law controlled the case, the court is supposed to "disregard the application of a family member if their interest and those of the ward would conflict."[163] Donald Kowalski's interests conflicted with those of Sharon Kowalski about her lifestyle. Donald Kowalski, given his opinions about gay people,[164] was extremely unqualified to serve as the guardian of a lesbian woman, regardless of his and his daughter's blood relationship. This is true whether judged on the best interests or substituted judgment standard.[165]

The judge's own homophobic feelings are apparent from the language of the opinion. The opinion stated that "[t]he relationship between Sharon Kowalski and Karen Thompson is uncertain,"[166] yet also acknowledged that Sharon and Karen "had been roommates for four years prior to the accident, had *exchanged rings,* and had *named each other as beneficiary in their life insurance policies.*"[167] Clearly, the actions of Karen and Sharon are strong evidence of the existence of a committed, quasi-spousal relationship between the two women. Roommates do not usually name each other as beneficiaries in insurance policies if their relationship is truly that of just roommates. Also, the exchange of rings is a powerful symbol in modern Western society, usually signifying a serious commitment and relationship. It is difficult to discern what circumstances would have convinced the court of the existence of a quasi-spousal relationship between the two women.[168]

163. *Id.* at 865 (quoting Schmidt v. Hebeisen, 347 N.W.2d 62, 64 (Minn. Ct. App. 1984)).

164. Donald Kowalski stated in an interview: " 'On the farm and in the Army we called them queers and fruits, not gays and lesbians.' Kowalski further stated that Karen would never be granted guardianship because 'there ain't a law in the United States that allows a lesbian relationship.' " San Francisco Chron., Sept. 11, 1988 (This World), at 11.

165. Objectively, it is not in a patient's best interest for someone with extreme disapproval of the patient's lifestyle and of the patient's life partner to control decisions for the patient. The reasonable person in this situation would not choose Donald Kowalski as guardian. Subjectively, Donald Kowalski probably would not be able to overlook his own strongly held viewpoints in order to effectuate Sharon's choices. In addition, this schism of values leads to real doubt as to whether the father and daughter were really close enough for him even to be able to ascertain her viewpoints and make decisions from her point of view.

166. 382 N.W.2d at 863.

167. *Id.* (emphasis added). If Sharon had been living with a member of the opposite sex, even without all the other evidence, the court probably would have accepted the existence of a serious relationship between them. There is a presumption in society that any time a man and woman are close, and especially when they are living in the same house or apartment, that they are involved in a serious, sexual relationship. In same-sex relationships, however, the opposite presumption is made; even when there is evidence of such a relationship, the court treats the relationship as merely a friendship.

168. Even if the court had believed the two women shared a quasi-spousal relationship, it still could have appointed Sharon's father as guardian and allowed him to bar Karen from

Moreover, it is difficult to see what else Karen and Sharon could have done to establish such a relationship. Gay couples are unable to marry legally, often are unable to live openly as a couple because of job or housing discrimination, and suffer family and societal condemnation and even violent attacks. Sharon and Karen had more evidence of their intimate, marital equivalent relationship than many gay couples probably have. Yet the court deemed the relationship "uncertain"[169] because "Sharon had closed their *joint bank account,*"[170] and because Sharon's sister claimed that Sharon had said "she was considering moving to Colorado or moving home[171] and that Karen Thompson was becoming very possessive."[172]

Of course, there are many reasons to close a joint bank account,[173] and many married couples choose not to have joint accounts without the nature of their relationship being called into question. Sharon and Karen continued to live together, to hold life insurance policies naming each other as beneficiary, and to wear each other's rings.[174] The court seemed to seize on the closed bank account and Sharon's alleged statements to her sister about moving, and assumed that since the women might have been experiencing problems in their relationship, the court did not have to deal with the existence of a serious relationship between the two women. This rationale is inconsistent. Acknowledging that there may have been problems between the two presupposes that a relationship existed.

The court continued, "Karen Thompson *claims* a lesbian relationship with Sharon Kowalski. Sharon never told her family of such a relationship or *admitted* it prior to the accident."[175] The choice of the

seeing Sharon. Currently, the law does not extend spousal privileges and priorities to quasi-spousal relationships. The law should do so particularly in cases involving unmarried gay couples whose relationships may be as committed as one would find in any marriage, but who are not allowed to legally marry.

169. *Kowalski,* 382 N.W.2d at 863.

170. *Id.*

171. The fact that the court uses the word "home" to refer to Sharon's parents' house, when Sharon had not lived there for more than four years, suggests the court's bias in the case.

172. *Kowalski,* 382 N.W.2d at 863.

173. Indeed, Karen Thompson explains that:

> Sharon and I had decided a month before the accident to close our joint account. At that time Sharon was making no money to contribute to the house expenses (and the purpose of the joint account was to pay mutual expenses), so it seemed silly to pay bank charges for an account we weren't using. Based on that mutual decision, *I* closed the joint account. . . . But we weren't able to present these points to the appellate court.

K. THOMPSON & J. ANDRZEJEWSKI, *supra* note 2, at 181.

174. In fact, the joint bank account may have been the most difficult of all of these to change, requiring signatures of both women, as joint holders of the account, in order to close it. On the other hand, Sharon could have moved out, returned the ring, or changed her insurance policy unilaterally.

175. *Kowalski,* 382 N.W.2d at 863 (emphasis added). Given Donald Kowalski's attitudes

pejorative verb "admitted" implies that homosexuality is something that should give rise to guilt and shame.[176] And while the court accepted the testimony of Sharon's parents and sister at face value, it characterized Karen's statements as merely "claims,"[177] implying that she was lying and untrustworthy.[178] The outcome of the case is apparent just from observing the judge's wording in the opinion's initial statement of facts.

Similarly, the judge's attitude toward people with disabilities is apparent from the first paragraph of the facts.

> [Sharon Kowalski] is *confined* to a wheelchair. Her communication skills are *limited* to hand and face signals, pointing to written words, one-finger typing on an electric typewriter, and physical displays of emotion. She often gives inconsistent responses. She is *burdened* with a *child's* mental capacity between four and six years of age.[179]

After characterizing Sharon as a diminished, broken person, reduced to being a child again, the court and the guardian easily could justify their decisions to discount Sharon's wishes and choices about her own life, to deny her right to autonomy and self-determination, and to substitute their own choices as being what is really for Sharon's own good. This language, focusing on her limitations rather than her capabilities, dehumanized Sharon. Much like viewing the glass as half empty rather than half full, this type of characterization limits Sharon and other people with disabilities far more than their physical injuries do.

In re Guardianship of Kowalski thus illustrates the preference for legal family members in guardianship appointment. The *Kowalski* court acted from the presumption that Sharon's father was the best guardian because he was her closest legal relative despite evidence that Sharon had a much closer relationship with Karen Thompson and would have preferred Karen as guardian. This case also illustrates the unfettered discretion trial courts possess in appointing guardians and the absolute power

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toward gay people in general, *see supra* note 164, which presumably Sharon knew about from previous similar comments, it is not surprising that she did not tell her parents about her sexuality or her relationship with Karen.

176. Indeed, the fact that the two women were lesbian lovers may have been the impetus for appointing Donald Kowalski guardian and giving him the paternalistic power to "rescue" his daughter from that lifestyle, much as the parents in Katz v. Superior Court, 73 Cal. App. 3d 952, 972-73, 141 Cal. Rptr. 234, 246 (1977), wanted to "save" their adult children from the Unification Church. *See supra* notes 137-38 and accompanying text. Surely, if Karen and Sharon had been just roommates and good friends, neither the guardian nor the court would have banned Karen from ever seeing Sharon again.

177. *Kowalski,* 382 N.W.2d at 863.

178. The court did not posit why, in a society where homosexual people face job and housing discrimination, physical and verbal assaults, and even criminal penalties in some states, Karen Thompson would lie about her relationship with Sharon. Thompson had much to lose and nothing material to gain by announcing her sexual preference in such a public manner.

179. *Kowalski,* 382 N.W.2d at 863 (emphasis added).

the guardian has once appointed. Most importantly, it illustrates the need for change.

IV. Current State of the Law

The goal of the law of guardianship and proxy decisionmaking is to empower someone to do either what is best for the patient or, preferably, what the patient herself would do if she were competent.[180] According to one commentator, the law's preference for legal relatives results from trying to implement this goal:

> The law confers the power to consent on the next-of-kin, not because a relative has an independent legal interest in the patient's health, but on the theory that a close relative is likely to know the patient's attitudes and to have his best interests at heart. The rule serves to approximate the patient's wishes, by appointing as a stand-in the person that most patients would appoint for themselves. . . . Thus, the effect of the current law is to nominate the person whom the patient probably would have chosen as his agent, to make the decision the patient probably would have made if competent.[181]

There is certainly evidence that in many cases the appointment of a family member is indeed what the patient would have wanted,[182] and that the relative does have the patient's best interests at heart and is familiar enough with the patient's values and desires to be able to effectuate the patient's own will in making certain decisions. Keeping in mind the goals of the law and remembering that the only valid reason for appointing family members is because they often fulfill those goals, one must reject a per se rule that the court automatically should appoint the nearest available relative to act on behalf of an incapacitated adult or that the hospital always should look to relatives and abide by their decisions.

Clearly, when a court searches for a relative distant both in terms of consanguinity and intimacy of relationship, and empowers her to approve an amputation for a patient who has refused to submit to the oper-

180. The substituted judgment standard requires that a surrogate attempt to reach the decision that the incapacitated person would make if he or she were able to choose. As a result, the patient's own definition of 'well-being' is respected; indeed, the patient's interest in 'self-determination' is preserved to a certain extent. . . . The Commission believes that, when possible, decisionmaking for incapacitated patients should be guided by the principle of substituted judgment, which promotes the underlying values of self-determination and well-being better than the best interests standard does.

DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 16, at 132-36; *see also* Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 750, 370 N.E.2d 417, 430 (1977) ("goal is to determine with as much accuracy as possible the wants and needs of the individual involved").

181. Note, *supra* note 59, at 1011 (footnotes omitted).

182. *See infra* note 197.

ation,[183] the goals of the law are not being served. When courts are more concerned with who is paying the bills for the incompetent person than with what the patient wants,[184] the goals of the law are being ignored. When family members are allowed to ignore the previously expressed wishes of the incapacitated adult, the goals of the law are not being met.[185] When statutes and cases provide that a relative has a "right" to make decisions for an incompetent adult, or to be named guardian,[186] neither goal—the best interests of the patient nor the rights and desires of the patient—is being served.

The current state of the law fails to meet the goal of self-determination and best interests for those incapacitated adults who would not choose a family member as their surrogate decisionmaker, or for those who would not choose the particular relative to whom the law gives preference. The law still is built on the premise that family members are close geographically and emotionally, as well as in degree of kinship. While this often may be true, and the relative may indeed be the best proxy, such is not always the case.[187]

In the last two decades, statistics and news reports often have proclaimed that society is changing radically. The divorce rate is rising quickly,[188] fewer people are getting married at all,[189] more people are

183. Long Island Jewish-Hillside Med. Center v. Levitt, 73 Misc. 2d 395, 342 N.Y.S.2d 356 (N. Y. Sup. Ct. 1973). See the text accompanying notes 109-14 for a discussion of this case.

184. See the text accompanying notes 57-59 for cases, and notes 98-100 and accompanying text for statutes, that emphasize financial and property concerns. In this regard, it seems that the probate court, where guardianship proceedings usually are conducted, is the wrong court to decide such issues. Probate courts usually are concerned with processing wills and administering estates, not protecting a powerless person's civil rights. Perhaps at one time, guardianship proceedings were more concerned with protecting the estate of the ward than personal rights, but this should no longer be the case. Continuing to hold proceedings in probate court sends the wrong signal about what is at stake and what should be the focus in appointing a guardian—the individual interests and rights of the ward.

185. *In re* Guardianship of Grant, 109 Wash. 2d 545, 747 P.2d 445 (1987). *See supra* text accompanying notes 128-36. *Cf.* Brophy v. New England Sinai Hosp., 398 Mass. 417, 430-33, 497 N.E.2d 626, 633-35 (1986) (in which the patient's previously expressed opinions about receiving life support were used to justify allowing his wife to order his nasogastric tube removed, causing the patient to die of starvation and dehydration. The court stated that this was an exercise of the patient's right of self-determination.).

186. *See supra* notes 91, 105-08 and accompanying text.

187. Family members are most likely to know the preferences of the patient and other family members. On the other hand, they are more likely than others to be emotionally and psychologically disturbed by a patient's impending death. Guilt or other emotions might lock them into a narrow perspective . . . . And perhaps, less nobly, concern over costs, effects on other members of the family, or even latent animosities might inject improper considerations into their death control decisions.

Note, *supra* note 59, at 1002 n.17 (quoting M. SHAPIRO & R. SPECE, CASES, MATERIALS AND PROBLEMS ON BIOETHICS AND LAW 697 (1981)).

188. "The divorce ratio (the number of currently divorced persons per 1,000 currently

waiting longer to tie the knot,[190] more unmarried people are having children,[191] adult children often move far away from childhood homes for educational or employment opportunities, and extended step-families have become the norm.[192] In short, the image of the traditional, nuclear family portrayed in 1950s television programs—never fully accurate—has changed quite a bit,[193] yet many aspects of society, including the law, hold outdated images and premises about the American family.

Unmarried heterosexual and homosexual[194] couples form significant minorities within the United States population.[195] Not surprisingly, many people would prefer that someone outside their immediate legal family make decisions for them if they ever become incapacitated. In a recent poll, two percent of the people surveyed said that they would want a close friend to make decisions for them.[196] Even though the common-

married persons living with their spouse) has increased from 47 in 1970 to 100 in 1980 to 128 in 1985." BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, SPECIAL STUDIES SERIES P-23, NO. 150, POPULATION PROFILE OF THE UNITED STATES 1984/85, at 2 (1987) [hereinafter POPULATION PROFILE].

189. In 1985, 2 million unmarried couples headed households and 20.6 million persons lived alone. *Id.* "Unmarried couples totaled 2,334,000 . . . in 1987—745,000 . . . more than in 1980." BUREAU OF THE CENSUS, U.S. DEP'T. OF COMMERCE, CURRENT POPULATION REPORTS, POPULATION CHARACTERISTIC SERIES P-20, NO. 423, MARITAL STATUS AND LIVING ARRANGEMENTS: MARCH 1987 (1988) [hereinafter MARITAL STATUS AND LIVING ARRANGEMENTS]. *See also* Marvin v. Marvin, 18 Cal. 3d 660, 683, 557 P.2d 106, 122, 134 Cal. Rptr. 815, 831 (1976) (serious relationships between unmarried adults are "pervasive" and "prevalent" in modern society); Willemsen, *Justice Tobriner and the Tolerance of Evolving Lifestyles: Adapting the Law to Social Change,* 29 HASTINGS L.J. 73, 74 (1977) ("The number of unmarried couples living together increased eightfold in the 1960's, and there are no signs that this trend will reverse itself.").

190. POPULATION PROFILE, *supra* note 188, at 2 (1987) ("median age at first marriage was 25.5 years for men and 23.3 years for women in 1985"); MARITAL STATUS AND LIVING ARRANGEMENTS, *supra* note 189, at 1 ("Among all 29-year-olds, 24.9 . . . percent had not yet married for the first time, compared with 19.1 . . . percent in 1980.").

191. *See, e.g.,* POPULATION PROFILE, *supra* note 188, at 1 (about 18 percent of women who had a child between June 1984 and June 1985 were not married, whether single, widowed, or divorced, at the survey date).

192. Jarmulowski, *The Blended Family: Who are They?,* MS. MAG. 33 (Feb. 1985).

193. "What was once the stereotypical family—a married couple with children under 18 years old living at home—represented only 48 percent of all families and 28 percent of all households in 1985." POPULATION PROFILE, *supra* note 188, at 2.

194. Ten percent of the U.S. population generally is estimated to be homosexual. Rivera, *Our Straight-Laced Judges: The Legal Position of Homosexual Persons in the United States,* 30 HASTINGS L.J. 799, 800 n.4 (1979) (estimating that in 1977 9.13 percent of the population, or about 19 million people, were gay). This statistic is not meant to imply that all gay people would prefer nonrelatives to act as surrogate decisionmakers, but homosexuality does increase the likelihood that a person will be involved in a legally unrecognized relationship. Presumably both homosexual and heterosexual people involved in committed relationships would prefer their partner to act for them, just as most married people would prefer their spouse to act in their behalf. Unfortunately, the law only recognizes the validity of the latter preference.

195. More than 2 million people are hard to ignore. *See supra* note 189.

196. 2 PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBS. IN MEDICINE AND

law and statutory preferences do agree with the majority of people responding to this poll,[197] generalizing the results of this particular poll to the United States population at large means that about five million people would prefer a close friend as surrogate decisionmaker.

In addition, the current AIDS epidemic may result in more cases in which the lover of an incapacitated adult will have to fight the judicial and medical systems, the patient's legal family, and society's views in order to have a say in the patient's treatment and living conditions, and perhaps in order to visit the patient. Young adults rarely become incapacitated; serious car accidents, drug overdoses, physical attacks, or serious illnesses are the most common threats, and these occur relatively infrequently. The prevalence of AIDS, however, makes the threat of incapacity for young adults more likely. Because of the frequent occurrence of AIDS among gay men, who may not legally marry their partners, there is great potential for more conflict over the presumptive role and power the legal family is given to the exclusion of others who have a significant place in the patient's life.

Courts must not use consanguinity as a substitute for a real factual inquiry and finding that results in the selection of the person who is truly the closest to the incompetent person, who truly knows the patient's opinions and desires best, and who is truly the person the incapacitated person herself would have trusted to make the decisions. Courts must make sure that the closest relative in terms of consanguinity is also the closest person to the patient in personal relations before that relative is determined to be the correct proxy decisionmaker.[198] Some courts already have followed this course of action, even if it has taken more time and effort.[199] But courts must do more. If a family member's values conflict with those of the incapacitated person, then that family member should not be appointed guardian, because it seems certain that the incapacitated person would not feel the most comfortable with the relative as proxy, and the relative probably would be unable to put the patient's personal values first and act only on them.[200] The patient's self-determi-

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BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS 240 (1982) [hereinafter, MAKING HEALTH CARE DECISIONS]. In addition, 31 percent preferred that their doctor make the decisions, 2 percent wanted a lawyer to decide and 6 percent chose their doctor with their family or friend. *Id.*

197. The poll found that 57 percent wanted family members to make decisions for them. *Id.*

198. A rigid rule vesting the power to consent in the spouse or next-of-kin may, in some instances, give power to a person with interests plainly adverse to the patient—an adult child eager to inherit the patient's property, a spouse who goes to pieces in a crisis, a sibling who has been a lifelong enemy of the patient.

Note, *supra* note 59, at 1003 n.119.

199. *See supra* text accompanying notes 123-27.

200. Just as one state provides that the guardian of an adherent to faith-healing should share the patient's beliefs, *supra* note 96, guardians should share important values with the

nation interest would not be served. Even if there is no conflict, the person with the closest relationship to the patient should be appointed, regardless of whether that person is a legal relative, spousal equivalent, or close friend. If the patient's wishes about the ultimate decisions sometimes are deemed controlling,[201] her wishes about less compelling matters such as with whom she wants to associate, as expressed by actions before the incapacity, should also be controlling.

Many cases characterize the incapacitated adult as if she were a child,[202] and accordingly proceed as if the parents or nearest adult relative were the natural choice for guardian or decisionmaker. While some incapacitated adults may become childlike, they do not magically become children again. These people were once competent adults, free to make their own choices;[203] the choices that they have made should not be ignored or swept away because of incapacity. If a person chooses to live with or love someone, or to live in a certain place or way while she is a competent adult, those choices should continue to be honored if she becomes incompetent. A patient's significant other, friends, and life decisions do not vanish as if they never existed because a court, the patient's relatives, or both, treat her like a child again. The course that the patient set for herself must be continued if true self-determination is the goal of the law, even if her relatives, the court, or even most of society disapprove of that course.[204]

There is another reason why it is important to honor an incapacitated adult's choices and preferences in naming a decisionmaker and in making substitute decisions. Unlike a minor child or an elderly person who needs a guardian, unless the incapacity is temporary, an incapacitated adult likely will live a long time with her disability and with the decisions made for her. For example, Sharon Kowalski easily could have lived for fifty years under the domain of her father as guardian and of the replacement he could have named for himself in his will. Such scenarios make it imperative that the court appoint someone who can effectuate

patient beyond just religious views. For example, a man who calls gay people "queers and fruits," *see supra* note 164, should never be given plenary guardianship powers over a lesbian. This man would not have respect for the lesbian woman's lifestyle and significant relationships and consequently would not effectuate the patient's wishes about her place of abode, visitors, and other issues.

201. *See, e.g., In re* Quinlan, 70 N.J. 10, 41-42, 355 A.2d 647, 664 (1976), *cert. denied* 429 U.S. 922 (1976).

202. *See, e.g., In re* Guardianship of Kowalski, 382 N.W.2d 861, 865 (Minn. Ct. App. 1986).

203. Even if that choice is to join the Unification Church, parents are powerless to prevent their adult children from choosing it. *See* Katz v. Superior Court, 73 Cal. App. 3d 952, 141 Cal. Rptr. 234 (1977).

204. Indeed, in our legal system, one of the most important roles of the courts has been to protect minorities from oppressive majoritarian decisionmaking.

the patient's right to self-determination. Otherwise, the guardianship appointment can be a life sentence for the patient.

In addition, a case like Sharon Kowalski's implicates constitutional concerns. First, basing legal preferences on family relationships discriminates against same-sex couples because such couples cannot establish a legal family relationship.[205] Unmarried heterosexual cohabitators may choose to forego the considerable legal, financial, and psychological benefits of marriage.[206] Marriage, however, is still always an option. This option is unavailable to same-sex couples, solely because of their sexual preference. Thus, classifications based on marital status discriminate disproportionately against homosexual couples because the opportunity to marry is denied to same-sex couples. This situation should violate equal protection of the law.[207]

If the goal of the law in proxy decisionmaking and guardianship is truly to promote the self-determination of the patient by empowering the person who best knows the patient to act for her, then any significant relationships the patient has must be recognized. This is especially true when the relationship constitutes a marriage in all but legal aspects. If the policies of the law are served by giving the highest preference and deference to a married patient's spouse, and in most cases they are,[208] then the same policies would be served by giving preferential treatment to a patient's chosen partner, whether the couple is legally married or not. The goals of the law are not served by stopping the inquiry at whether the patient has a legal spouse, when there very well may be a significant other who fulfills the same role for the patient, and who is her spouse for all practical purposes.

The goals of the law are not fulfilled by following a rigid rule that empowers the patient's parents or closest blood relative if there is no

205. Some gay couples do try to adopt one another in order to establish a legally recognized relationship. *See* Note, *Marital Status Classifications: Protecting Homosexual and Heterosexual Cohabitators,* 14 HASTINGS CONST. L.Q. 111, 114 (1986) (authored by Stacey Lynne Boyle).

206. For example, married people receive:

> preferential tax treatment, a right of action with regard to a [spouse's] fatal accident, . . . social security benefits, and the protection of the law of intestate succession. Moreover, the married couple benefits from innumerable nongovernmental benefits such as employee family health care, group insurance, lower automobile insurance, family memberships in various organizations, and the ability to hold real estate by the entirety. Beyond these legal and economic benefits, marriage is . . . psychologically beneficial to the participants by strengthening the stability, emotional health, and societal respectability of the relationship.

Rivera, *supra* note 194, at 874.

207. *See* Note, *supra* note 205, at 117-34.

208. Certainly the court should still make a factual inquiry into the nature of the spouses' relationship, to make sure it is still on good terms. A spouse or spousal equivalent ordinarily should be the person closest to the patient, and consequently the best choice, absent evidence of a breakdown in the relationship or physical or emotional abuse by one spouse.

legal spouse. A spouse is the legally preferred proxy for an incapacitated adult because the marital relationship is presumed to be closer and more intimate than any other relationship an adult has. Spouses, like partners and close friends, evidence a chosen relationship unlike family relationships, which are accidents of birth. Thus, the use of the term "spouse" in statutes and cases is really just shorthand for all that the marital relationship embodies. The goals of the law would be served better by expanding the definition to include spousal equivalents, people with an intimate relationship just like a marriage who, by choice or because of legal prohibition, are not legally married. The law is unfair and arbitrary when it draws the line at legal spouses, and it defeats the goals of proxy decisionmaking and guardianship.

Freedom of association also is impinged when someone the incompetent adult chooses to associate with and love is barred from participating in the decisionmaking process or from even seeing the patient. No one should have the power to ban a significant loved one from another adult's life.[209] That this can occur is an indictment of the entire guardianship process. Guardians are granted too much power if they can trample the patient's civil rights in this manner. Certainly the freedom to associate with whomever one wishes, especially in the area of intimate personal relationships, is a fundamental individual right,[210] and one should not lose that right because of incapacity. "The trend in the law has been to give incompetent persons the same rights as other individuals."[211] Neither the courts nor parents nor other relatives of the incompetent adult patient should have the power to violate the patient's choices, or her freedom of association.[212] "The rights to choose who you talk to, who you visit, who you befriend, and who you love are the most basic of constitutional and human rights. They are fundamental to our concept of what it is to be a human being."[213]

209. A person might be banned or at least restricted from unsupervised visitation if the court determined from evidence that the significant other has physically or emotionally abused or neglected the now incapacitated partner.

210. Roberts v. United States Jaycees, 468 U.S. 609, 617-18 (1984).

211. Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 747, 370 N.E.2d 417, 428 (1977); *see also In re* Grady, 85 N.J. 235, 245, 426 A.2d 467, 474 (1981); Clarke, *The Choice to Refuse or Withhold Medical Treatment: The Emerging Technology and Medical-Ethical Consensus,* 13 CREIGHTON L. REV. 795, 806 (1980) ("minors and incompetents are said to be possessed of all rights attributable to competent adults").

212. In Katz v. Superior Court, 73 Cal. App. 3d 952, 141 Cal. Rptr. 234 (1977), the court overturned the guardianship appointments of the parents of five young adults because the parents wanted the guardianship in order to take physical custody of the adults and have them "deprogrammed" of their religious beliefs. The court held that the guardianship appointments would violate the adults' freedom of association. *Id.* at 988-89, 141 Cal. Rptr. at 256. The court stated that when "restraint on one's person" is involved, "fundamental rights are at stake." *Id.* at 968, 141 Cal. Rptr. at 243.

213. K. THOMPSON & J. ANDRZEJEWSKI, *supra* note 2, at 171; (quoting the amicus brief of the Minnesota Civil Liberties Union filed in the *Kowalski* case).

V. Attempted Solutions

Some states and courts have attempted to broaden common-law preferences for legal family members and give the patient more power of self-determination or include more of the patient's loved ones in the decisionmaking process. For example, at least thirty-three states and the District of Columbia have statutes providing for the use of living wills, with which a competent adult can express her wishes about the use of extraordinary life-sustaining care in the event the adult ever becomes incompetent.[214] Living wills, however, primarily are limited to life-sustaining treatment and life-and-death decisions. Many cases are not that extreme, and these are the cases in which the patient must continue to live under the dominion of a guardian or other proxy. Also, technicalities in the statute may frustrate the patient's intentions. For example, in California, the person must be diagnosed as terminally ill, then wait fourteen days before drafting a living will in order for it to be effective.[215] In addition, as one commentator has observed, "no living will—no matter how broadly or how specifically worded—can possibly anticipate the full range of difficult medical decisions to be made. Inevitably, questions of interpretation arise concerning whether an incompetent patient's actual situation conforms to the situation described in the living will."[216]

214. ALA. CODE §§ 22-8A-1 to -10 (1984); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210 (1986); ARK. STAT. ANN. §§ 20-17-201 to -217 (Supp. 1989), CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West. Supp. 1989); COLO. REV. STAT. §§ 15-18-101 to -113 (1987 & Supp. 1989); DEL. CODE ANN. tit. 16, §§ 2501-2508 (1983); D.C. CODE ANN. §§ 6-2421 to -2430 (1989); FLA. STAT. ANN. §§ 765.01 to .15 (West 1986); GA. CODE ANN. §§ 88-4101 to -4112 (1986); IDAHO CODE §§ 39-4501 to -4508 (1985 & Supp. 1988); ILL. ANN. STAT. ch. 110 1/2, paras. 701-710 (Smith-Hurd Supp. 1989); IND. CODE ANN. §§ 16-8-11-1 to -22 (Burns Supp. 1989); IOWA CODE ANN. §§ 144A.1 to .11 (West 1989); KAN. STAT. ANN. §§ 65-28, 101-28, 109 (1985); LA. REV. STAT. ANN. §§ 40:1299.58.1 to .10 (West Supp. 1989); ME. REV. STAT. ANN. tit. 22, §§ 2921 to 2931 (Supp. 1989); MD. HEALTH - GEN. CODE ANN. §§ 5-601 to -614 (Supp. 1989); MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1989); MO. ANN. STAT. §§ 459.010 to .055 (Vernon Supp. 1989); MONT. CODE ANN. §§ 50-9-101 to -111 (1989); NEV. REV. STAT. ANN. §§ 449.540 to .690 (Michie 1986); N.H. REV. STAT. ANN. §§ 137-H:1 to :16 (Supp. 1988); N.M. STAT. ANN. §§ 24-7-1 to -11 (1986); N.C. GEN. STAT. §§ 90-320 to -323 (1985); OKLA. STAT. ANN. tit. 63, §§ 3101 to 3111 (West Supp. 1989); OR. REV. STAT. §§ 97.050 to .090 (1984); TENN. CODE ANN. 32-11-101 to -110 (Supp. 1989); UTAH CODE ANN. §§ 75-2-1101 to -1118 (Supp. 1986); VT. STAT. ANN. tit 18, §§ 5251 to 5262 (1987); VA. CODE .ANN. §§ 54.1-2981 to 2992 (1988 & Supp. 1989); WASH. REV. CODE ANN. §§ 70.122.010 to .905 (Supp. 1989); W. VA. CODE §§ 16-30-1 to -10 (1985); WIS. STAT. ANN. §§ 154.01 to .15 (West 1989); WYO. STAT. §§ 35-22-101 to -109 (1989).

215. CAL. HEALTH & SAFETY CODE § 7191(b) (West Supp. 1989). "Yet only about half of all patients diagnosed as terminally ill remain conscious for the requisite fourteen days; for the other half—and for all of the patients with nonterminal conditions—the California law makes no provision." Note, *supra* note 59, at 999-1000 (footnote omitted).

216. Note, *supra* note 59, at 999 (footnotes omitted).

All fifty states and the District of Columbia statutorily authorize the execution of durable[217] powers of attorney,[218] but these documents for the most part can be used to enable an agent to act for the principal only in matters of property and finances, not in matters involving health care.[219] Six states now provide for the execution of durable powers of attorney for health care.[220]

While the expanded version of durable powers of attorney is a step in the right direction, durable powers of attorney still do not go far enough. A court apparently has the power to terminate the appointment or to appoint a guardian, whose power would supersede that of the

217. "Durable" means that the appointment continues to be effective even when the principal becomes incapacitated. *See, e.g.*, Cal. Civ. Code § 2400 (West. Cum. Supp. 1990); Note, *supra* note 59, at 1009.

218. ALA. CODE § 26-1-2 (1986); ALASKA STAT. §§ 13.26.325, 13.26.330 (1985); ARIZ. REV. STAT. ANN. §§ 14-5501 to -5502 (1956); ARK. STAT. ANN. §§ 28-68-201 to -203 (1987), CAL. CIV. CODE §§ 2400-2407 (West. Supp. 1989); COLO. REV. STAT. §§ 15-14-501 to -502 (1987); DEL. CODE ANN. tit. 12, §§ 4901-4905 (1983); D.C. CODE ANN. §§ 21-2081 to -2085 (1989); FLA. STAT. § 709.08 (1988 & Supp. 1989); GA. CODE ANN. § 29-2-21 (Harrison 1989); HAW. REV. STAT. §§ 560:5-501, -502 (1985); IDAHO CODE §§ 15-5-501 to -507 (1979 & Supp. 1988); ILL. ANN. STAT. ch. 110 1/2, paras. 802-1 to -11 (Smith-Hurd Supp. 1989); IND. CODE ANN. §§ 30-2-11-1 to -7 (Burns 1989); IOWA CODE ANN. §§ 633.705 to .706 (West Supp. 1989); KAN. STAT. ANN. § 58-610 to -617 (1983); KY. REV. STAT. ANN. § 386.093 (Baldwin 1984); LA. CIV. CODE ANN. art. 3027 (West Supp. 1989); ME. REV. STAT. ANN. tit. 18-A, § 5-501 (Supp. 1989); MD. EST. & TRUSTS CODE ANN. § § 13 -601 to -602 (1974); MASS. GEN. LAWS ANN. ch. 201B, §§ 1-7 (West 1983); MICH. STAT. ANN., §§ 700.495 to .499 (West 1980); MINN. STAT. ANN. § § 523.07 to .08 (West Supp. 1990); MISS. CODE ANN. § 87-3-13 (Supp. 1989); MO. ANN. STAT. §§ 486.550 to .595 (Vernon 1987); MONT. CODE ANN. §§ 72-5-501 to -502 (1989); NEB. REV. STAT. §§ 30-2664 to -2672 (1985); NEV. REV. STAT. §§ 111.460 to 470 (1979); N.H. REV. STAT. ANN. § 506:6 (1983 & Supp. 1988); N.J. STAT. ANN. §§ 46:2B-8, -9 (West 1989); N.M. STAT. ANN. §§ 45-5-501 to -502 (1989); N.Y. GEN. OBLIG. LAW §§ 5-1601 to -1602 (McKinney 1989); N.C. GEN. STAT. §§ 32A-8 to -14 (1987); N.D. CENT. CODE §§ 30.1-30-01 to 05 (Supp. 1989); OHIO REV. CODE ANN. §§ 1337.09 to .092 (Anderson 1979 & Supp. 1988); OKLA. STAT. ANN. tit. 58, §§ 1051 to 1063 (West Supp. 1990); OR. REV. STAT. §§ 126.407, 126.413 (1984); 20 PA. CONS. STAT. ANN. §§ 5604 to 5606 (Purdon Supp. 1989); R.I. GEN. LAWS § 34-22-6.1 (1984); S.C. CODE ANN. §§ 62-5-501 to -502 (Law. Co-op.1987); S.D. CODIFIED LAWS ANN. §§ 59-7-2.1 to -2.4 (1978); TENN. CODE ANN. §§ 34-6-101 to -107 (1984); TEX. REV. CIV. STAT. ANN. art. 4590h-1 (Vernon Supp. 1990); UTAH CODE ANN. §§ 75-5-501 to -502 (1978); VT. STAT. ANN. tit 14, §§ 3051 to 3052 (Supp. 1988); VA. CODE ANN. §§ 11-9.1 to 9.2 (1979); WASH. REV. CODE ANN. §§ 11.94.010 to .020 (1987); W. VA. CODE §§ 39-4-1 to -7 (Supp. 1989); WIS. STAT. ANN. § 243.07 (West 1982); WYO. STAT. §§ 3-5-101 to -103 (1985).

219. "[T]he durable power of attorney has seldom been used in a medical decisionmaking context, and it is possible that the courts might construe the statutes narrowly to exclude such use." Note, *supra* note 59, at 1009.

220. CAL. CIV. CODE §§ 2430-2444 (West Supp. 1989); IDAHO CODE §§ 39-4501 to 39-4509 (Supp. 1988); ILL. ANN. STAT. ch. 110 1/2, paras. 804-1 to -12 (Smith-Hurd Supp. 1989); NEV. REV. STAT. §§ 449.800 to .860 (1989); R.I. GEN. LAWS §§ 23-4.10-1 to -4.10-2 (1989); UTAH CODE ANN. §§ 75-2-1101 to -1118 (Supp. 1986).

agent.[221] The biggest problem with both living wills and durable powers of attorney, however, is that few healthy, young adults plan ahead for catastrophes.[222] No one thinks it will happen to her.

In addition to these attempts, some statutes and cases have provided for greater autonomy for the patient and for the consideration of significant others in the patient's life outside the patient's legal family.[223] Even the statutes that do rank significant others as potential guardians place the nonrelatives at the bottom of the list, after a long line of legal family members who have priority. As for the cases, courts have so much discretion and the common law is so pro-family that a judge who happens to consider significant relationships outside the legal family in appointing a decisionmaker is a matter of chance.

VI. A Proposal for Change

"When it is determined that the common law or the judge-made law is unjust or out of step with the times, we should have no reluctance to change it. . . . The law is not, nor should it be, static. It must keep pace with changes in our society . . . ."[224]

The statutes, cases, and failed attempts demonstrate the inadequacies of current law. Legislatures and courts need to take action to expand the definition of the appropriate guardian or proxy decisionmaker; to realign the procedures to ensure that they are really serving the goals of promoting the incompetent person's best interests and self-determination; to clarify procedures so that hospitals, doctors, family members, and other loved ones know where they stand; and to make sure that the rights of the minority, in this case those who would prefer someone outside their legal family to act for them, are protected. As one commentary has noted:

> If there is any single area of medical decision making in need of legislative attention, it is the problem of proxy decision making. The tremendous uncertainty as to the conditions under which a proxy is needed, the identity of the appropriate proxy, the method of selection,

221. *See, e.g.*, UNIF. PROB. CODE § 5-501 (1972); *see also* Note, *supra* note 59, at 1027 (listing state statutes allowing guardians to override patient's appointed agent).

222. According to one study, 36 percent of the public have expressed orally their wishes about treatment to a friend or relative, but only about a fourth of that number have expressed their desires in writing. 2 MAKING HEALTH CARE DECISIONS, *supra* note 196, at 219, 241-42. The lack of wills is another good example of the general reluctance to face one's own mortality and prepare for the inevitable. Few people would disagree that drafting a will is a good idea. Yet, 80 percent of Americans die without a will. Hoffmaster, *Freedom to Choose,* 17 TRANSPLANT. PROC. 24, 29 (1985).

223. *See supra* notes 76-82, 95-97, 125-27 and accompanying text for discussion of these cases and statutes.

224. Butcher v. Superior Ct., 139 Cal. App. 3d 58, 64, 188 Cal. Rptr. 503, 507 (1983).

and the scope of the proxy's authority are all in need of substantial clarification.[225]

Yet, the law is slow to change, and legislators have not hastened to revise the medical decisionmaking process. This may be due in part to the lack of political power of those most affected. "Adults who are placed or who may be placed under guardianship form an amorphous class whose legal powerlessness is unrivaled by any other segment of society, with the possible exception of children."[226] Of course, this powerlessness is precisely why the state, through legislators and judges, must act to protect this class of individuals.

Statutes should be adopted that will replace the UPC-model list of priorities with an instruction that courts are to consider for guardianship or authority to make decisions *all* people who have significant relationships with the incapacitated person. All people should receive equal consideration; no preferences should be enumerated in the new statutes.

Although the statutes should not state preferences, "family" still should receive some preferential treatment from the court because in many cases they will be best suited to protect the patient's best interests and self-determination. The definition of "family," however, should be changed radically from the common-law meaning. If the patient's personal choices are to be effectuated by the court and the proxy, "family" must signify something more than consanguinity. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research recognized that family members often were the best surrogates because of concern about "the good of the patient" and knowledge about "the patient's goals, preferences, and values."[227] The Commission stated, however, that:

> [T]he Commission's broad use of the term "family" reflects a recognition of the fact that often those with most knowledge and concern for a patient are not relatives by blood or marriage. . . . No neat formulas will capture the complexities involved in determining who among a patient's friends and relatives knows the patient best and is most capable of making decisions in the patient's place.[228]

225. Meisel & Kabnick, *Informed Consent to Medical Treatment: An Analysis of Recent Legislation,* 41 U. PITT. L. REV. 407, 461 (1980) (footnote omitted).

226. Mitchell, *supra* note 66, at 1427.

227. DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 16, at 128.

228. *Id.* at 127. The accompanying footnote adds,

> "We have had situations where the only family member was a daughter on the West Coast who had not seen her father for the last 20 years. He had lived with a drinking buddy of his for the last 20 years. Do we ignore this friend of his whose actions show that he cared also about him? Do we rely on the daughter who has no relationship in terms of interest in this patient? Often there are no family members at all, yet there may be friends and associates who knew the patient well. Do we ignore them because they do not constitute the traditional concept of family?"

Id. at 127 n.20 (quoting testimony of David Spackman).

This same recognition must be adopted by the courts to protect the self-determination of the patient. Consanguinity no longer can take the place of a real factual inquiry.

To overcome homophobia and stereotypes about what constitutes a significant relationship, judges should be required to scrutinize the patient's significant relationships for evidence of stability and significance. Marital status no longer should be the only evidence of significance. The judge should look at the length of the relationship; whether the parties have any contracts or documentation of commitment; whether the couple commingles funds, is financially interdependent, or owns property together; whether the parties are sexually monogamous; whether they are viewed as a couple by friends or others; whether they are named as beneficiaries in wills, pension plans, or insurance policies; whether they live together; whether they have exchanged rings or vows; and whether they are raising children together as a family. Not all of these elements must be present, of course, and courts must be sensitive to the fact that homosexual couples may meet only a few of these criteria, but still have a significant relationship, deserving of recognition and protection as a de facto marriage.

Whomever is determined by the court to be involved in the patient's primary significant relationship, the person most familiar with the patient's desires and most intimate with the patient, whether that be the patient's spouse, spousal equivalent in the case of unmarried adults, a close friend, or a relative, should then receive guardianship and custody of the person.[229] Only when a preponderance of the evidence shows physical or emotional abuse or neglect on the part of the presumed guardian should the court be allowed to deviate from this course. This process will prevent anyone from being able to ban a patient's lover from seeing her and will ensure that the patient's prior lifestyle will continue to the fullest extent possible.

In addition, the guardian or decisionmaker should not have the power to ban anyone who was a friend of the patient before the accident from visiting the patient once she has become incompetent. Even if the guardian is not compatible with the patient's family or friends, the patient's prior expressed choices should control, not the guardian's feelings. Guardianship should not provide the opportunity for someone to interfere with the ward's relationship with a relative or friend whom the guardian never liked. Nor should the patient's lifestyle or place of abode be changed without good reason. For example, Sharon Kowalski left Minnesota's rural Iron Range to live in the city of St. Cloud, Minnesota. Her father, as guardian, moved Sharon away from her chosen home and

229. This consideration is similar to the codes of Ohio and Massachusetts. *See supra* notes 141-42 and accompanying text. Someone else then could be appointed guardian of the estate if there is concern about finances or if the guardian of the person has no business acumen.

the friends and support system she had there back to the small town of Hibbing.[230] If better care or treatment were available outside St. Cloud, the move might have been valid. It is improbable, however, that moving Sharon away from her chosen home to a small town was so motivated. Such unnecessary lifestyle changes should be prohibited. The course the incapacitated person set for herself must be continued by the guardian, regardless of the guardian's feelings.[231]

Similarly, when the court is considering who is the most significant person in the patient's life, or when the guardian or decisionmaker is making decisions for the patient, the patient's actions prior to incapacitation should control over comments supposedly made by the patient. A witness' memory may have faded, or the witness may have misunderstood or subjectively interpreted the statements. The witness also might have a conflict of interest with either the ward or the proposed guardian, be interested in the appointment himself, or have some other motivation to misrepresent the incapacitated adult's comments. Since there probably would not be any way to corroborate the declarant's statement, the court or the guardian should view testimony as to what the patient said with suspicion, and certainly should not base decisions solely on such testimony. Past actions of the incapacitated person, such as where she chose to live and with whom, are more objective than statements attributed to the incapacitated person. Thus, actions should speak louder than words.

Critics may object that these changes will require more judicial time and reduce judicial efficiency. Perhaps efficiency will be lessened somewhat, but fairness will be greatly enhanced and the rights of a relatively powerless group of citizens will receive greater protection. The trade-off is justified. One of the primary purposes of the justice system is to protect civil rights and to ensure justice, not just to run parties through the courtroom. In addition, the vast body of case law on guardianship and proxy decisionmaking suggests that the current system does not promote judicial economy. Many cases still end up in court.

Critics also may argue that the current presumptions in the law promote a legitimate state interest in marriage and family. In response, however, one commentator has noted that "[t]here is not evidence that the current and long-standing policy of promoting marriage by penalizing the unmarried encourages a heterosexual to marry if he or she was not already so inclined, and homosexual orientation will certainly not be changed by punishing homosexual couples with same-sex marriage

230. K. THOMPSON & J. ANDRZEJESWKI, *supra* note 2, at 159. Testimony from a social worker indicated that Sharon wanted to remain in St. Cloud. *Id.* at 60.

231. Substituted judgment should be adopted as the only goal of the law because it promotes the self-determination and welfare of the patient better than the best interests standard, which can be used to justify paternalistic exercise of power over the incapacitated adult, such as in Sharon Kowalski's case. *See supra* note 155.

bans."[232] In addition, the law should not be used to promote a moral agenda at the expense of fairness and just treatment for those situated similarly to the legally married.

Conclusion

"Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficent. . . . The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding."[233] The law of guardianship and proxy decisionmaking developed from a desire to protect those who can no longer take care of themselves. This intention was surely good; yet the rules of selection that have developed and the powers bestowed upon the decisionmaker easily can be misused and result in anything but what is best for the incapacitated person.

The rules and presumptions must be modernized and rethought, so that the self-determination and well-being of the incompetent person truly are furthered by the process, and so that no other couple ever has to live through a tragedy, only to have it compounded by a rigid system that arbitrarily refuses to recognize their relationship and empowers another to destroy it.

232. Note, *supra* note 205, at 132. In addition, "the conventional family unit has disintegrated remarkably in past decades despite the benefits of marital status classifications." *Id.* at 133 (footnote omitted).

233. Olmstead v. United States, 277 U.S. 438, 479 (1928) (Brandeis, J., dissenting) (overruled by Berger v. New York, 388 U.S. 41 (1967); Katz v. United States, 389 U.S. 347 (1967); United States v. Leon, 468 U.S. 897 (1984)).