

The Professional Guardian: A New Type of Non-Institutional Administrator

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While many forensic psychiatrists are currently obsessed with due process, rights to treatment and rights to refuse treatment, they give little attention to an equally important problem: to whom or to what group can rights of the mentally disabled be entrusted under due process? This paper proposes creation of a *non*-service institution or tribunal which will plan curriculum and training for, and determine the qualifications of, a *non*-institutional service professional. Under court authority the professional could act as a guardian or co-guardian to least restrictively administrate specific rights and powers over persons found to be partially, temporarily or totally mentally disabled. A goal of interaction between this professional guardian (PG) and a guardian advisory council (GAC) would be the prevention of deficiencies which often occur in individual and institutional approaches to the problem of providing proper care to the mentally disabled. The problem cannot be evaded by denial of existence of disabilities any more than by denial of the fact that most disabled people really need the care they are receiving. Yet a large number of citizens, particularly the elderly and the mentally ill, literally do not know what they are doing when deciding, agreeing and refusing.²⁶ Even moderate impairment of any of several mental functions (*e.g.*, recent memory loss or impairment of abstract reasoning capacity) can partly or completely vitiate "informed" or "voluntary" consents or contracts. Explanations of treatment are often not understood, and most physicians mistake signatures for assent rather than mere compliance.³⁴

Nevertheless, there is increasing reluctance to recognize any necessity to deprive a citizen of any civil right. During the last decade revisions of civil commitment laws have greatly restricted involuntary treatment of the mentally ill. State institution populations are being reduced to include only those patients well enough to voluntarily seek hospitalization and a small "dangerous" fraction of those thought to need involuntary care. Consequently, large numbers of mentally disabled persons who *do not want* treatment or care now live without treatment in local communities or urban areas.³⁰ Welfare workers with heavy client caseloads are barely able to supervise welfare and benefit payments. There is usually no one to advocate individual interests or needs.³¹ When a disabled person does request help, the disability itself often prevents informed consent. For those considered dangerous or gravely disabled (which most disabled are not), involuntary institutional care is a limited and often more disabling option.

Treatments when they are given often incur liability. Proxy consent

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possibly lessens the chances that a treatment would later be regarded as an assault, but it doesn't prejudice future damage claims for adverse affects. In the absence of court-supervised procedures to safeguard rights, injuries imposed during an unauthorized treatment are precisely those which due process can prevent. Contrariwise, local courts usually require a disabled person to pay the costs of an unauthorized *successful* treatment. Thus, liability for deprivation of rights could be a *modus operandi*³⁵ of many who give "voluntary" care²⁹ to the mentally disabled. In each case the basic question which few doctors, nurses and institutional operators know enough to ask and perhaps even fewer want to answer is: "In case something goes wrong, am I willing to defend what I consider to be optimum care and finance the litigation to find out whether the courts would agree that rights were not violated?"³³

In the future most mental disability will have to be cared for less restrictively in each individual's local community¹² or in regional voluntary institutions. Yet the more serious a disability is, the more vulnerable an individual is to predatory exploitation and abuse and the more dependent he is upon conventional approaches to social and medical complications of disability. For more than 150 years these approaches have included family and community charity (which leaves many uncared for), doctor's house calls (many never made), custodial homes and hospitals, peonage, stigmatization, incarceration, and capital punishment. The rationalization for the failure of these systems often used the widely accepted concept of individual sin or inferiority as well as the belief that all personal events are, after all, under divine control: only God was the perfect teacher, physician and protector . . . all physicians and keepers were merely servants of God . . . patients or inmates were good or bad; if they succumbed despite efforts on their behalf, it was a result of personal insufficiency¹⁸ and possibly not enough prayer. Today such traditional or prescriptive approaches are less acceptable in a world of choice and secular pluralism. There is irreverent skepticism about the outcome of relationships with most physicians, psychiatrists and other experts and with institutions run by attorneys, businessmen, clergymen, doctors . . . mechanics . . . wardens. Although much of the change in our society began at the time of the industrial revolution, since World War II geographic mobility, improvement in media communication, and consumerism have accelerated explosions of myths regarding the altruism, expertise and ethics of the professions and the inferiority of those who are served. Doctors are no longer seen as sanctified servants. They have real technical capability against most known diseases, but they are also prosperous fee-gatherers. Most citizens now value the right of everyone — professionals included — to attempt to acquire wealth²³ as well as to protect privacy-nurtured beliefs and values that conflict with those of others. Perhaps this is because status is no longer exclusively based upon family connections, occupation, spiritual virtues and moneyed graces but also increasingly upon unique values, ideas and experience which make the potential innovator successful in problem-solving. Consider the revision of the Golden Rule by George Bernard Shaw, almost 75 years ago, which has since become seriously pertinent as well as amusing: "Do *not* do unto others . . . their tastes may not be the same."³²

Given the broad range of disparate individual tastes, values and ethics, dependency upon another evokes fear of neglect. Submission to the power of another evokes fear of exploitation. Applicability of knowledge based upon someone else's experience therefore requires scrutiny. Even family loyalties cannot always be reckoned to be stronger than a conflicting need.³ To minimize risk, every intrusion must be contractually stipulated and limited, its side effects and risks clearly explained. Tort and civil rights law must be resorted to and refined more frequently. Unless totally demented or comatose, A is likely to be dissatisfied with B's exercise of A's rights. The court might find merit in A's case unless B is of a type rarely seen in competency hearings: sensitive but disinterested, knowledgeable about pathology and treatment but rehabilitation-oriented, able but ethically restrained. Protective but discriminating intelligence is needed to exercise rights of the disabled as well as to minister to their care and treatment requirements. Courts cannot be expected to accept clinical or rehabilitative responsibility for persons considered incompetent. Judges are neither trained or paid to do this, yet they do assign guardians as administrators and protectors of individual rights. Whom or what groups do they qualify to act as guardians?

Most states now set minimal requirements which really *do* minimally qualify almost anyone to become a guardian, preferably a family member who is a voter without a record of crime or financial unreliability. Emphasis upon kinfolk is obviously based upon the unproven assumption that family loyalty and shared values will outweigh private issues and family psychopathology which by use of a simple-minded selection process the courts can thereby avoid. Ultimately, the courts have to select the most able from the few who would accept responsibility. So they are reluctant to declare mental incompetence² unless the extent is extreme to the degree where there would be benefit from guardianship by just about any volunteer who is not similarly incapacitated, and advanced to the degree where there would be little likelihood of complaint. Legislatures distract themselves from the qualification issue by obsessive focus upon procedural refinements and more effective checks and balances. Typically, most laws show exclusive⁷ concern with matters of *estate* management and accountability. Thus, most statutes are selectively silent about the orientation, preparation, and training a *personal* guardian might require to properly exercise awesome civil powers.¹¹ Discussion of qualifications of someone to assume powers over another embarrasses our equalitarianism. But overcoming that embarrassment, can we agree about specific *capacities* of a guardian? If so, over what kinds of disability should he/she be granted powers?

Existing Professionals

In what groups of already trained persons could effective guardians be found? Those which usually come to mind are social workers, attorneys and doctors. Social workers are proficient in counseling, case management and organization roles. They are also trained to recognize social disabilities. Many graduate S.W. programs teach courses in professional ethics. But most social workers have not had opportunity to make life/limb clinical decisions and to be directly responsible for effects and complications of

medical/rehabilitative treatment. The best teacher of planning discrimination is responsibility for the consequences of decisions. Opportunities for social workers to work independently of and unsupervised by agencies or other institutions are still quite restricted. Often their agency and institutional roles have been rigidly distanced and bureaucratized.²⁸ Social work training also does not include training in law. Members of the legal profession have opportunity to develop in private practice a sensitivity to the different values and interests of their clients as well as variable degrees of professional autonomy. Unlike all other professional groups, as trained adversaries they are able to recognize and protect individual rights. But although most law schools teach courses in ethics of attorney-client relations, few³⁷ study special ethical problems of dependency, compliance, stigma and organizational dysfunction. Attorneys are rarely able to discriminate among medical treatment/rehabilitative alternatives even with consultative advice. Like social workers, they lack experience in direct management and responsibility for major medical care decisions. They also have no training in case management and charting and follow-up of clinical progress. Medical schools and hospitals give great emphasis to preparation of doctors for selection and application of treatment and rehabilitative techniques. The best training programs prepare physicians to accept responsibility for tenacious clinical follow-up of every decision. Psychiatrists are specially trained to recognize impairment of mental functions. But only a few physician training programs offer required courses concerning patient rights, confidentiality, tort law and legal concepts of responsibility. Although some offer elective courses on the subject, only one medical school in the U.S.A.¹⁹ teaches a required course in medical ethics. Despite a widespread myth, most medical students are not required to take the Hippocratic Oath and many have never read it. The assumption, dubiously made, is that students, interns and residents "pick up ethics by personal example of clinical faculty." Even most psychiatric training programs do not directly approach ethical problems, although related issues are often touched upon when there is careful study of counter-transference problems. The ethical training of most M.D.'s and many psychiatrists is spotty indeed. Another consideration: foreseeably, all M.D.'s will be in short supply; it is doubtful that more than a very few will ever be available as professionally trained guardians. In summary, although the members of legal, medical and S.W. professions seem to have some qualifications to act as guardians for disabled persons, all have significant preparation disadvantages and are often unavailable for court assignment of civil power over others.

Institutions as Guardians

How capable are institutions to act as guardians of rights? Service institutions are indispensable to modern society because they, unlike individuals, give group power and capacity to innovative value expression of ideas which nourish improvement in the quality of life. They can mass-utilize and organize the creativity of institutional members in problem identification and solution, and they can mass-disseminate basic and applied knowledge and techniques. They can organize individual volunteer effort. Despite almost predictable failure of service institutions to perform fully the

functions expected of them, Americans spend upon them over half of the gross national product, not as luxuries or ornaments but as organizations paradoxically essential. Service institutions have enacted or allocated budgets which are earned not by services but for what they *promise* in programs and "good intentions." When they fail to deliver (as they usually do because, unlike business institutions, they cannot concentrate or limit service to satisfy only a minority,¹⁴ and they seldom consider efficiency cost control an organizational virtue¹³), the temptation is great for the public to "redouble the allocated budget precisely because there is no performance."¹⁴

They are not just coddled monetarily. The constitutional system which guarantees right of assembly offers limited and ineffectual protection against the tendency of every institution to exploit individuals both in and outside of its organization. Although to a limited extent service institutions recruit with monetary reward and perquisites, they also attract by formal profession of purpose(s) and of a structure of ideas about how to successfully carry out the purpose: to advocate an interest, to treat and rehabilitate, to save souls, to bureaucratize a service, to educate, to wage war, to punish, etc. They tend to hold their members because their hierarchies and role definitions often form the basis of secure and successful interpersonal relationships which are much more difficult to achieve privately. But a direct result of this is that *organizational survival tends to assume priority over all purposes*,¹⁵ and since every purpose eventually becomes obsolete, unless new purposes can be found, the compulsive reaction to reduced utilization is direct or indirect stimulation of increased demand.⁴ An example of direct stimulation is the over-prescription or protraction of hospitalization (which increases disability) when there is insufficient bed occupancy.^{10, 16} An example of indirect stimulation is that of prisons which become more regressive when under-budgeted because of reduced occupancy.¹⁷ This condition provokes escapes and generates social disability and antisocial attitudes among released convicts; the crime rate increases; it in turn stimulates public desire to increase expenditure on prisons. The eternal cycle.

Institutional survival also takes priority over welfare of institutional members. Examples of this include union exploitation of rank and file.⁵ Again, such abuses are possible because of successful gratification of relational needs within the organization. For example: the willingness of a soldier to risk death to sustain honor among fellow soldiers, and individual participation in group-sanctioned acts which from an individual standpoint are morally repugnant.⁶ Institutions of all kinds systematically enhance themselves while making some members or inmates much better and some much worse.³⁶ Government control of institutions or bureaucracies tends to fix inflexible purposes which organizations (in order to survive) cannot afford to completely fulfill. Civil service tenure simply adds inertia to function and momentum to self-perpetuation. To summarize: without independent monitoring and rights advocacy, the fortune or misfortune of a disabled inmate or patient with an institution for guardian will be influenced by institutional rather than individual need.

A New Professional

An alternative to using presently available but unsuccessful professionals and institutions could be to create a new private service professional whose performance would be complementary to that of a public non-service institution whose function would be to supervise the training and performance of the professional. The roles of the professional and the institution would be designed with the aim to prevent and avoid some of the dysfunctions already described.

Private or non-institutional persons directly responsible to the courts could be specially trained to maintain a high trust as professional guardians or co-guardians (P.G.) of rights to treatment, rights to refuse treatment or other rights. They could have autonomy of recourse to private practice of a profession (*e.g.*, as attorneys) so that they would tend to be financially independent of political or bureaucratic pressure. The P.G. would be trained to keep careful clinical records and to follow the progress of each of his charges in and out of hospitals and other institutions as well as in the community where the disabled person lives. For any treatments, voluntary or involuntary, to be given to a person found by the court unable to give informed consent, any hospital administrator or physician would be required to get permission from the P.G. No court would be required to appoint a P.G. instead of any other person it regarded as qualified to act as a guardian. But it would have available to it a list of P.G.'s who would agree on ongoing supervision by the G.A.C. in the event of appointment to act as guardian or co-guardian. The P.G. would, through clinical experience and training, be familiar with advantages and risks of all treatments and rehabilitative procedures for mentally ill persons.

This would require the most extensive change in guardianship law since the early 19th century. It would be necessary to outline:

1. Recommended procedures for determining specific types and severities of disability.
2. Suggested guidelines to courts by which different types and extents of guardianship and co-guardianship could be appropriately selected and limited to each type of disability.
3. Required restoration procedures similar in some respects to those of California, which place the burden of proof upon guardianship petitioners.
4. Required procedures which would establish minimum qualifications of competence, education, training and certification of P.G.'s as well as malpractice insurance underwriting.

A Guardian Advisory Council (G.A.C.)

It is proposed that a non-service institution be enacted whose purposes would be:

1. To supervise the graduate training curriculum and review court-appointed functions of professional guardians.
2. To develop and publish standards and recommendations of professional and ethical performance by guardians.

3. To provide counsel and advice regarding personal guardianship matters to courts upon request. This would include reviewing case records and reporting findings to the appointing court.

The membership of this council would be comprised of representatives of legal, educational, social work, medical, vocational rehabilitation and mental retardation professional associations, representatives chosen and requested by their associations to volunteer time and effort without remuneration. Cost incurred in performance of Council services would be borne by probate court revenues and special grant resources. Upon request the Council could review facts concerning disability brought before courts and recommend on a case-by-case method the degree, duration and types of guardian/co-guardian service which the Council would find appropriate to a) enhance recovery from each disability, b) maximize use of least restrictive¹⁹ alternatives, and c) minimize resort to use of custodial services. In this way an attempt can be made to *institutionalize* rehabilitative/treatment emphasis of partial rather than custodial (and total) approaches which tend to perpetuate and aggravate complete disability.

Laws would be required to provide appointment and financial support of a small administrative staff which would do the following:

1. Assist probate courts and Guardian Advisory Council in gathering and collating evidence of competence and disability in cases before the courts.
2. Administer office and clerical services to courts and guardians.
3. Safeguard clinical charts and records.
4. Maintain and facilitate communication linkage between courts, guardians, co-guardians and Council.

Federal, state and private grants would be needed initially to support the post-graduate clinical training and stipends of trainees. A pilot program of approximately two years' duration could aim to provide to four or six carefully selected attorneys some general medical, psychiatric and rehabilitative training as well as an ethical orientation which included focus upon problems of institutionalization and psychological dependency. The training would enable a P.G. discriminately to select and plan voluntary and involuntary treatment programs for wards which would allow the least restrictive management of disabilities and aim at efficient restoration of competence.

Disadvantages

Obviously, a great disadvantage will be cost. Since poverty is associated with many forms of incompetence, the bulk of guardians' fees would ultimately have to be paid from public funds. The private practice autonomy of the P.G. would preclude the political patronage usually necessary to attract legislative support, particularly because of reduction of bureaucratic control of care/custody utilization decisions. The autonomous professional, backed by the Council, would try to use only those services and care

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programs (private as well as public) required to rehabilitate or care for specific disability. Also, the legal training of the P.G. as an advocate of rights to refuse treatment would enable him/her to prevent self-prescription and over-utilization by institutions. Reduced costs of care, while popular, might be politically disadvantageous if civil service jobs are jeopardized.

Assuming there would be no public funds available to pay costs of services to anyone who could not afford them, most professional guardian work, at least initially, would be available only to those who could. As highly trained professionals the P.G.s could charge high fees for services. But there is no evidence that they would be used enough to pay for the costs of time and training. The risk would be loss in a private sector effort to show how private professionals under non-service volunteer institutional guidance might provide more effective and less costly protection and care to the disabled than public officials, untrained guardians and institutions can. Unfortunately, I am aware of no other state or nation which has experience with a similar or comparable program for disabled persons. Public guardians are provided in a number of states and in other nations,^{8,25} but in none of them is there effort to prepare and train guardians as private professionals, or to use an institutional method for their training and supervision.

One final consideration: the greatest advantage of clinical training of attorneys or the legal and ethical training of other clinicians to become guardian/advocates will not be their addition to the huge host of therapists and counselors already in existence. Their more direct familiarity with the science, art, responsibility and follow-up of patient care is sure to enlighten case or common law modification of rules which can guide humane systems of care for the disabled. The risk would be worthwhile.

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