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Authors

Thakur, Saumitra

Czypinski, Linda

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CLINICAL VIGNETTE

Public Conservatorship: An Ancient, Evolving Tool for Our Most Vulnerable Patients

Saumitra Thakur, MD and Linda Czepinski, MD

A 44-year-old male with no known past medical history was brought to the ED by ambulance after entering a public establishment and stating that he could not walk. The patient was a poor historian and was described as paranoid in the emergency room. He had no identification, denied any past medical history, and refused to provide any family contact information.

On exam, the patient had diffuse weakness, particularly of his hands, though exam was limited by patient effort. He also reported severe pain of his hands that was consistent with neuropathic pain. Initial labs revealed a peripheral eosinophilia. After initial labs were drawn on presentation, the patient refused all further lab draws and imaging. Multiple attempts by the medicine primary team, Ethics, Psychiatry, and hospital staff to speak with the patient about his goals of care failed. He would refuse to speak, or when he would speak his thoughts were tangential. Multiple providers observed him express paranoid thoughts and make statements suggesting he did not understand the indication for performing further medical testing to diagnose his underlying disease. During this time, the patient developed intermittent fevers and his neuropathy progressed to frank wrist drop. The medical team deemed the patient to lack the decision-making capacity to decline work-up. Because the medical teams agreed the benefits of pursuing further work-up to diagnose his underlying condition outweighed the risks, the patient was sedated with consent from two attending physicians to perform blood draws for further diagnostic lab studies, imaging, and invasive procedures including LP. Results of these tests supported a diagnosis of eosinophilic granulomatosis with polyangiitis.

When the diagnosis was confirmed, the medical team assessed that the patient lacked capacity to decline immunosuppressive therapy. He had developed severe polyneuropathy and the medicine primary team, and Rheumatology and Ethics consultants agreed that treatment was urgent. In anticipation of the patient's ongoing need for management and treatment, the medical team attempted to have the patient conserved by the City of Los Angeles. Ultimately, the patient identified a distant family member to aid in the decision making. Given that he had an available surrogate, his application for conservatorship was declined by the city of Los Angeles.

This case highlights the challenges of assessing capacity and the role for public conservatorship. In an influential 1988 contribution to *The New England Journal of Medicine*, Appelbaum and Grisso delineated four components to medical

capacity. These include communicating their choice (which presupposes communicating at all), understanding information related to the decision at a theoretical level, understanding how that information relates to their specific circumstance, and performing rational manipulations of information.¹

Our patient could not communicate a choice. Although we could not determine precisely whether this was due to lack of volition or lack of ability to process information, his inability to communicate prevented assessment of capacity to consent to treatment.

We chose to pursue public conservatorship when we were unable to find a surrogate decision-maker. Conservatorship permits the court to appoint a surrogate decision-maker. Certain cities such as Los Angeles operate offices of public guardians to provide a government conservator for patients who have no appropriate surrogates. These offices have seen increasing need as dementia becomes more prevalent in the aging population.^{1, 2}

Both in medical ethics scholarship¹ and in legislation³, capacity in healthcare is narrowly assessed for a specific decision. A patient can have capacity in one decision while lacking capacity in others. Patients who warrant conservatorship are deemed by a court to be globally incompetent. As such, conservatorship goes beyond merely deeming a patient to lack capacity and should be reserved for those extreme cases where a patient is unable to participate in most or all decisions in his or her care.

This patient was uncommonly challenging, but conserving patients is by no means uncommon. At least 500,000 Americans have incompetency warranting court-appointed conservators, and these numbers will grow considerably as the population ages.⁴ They are part of a long tradition in U.S. common law and prior English and Roman common law of the government exercising its *parens patriae* obligation to tend to the less fortunate and vulnerable.³

The concept of lacking competency is a legal fiction whose meaning has fluctuated over time. Despite centuries of attempts to assess it objectively, in practice it has reflected prevailing social thought. In English and Roman common law, the priority of the sovereign was not to care for the vulnerable but to prevent their economic holdings from languishing. As recently as the mid-twentieth century, the rise of mental institutionalization led to courts conflating conservatorship with the state's policing

obligation to isolate dangerous individuals. Many states require that judgments of incompetence have associated disabling medical conditions. While ostensibly done to make these decisions more objective, in practice they merely shift some of the discretion to physicians, who are no less subject to prevailing social thought and practical considerations.³

Considering its challenges with individuals without homes, California's legislature is revisiting its existing conservator laws. The Lanterman-Petris-Short (LPS) Act currently sets conditions to appoint conservators for those with mental illness. When the LPS Act was passed, it was intended to set limits on the government's ability to commit people with mental illnesses to facilities and treatments at a time when abuse was rampant. In 2018, California passed Senate Bill 1045 allows counties to create simpler procedures to initiate conservatorship in individuals who have had 8 or more 72-hour holds placed on them by facilities in the past 12 months. The bill intends to permit the government to place these individuals in "the least restrictive and most clinically appropriate" setting, from community facilities to locked housing.⁵

Conservatorship has entered national discussion recently after the television show *Last Week Tonight with John Oliver* highlighted how the system has been used to seize property from vulnerable elderly people.⁶ Conservatorship has longstanding critics, with criticisms ranging from too much ambiguity in how we assess capacity to the propensity for abuse given poor oversight of this system.^{4,7} Indeed, the ACLU and disability rights organizations criticize SB 1045 as overly empowering the state to withdraw individuals' rights without significant evidence that guardianship is better than an alternative approach, like providing housing first, to reduce homelessness among those with mental illness.⁸

As the population ages, conservatorship will gain more prominence and these policies may change. Physicians should play an active role in influencing these changes. Our judgment of how medical conditions affect our patients' abilities to function influences how courts view our patients. Furthermore, public conservators provide an important resource for us in caring for some of our most vulnerable patients. Third, by virtue of our proximity to the incapacitated, we are one of the fields best positioned to identify people who may be abused by their conservator.

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