

Illinois Department on Aging
**Illinois Long-Term Care Ombudsman Program
Supplemental Training Curriculum**

**Supplemental Module #10
Advance and Court/Operation of Law Directives**

Pre-publication Edition I

Funded by the Retirement Research Foundation

Contributors

Authors

**David Sutterfield, Attorney at Law, Effingham
Erin Strotheide, Grant Specialist, I CARE
Margaret Niederer, Director of Special Projects, ICARE**

Legal Editors

**Lee Beneze, Legal Services Provider, Department on Aging
Robyn O'Neill, Regional Ombudsman, Legal Assistance Foundation of Chicago**

Rod R. Blagojevich, Governor

Charles D. Johnson, Director

TABLE OF CONTENTS

I. Introduction

- A. The Difference Between Capacity and Competent
- B. Terminology

II. Advance Directives

- A. Durable Powers of Attorney
 - A.1. What Is a Power of Attorney?
 - A.2. What or Who Is a “Principal”?
 - A.3. What or Who Is an “Agent”?
 - A.4. What Does “Durable” Mean?
 - A.5. Are There Different Kinds of Power of Attorney?
 - A.6. What Is a Power of Attorney for Property?
 - A.7. Who Should Be Selected as the Agent for Property?
 - A.8. What Is a Power of Attorney for Health Care?
 - A.9. What if the Principal Never Wants Life Support Terminated?
 - A.10. Who Should Be Selected to Act as Agent for Health Care?
 - A.11. Should More Than One Agent Be Named at the Same Time?
 - A.12. Are There Special Requirements for the Power of Attorney to Be Valid?
 - A.13. Can an Agent Ignore the Principal’s Wishes?
 - A.14. Can Health Care Providers Ignore the Principal’s Wishes?
 - A.15. Does the Principal Have to Give Her Agent *Carte Blanche*?
 - A.16. What Can Happen if a Power of Attorney Is Not Executed?

- A.17. Can a Power of Attorney Be Revoked or Modified?
- A.18. Are There Limitations to Powers of Attorney?
- A.19. Are There Risks to Using a Power of Attorney?
- A.20. The Agent as “Fiduciary”---What Does that Mean?
- A.21. What Can Happen if an Agent Exploits the Principal?
- A.22. How Can One Protect Oneself Against Exploitation by the Agent?
- A.23. What if a Court Appoints a Guardian for an Individual after a Power of Attorney Has Been Executed?

B. Living Will

- B.1. What Is a Living Will?
- B.2. Are There Special Requirements for the Living Will to Be Valid?
- B.3. Why Does One Need a Living Will?
- B.4. When Should a Living Will Be Made?
- B.5. What Does a Living Will Signify?
- B.6. What Are the Basic Choices in a Living Will?
- B.7. What Is a “Death Delaying Procedure”?
- B.8. What Are Irreversible Coma /Incurable or Irreversible Terminal Conditions?
- B.9. Can a Living Will Be Revoked or Modified?
- B.10. Can a Health Care Provider Ignore a Person’s Wishes as Stated in the Living Will?
- B.11. Will My Doctor Be in Trouble if She Honors My Wishes?
- B.12. Is It Necessary to Complete Both a Power of Attorney for Health Care and a Living Will?

- C. Do-Not-Resuscitate (DNR) Orders
 - C.1. What Is a Do-Not-Resuscitate Order?
 - C.2. Is a Specific Form Needed?
 - C.3. What Are the Requirements to Make the DNR Order Valid?
 - C.4. Is the DNR Order Permanent?
 - C.5. Does a DNR Order Prevent the Heimlich Maneuver for Choking?
- D. Mental Health Treatment Preferences Declaration
 - D.1. What Is a Mental Health Treatment Declaration?
 - D.2. What or Who Is the “Principal” in a Declaration?
 - D.3. What or Who Is an “Attorney-In-Fact” in a Declaration?
 - D.4. What Treatments Are Covered by the Declaration?
 - D.5. When Does the Declaration Become Operative?
 - D.6. What Are the Requirements for the Mental Health Treatment Preferences Declaration to Be Valid?
 - D.7. Can the Attorney-In-Fact Ignore the Principal’s Wishes?
 - D.8. Is a Mental Health Treatment Preferences Declaration Permanent?
- E. Organ Donation
 - E.1. What Is “Organ/Tissue Donation”?
 - E.2. What Is the Organ/Tissue Donor Registry?
 - E.3. How Can the Intent to Donate Be Effectuated?
 - E.4. What Can Be Donated?
 - E.5. Can a Principal Change His Mind about Donation?
- F. Considerations for Advocacy
 - F.1. Power of Attorney Agent Authority/Confidentiality Issues

- F.2. Knowledge Is Power in the Protection of a Resident Against an Agent
- F.3. Living Will and Power of Attorney Conflict
- F.4. Advance Directive Executed Out-Of-State
- F.5. Health Care Provider Right of Conscience
- F.6. Physician Responsibility of Do-Not-Resuscitate Order Explanation

III. Directives by the Court/Operation of Law

A. Health Care Surrogate Act

- A.1. What Is the Health Care Surrogate Act?
- A.2. What Is a “Surrogate”?
- A.3. What Treatment Decisions Are Allowed by the Health Care Surrogate Act?
- A.4. How Is a Surrogate Chosen?
- A.5. Is There a Specific Form to Document Health Care Surrogate Decisions?
- A.6. What if a POA Document Exists, but the Agent Is Not Available?
- A.7. Can a Surrogate Make a Decision Regarding Termination of Life Support?

B. Guardianship

- B.1. What Is Guardianship?
- B.2. Who Is an “Alleged Disabled Adult”?
- B.3. What or Who Is the “Ward”?
- B.4. What Is Incompetent?
- B.5. What or Who Is the “Guardian”?
- B.6. How Is the Guardianship Process Started?

- B.7. What Is the Role of Title III B Senior Legal Services Providers in Guardianship Petitions?
- B.8. Why Are There Different Types of Guardians?
- B.9. Is the Alleged Disabled Adult Entitled to an Attorney?
- B.10. Does the Alleged Disabled Adult Have a Right to a Jury Trial?
- B.11. What Are the Issues to Be Decided?
- B.12. Is a Guardianship All or Nothing?
- B.13. Does a Guardian Have Authority in End-Of-Life Issues?
- B.14. Can the Guardian Put the Ward in a Nursing Home?
- B.15. Are There Other Protections for the Ward?
- B.16. Is the Guardianship Permanent?
- B.17. After the Proceedings, What Is the Relationship of the Court to the Ward?
- B.18. What Standards Govern the Guardian's Actions?
- B.19. Who Pays for Guardianship Proceedings?
- C. Selected Information for Advocacy for Surrogates and Wards
 - C.1. Health Care Surrogate Act Assumption
 - C.2. Ombudsman Procedural Responsibilities for Handling Issues of Wards
 - C.3. Facilities Can Petition the Court for Guardianships

IV. A Consistent Ombudsman Program Procedure In Handling Issues Involving Directives

References

Legal Citations

PROCESS FOR USING THIS MODULE

The supplemental modules for ombudsmen have been created to accommodate different learning styles and are based on research about how most people learn. The premise on which this module is based is the idea that new information is learned best when there is an opportunity for discussion and to ask questions. This module incorporates group discussion, questions on what is not clear to you and an evaluation of what you have learned.

This module is designed to be adaptable to various teaching methods and settings: training/in-service for ombudsmen or presentations to families or facility staff. This module can be divided into as many training sessions as needed and a variety of methods can be used.

This module is formatted for use as a reference document as well as a training tool.

After the discussion, you will be asked to work as a group to:

- Develop a chart, listing all the advance directives, court and operation of law directives; identify each by its attributes, e.g., requirements for a witness or notary, who appoints the decision maker, the amount of decision-making authority, court supervision, requirements for revocation, etc.; and
- List at least five questions, but as many questions as the group has, about the information in this module.

PURPOSES OF THIS MODULE

The purposes of this module are to:

- Provide information on the requirements pertaining to directives: power of attorney, living will, do-not-resuscitate order, and mental health treatment preferences declaration, health care surrogate and guardianship.
- Identify for ombudsmen the considerations for advocacy to empower residents, while understanding the limitations and authority of each directive.
- Provide a reference ombudsmen can use to refresh memory and clarify questions following training.

Note of clarification: Pronouns are rarely used in this document. When pronouns are used, the male gender pronouns, "he, his, him," are used to refer to the resident, and the female gender pronouns "she, her, " are used to refer to all other persons.

SUPPLEMENTAL MODULE #10 ADVANCE AND COURT/OPERATION OF LAW DIRECTIVES

I. INTRODUCTION

This module provides basic information on advance directives and directives by the courts/third parties/operation of law necessary for handling concerns of residents having these directives or needing one of these directives. Also, presented are the methods by which other people become a legal representative for a resident.

This module will not answer all questions the ombudsman may encounter about directives or in handling resident issues. The ombudsman should not give an opinion about what the law says or guess about what the law means, because not every aspect of the laws governing directives has been addressed in this module. For questions not addressed or those that require some legal interpretation, they need to be brought to the attention of the supervisor, who will then contact the State Ombudsman and the Legal Services Provider.

Determining the capability of a resident to make decisions is perhaps one of the most difficult responsibilities for an ombudsman. Knowing what to advocate for is another, since the ombudsman always advocates for the wishes of the resident whenever the resident is capable of expressing what he wants. It is critical for the ombudsman to have knowledge about how a particular directive does or does not impact the ability of the resident to choose.

All directives should be as closely aligned with the resident's wishes as possible. In all instances in which there is a question on directives or how, or if, mitigating circumstances impact on the wishes of the resident, the supervisor should be contacted.

All directives should be as closely aligned with the resident's wishes as possible.

A. THE DIFFERENCE BETWEEN CAPACITY AND COMPETENT

WHAT IS THE DIFFERENCE BETWEEN CAPACITY AND COMPETENT?

There is a major difference between the terms, “capacity” and “competent,” and how they relate to advance directives.

Competent—Legal competency for adults is always presumed and cannot be overcome except by legal means (commitment by the court or guardianship). If the resident is legally competent, his wishes ought to prevail. A person who has been adjudicated “incompetent” by a court of law lacks the ability to care for his person or property.

Capacity (capability)—Decision-making capacity is used to describe an individual’s ability to make an informed decision. It is a [good faith] judgment and does not have a legal meaning.

Decision-making capacity is different from legal competency. For example, an individual may be able to choose what daily activities he likes, but may not be legally competent as determined by a court.

The two terms, competent and capacity, are not interchangeable.

To determine the mental capacity (capability) of a resident and, therefore, whether ombudsmen will advocate for the resident’s wishes, ombudsmen are to assess the following:

- Does the resident understand the facts?
- Does the resident understand the risks and benefits of the choice?
- Is the resident expressing a free choice?

An important issue for the ombudsman is to determine if there is anyone who has the decision-making authority for a resident who lacks decision-making capacity when the resident has advocacy needs. If so, the ombudsman has the responsibility of contacting the resident’s decision-maker.

The ombudsman is likely to experience that the general public has much confusion about directives, even the people who have been appointed as an agent pursuant to power of attorney or a guardian for a resident. Additionally, the resident’s records may not contain correct or most current information, or any documentation about a directive.

If the ombudsman has not seen the directive document, in order to confirm what type of directive a resident has, the ombudsman will need to investigate, such as questioning the circumstances on how the directive came to be presented to and then executed by the resident.

One ombudsman relayed some of the problems she encountered in dealing with issues related to directives:

“[An agent pursuant to] a power of attorney may be called the “guardian.” I have heard a family member say, ‘I am the power of attorney and I am the guardian for my mother.’ There are often questions that need to be answered about family representatives. A ‘daughter’ may not be the resident’s legal daughter, and a person handling the interests of the resident may not have been designated by anyone. Facility staff may say that there is a power of attorney for finances in the resident’s records, but are unable to produce the document. In another case, there was a power of attorney document in the record, but it was not current. The resident had revoked a power of attorney for one person and named a new one.”

For most cases involving residents who lack decision-making capacity, the ombudsman has to find out if there is a legal representative, and if so, what kind of legal representative. If there is no legal representative, it is often necessary to know the family structure and who is making decisions for the resident.

In this module, two types of directives are described. A person prior to his needing someone to make decisions for him executes the first type, **advance directive**. The person decides, in advance of his lacking the capacity of making an informed decision, who will be his legal representative. For the second type, **directives by the courts/ operation of law**, a person does not designate this in advance of needing it. When such a person lacks decision-making capacity, but does not have an advance directive, the legal representative is determined by the courts (guardianship), or by operation of law (Health Care Surrogate Act).

The purpose of advance directives is to afford individuals an opportunity to clarify and formally state their wishes on future medical and financial decisions in the event that they are deemed to lack the capacity to make decisions. This lack of capacity may result from a variety of conditions or events, such as terminal illness, brain damage, dementia, etc. It is best for an individual to discuss his wishes regarding advance directives with family members, and if no family members, then trusted friends. It may be appropriate for a physician, to be included in discussions pertaining to advance directives for health care (i.e., Health Care Power of Attorney and Living Will).

All of one’s health care providers should be given a copy of this type of advance directive.

In essence, advance directives embody the principle of individualized care as promoted in best nursing home practices, i.e., Pioneer Network Practices. Just as every individual has a right to care that meets his needs, so he has the right to have his wishes and preferences respected even after he can no longer speak for himself.

Should a person not make an advance directive, other directives can be obtained to make decisions for an individual who lacks this ability. These other directives include: health care surrogate and guardianship.

A hierarchy of directives can be listed as follows, ranging from capacity to make personal decisions to someone else carrying out all decisions on behalf of an individual:

- Competent individual decision-making
- Power of Attorney (greatest autonomy)
- Living Will declaration
- Health Care Surrogate
- Guardianship (least autonomy)

B. TERMINOLOGY

To enable the ombudsman to be more familiar with the terminology in law, the legal terms are used in describing the types of advance and other directives. In nearly every case involving a legal representative issue, someone other than the resident will be the legal representative or acting as a legal representative. (Rarely, will the ombudsman have a case in which a resident acts as the legal representative for someone else.)

Therefore, in explaining the following directives, when the word, **resident**, is not used, the legal or common term that would usually apply to a resident is used:

- **Power of Attorney:** the resident is the principal; the legal representative is the agent.
- **Living Will:** the resident is the declarant; there is no legal representative.
- **Do-not-Resuscitate Order:** the resident is the patient.
- **Mental Health Treatment Preference Declaration:** the resident is the principal; the legal representative is the attorney-in-fact.
- **Organ or Tissue Donation:** the resident is the principal.
- **Health Care Surrogate Act:** the resident is the patient; the legal representative is the surrogate.
- **Guardianship:** A petition is filed in court, alleging that the resident is a disabled adult. If the court determines a resident lacks the capacity to manage the affairs of his person and/or his estate, a guardian will be appointed by the court. If this occurs, the resident is the ward; the legal representative is the guardian.

II. ADVANCE DIRECTIVES

A federal law, the Patient Self-Determination Act (PSDA), requires all nursing homes, hospitals, home health agencies, etc. that participate in Medicare or Medicaid to inform all who receive services 1) about advance directives and 2) the facility's policies regarding advance directives. The facility is to ask each resident if he has an advance directive and document it in his record.

PSDA also requires facilities to provide education on advance directives to their staff. The Act prohibits discrimination against residents on the basis of having or not having an advance directive. The Illinois Department of Public Health's "Statement of Illinois Law on Advance Directives and DNR Orders" lists the health care power of attorney, living will, mental health treatment preference declaration and do-not-resuscitate order as advance directives for health care.

A. DURABLE POWERS OF ATTORNEY

A.1. WHAT IS A POWER OF ATTORNEY?

A power of attorney (POA) is a document whereby an individual authorizes another individual to act on his behalf.

A.2. WHAT OR WHO IS A "PRINCIPAL"?

The individual granting the authority, by signing (executing) a power of attorney is called the principal.

A.3. WHAT OR WHO IS AN "AGENT"?

The individual receiving the authority is known as the agent. If an individual executes a power of attorney and names his daughter to act on his behalf, his daughter is called the "agent."

A.4. WHAT DOES "DURABLE" MEAN?

The term "durable" means that the authority granted to the agent by the principal survives the principal's incompetence. Under Illinois law, all powers of attorney are presumed to be durable unless otherwise specified.

A.5. ARE THERE DIFFERENT KINDS OF POWER OF ATTORNEY?

The authority granted by the principal falls into two broad categories:

- Property; and
- Health Care.

A.6. WHAT IS A POWER OF ATTORNEY FOR PROPERTY?

A power of attorney for property can cover the management of all of a principal's financial affairs. This includes assets, income and liabilities, in short, all of one's business affairs. This type of power of attorney is terminated upon the death of the principal.

A.7. WHO SHOULD BE SELECTED AS THE AGENT FOR PROPERTY?

When naming an agent, the principal should keep in mind the talents and disposition of the proposed agent. It would not be wise to name as agent for property, a person who has repeatedly declared bankruptcy or who has never balanced a checkbook. Many individuals consider irrelevant factors, such as who is the oldest child or what child lives the closest to them, when making this decision. Most importantly, the individual chosen to act as the agent should fully understand the principal's wishes and have a cooperative attitude toward other family members. The agent does not have to be an Illinois resident.

A.8. WHAT IS A POWER OF ATTORNEY FOR HEALTH CARE?

A power of attorney for health care covers all aspects of health care. Unlike a power of attorney for property, the authority stated in the power of attorney for health care does not end at the time of death. The document generally includes a provision that allows the agent to authorize an autopsy, dispose of the remains of the principal after the principal's death, and to make a donation of body organs. The power of attorney for health care has a provision regarding perpetuation of life support.

A.9. WHAT IF THE PRINCIPAL NEVER WANTS LIFE SUPPORT TERMINATED?

Instructions to never terminate life support are an extreme rarity. An individual wishing to make such a decision needs to commit that decision to writing and make that decision well known to both the agent and the health care provider. This is particularly true in view of the fact that the Health Care Surrogate Act provides a method for the termination of life support in the absence of a living will. This was a significant change in the law. Living wills grew out of the need to give individuals a tool to terminate medical treatment in response to stories of individuals who were being perpetuated in a vegetative state against the family wishes. The rise of the Health Care Surrogate Act reversed that scenario such that it is now critical that individuals who want life support perpetuated in all circumstances execute a living will reflecting their wishes.

Power of attorney agents should be chosen based on who is likely to act in a manner that is consistent with the principal's own wishes and philosophy, and who can work cooperatively with other family members.

A.10. WHO SHOULD BE SELECTED TO ACT AS AGENT FOR HEALTH CARE?

When making the decision regarding whom to name as an agent, the principal should choose an individual likely to act in a manner that is consistent with the principal's own wishes and philosophy. Again, choosing a child because she is older or because she would be upset if she were not chosen is inappropriate. The agent does not have to be an Illinois resident. The principal's primary health care provider cannot be named as the health care agent.

A.11. SHOULD MORE THAN ONE AGENT BE NAMED AT THE SAME TIME?

The law is designed to have only one agent named for each type of power of attorney, one for property and one for health care, or to have one person do both. Many times one person is named to act as the agent for both property and health care; this is permitted and may be the best delegation of authority. Although it is not illegal to name more than one POA agent, more than one acting at a given time can create serious conflicts.

An individual can name as many successor POA agents as he desires in the document, and probably should have more than one successor agent, if possible.

A.12. ARE THERE SPECIAL REQUIREMENTS FOR THE POWER OF ATTORNEY TO BE VALID?

The forms most often seen in resident files are the “statutory short form for property” and the “statutory short form for health care.” Other forms may be used. If a form does not look familiar, contact the supervisor for assistance. The following paragraphs refer to the statutory short forms.

The power of attorney for property needs to be signed by a notary and

- if it were executed on or before June 8, 2000, by the principal, but
- if executed on or after June 9, 2000, by the principal and one witness.

If a POA for property is being executed, it is preferred for the principal to have two witnesses and a notary, none of who are related to the principal. The notary should not be a witness.

The power of attorney for health care needs to be signed by the principal and only one witness. It should not be witnessed by the principal’s physician, the physician’s staff, or nursing home personnel where the principal resides.

Although it is preferable for this document to be notarized, it does not require a notary.

A.13. CAN AN AGENT IGNORE THE PRINCIPAL’S WISHES?

No. The agent can only act in accordance with the directions given by the principal. The agent cannot perform acts that the principal does not authorize. The easiest way to conceptualize this relationship is to think of the principal as the employer and agent as the employee. Just as a secretary does not tell the boss what to do and how to do it, so an agent cannot tell the principal that she is going to use a power of attorney to place the principal in a nursing home if the principal does not want to go to a nursing home. An agent cannot override any decisions made by the principal.

A.14. CAN A HEALTH CARE PROVIDER IGNORE THE PRINCIPAL'S WISHES?

Occasionally a health care provider (e.g., nursing home, doctor, hospital) will object to following the wishes of the principal. This objection is allowed per a provision for "third party compliance" under the Health Care Right of Conscience Act. This objection can occur either because the provider does not agree with:

- the wish of the principal to receive all life-sustaining treatments available, or
- the wish of the principal to not start life-sustaining treatment or to terminate life-sustaining treatment sooner than the provider believes appropriate.

Therefore, it is important for the principal or agent to learn the facility's (nursing home's) policies about life sustaining treatment prior to admission. The ombudsman should learn and verify the facility's policy very early in the investigation process of a complaint involving the provider's objection to following the wishes of the principal.

A.15. DOES THE PRINCIPAL HAVE TO GIVE HIS AGENT CARTE BLANCHE?

No. The authority granted by the principal to the agent can be as broad or as narrow as the principal cares to make it. Both the power of attorney for health care and the power of attorney for property statutory forms have a space in which the principal can define the authority of the agent. A common example of a very narrow power of attorney would be a real estate listing contract. That document authorizes a real estate agent to act on behalf of a principal for the purpose of soliciting bids and conducting negotiations for the sale of real estate. A power of attorney document that serves as an estate-planning device generally provides for very broad powers.

A.16. WHAT CAN HAPPEN IF A POWER OF ATTORNEY IS NOT EXECUTED?

If an individual does not execute a power of attorney naming an agent to act on his behalf and the individual then becomes incompetent, "other" directives may be pursued. The absence of a power of attorney removes the ability of an individual to name the particular person(s) that he wants to act on his behalf in the event of his becoming incapacitated.

The absence of a power of attorney removes the ability of an individual to name the particular person(s) that he wants to act on his behalf in the event of his becoming incapacitated.

A.17. CAN A POWER OF ATTORNEY BE REVOKED OR MODIFIED?

Yes. The effectiveness of the revocation will depend, however, on the decision-making capacity of the principal. The principal can accomplish revocation by:

- obliterating, burning, tearing or defacing the power of attorney document in a manner indicating intent to revoke;
- signing a written revocation; or
- making an oral or other expression of intent to revoke in the presence of a witness 18 years of age or older who signs and dates a confirmation of the expression of the intent.

A power of attorney for property may be revoked by specifying a date or event in the power of attorney document on which the appointment terminates. The principal may also communicate a revocation to the agent in any manner. When revoking a property agent, the principal should also notify third parties who have been dealing with the agent, such as banks or brokerage firms.

Modification of a power of attorney document usually entails drafting a new power of attorney.

A.18. ARE THERE LIMITATIONS TO POWERS OF ATTORNEY?

Often it is difficult to use powers of attorney to transfer real estate or stocks. Many companies require that the power of attorney be recorded with the county clerk or recorder of deeds office prior to recognizing the agent's authority stated therein as a basis to make a stock transfer. Some title insurance companies will not issue a title insurance policy to transfer real estate pursuant to a power of attorney unless the legal description for the subject property is contained within the power of attorney document.

A.19. ARE THERE RISKS TO USING A POWER OF ATTORNEY?

Yes. This points to one of the pitfalls for powers of attorney: there is not active court or other supervision of the agent.

A.20. THE AGENT AS "FIDUCIARY"---WHAT DOES THAT MEAN?

The agent stands in a fiduciary capacity to the principal. Another way of stating this is that she acts as a kind of trustee and protects the principal's interests, whether financial or physical well being. An agent named power of attorney cannot engage in "self-dealing", meaning that she cannot act to benefit herself at the expense of the principal. Just like the trust department of a bank cannot use an individual's money for its own purposes, an agent cannot use the principal's assets to benefit herself. An agent can be held personally liable for her acts if a reasonably prudent individual would not have acted in the manner that the agent did.

A.21. WHAT CAN HAPPEN IF AN AGENT EXPLOITS THE PRINCIPAL?

If the agent does misuse her position, the principal or individuals acting on behalf of the principal can initiate legal proceedings for an accounting to recover any property wrongfully taken. The Illinois Criminal Code provides for the recovery of triple damages and attorney's fees in instances of financial exploitation, provided the state's attorney files a criminal information or a grand jury returns an indictment and the alleged wrongdoer fails to return the property within ninety (90) days of a written demand from an attorney representing the aggrieved party.

A.22. HOW CAN ONE PROTECT ONESELF AGAINST EXPLOITATION BY THE AGENT?

When financial exploitation does occur, it usually occurs over a period of years. To protect against financial exploitation, it is a common drafting technique to make the power of attorney effective upon a doctor signing a statement stating that the principal can no longer manage his financial affairs. The document is executed and effectively remains dormant until the physician's statement is attached to the document. It is appropriate to make the power of attorney for finances appointment effective immediately when an individual has been receiving ongoing assistance from another person with regard to management of his financial affairs.

A.23. WHAT IF A COURT APPOINTS A GUARDIAN FOR AN INDIVIDUAL AFTER A POWER OF ATTORNEY HAS BEEN EXECUTED?

The authority granted to a power of attorney agent remains intact even if the court appoints a guardian unless the court specifically revokes the authority of the agent in the course of the guardianship proceeding. The guardian's authority does not encroach upon and is subject to the authority granted to the agent in the durable power of attorney document.

B. LIVING WILL

B.1. WHAT IS A LIVING WILL?

A living will is a written declaration of an individual's wishes regarding the use of life-sustaining treatment in the event of a terminal condition. Terminal condition is defined in the law as "an incurable and irreversible condition, which is such that death is imminent and the application of death-delaying procedures serves only to prolong the dying process." Permanently unconscious or a persistent vegetative condition is not necessarily included in the purview of a living will since this document deals only with "end of life" issues. The statutory form of the living will is in the Illinois Living Will Act.

Illinois law lists health care power of attorney, living will, mental health treatment preference declaration and do-not-resuscitate order as health care advance directives.

B.2. ARE THERE SPECIAL REQUIREMENTS FOR THE LIVING WILL TO BE VALID?

The living will document has to be signed by the declarant and two witnesses, neither of who is the declarant's physician. If a living will is being executed, it is best if the signatures of the two witnesses are notarized. Neither the witnesses, nor the notary, should be related to the declarant executing the document, nor should they be in a position of being financially responsible for the person's health care costs, or in a position to inherit some portion of the estate of the declarant.

The living will becomes a relevant document only when the attending physician certifies that the declarant is in a terminal condition.

B.3. WHY DOES ONE NEED A LIVING WILL?

The lack of a living will or a health care power of attorney will leave the family and medical care providers without documentation and guidance regarding the individual's end of life wishes. This can lead to the individual receiving medical care that is totally inconsistent with his wishes. It can also result in litigation among family members when there is disagreement as to what the individual may or may not have wanted with regard to life-sustaining treatments.

B.4. WHEN SHOULD A LIVING WILL BE MADE?

A living will, as with all advanced directives, should be executed well in advance of any immediate need. An individual has to be capable of making an informed decision to execute a living will.

B.5. WHAT DOES A LIVING WILL SIGNIFY?

A signed living will typically signify that the declarant wants only medication, food, fluid and medical procedure that provide comfort, and he does not want medication and medical procedures that will prolong the dying process.

If a person has both a power of attorney for health care and a living will, the person needs to be certain that the language regarding end of life wishes is virtually identical in the two documents. Inconsistency between these two documents will only lead to confusion and potential failure of the individual's wishes being honored.

If the person has selected the second option on the power of attorney (POA) form, which begins, "I want my life to be prolonged and I want life-sustaining treatment to be provided or continued unless I am in a coma which my attending physician believes to be irreversible," the instructions should be consistent with the instructions in a living will. (Note that the form mentioned above is a POA form not a living will form.)

B.6. WHAT ARE THE BASIC CHOICES IN A LIVING WILL?

There are three (3) basic choices that an individual can choose from:

- never terminate life support;
- life support will only be discontinued in the event of an irreversible coma or other irreversible or incurable disease that is judged to be in a terminal condition;
- a quality of life standard in which the determination is made that the burdens of treatment outweigh the expected benefits, taking into account the relief of suffering, the expense involved, and the quality as well as the possible extension of the individual's life if the treatment options are instituted.

B.7. WHAT IS A “DEATH DELAYING PROCEDURE”?

Death delaying procedures include assisted ventilation, artificial kidney treatments, intravenous feeding or medication, blood transfusions and tube feeding. Under Illinois law, nutrition (this does not include a feeding tube, per the *Greenspan* case) and hydration shall not be withdrawn or withheld if the withdrawal or withholding would result in death solely from dehydration or starvation rather than the existing terminal condition. Medical procedures to ease pain are not considered death-delaying procedures.

B.8. WHAT ARE IRREVERSIBLE COMA /INCURABLE OR IRREVERSIBLE TERMINAL CONDITIONS?

The ombudsman will find that some living will forms, which provide for a listing of medical circumstances concerning termination of life support, have been modified. Some attorneys will never modify a living will form, while others will recommend that specific language be included.

The modifications added are to reflect the declarant's specific instructions regarding the medical circumstances under which life support is perpetuated or terminated when there is a terminal condition. For example, a living will that gives instructions providing that life support is to be terminated only in the event of an irreversible coma or an incurable or irreversible disease that is judged to be a terminal condition is quite restrictive and is inconsistent with the desires of many people.

Many individuals might choose not to have life support initiated for them by if they were a nursing home resident, severely demented, and were being fed with a syringe containing pureed food that was squirted down the back of his throat.

On the other hand, a heart attack is not necessarily an incurable or irreversible injury, disease or illness that is a terminal condition. A living will that uses a “terminal condition” as the basis for termination of life support might result in life sustaining treatment being utilized when a severely demented person, as described above, suffers from a heart attack.

An ombudsman should never give advice on what should be in a living will, but should provide accurate and objective information about living will restrictions and the benefits of a power of attorney agent. The major benefit of having an agent is that she can make unanticipated health decisions in accord with the situation at hand and knowledge of the resident's wishes concerning terminal conditions.

B.9. CAN A LIVING WILL BE REVOKED OR MODIFIED?

Yes. Just as with the power of attorney for health care, the living will can be changed or revoked by the declarant at anytime without regard to his mental or physical condition. The resident can revoke a living will by his

- obliterating, burning, tearing or defacing the document in a manner indicating intent to cancel;
- writing, signing and dating a statement revoking the original living will, or
- making an oral or other expression of intent to revoke in the presence of a witness who is 18 years of age or older, who signs and dates a written statement that the expression of intent to revoke was made by the declarant.

The revocation is effective upon communication to the attending physician by the declarant or by another person who witnessed the revocation.

B.10. CAN A HEALTH CARE PROVIDER IGNORE A PERSON'S WISHES AS STATED IN THE LIVING WILL?

A health care provider is to carry out the instruction of the declarant. However, occasionally a health care provider (e.g., nursing home, doctor, hospital) will object to following the wishes of the declarant. This objection is allowed per the provision for "third party compliance" under the Health Care Right of Conscience Act. This objection may occur because the provider does not agree with the wish of the declarant not to start life-sustaining treatment or to terminate life-sustaining treatment sooner than the provider believes appropriate.

Therefore, it is important for the principal, declarant or agent to know and understand the facility's (nursing home's) policies about life sustaining treatment prior to admission. An ombudsman should verify the facility's policy very early in the investigation process of a complaint involving the provider' objection to following the end of life wishes of the resident. This decision should also be discussed with the resident's medical doctor.

Be cautious about taking direction from the POA agent because an agent does not assume exclusive decision-making authority unless the resident lacks decision-making capacity.

B.11. WILL MY DOCTOR BE IN TROUBLE IF SHE HONORS MY WISHES?

Physicians and health care providers should presume that living wills are valid unless there are contrary indications. They are immune from civil or criminal liability if they follow a standard of reasonable professional care and judgment in reliance upon the living will. A physician that is unwilling to comply with the person's wishes (see third party compliance in B.10) as expressed in the living will is required to transfer her responsibility to another physician.

B.12. IS IT NECESSARY TO COMPLETE BOTH A POWER OF ATTORNEY FOR HEALTH CARE AND A LIVING WILL?

No. In Illinois, there is no requirement for completing both a living will and a Power of Attorney (POA) for Health Care. There is a difference of opinion among attorneys whether or not a person should have both a POA agent and a living will at the same time. The argument for both is that the POA agent may not be available, in which case (in some life and death medical circumstances) the only guidance available would be the living will. Thus, the living will provides a backup statement with respect to termination of life-support.

The argument for not having both directives is that an inconsistency between these documents can create ambiguity and confusion, which may have to be resolved either through medical/ethical determination by the family, legal representative or by the court.

C. DO-NOT-RESUSCITATE (DNR) ORDERS

C.1. WHAT IS A DO-NOT-RESUSCITATE ORDER?

A do-not-resuscitate (DNR) or "no code" order is a doctor's order stating that if a resident's heart or breathing stops, cardiopulmonary resuscitation (CPR) is not to be initiated by the facility staff. A living will by itself cannot be recognized as a DNR order.

C.2. IS A SPECIFIC FORM NEEDED?

Since July 1, 2001, the Department of Public Health requires that a specific form, **State of Illinois Do Not Resuscitate (DNR) Order**, the only document emergency medical technicians (EMT) accept. This DNR form would permit the EMTs to not initiate CPR when they are called to serve a resident who is not breathing and does not have a heart beat. Without this form the EMT will examine the resident, initiate CPR, contact the supervisory physician, provide an assessment of the resident's condition and notice of any advance directives and request further orders. It will be at this time that the physician will decide if a resident's advance directives are sufficient to stop CPR. If not, CPR is to continue until the resident reaches the hospital for a physician assessment; the CPR may then be stopped if appropriate. This form is easily identifiable by the seal of the State of Illinois in the lower right hand corner and the "brightly colored orange" paper.

Because the use of this form is not required in the Illinois Nursing Home Care Act, the Department of Public Health does not consider the non-use of this official form to indicate a DNR order an automatic violation of the Nursing Home Care Act.

C.3. WHAT ARE THE REQUIREMENTS TO MAKE THE DNR ORDER VALID?

The Department of Public Health DNR form requires either the signature of a resident, or, if the resident does not have decision-making capacity, the legal representative and the physician.

C.4. IS THE DNR ORDER PERMANENT?

No. The physician who signed the order, or the resident/legal representative who gave written consent to the order, can revoke a DNR order at any time, by:

- physically destroying the document, or
- verbally rescinding the order

Upon revocation, the DNR form should be removed from the resident's medical record and CPR will be provided as required.

C.5. DOES A DNR ORDER PREVENT THE HEIMLICH MANEUVER FOR CHOKING?

No, if a resident is choking, a DNR order will not prevent facility staff from performing the Heimlich. DNR orders only stop CPR in the event of cardiac or pulmonary arrest and are not to influence other therapeutic or emergency interventions that may be appropriate for the resident (*AMA Policy Finder*, Policy E-2.22).

D. MENTAL HEALTH TREATMENT PREFERENCES DECLARATION

D.1. WHAT IS A MENTAL HEALTH TREATMENT DECLARATION?

The Illinois Mental Health Treatment Preferences Declaration (declaration) is a document that allows an individual (the principal), when competent, to specify in advance what mental health treatment he would like to receive (or not receive) if he should become incompetent due to the symptoms of a mental disorder. Note: Alzheimer Disease or another type of dementia is not a mental illness.

D.2. WHAT OR WHO IS THE "PRINCIPAL" IN A DECLARATION?

If an individual executes a declaration for mental health treatment, that person is called the "principal."

D.3. WHAT OR WHO IS AN "ATTORNEY-IN-FACT" IN A DECLARATION?

The individual receiving the authority to act on behalf of the principal is known as the attorney-in-fact. The declaration form, found in the law, appoints one attorney-in-fact and a successor attorney-in-fact to be the substitute decision makers. The attorney-in-fact may not be the attending physician, mental health service provider, staff of the physician or mental health service provider, or health care facility staff unless the person named is also a relative.

D.4. WHAT TREATMENTS ARE COVERED BY THE DECLARATION?

The mental health treatments covered by the declaration include:

- Electro-convulsive treatment (ECT),
- Psychotropic medications,
- Any tests or related procedures essential for the safe administration of those treatments, and
- Admission into a mental health facility for up to 17 days

D.5. WHEN DOES THE DECLARATION BECOME OPERATIVE?

The declaration becomes operative in the event

- a court of law finds the individual to be incompetent, or
- two physicians determine an individual lacks the capacity to consent to mental health treatment.

Ombudsmen can expect physicians to determine a resident's incapacity to consent by one of the following:

- The resident cannot sufficiently understand the treatment rationale, **or**
- The resident is not able to voice his concerns or preferences for treatment.

An example of when a provider might activate the declaration is when the principal with a debilitating mental illness refuses or forgets to take his medication.

D.6. WHAT ARE THE REQUIREMENTS FOR THE MENTAL HEALTH TREATMENT PREFERENCES DECLARATION TO BE VALID?

The principal and two (2) competent adult witnesses must sign the declaration. A witness may not be

- The attending physician or mental health service provider or a relative of the physician or provider,
- An owner or operator, of a health care facility where the principal is receiving treatment,
- A relative of the owner or operator of a health care facility where the principal is receiving treatment, or
- A person related to the principal by blood, marriage, or adoption.

When the witness signs, she is stating that the principal appears to be of sound mind and is not under duress, fraud or undue influence.

A declaration is not active until the mental health care provider has a copy of the document and the principal is found to be incompetent by the court or incapable by two physicians.

The declaration is valid for three (3) years after signing, unless the declaration has been invoked and the three-year period ended while the principal remains incompetent or incapable. The declaration expires when the principal again becomes competent or capable.

The Mental Health Treatment Preference Act includes a sample form for the declaration. If the sample form is not used, the ombudsman should contact the supervisor for direction.

D.7. CAN THE ATTORNEY-IN-FACT IGNORE THE PRINCIPAL'S WISHES?

No, unless one of the following exceptions occur:

- A court order is obtained that contradicts the principal's wishes as specified in the declaration, or
- An emergency, endangering the life or health of the principal has occurred.

An example is the principal who has declared that he does not want ECT, but the attorney-in-fact believe the principal will benefit from ECT and obtains a court order that says the principal is to receive ECT. The resident will receive ECT through this order.

The attorney-in-fact who no longer wants to fulfill her duties must revoke her appointment as attorney-in-fact in writing to the attending physician or principal.

D.8. IS A MENTAL HEALTH TREATMENT PREFERENCES DECLARATION PERMANENT?

No. A signed declaration is only effective for three years, unless the declaration expires while the principal is receiving treatment.

The principal can revoke a declaration by a written statement signed by an attending mental health professional that determines the principal is competent. Though two physicians must determine incapacity for a declaration to go into effect, it takes only one physician to determine competency for revocation.

E. ORGAN DONATION

E.1. WHAT IS "ORGAN/TISSUE DONATION"?

Organ and tissue donation is having an organ or tissue removed from a person's body after death. Usually the removed organ or tissue is given to another person who is in need. The decision to donate an organ or tissue must be made by an individual in advance of death.

E.2. WHAT IS THE ORGAN/TISSUE DONOR REGISTRY?

The Secretary of State maintains an Organ/Tissue Donor Registry database that specifies persons who are willing to donate organs and tissues after death. All

Illinois citizens with a “Y” under “DONOR” on the front of their driver’s licenses are currently registered on the database. The information in the registry is only available to organ and tissue bank personnel, coroners and medical examiners after all efforts to save a person’s life have failed. However, simply joining the registry does not guarantee donation. An individual’s family members or health care agent must still make the final decision for donation.

E.3. HOW CAN THE INTENT TO DONATE BE EFFECTUATED?

The intent to donate an organ or tissue can be specified in an individual’s last will, or on a written, signed document other than a will, such as a card or valid driver’s license. The card or driver’s license must be signed in the presence of two witnesses. The two witnesses must also sign the document to certify that the individual is “of sound mind and memory and free from any undue influence.”

An organ/tissue donation can be authorized by the (principal’s) health care agent. Under the Power of Attorney Act, an anatomical gift is deemed to be a gift by the principal and takes effect without need to obtain the consent of any other person.

If the principal does not make his wishes known in writing, and does not have a power of attorney for health care, then the following persons, in this order, can consent to, or refuse donation of the principal’s organs/tissues:

- the individual’s spouse
- the individual’s adult sons or daughters
- either of the individual’s parents
- any of the individual’s adult brothers or sisters
- the guardian of the individual at the time of his death
- any person authorized or under obligation to dispose of the body.

If the people in the highest class cannot agree, then the people in the next lower class make the decision.

E.4. WHAT CAN BE DONATED?

Organs that can be donated include: heart, kidneys, pancreas, lungs, and liver. Tissues include: skin, bones, heart valves, eyes, and veins.

E.5. CAN A PRINCIPAL CHANGE HIS MIND ABOUT DONATION?

Yes. Any adult Illinois citizen can destroy his donor card, write VOID across the donor form on the back of his driver’s license, or put an “X” through the signature. The Office of the Secretary of State can be contacted to have one’s name removed from the registry. A person with decision-making capacity can also change his power of attorney for health care document that was previously given to the agent to consent to organ or tissues donation.

Any changes to the terms of an individual’s last will should be made with the advice and assistance of an attorney.

Most importantly, family members and the attending physician should be aware of the principal's wishes regarding organ and tissue donation in the event of death, particularly if the principal has recently made a change.

F. CONSIDERATIONS FOR ADVOCACY

Ombudsmen should always advocate for the wishes of a resident. Family, friends and legal representatives of residents most often report the resident's position concerning a complaint or issue to the ombudsman. The need to investigate the accuracy of the complaint or whether the complainant is the legal representative of the resident is usually not necessary before initiating the investigation. It is necessary before seeking to resolve the issue. Legal representatives for residents may confuse the terms used in directives and also may not know the limits of their responsibilities.

Ombudsmen are often involved in cases that require knowledge of advance directives in order to proceed toward complaint resolution. Knowledge of advance directives illuminates the lines of decision-making authority for residents. Family members, residents, and even facility staff all may have questions related to the provisions and content of advance directives as the understanding of advance directives can be difficult.

Ombudsmen should contact their supervisor for clarification and technical assistance in complex cases. Almost every case involving a dispute or issue about an advance or other directive should be considered a complex case.

F.1. POWER OF ATTORNEY AGENT AUTHORITY/CONFIDENTIALITY ISSUES

An ombudsman takes direction from a resident who has the decision-making capacity to give direction, regardless of any contrary directives from the resident's power of attorney agent. In the case of a capable resident with a power of attorney, **the ombudsman must be cautious about taking direction from the agent because an agent does not assume exclusive decision-making authority unless the resident lacks decision-making capacity.**

Any information received from a capable resident must not be disclosed to an agent without prior resident permission.

The power of attorney for property does not give an agent the authority to make health care decisions nor does the power of attorney for health care give an agent the authority to make financial decisions. Agents and many third parties (e.g., nursing home personnel, police officers, bank tellers, etc.) don't always know the difference and some mistakenly believe that receiving the authorization under one includes the other.

As a very last resort, when an agent is refusing to listen to and follow the wishes of the resident, an ombudsman must educate and support the resident's right to revoke the power of attorney and assist the resident in designating another agent.

F.2. KNOWLEDGE IS POWER IN THE PROTECTION OF A RESIDENT AGAINST AN AGENT

The ombudsman's knowledge of the POA revocation procedure and the knowledge of the resident's capacity for decision-making combine to make a powerful instrument in supporting a resident in opposition to his agent.

When there is an allegation of financial abuse by the agent named in a power of attorney, state law allows an ombudsman to request the agent to produce a record of all expenditures and supporting documentation. An ombudsman should be aware of the increased opportunity for exploitation and abuse when a resident, who is not fully capable, has a designated substitute decision-maker who has assumed full decision-making power.

F.3. LIVING WILL AND POWER OF ATTORNEY CONFLICT

A resident with only a living will has no designated substitute decision-maker. A living will is only documentation of a resident's end of life wishes. The ombudsman uses this as needed with the family or facility for assuring that the resident's wishes are met, when the resident is not capable of expressing his wishes.

If the resident has both a living will and a health care agent, it is important to review documents to ensure they are consistent. Health care providers are generally unwilling to "stick their necks out" and choose the authority stated in one document over the authority stated in another document. *Therefore, the decision-making process regarding the perpetuation of life support usually comes to a screeching halt if there is a conflict.* Should the ombudsman become involved in the complaint involving an incapable resident who has a living will in conflict with a power of attorney for health care, the ombudsman needs to contact the supervisor. Information that will be needed includes:

- the date each was signed
- information as to the possible revocation of either, and
- the most recent wishes expressed by the resident.

When a physician refuses to follow a resident's wishes, the physician cannot abandon the resident without an appointment of another one.

F.4. ADVANCE DIRECTIVE EXECUTED OUT-OF-STATE

The use and acceptance of advance directive documents are universal. If an Illinois medical provider refuses to honor a document that was executed out-of-state and the resident is incapable, contact the supervisor. One of the following legal actions may be needed:

- petition for declaratory judgment and injunctive relief, which would seek a court declaration that the living will or power of attorney is valid and include specific directions for the third party healthcare provider; **or**
- guardianship proceedings.

F.5. HEALTH CARE PROVIDER RIGHT OF CONSCIENCE

Should an ombudsman become involved in a complaint involving a physician or nursing home's not following a resident or his legal representative's end of life decisions as declared in a living will or a power of attorney for health care, the supervisor needs to be notified immediately. These cases are complex and are likely to require legal intervention.

Both physicians and nursing homes have the right to object to a resident's end of life wishes based on their right of conscience. When a physician refuses to follow a resident's wishes, the resident/legal representative needs to seek another physician who will provide the care the resident wishes as stated in the living will and or power of attorney for health care. The ombudsman should expect assistance from the physician in the selection of another. The physician cannot abandon a resident without an appointment of another physician.

When a nursing facility objects to a resident's end of life wishes, the resolution of the complaint becomes more complicated. Selecting another nursing home that will follow the resident's wishes is the responsibility of the resident or the resident's legal representative.

The ombudsman should expect the facility to help with the selection of another facility. A facility cannot involuntarily move (discharge) a resident to another facility without an involuntary discharge notice.

The ombudsman may use the involuntary discharge process, including an appeal, to either obtain more time for the resident to choose another facility or to allow the resident to die in the nursing home. For example, if a religiously affiliated facility believes the withholding or withdrawal of life-sustaining treatments is not in accord with its religious principles, a resident with such an advance directive may be issued a discharge notice and asked to move to another facility to have his end-of-life treatment choices followed.

Legal action may be pursued if a health care provider desires to perpetuate life support contrary to the instructions set forth in the living will or power of attorney. The litigation might seek a declaratory judgment and injunctive relief from the

court. *A favorable court decision would declare that the living will and/or power of attorney is valid and would includes specific directions for the third party healthcare provider to follow the order of the court. The court order, in turn, would mirror the instructions set forth in the living will and/or durable power of attorney.*

F.6. PHYSICIAN RESPONSIBILITY OF DO-NOT-RESUSCITATE ORDER EXPLANATION

An ombudsman should expect the physician to inform the resident, or the incapable resident's legal representative, of the content of the DNR order, as well as the basis for its implementation. When this is presented, the physician should be prepared to discuss appropriate alternatives, such as obtaining a second opinion, or consulting a person trained in bioethics, or arranging for transfer of care to another physician.

Selecting another nursing home that will follow the resident's wishes regarding end of life decisions is the responsibility of the resident or the resident's legal representative. A facility cannot involuntarily move (discharge) a resident to another facility without an involuntary discharge notice.

III. DIRECTIVES BY THE COURT/OPERATION OF LAW

A. HEALTH CARE SURROGATE ACT

A.1. WHAT IS THE HEALTH CARE SURROGATE ACT?

The Health Care Surrogate Act is designed to fill the void when an individual lacks the decision-making capacity to make medical decisions for himself, and there is neither a valid executed power of attorney for health care nor a court appointed guardian. The Health Care Surrogate Act allows a person to be a substitute decision maker (surrogate) for both routine medical and life-sustaining treatment for an individual who has been declared incapable.

A.2. WHAT IS A “SURROGATE”?

A surrogate is an individual acting on a patient’s behalf. The surrogate is different from a guardian or an agent named in a valid power of attorney for health care. A surrogate has not been formally designated in any written document by the patient prior to becoming incapable or by a court.

A.3. WHAT TREATMENT DECISIONS ARE ALLOWED BY THE HEALTH CARE SURROGATE ACT?

If one physician determines a resident lacks decision-making capacity, the surrogate can make nearly all-medical decisions for the resident with the exception of two restrictions. They are:

- the decision to withhold or withdraw life sustaining treatment; and
 - the decision to determine mental health treatment.
-
- **The decision to withhold or withdraw life-sustaining treatment**
The determination of a resident’s incapacity and the presence of a qualifying condition must be certified by two physicians in order for the surrogate to request the withdrawal or withholding of life-sustaining treatments. A “qualifying condition” is
 - a terminal condition—an illness or injury for which there is no reasonable prospect of cure or recovery, death is imminent, and the application of life-sustaining treatment would only prolong the dying process,
 - permanent unconsciousness—a condition that, to a high degree of medical certainty, (i) will last permanently, without improvement, (ii) and in which thought, sensation, purposeful action, social interaction, and awareness of self and environment are absent, and (iii) for which initiating or continuing life-sustaining treatment, in light of the patient’s medical condition, provides only minimal medical benefit, **or**

- an incurable or irreversible condition—an illness or injury (i) for which there is no reasonable prospect of cure or recovery, (ii) that ultimately will cause the patient’s death, even if life-sustaining treatment is initiated or continued, (iii) that imposes severe pain or otherwise imposes an inhumane burden, and/or (iv) for which initiating or continuing life-sustaining treatment, in light of the medical condition, provides only minimal medical benefit.
- **Decisions concerning mental health treatment**
A surrogate cannot make decisions concerning mental health treatment, including treatment by electro-convulsive treatment (ECT), psychotropic medication, or admission to a mental health facility. The only way these services can be provided is by the health care surrogate petitioning the court to order the mental health services.

A.4. HOW IS A SURROGATE CHOSEN?

It must first be determined that no valid agent under the power of attorney for health care, living will, or guardian exists or is not available, before the surrogate hierarchy is instituted.

The hierarchy of health care surrogate decision makers is as follows:

- the resident’s guardian of the person;
- the resident’s spouse;
- any adult son or daughter of the resident;
- either parent of the resident;
- any adult brother or sister of the parent;
- any adult grandchild of the resident;
- a close friend of the resident;
- the resident’s guardian of the estate.

If there is more than one person available and willing to act in a given category, (e.g., sons and daughters), then all of the persons in that category must vote on a given action with a majority controlling. If there is a deadlock, then the decision reverts to the next lower category in the hierarchy.

A.5. IS THERE A SPECIFIC FORM TO DOCUMENT HEALTH CARE SURROGATE DECISIONS?

No. While law does not require a specific form, the process of determining the need for a surrogate, who should serve as the surrogate and the decisions made must be documented and included in the resident’s medical record.

The process of determining the need for a surrogate, who should serve as the surrogate and the decisions made must be documented and included in the resident’s medical record.

A.6. WHAT IF A POA DOCUMENT EXISTS, BUT THE AGENT IS NOT AVAILABLE?

The law is silent regarding whether a surrogate must follow the directions as stated in the POA document if the appointed agent has died or is unavailable; however, good practice indicates a surrogate should familiarize herself with the individual's wishes as stated in the advance health care directive, and follow these to the extent possible.

A.7. CAN A SURROGATE MAKE A DECISION REGARDING TERMINATION OF LIFE SUPPORT?

Yes, if two physicians have certified that the individual has a qualifying condition. (See A.3, "What Treatment Decisions Are Allowed by the Health Care Surrogate Act?")

B. GUARDIANSHIP

B.1. WHAT IS GUARDIANSHIP?

Guardianship is the appointment by the court of an individual (guardian) to provide substitute decision-making for an incompetent person (ward). The basis for guardianship and the process for selecting a guardian are governed by the Probate Act.

B.2. WHO IS AN "ALLEGED DISABLED ADULT"?

In legal terms, "alleged disabled adult" is the term used for a person believed to need a guardian, prior to a court establishing incompetence and actual need for a guardian. If a guardian is appointed, the alleged disabled adult is then called a ward of the court.

B.3. WHAT OR WHO IS THE "WARD"?

The ward of the court (ward) is a person who has been determined to be incompetent, thus in need of a guardian, by a court.

B.4. WHAT IS INCOMPETENT?

Incompetent means that the ward has mental deterioration or physical incapacity that prevents him from managing his affairs. The reason for determining incompetence might be due to mental deterioration, physical incapacity, mental illness, developmental disability, gambling, idleness, excessive use of intoxicants or drugs, or simply wasting one's estate so as to expose one's family to want or suffering. Ombudsmen may hear the term "disabled adult" used instead of incompetent adult.

A guardian must be capable of providing an active and suitable program of care for the ward.

B.5. WHAT OR WHO IS THE “GUARDIAN”?

A guardian is the person named by the court to make decisions as to medical treatment, medication, residential placement, money management and care planning for the ward.

A guardian must meet the following criteria:

- be at least 18 years of age;
- be of sound mind, not have a guardian him/herself;
- be a resident of the United States;
- has not been convicted of a felony; and
- be capable of providing an active and suitable program of care for the ward.

The alleged disabled person may make known to the court his wishes as to who should be appointed as guardian, but the naming of the guardian is within the discretion of the court. An agency providing residential services to the ward cannot be appointed guardian.

Alternatives are generally sought when there is no friend or relative available, qualified or willing to be guardian. Alternatives include:

- The Public Guardian, if the ward has assets equal to or greater than \$25,000, some portion of which are used to pay the fees of the Public Guardian (usually a private lawyer, appointed by the Governor, who ordinarily serves as guardian of the estate, but may serve as guardian of the person); or
- A banking institution, which may be appointed guardian of the estate, but not guardian of the person.

The Office of State Guardian (OSG), a division of the Guardianship and Advocacy Commission, will only assume guardianship of an adult with disabilities, if appointed, when alternative persons who could serve as the guardian have been exhausted.

B.6. HOW IS THE GUARDIANSHIP PROCESS STARTED?

The process is initiated by filing with the court a Petition for Appointment of a Guardian. In addition, a report from a physician should accompany the petition detailing the reasons a guardianship is needed and the scope of the guardianship. If a physician's report does not accompany the petition, one must be filed with the court at least ten (10) days before the hearing. The physician must have examined the alleged disabled adult within ninety (90) days of the filing of a petition.

A guardian ad litem (GAL) as an investigative arm of the court who is either a licensed attorney or someone qualified to work with the type of condition affecting the alleged disabled adult.

A petition includes:

- the identity of the alleged disabled adult,
- the nature of his incapacity,
- the nature of his inability to make decisions regarding management of his person and estate,
- the nature of his assets and income,
- the identity of his nearest adult relatives,
- the existence of any durable powers of attorney naming agents to act on behalf of the alleged disabled adult, and
- the name(s) of a qualified individual(s) or entity willing to act as the guardian of the alleged disabled adult.

The alleged disabled adult is served with the petition and a summons by the sheriff. A Notice to Interested Parties and a copy of the petition are sent to all parties whose names and addresses appear in the petition.

Before the hearing, the court usually appoints a guardian ad litem (GAL) as an investigative arm of the court. The GAL is either a licensed attorney or someone qualified to work with the type of disability or condition affecting the alleged disabled adult.

The GAL will visit and interview the alleged disabled adult, inform him of his rights, review medical evidence, and consult other professionals relevant to the case. When the GAL has determined to what extent, if any, the alleged disabled adult needs a court appointed guardian, the GAL then makes a written report to the court regarding her findings and testifies at the hearing. The guardian ad litem may, or may not agree with an alleged disabled adult's point of view regarding his alleged disability, the proposed guardian, or any other matter.

Not all cases will include a GAL because it is not required in the Probate Act. However, most courts in downstate Illinois do appoint a GAL, except in temporary guardianships. In Cook County, the appointment of a GAL is required in all estate guardianships, and in person guardianships "which might result in a physical intrusion (surgery or forced medication) or a denial or rights (involuntary placement. . .)"

The alleged disabled adult has the right to have the case decided by a six-person jury. Any other parties have a right to, and often have, attorneys representing their interests in the case. If the alleged disabled adult does not have an attorney, he should ask the court to appoint one.

Once a case is filed, it usually takes fourteen days to two months, or longer for contested guardianships, for a decision to be reached by the court.

B.7. WHAT IS THE ROLE OF TITLE III B SENIOR LEGAL SERVICES PROVIDERS IN GUARDIANSHIP PETITIONS?

Most Title III B Senior Legal Services Providers have policies that prohibit them from filing a guardianship petition. Some legal services providers take the position that they should initiate a guardianship case in the most extreme and rare set of circumstances.

The Title III B Senior Legal Services Provider should be contacted to assist the alleged disabled adult who opposes a guardianship petition and the ward who wishes to have his guardianship revoked. These legal services providers will take these kinds of cases.

B.8. WHY ARE THERE DIFFERENT TYPES OF GUARDIANS?

When a alleged disabled adult is before a court, the court has to determine if person is incapable of fully managing his own business or financial affairs or the care of his person and then determine the kind of guardianship needed.

“Fully managing” refers to the capacity to make informed decisions regarding one’s affairs. On one end of the spectrum are individuals who have extreme unabated limitations in their capacity. On the opposite end of the spectrum are individuals who have mild episodic limitations in their capacity to make decisions regarding their affairs.

Both individuals are incapable of “fully managing” their affairs. The question becomes, what relief should the court fashion, if any, to accommodate the lack of capacity of the impaired individual? A ward of the court is a person that has a guardian (temporary, limited, or plenary) appointed over his affairs.

The different kinds of guardians include:

- guardian of the person
- guardian of the estate
- plenary guardian
- limited guardian
- temporary guardian

The first two divisions are based on the scope of the guardian’s authority:

- **Guardian of the Person**—a guardian appointed when a person cannot manage health or personal care affairs. Two key issues for a guardian of the person are medical decision-making and residential placement.
- **Guardian of the Estate**—a guardian appointed when a person cannot manage his own financial affairs.

Either of these types may be plenary, temporary or limited.

The next division is based on the level of authority granted the guardian:

Plenary Guardian—a guardianship which is “complete and unqualified”. It is utilized when an individual lacks consistent decision-making capacity regarding the care of his person and/or finances. An individual can have a plenary guardian of his estate, but only a limited guardian of his person or vice-versa. Illinois law requires that guardianships be personally tailored to the individual’s actual limitations. Section 11a-17 of the Probate Act sets forth the duties of the personal guardian. Section 11a-18 sets forth the duties of the estate guardian.

Even if a court appoints a plenary guardian of an individual’s person and estate, the scope of that guardianship is subject to the authority granted to an agent pursuant to the Illinois Durable Power of Attorney Act. Therefore, it is important that the existence of a durable power of attorney be brought to the court’s attention in guardianship proceedings so that the court can make a decision as to whether to revoke the power of attorney or allow it to remain in effect.

This type of guardianship has the broadest responsibility as the law allows plenary guardianships to assume the authority for everything except specific exclusions.

- **Limited Guardian**—a guardianship which has granted less than plenary authority for the ward’s affairs. Limited guardians may be of the person, of the estate, or one guardian of both

The authority of a limited guardianship applies only to what is specifically described in the court order. **If the court order does not specify certain actions/items**, the ombudsman should **assume that a capable resident might make his own decisions regarding any actions/items not listed in the order.**

A limited guardianship is complicated when compared to plenary guardianship. A physician must clearly differentiate between those things a person can and cannot do, and must clearly describe these things to the court. While the state statute includes a preference for limited guardianship, which would be carefully tailored to the specific needs of the ward, in fact, over 95 percent of all guardianships are plenary.

Examples of limitations in a guardianship include the following:

- The ward retains authority over his estate with the exception that he can no longer own a motor vehicle (typically there would be a corresponding limitation in the guardianship of his person providing that the ward can no longer operate a motor vehicle); and

- The ward retains the right to make his own medical decisions, provided that in the event he declines or refuses medical treatment, the guardian shall contact the physician and/or medical provider and obtain all relevant facts and opinions from said individual(s), and discuss the information with the ward. The guardian then has the sole discretion to make a decision as to whether the ward shall receive the prescribed medical treatment.
- **Temporary Guardian**—a guardianship authorized in emergency situations. The court has found the need for an immediate guardian to safeguard the welfare and protection of the alleged disabled person or his estate. Temporary guardians may be of the person, of the estate, or one temporary guardian of both.

A temporary guardianship is frequently obtained “ex parte,” meaning without all parties present. In these cases, the petitioner goes to the judge, explains the situation, including the need for immediate action, presents the medical report and gains a temporary order. A temporary order is then issued without the other parties, or even the alleged disabled adult being present. In this type of petition, the petitioner has to prove the need for a temporary guardianship without the participation of these parties and that it is necessary for the immediate welfare and protection of the alleged disabled adult.

The court will then require a hearing be scheduled on rather short order, typically 10-14 days later, at which time the alleged disabled adult and all interested persons are to be provided with a copy of the petition, a copy of the temporary order, and notice of hearing.

A temporary guardianship expires automatically when a permanent guardian is appointed, when the guardianship petition is dismissed, or in 60 days, whichever comes first. Under certain circumstances, a court may extend the temporary guardianship for an additional period beyond sixty (60) days, particularly in complex and contested cases.

B.9. IS THE ALLEGED DISABLED ADULT ENTITLED TO AN ATTORNEY?

The alleged disabled adult has the choice of retaining his own legal counsel. A regional Office of State Guardian office will provide callers with referrals for attorneys who practice in the adult guardianship area. The Illinois State Bar Association, the Chicago Bar Association and the local bar association also offer lawyer referral services.

The State statute includes a preference for limited guardianship, which would be carefully tailored to the specific needs of the ward.

If a person chooses to not retain legal counsel, a regional office of the Office of State Guardian (OSG) attorney or a legal assistance agency may be consulted by an ombudsman or the resident's family to learn about specific practices or requirements in a particular court.

If the alleged disabled adult does not retain an attorney and the alleged disabled adult's goals are clearly stated, but disputes the recommendations of the guardian ad litem (GAL), the court will appoint an attorney to represent the interests of the alleged disabled adult.

B.10. DOES THE ALLEGED DISABLED ADULT HAVE A RIGHT TO A JURY TRIAL?

The alleged disabled adult, or his legal counsel, has the right to demand a jury trial before six persons. The alleged disabled adult has the right to present evidence and confront and examine all witnesses. Witnesses could include a physician and all other participants who have submitted written reports, setting forth the medical basis for the allegation that the alleged disabled adult does need a guardian.

B.11. WHAT ARE THE ISSUES TO BE DECIDED?

At the hearing the court decides:

- The nature and extent of the alleged disabled adult's general intellectual and physical functioning;
- The extent of the impairment of his adaptive behavior if there is a developmental disability, or the nature and severity of his mental illness if there is mental illness;
- The understanding and capacity of the alleged disabled adult to make and communicate responsible decisions concerning his person;
- The capacity of the alleged disabled adult to manage his estate and financial affairs;
- The appropriateness of proposed and alternative living arrangements;
- The impact of the disability upon the alleged disabled adult's functioning and the basic activities of daily living and the important decisions being faced by the alleged disabled adult or normally faced by adult members of the alleged disabled adult's community;
- The qualifications of proposed guardians (this includes decision of competing interests between two or more individuals who wish to act as guardian); and
- Whether there has been financial exploitation or neglect (if raised as an issue); and
- Any other area of inquiry deemed appropriate by the court.

If the court finds the alleged disabled adult needs a guardian, one is appointed by a guardianship order, usually drafted by one or more of the attorneys, which incorporates the powers of the guardian as decided by the judge.

B.12. IS A GUARDIANSHIP ALL OR NOTHING?

No. The court is to appoint a guardian only to the extent that it finds that the disabled adult needs a guardian. The guardian law incorporates a preference (widely ignored) for limited guardianships. The court is to state in its order the factual basis for its findings and specify the duties and powers of the guardian and the legal disabilities to which the respondent is subject.

B.13. DOES A GUARDIAN HAVE AUTHORITY IN END-OF-LIFE ISSUES?

The court order for guardianship must specify the guardian's authority as to end-of-life issues for a guardian to make decisions as to maintaining or terminating life-sustaining procedures.

B.14. CAN THE GUARDIAN PUT THE WARD IN A NURSING HOME?

Yes, but there are certain limitations on this authority. A ward can only be placed in a residential care type facility. The authority to place a ward in a residential care facility must be particularly identified in the court order per the requirements of Section 11a-14.1 of the Probate Act. Otherwise the guardian lacks the authority to place a ward in a residential care facility. The judge may have included in the court order a specific set of circumstances to make residential placement without further order. The guardian has a duty to investigate less restrictive alternative placements.

A Public Guardian, or a State Guardian may make a residential placement without a court order.

Nursing homes routinely accept the signature of the guardian to admit a ward; however, the guardian should make residential placement decisions in accordance with the preferences of the ward, but is not legally bound to do so.

The guardian has a duty to monitor the care given in the facility in which the ward is placed. The guardian may take into account the desires of the ward, except when the guardian believes those would be seriously adverse to the safety and behalf of the ward.

B.15. ARE THERE OTHER PROTECTIONS FOR THE WARD?

Yes. Many matters must be brought to the court's attention for hearing upon proper notice to interested parties before the guardian can act. These matters would include disposition of assets and certain forms of mental health treatment.

The court can be petitioned at any time to terminate or modify the guardianship.

B.16. IS THE GUARDIANSHIP PERMANENT?

No, a plenary or limited guardianship may be overturned if there is sufficient evidence of a significant change in condition. This would generally be some recovery of decisional capacity. For the ward with a profound disability and little chance of recovery, the guardianship, for all practical purposes, is permanent.

The court can be petitioned at any time to terminate or modify the guardianship. A petition can be brought by the ward himself or by anyone on the ward's behalf. A formal petition, an informal letter, a telephone call or a visit to the circuit clerk's office or judge can accomplish this. No particular form is required for this contact.

The information should argue that the circumstances have changed, and should (by law) trigger a review of the guardianship. The changed circumstances may be an improvement in the capacity of the ward; abuse, neglect or exploitation by the guardian; or the failure of the guardian to ensure that the care program adequately protects the ward.

If the judge believes some relevant circumstance has changed that may indicate that the guardianship should be modified or terminated, a GAL may be appointed to investigate and report to the judge. The guardian may be required to appear at a hearing and the issues will be reviewed. The judge might terminate the guardianship, reduce the scope of the guardianship or replace the guardian.

B.17. AFTER THE PROCEEDINGS, WHAT IS THE RELATIONSHIP OF THE COURT TO THE WARD?

The court has continuing supervisory jurisdiction over the ward, the guardian, and the guardianship. At any time, the court can require a guardian to submit accounts or make reports to the court.

The guardian of the estate is required to make annual reports to the court regarding the status of the ward's financial affairs and the care and living arrangements of the ward. The guardian may be scheduled to present the annual report at hearings to interested persons, such as the ward's nearest adult relatives. At a hearing, interested persons can testify on issues and provide information to the court, if the request is made prior and if the court permits.

The guardian of the person reports to the court only if directed by the court and at intervals chosen by the court.

B.18. WHAT STANDARDS GOVERN THE GUARDIAN'S ACTIONS?

The guardian is to act in the best interests of the ward. The guardian must undertake her duties in good faith and is responsible for what is and is not done for the ward, such as a parent is responsible for a child. If a guardian fails to properly care for the ward because of neglect, lack of good faith, or fails to act in

the best interest of the ward, or takes advantage of the ward for selfish purposes, the guardian could face civil liability and criminal prosecution.

In many instances, particularly where there are significant assets, the guardian is directed by the court to post a bond. If the court required a bond, this would be indicated in the court records of the guardianship appointment.

B.19. WHO PAYS FOR GUARDIANSHIP PROCEEDINGS?

In a successful guardianship petition, the expenses of the proceeding, including the filing of the petition, service of process, and GAL fees, are reimbursed from the ward's estate. In the event the alleged disabled adult does not have resources, the court has the authority to have the expenses of the entire proceedings born by the petitioner, unless the petitioner is the Office of State Guardian or the Elder Abuse Program. The petitioner can request that the court waive the filing fees, by virtue of the alleged disabled adult being a pauper, **but the court may not grant the request.** The request for filing fees does not waive attorney's fees.

C. SELECTED INFORMATION FOR ADVOCACY FOR SURROGATES AND WARDS

Understanding directives by the courts/operations of law, and their relationship to advance directives can involve complex issues. The ombudsman should contact the supervisor for clarification and technical assistance when there is a dispute or issues about directives.

C.1. HEALTH CARE SURROGATE ACT ASSUMPTION

If a resident has a surrogate under the Health Care Surrogate Act, it is assumed the resident does not have decision-making capacity. A physician must document this condition before a surrogate decision-maker can be designated.

C.2. OMBUDSMAN PROCEDURAL RESPONSIBILITIES FOR HANDLING ISSUES OF WARDS

Ombudsmen should always advocate for the well being of a ward, protecting 1) his rights to quality care and a quality of life and 2) his basic rights of a citizen to choose, considering his decision-making capacity. The ombudsman needs to have assessed and documented the ward's decision-making capacity in order to substantiate actions required to advocate for the ward.

The ombudsman must be knowledgeable about the specific guardianship the court has ordered. Therefore, the ombudsman should review the actual order appointing the guardian to determine the guardian's specific authority and what limitations, if any, the court has ordered.

There is a legal assumption that if the guardianship document does not specify an issue, the guardian does not have the decision-making power on that specific issue. For example, unless specified otherwise in the court order, a resident retains his right to refuse treatment. A guardian cannot require a ward to receive treatment against his will. When in dispute and the ombudsman believes that a ward's rights are violated, the court must consider the matter.

Unless the guardian is not fulfilling her responsibility under the court order or the guardian is abusing or neglecting a resident, in which case the court should be notified, the ombudsman should keep the guardian informed about the needs and wishes of the resident and request her help in resolving issues.

To gain access to a ward's nursing home medical record, the ombudsman is to use the following appropriate procedure, depending on the decision making capacity of the ward and the involvement, or lack of involvement, of the guardian:

- Use the ***Release of Information*** form to obtain written consent from the ward, or obtain oral consent from the ward that is documented immediately in the LTCOP case record, when the ombudsman believes the **ward has the decision-making capacity to make** an informed decision to allow the ombudsman access to the ward's medical records

- Use the ***Release of Information*** form to obtain written consent from the resident's guardian, or obtain oral consent from the guardian that is documented immediately in the LTCOP case record, when the ombudsman believes the **ward does not have the decision-making capacity to make** an informed decision to allow the ombudsman access to the ward's medical records,
 - Use the ***Release of Information for the Incapable Resident*** form when the ombudsman believes that the **ward does not have the decision-making capacity to make** an informed decision to allow the ombudsman access to the ward's medical records, **and**
 - The guardian is implicated in the complaint;
 - The guardian is not acting in the resident's best interest; or
 - The guardian cannot be located within 24 hours.

C. 3. FACILITIES CAN PETITION THE COURT FOR GUARDIANSHIPS

Facilities can challenge decisions of legal representatives. The court through the guardianship process is the method by which a nursing home can challenge a decision of a power of attorney agent, surrogate decision maker or even a guardian if it believes the power of attorney agent, surrogate or guardian is not acting in the best interest of the resident. The Nursing Home Care Act gives a facility the right to petition for guardianship although it may not be appointed as guardian.

IV. A CONSISTENT OMBUDSMAN PROGRAM PROCEDURE IN HANDLING ISSUES INVOLVING DIRECTIVES

When an ombudsman receives a letter, request, notice or complaint from an attorney, she should take the matter immediately to her supervisor. Letters and other communications from attorneys require the advice from the supervisor and may require the advice of an attorney before responding.

When an ombudsman has a complex case of a resident, which involves a legal representative or some type of directive, the ombudsman is required to contact her supervisor. In some regional areas, the supervisor is the Regional Ombudsman; in other areas it is a paid ombudsman who links the Regional Ombudsman with ombudsmen handling complaints.

In complex cases, the Regional Ombudsman will contact the State Ombudsman, who has the advice of the Ombudsman Legal Counsel. This structure is established to ensure that ombudsmen handling complaints have resources and legal technical assistance needed and that legal situations are handled in a consistent manner statewide.

**When you hear from an attorney, or have a complex case,
consult your supervisor.**

REFERENCES

- AMA Policy Finder—Current Opinions of the Council on Ethical and Judicial Affairs.* Policies E-2.20, E-2.25, E-2.225. American Medical Association. 26 Oct. 2001 www.ama-assn.org/advocacy.
- Commission on Legal Problems of the Elderly. *In Your Hands: Tools for Preserving Personal Autonomy Program Guide.* Washington, D.C.: American Bar Association, 1997.
- Hunt, Sarah. *Access Module.* Long-Term Care Ombudsman Program Level II Training Curriculum. Springfield, IL: Illinois Department on Aging, 2001.
- Illinois Council on Long-Term Care: Advance Directives.* Illinois Council on Long-Term Care. 26 Oct. 2001 www.nursinghome.org/advanced.html.
- Illinois Council on Long-Term Care. *Advance Directive Protocol.* n.p.: Illinois Council on Long-Term Care, March 1998.
- Illinois Department on Aging. *Long-Term Care Ombudsman Program Standards.* Proposed. 2001.
- Illinois Guardianship and Advocacy Commission. *A Guide to Adult Guardianship in Illinois.* Pamphlet. n.p.: Illinois Guardianship and Advocacy Commission, August 2001.
- - -. *A Practitioner's Guide to Adult Guardianship in Illinois.* Chicago: Guardianship and Advocacy Commission, July 1999.
- - -. *Illinois Guardianship and Advocacy Commission: An executive state agency created to safeguard the rights of persons with disabilities through: Office of State Guardian, Legal Advocacy Service, Human Rights Authority.* Brochure. n.p.: Illinois Guardianship and Advocacy Commission, August 2001.
- Secretary of State CyberDrive Illinois: Life Goes On—Organ and Tissue Donation.* Office of Illinois Secretary of State, Jesse White. 30 Oct. 2001 cyberdriveillinois.com/depts/drivers/programs/donor/factsht.html.
- Seward Mool, Deanna. "Statement of Illinois Law on Advance Directives." *Advance Directive Protocol.* n.p.: Illinois Council on Long-Term Care, March 1998.
- Sutterfield, David. *Advance Directives.* Unpublished paper. 1995
- Tomkowiak M.D., Tom, "Illinois Mental Health Treatment Preferences Act," *Advance Directives and Surrogate Decision Making in Illinois.* Eds. Thomas May and Paul Tudico. Springfield, IL: Human Services Press, 1999.

LEGAL CITATIONS

"Guardianship for Disabled Adults" (part of Probate Code)
755 ILCS 5/11a-1 et seq.

Illinois Power of Attorney Act
755 ILCS 45/1-1 et seq.

Health Care Surrogate Act
755 ILCS 40/1 et seq.

Mental Health Treatment Preference Declaration Act
(contains the "Declaration for Mental Health Treatment")
755 ILCS 43/1 et seq.

Illinois Living Will Act
755 ILCS 35/1 et seq.