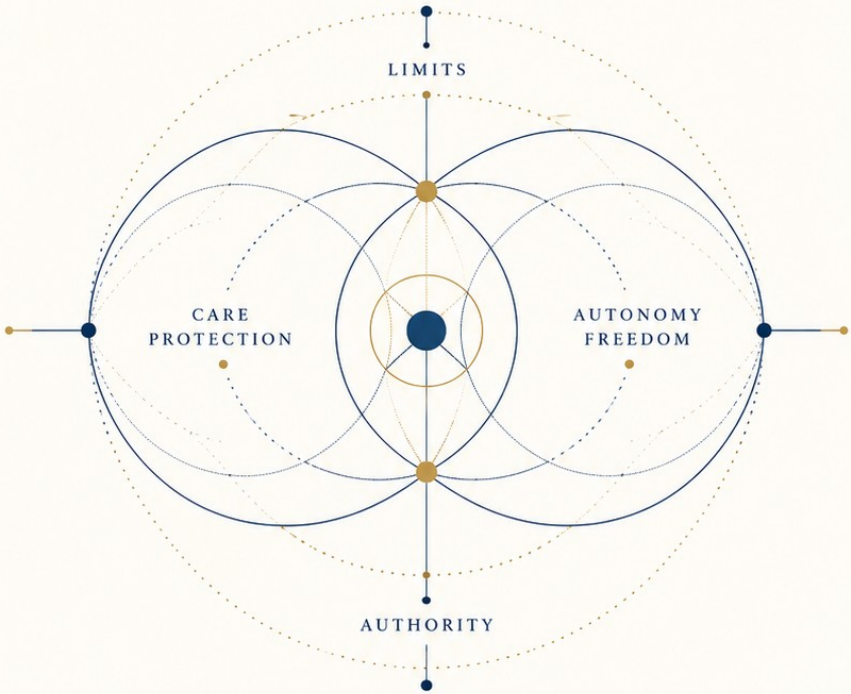
A LEGAL AND HUMAN GUIDE
TO LIFE'S MOST IMPORTANT BOUNDARY

PROTECTING WITHOUT TAKING OVER

When Is It Legitimate to Decide for Someone Else?



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This book was developed through a collaboration between Hieronymus Anonymus and Noosophy AI. Hieronymus Anonymus initiated the project, defined its subject and purposes, arbitrated its orientations, reviewed, corrected, and validated the manuscript. Noosophy AI contributed to documentary research, structuring, drafting, comparison of arguments, coherence audits, and editing. The text is therefore neither a raw model output nor a human text merely corrected by AI: it results from an iterative process of generation, critique, verification, and human validation. Decisions concerning purpose, validation, and publication remain human.

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CHAPTER 1 - THERE IS NO MAGIC AGE

There is a strange legal scene in American life, so familiar that it often stops looking strange at all. A person is seventeen years, eleven months, and twenty-nine days old. The next day, that person turns eighteen. Nothing biological resets at midnight. Their history, preferences, fears, judgment, habits, dependencies, relationships, and ability to reason do not suddenly belong to a different human being. Yet the law may move a major boundary around them. In most states, eighteen functions as the general age of majority. At the federal constitutional level, the Twenty-Sixth Amendment protects the right of citizens eighteen and older to vote against denial or abridgment on account of age. But American law does not use one age for every purpose, and the legal meaning of adulthood is layered across state and federal rules.

That tension is where this book begins.

Two opposite conclusions are tempting, and both are inadequate. The first says that because an age line is artificial, it must be illegitimate: nobody becomes a fully different kind of person at midnight, so every legal distinction between minors and adults must be suspect. The second says that children develop over time and institutions need administrable rules, so a bright-line threshold solves the problem. Neither conclusion is enough. A conventional line can be useful without being natural. And a useful simplification does not justify every consequence attached to it.

The harder question is this: what may age reasonably allow us to presume, and what may it not allow us to conclude?

A child is not a miniature adult. Developmental differences are real. Some capacities appear early, some consolidate later, and many are highly sensitive to context. Emotional regulation, future orientation, experience with consequences, knowledge, self-control, susceptibility to social pressure, and material dependence all change over time. Denying these differences in the name of abstract equality would be as careless as turning them into a blanket incapacity. This book will not erase developmental differences. It will ask what those differences can legitimately justify when freedom and power are at stake.

Because a difference in capacity is never only descriptive once it is used to authorize someone else to decide, forbid, compel, monitor, move, medicate, represent, confine, or control. At that point, a claim about development becomes a claim about power.

The American legal system makes this especially visible because there is no single national family code that resolves the issue in one place. Most family authority, age-of-majority rules, medical-consent rules, emancipation, guardianship, and civil commitment are matters of state law. Federal constitutional rights and federal statutes impose additional constraints. The result is not one clean line but a patchwork of bright lines, exceptions, presumptions, procedures, and domain-specific rules.

That patchwork matters. American law strongly protects parental authority. In Troxel v. Granville, the Supreme Court described the interest of parents in the care, custody, and control of their children as a fundamental liberty interest protected by the Fourteenth Amendment. Yet the constitutional picture is not simply “parents decide, children do not.” In Tinker v. Des Moines, the Court famously rejected the idea that students shed constitutional rights at the schoolhouse gate. In In re Gault, the Court recognized major due-process protections for juveniles in delinquency proceedings. In Parham v. J. R., dealing with the admission of children to state mental hospitals, the Court gave parents a substantial role but also recognized the child’s liberty interest in avoiding unnecessary confinement and rejected the idea that parental discretion in that setting must always be absolute and unreviewable.

These decisions do not create one general doctrine of childhood autonomy. They arose in different legal settings and should not be flattened into a single rule. But together they make one point difficult to deny: a minor is not a legal nonperson whose interests disappear into parental authority. The law may recognize dependency and parental responsibility while still treating the child as someone whose own liberty matters.

This distinction is crucial because participation is not the same thing as control. A teenager may be heard and still have no effective power over the outcome. A child may possess a constitutional interest without having the final legal say. A state may recognize a minor’s ability to consent in one medical context and require parental involvement in another. An emancipation statute may shift some powers without making the young person legally identical to every other adult. American law is full of these partial transitions.

That complexity is not necessarily a defect. It may reflect a basic fact about human development: the capacity relevant to one decision does not mature on the same schedule as the capacity relevant to another.

Developmental psychology points in the same direction, though it asks different questions from law. A large multinational study by Icenogle and colleagues, published in Law and Human Behavior in 2019, examined 5,227 participants between ages ten and thirty across eleven countries. The

researchers distinguished forms of deliberative cognitive capacity from dimensions of psychosocial maturity. In the pooled sample, cognitive capacity reached levels close to adults around the mid-teens, while psychosocial maturity continued to develop beyond eighteen. The authors did not claim that sixteen is the “real” age of adulthood. Their argument was more careful: different kinds of legal decisions may implicate different developmental capacities.

That finding should not be turned into a new magic number. A group average is not a person. A laboratory measure is not a complete life. A plateau in one measured capacity does not mean that every sixteen-year-old should automatically possess every legal power, any more than continued psychosocial development after eighteen means that twenty-year-olds should lose adult rights. The stronger lesson is that “At what age is a person capable?” is usually the wrong question unless we also ask: capable of what, under what conditions, and with what consequences?

Capable of what?

A ten-year-old may be fully capable of choosing clothes, refusing a haircut, identifying a friendship that feels unsafe, deciding which hobbies matter, or managing a modest amount of money, while being unable to understand a complex loan agreement. A teenager may understand a school-placement decision in great detail while needing help to evaluate distant financial consequences. An adult may vote, work, sign contracts, raise children, and still become temporarily unable to consent to medical treatment during delirium. A person with a communication disability may need an interpreter, device, or trusted supporter to express a decision without being unable to form one. An older adult may have memory impairment in one domain while retaining stable preferences, practical judgment, and a clear ability to refuse what others want.

The basic error is to let a specific limitation migrate across the entire person.

This migration is especially easy with children. Some limitations are obvious. An infant cannot independently secure food, shelter, medical care, or physical safety. A young child cannot be expected to evaluate every long-term risk. From these undeniable facts, however, it is easy to slide into a much broader idea: because the child needs extensive protection in some domains, the child is naturally governable in all domains.

That conclusion does not follow. Serious dependency in one area does not make every preference trivial. Needing adults for housing does not make the child’s private life belong to them. Needing protection from dangerous traffic

does not justify unlimited surveillance. Being unable to sign a mortgage does not explain why every disagreement should be dismissed as immaturity.

The language of ownership sometimes appears in criticism of parental power, and it must be used carefully. American law does not treat children as the property of their parents. In fact, the Supreme Court's parental-rights cases repeatedly describe parental liberty together with responsibility, nurture, upbringing, education, and preparation of the child for future obligations. The child is not an object of title.

But the ownership analogy can still reveal something if it is used narrowly as an analogy of power rather than a claim about legal status. If one person controls where another lives, who they may see, what information they may access, whether they may leave, what they may keep private, what money they may use, what medical care they may receive, and which risks they may take, that is a real concentration of power. Calling it protection does not make the power unreal. The right question is what functions justify it, what limits it, and how it should change as the person changes.

This moves the analysis away from slogans. The question is not whether parents "own" children. They do not. The question is which powers adults actually exercise over children, which of those powers are connected to genuine protective or developmental functions, and which exceed those functions.

Stopping a young child from running into traffic is not morally equivalent to forbidding a harmless hairstyle. Refusing to let an unlicensed teenager drive a car is not the same kind of intervention as reading every private message. Requiring a child to attend school is not identical to selecting every belief the child must hold. The fact that all these acts can be placed under a broad word such as "parenting" does not make them equivalent exercises of power.

A serious analysis therefore needs at least four questions. What decision is being restricted? What capacity is actually in doubt? What harm is the restriction trying to prevent? And why does preventing that harm require this particular degree of control?

Those questions become even more important in the United States because legal adulthood is not a single nationwide switch. The Twenty-Sixth Amendment creates a federal constitutional floor against age-based denial of voting rights for citizens eighteen and older. State law generally uses eighteen as the age of majority, but different states and different domains may use other thresholds. Driving, alcohol, firearms, medical consent, emancipation, contractual authority, school attendance, marriage, and juvenile-court

jurisdiction do not all map onto one age in one way. The legal system already reveals, through its own complexity, that “adult” and “capable” are not synonyms.

Bright lines still have major advantages. They are predictable. They reduce the need for intrusive individualized testing. They limit the ability of officials to make rights depend on subjective judgments about maturity. They prevent a person from having to prove, one evaluator at a time, that they deserve ordinary legal freedom.

This protection against individualized judgment should not be underestimated. A system that replaced every age rule with a maturity test could become more oppressive than the rule it replaced. Differences in education, language, disability, culture, class, or communication style could be converted into differences in legal freedom. People from already marginalized groups would be especially vulnerable to being judged “not ready” by institutions with different norms and more power.

So the choice is not between a crude age rule and a perfectly liberating individual assessment. General rules can protect. Individual assessments can protect. General rules can oppress. Individual assessments can oppress.

The more useful question is which functions need a simple rule and which decisions can recognize more participation, more supported choice, or more autonomy before the general threshold.

American law already does this unevenly. Minors may have procedural rights in court, speech rights in school subject to the school context, varying powers to consent to certain forms of medical care under state law, and access to emancipation in some circumstances. The details vary sharply by state. That variation is not a complete theory, but it confirms something important: there is no single capacity that appears all at once on a birthday.

This leads to a principle that will matter throughout the book: freedom should not be treated as a prize awarded only after development is complete.

People learn to decide by deciding.

That sentence also needs limits. A child does not learn highway driving by being sent alone onto an interstate. Nobody learns to manage irreversible life-threatening risk by being deliberately exposed to catastrophic consequences. But many forms of judgment require real practice: choosing, making a tolerable mistake, experiencing consequences, revising, and trying again. If a person is prevented from making any meaningful decision until they are expected to make decisions perfectly, the system creates a contradiction. It demands a competence that it has denied the person opportunities to build.

The question therefore becomes not only, “Is this child capable now?” but also, “What capacities does our way of protecting this child make possible later?”

Protection can increase future capacity. It can also delay it. Assistance can make a decision possible. Constant substitution can make a person more dependent than necessary. Monitoring can prevent real harm; permanent monitoring can prevent the development of privacy, responsibility, and judgment. A rule can teach a skill; an unquestionable rule can teach only obedience.

This dynamic extends far beyond childhood. An adult with a disability who is never allowed to manage even a small amount of money may later be described as incapable of managing money. An older adult whose family gradually removes every decision “to make life easier” may lose skills that could have remained active. A hospitalized person who is no longer asked for an opinion may become more passive and less able to participate. In each case, power exercised in the name of incapacity can help produce or amplify the incapacity later used to justify that power.

That is why the book will repeatedly distinguish a person’s capacity from the conditions under which the person is asked to decide.

An inaccessible explanation can make someone look incapable. So can time pressure. Fear, coercion, lack of interpretation, communication barriers, financial dependence, the threat of losing housing, or the presence of a dominating person can all affect what a decision looks like. Environment does not explain every incapacity. But it can create some and worsen others. Before deciding for someone, we should ask whether the person’s own decision can first be made more possible.

Needing help is not the same as lacking a will. Dependence is not the same as incapacity. And being unable to carry out a decision without assistance is not necessarily the same as being unable to make the decision.

At this point, childhood has served its first function in the book. It has exposed the problem. But it cannot contain the problem by itself.

The transition into legal adulthood reveals two opposite simplifications. Before majority, age can justify broad parental and institutional authority. After majority, adulthood generally creates a presumption that the person acts for themselves. Real life constantly crosses both categories. Some minors can reason with great sophistication about particular choices. Some adults cannot make particular decisions at particular times. This does not mean abolishing age of majority. It does not mean making every adult right conditional on

recurring competence tests. It means that general legal status and concrete decision-making capacity must not be confused.

That distinction will become decisive when we turn to disability, psychiatry, illness, dependency, guardianship, institutions, and aging. If a person may lack one capacity without losing authority over the rest of life, then every substitution of decision must be justified more precisely. Which decision is involved? What capacity is actually missing? What harm is being prevented? Could support be enough? How long should the restriction last? Who may challenge it? How will authority return when the justification ends?

We are then far from a simple division between the “capable” and the “incapable.”

We enter a harder problem: how to protect human freedom against real limitations without allowing protection itself to destroy the freedom it claims to serve.

The next chapter begins there. It will no longer start with age, diagnosis, or category. It will ask what should always be asked before deciding for someone else: what power is being claimed, what harm is it meant to prevent, and why is that power actually necessary here?

CHAPTER 2 - DECIDING FOR SOMEONE ELSE: WHAT COULD JUSTIFY IT?

Deciding for yourself is one of the most ordinary forms of freedom. Deciding for someone else is a different act altogether. Sometimes it looks almost trivial: pulling a child away from a hot stove, calling an ambulance for an unconscious person, stopping someone who is about to walk into traffic without perceiving the danger. Sometimes it becomes enormous: choosing where a person will live, controlling money, consenting to treatment, monitoring communication, restricting travel, deciding who may visit, seeking involuntary hospitalization, or defining what counts as the person's "best interest." The language of protection can make these very different acts look like one continuous category. Because some interventions are plainly necessary, we may move too quickly from "protection is sometimes justified" to "this person belongs to a class of people over whom broad substitute power is justified."

The first chapter showed why age is not enough. The same problem returns with other labels. A diagnosis is not enough. Dependence is not enough. A mistake is not enough. A choice that looks irrational is not enough. Family anxiety is not enough. Even risk is not enough unless we specify the seriousness of the harm, its probability, its timing, who would bear it, and whether less restrictive ways of reducing it exist. The real difficulty begins here: there are situations in which acting against a person's present wishes can be justified, but no simple property of the person provides a general license to govern that person.

This does not deny incapacity. A person may genuinely be unable to understand information that is essential to a particular decision. A person may be unconscious, severely delirious, profoundly disoriented, unable to communicate a choice, or so impaired in a particular moment that the consequences at stake cannot be grasped even with reasonable support. Someone may face an immediate danger they cannot perceive. Someone may also pose a direct threat to others. In such cases, refusing every intervention in the name of freedom can become abandonment. But recognizing a need to intervene does not yet tell us how far the intervention may go.

The burden of justification therefore has to move. The question should not be: "Does this person belong to a category for whom others usually decide?" It should become: "What specific decision are we proposing to take over, what concrete harm are we trying to prevent, what ability is missing for this decision, and why would a less restrictive response not be enough?" That shift

sounds modest. It changes almost everything. It replaces authority attached to a person with authority attached to a specific function.

American guardianship reform contains a partial legal expression of that logic, although there is no single nationwide guardianship code. Guardianship and conservatorship are primarily matters of state law. The Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act, a uniform act drafted for state enactment, not federal law, is designed around person-centered planning and the least-restrictive means necessary for protection. The National Center for State Courts likewise describes guardianship as a serious intervention that removes civil rights and should be used only when necessary and tailored to the specific areas in which the person lacks capacity. These sources do not create one national rule, but they provide an important institutional benchmark: protection should be individualized, limited, and no broader than necessary.

Three ideas follow from that benchmark: necessity, less-restrictive alternatives, and tailoring. Necessity means that power is not justified merely because it would be convenient, reassuring, efficient, or easier for a family or institution. Less-restrictive alternatives mean that if support, a limited power of attorney, representative payee arrangement, supported decision-making agreement, accessible communication, community service, or another workable arrangement can address the problem, a broader guardianship may be harder to justify. Tailoring means that a person should not lose authority in areas unrelated to the demonstrated problem.

The book will express that point in one sentence that will recur throughout the argument: a local incapacity should produce only local substitute power unless some additional independent reason justifies more. This is not a universal rule already written into every state statute. It is a normative principle. It responds to a recurring tendency of power to spill beyond the function that first justified it.

The spillover is easy to recognize. Someone begins helping with bills and gradually starts deciding what purchases are allowed. A family member takes over transportation and then decides where the person may go. A hospital crisis produces a judgment about incapacity that follows the person after the crisis resolves. A temporary restriction becomes institutional routine. An older adult allows a child to manage one account, and the child begins treating that role as authority over housing, visitors, and medical choices. The first intervention may be justified while the expansion is not.

Good intentions make this problem harder, not easier. People who exercise substitute power are often trying to help. That does not eliminate error, conflict

of interest, domination, overreach, or institutional convenience. At the same time, blanket hostility toward protection can expose people to exploitation, neglect, untreated emergencies, or catastrophic loss. The analysis therefore cannot rest on trust in the protector or suspicion of the protector. It has to examine what the power is for, what limits it, what alternatives exist, how it is reviewed, and what costs it creates.

The first criterion is concrete harm. A restriction should not be justified by phrases such as “it is better for her,” “he does not know what he is doing,” or “we cannot take any chances.” What harm is anticipated? To whom? How serious is it? How soon could it occur? How plausible is it? Is it reversible? Can the person bear it? The answer will look very different if the issue is a small financial loss, an unwanted haircut, a predatory transfer of an entire estate, a likely fall, a life-threatening emergency, violence toward another person, or a contract with decades of consequences.

Severity matters because not every mistake has the same moral or legal significance. A freedom that permits only costless choices is not meaningful freedom. Adults with ordinary legal authority make bad decisions about careers, relationships, spending, diet, investment, housing, and health. We do not generally conclude from this that someone else should take over their lives. If error becomes evidence of incapacity only for certain classes of people, we have created two standards of freedom: one in which risk is part of ordinary life and another in which risk becomes evidence that self-government should be withdrawn.

This does not make a right to error absolute. The more serious, imminent, and irreversible the harm, the stronger the case for intervention can become. A child wasting ten dollars is not in the same position as a severely confused adult about to transfer an entire life savings to a scammer. A person declining a routine screening is not in the same position as an unconscious patient in immediate danger. But even severe harm is not a shortcut to unlimited authority. The gravity of the danger may justify a stronger response; it does not convert the person into an object of decision across every domain.

Emergency is a special case because time can make support impossible. When a car is coming, we pull a child out of the road before holding a discussion. When a patient is unconscious and immediate treatment is necessary to preserve life or prevent serious impairment, American law recognizes circumstances in which care may proceed without express present consent. The details depend on the legal setting and applicable law. For example, federal regulations governing Veterans Health Administration care expressly allow necessary emergency treatment without express consent when

specified conditions are met. More generally, American informed-consent doctrine recognizes emergency situations in which consent may be implied because the patient cannot communicate and delay would threaten life or health.

The emergency justification is temporary by nature. It explains why action may come before deliberation. It does not explain why authority obtained during a crisis should continue after the person can participate again. A justified intervention can become unjustified simply because it lasts too long.

This temporal point matters because substitute power often originates in exceptional circumstances and then survives them. A daughter takes over paperwork during a parent's hospitalization and continues controlling everything after discharge. A guardianship is created during a period of severe instability and is never seriously reconsidered after conditions change. A facility starts close supervision after a fall and converts it into permanent restriction because the procedure is now embedded in routine. Duration is not an administrative detail. It is part of the justification.

The second major criterion is decision-specific capacity. The sentence "this person lacks capacity" is incomplete until we ask: capacity for what? Does the person need to understand the main information? Compare alternatives? Appreciate a decisive consequence? Maintain a sufficiently stable preference? Communicate a choice in a reliable way? Recognize an immediate danger? Different decisions require different abilities. Choosing dinner is not managing a complex securities account. Refusing a visitor is not the same task as evaluating a high-risk surgery.

This specificity protects against two opposite errors. One is overestimating capacity because a person speaks confidently, has adult legal status, or can repeat information. Expressing a preference does not always show that decisive consequences are understood. The other is underestimating capacity because a person communicates slowly, needs an interpreter or device, uses unfamiliar reasoning, or cannot perform in the format preferred by professionals. In that case, the environment can manufacture the appearance of incapacity.

This is why support should precede substitution whenever support can reasonably make the decision possible. In the United States, that principle appears in different forms rather than in one national capacity statute. Guardianship-reform organizations and courts increasingly emphasize less-restrictive alternatives; some states expressly recognize supported decision-making; powers of attorney, representative-payee arrangements, advance directives, communication accommodations, and limited protective orders can

all preserve more of the person's own authority than plenary substitution. The Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act is a uniform act drafted for state enactment, not nationwide federal law, but its person-centered and least-restrictive orientation reflects this broader reform direction.

The practical question should become reflexive: if we improve the conditions, can the person regain some of the decision-making power we assumed we needed to exercise? If yes, complete substitution becomes harder to justify. The better response may be accessible information, an interpreter, extra time, a trusted supporter, a limited financial arrangement, a trial period, a reversible step, or dividing one complex problem into smaller decisions. The alternative to "the person decides entirely alone" is not necessarily "we decide for the person." There is a wide space of supported decision-making between those poles.

Power can itself alter capacity. A person who is never asked to choose may lose practice in choosing. Someone whose mistakes are always prevented may never develop skills that require tolerable error. A person whose finances are completely controlled by another may lose opportunities to maintain abilities that were still present. None of this means that all incapacity is socially produced; neurological, psychiatric, developmental, and physical impairments can be profound and real. It means only that environments can increase or decrease the capacity that can actually be exercised.

The third criterion is whether the decision affects the rights of other people. Freedom to decide for oneself is not a general right to impose any harm on others. Dangerous driving involves the safety of strangers as well as the driver. Assault involves another person's bodily integrity. A parent making a decision for a child is not deciding only about the parent's own body or property. In these situations, intervention may be justified even if the decision-maker's capacity is not the problem. This distinction is essential: sometimes liberty is restricted because a person lacks a relevant ability to decide; sometimes it is restricted because the act threatens the rights of others. Confusing the two turns disagreement and danger into false diagnoses.

The distinction also protects dissent. A person may understand a situation and still make a choice that relatives or professionals regard as bad, offensive, foolish, or immoral. An adult may choose a frugal life, refuse recommended treatment, remain in a relationship the family dislikes, spend money in an unconventional way, change religion, leave a stable job, or live in housing others consider uncomfortable. Disagreement with the values of the evaluator is not incapacity.

A bad outcome does not prove incapacity either. We often reason backward: if the result was terrible, perhaps the person was not capable of deciding. But legally and morally capable adults make disastrous decisions. Error can coexist with understanding, a coherent preference, and voluntary choice. Conversely, a decision that looks objectively beneficial can be produced by coercion, manipulation, or fear. The quality of the result and the quality of the decision process are different questions.

Risk must be treated the same way. Protectors sometimes use a safety standard they would never accept for themselves: the protected person should choose the safest option. Yet people routinely accept risk for reasons they consider important—sport, travel, intimacy, work, investment, solitude, medical refusal, or independence. A regime that eliminates all avoidable risk can eliminate much of the freedom it claims to preserve. The question is not how to remove risk from life. It is when risk, combined with a relevant inability to decide or with serious harm to others, can justify intervention.

The fourth criterion is proportionality of the power itself. We often measure the danger facing a person without measuring the danger created by the intervention. Substitute decision-making can also produce loss: privacy, dignity, movement, relationships, skills, money, confidence, access to community, willingness to seek care, and the experience that one’s own words have consequences. These costs may sometimes be justified. They still have to be counted.

Protective action should therefore be assessed not only by what it prevents but by what it removes. Constant monitoring may reduce wandering or fall risk while eliminating privacy. Taking away all access to money may reduce impulsive spending while making every purchase dependent on permission. Prohibiting all unsupervised outings may prevent some accidents while producing isolation, deconditioning, and loss of orientation. Protection redistributes risk; it does not abolish risk.

This leads to the least-restrictive alternative principle. When two measures can provide adequate protection, the one that takes less decision-making power should generally be preferred. This does not mean always choosing the weakest intervention. A response that is too weak for an immediate catastrophic danger may be irresponsible. It means the amount of authority transferred should remain connected to the actual problem. If help paying rent solves the problem, full control of every purchase may be unnecessary. If accompaniment on one route is enough, banning all travel may be excessive. If temporary supervision addresses an acute crisis, it should not silently become permanent.

The fifth criterion is contestability. Power over another person becomes especially dangerous when the person cannot ask why, object, seek independent advice, obtain a second opinion, or request review. Contestability does not guarantee that the objection will succeed. It means the power cannot be its own justification.

This is central to guardianship. The National Center for State Courts emphasizes ongoing court monitoring, complaint response, review, and restoration of rights when a guardianship is no longer necessary. Modern guardianship reform is not only about deciding whether to appoint a guardian once. It is also about whether the scope remains justified, whether abuse or overreach can be detected, and whether less restrictive arrangements can replace the guardianship later.

The same principle applies outside courtrooms. A child should be able to ask why a restriction exists and see the answer change as circumstances change. A disabled person whose finances are assisted should have someone else to contact if the helper is also the source of the dispute. An older adult whose daily life is organized by family should retain access to people who are not dependent on that same family structure. A hospitalized person should know which restrictions are mandatory, which are negotiable, and how to request reassessment. Contestability does not turn every relationship into litigation. It prevents authority from becoming circular.

The sixth criterion is review. A substitute decision should not become permanent merely because it was once necessary. Abilities fluctuate. Treatments work or fail. Children grow. People learn. Crises resolve. Environments become more accessible. Supporters change. A guardian or helper may become unavailable or untrustworthy. A system without review tends to preserve power after the reason for the power has changed.

The stronger principle is restoration: authority should be oriented toward returning decision-making power when return becomes possible. This is one of the most demanding tests of protective authority. Institutions usually judge authority by whether it can act. Here, good authority must also be judged by whether it can shrink and end. Guardianship reform in the United States increasingly includes restoration of rights and reassessment of ongoing need. The success of protection should not be measured by the permanence of the protector’s role.

This does not promise recovery. Some impairments are lifelong. Some people will need substantial support for as long as they live. Restoration means something narrower: substitute authority should never remain broader than

current circumstances require. Even where assistance is permanent, its exact scope can change, and areas of personal choice can remain protected.

An extreme case makes the structure easier to see. Imagine an unconscious adult after a serious accident. Present consent may be impossible. Emergency treatment may be necessary. If the emergency passes and the person remains unable to decide, American law then looks to mechanisms that vary by jurisdiction and setting: an appointed health-care agent, an advance directive, a legally authorized surrogate, a guardian with appropriate authority, or another state-law process. The 2023 Uniform Health-Care Decisions Act is again a uniform act drafted for state enactment rather than nationwide federal law, but it illustrates the architecture: individuals may appoint agents and record instructions and values in advance; where a patient lacks capacity and has no appointed agent, authorized surrogates may sometimes make decisions without requiring a guardianship.

This allows us to distinguish two models of substitution. In the first, the substitute asks: “What do I think is best for this person?” In the second, the substitute asks first: “What do we know about this person’s prior wishes, values, instructions, relationships, and preferences; what can the person still communicate now; and only where those sources do not resolve the question, what protective judgment must we make?” These approaches can sometimes produce the same outcome. They do not give the person the same status.

American law does not provide one uniform nationwide answer to this problem. State statutes use different standards, and health-care decision law varies substantially. Model acts, advance-directive statutes, guardianship codes, and case law often distinguish substituted judgment based on the person’s wishes from best-interest decision-making when wishes cannot be determined. The exact hierarchy must therefore be verified in the relevant jurisdiction. For this book, the general point is normative: substitute power should preserve as much of the person’s own authorship as the situation permits.

We can now state the minimum structure of a justification for deciding for someone else. Before taking over a decision, we should be able to answer a series of questions—not as a bureaucratic checklist, but as parts of an actual justification. What exact decision is involved? What concrete harm is anticipated? What ability is missing for this decision? What accommodations or supports have been tried or are impossible? Why is a less restrictive option insufficient? Are other people’s rights at stake? What authority is being transferred, to whom, and for how long? How can the person object or obtain review? What conditions would allow authority to be returned?

None of these criteria should become a score. It would be tempting to assign numbers to risk, capacity, urgency, reversibility, and vulnerability and then declare substitution justified above some threshold. That would recreate the problem we are trying to solve: heterogeneous considerations converted into a single verdict. A life-threatening emergency and a long-term loss of privacy are not commensurable simply because we can give both numbers. Difficulty understanding a contract says nothing by itself about the ability to choose where to live. The criteria expose reasons and costs; they do not automate judgment.

They also cannot eliminate conflicts of value. Two people may agree on the facts and disagree about how much risk is acceptable. A family may value safety more strongly; the person may prefer a riskier but freer life. A clinician may consider treatment strongly indicated; the patient may value quality of life over longevity. A facility may want to reduce fall risk nearly to zero; the resident may believe that walking independently is worth the risk. The framework does not settle these conflicts by labeling one side incapable. It requires the conflict to be named for what it is.

This is a protection against a particularly subtle form of power. Saying "you do not understand" when the person does understand but rejects the evaluator's hierarchy of values turns a moral disagreement into a claim of cognitive defect. A serious evaluator must distinguish fact, decision-specific inability, risk, legal rule, institutional constraint, and value judgment. Without that separation, protective power can become a way to impose one person's idea of a reasonable life on another.

Chapter 1 showed why age is a poor shortcut when it pretends to summarize a whole person. This chapter leads to a more general claim: no category should by itself justify global substitution. Legitimate substitute power depends on the decision, the harm, the abilities relevant to that decision, the supports available, the rights of others, the scope and duration of the restriction, its contestability, and the possibility of review and restoration.

The framework is still incomplete until it is tested in relationships where power is daily and unavoidable. Childhood is the first test. Parents and institutions genuinely have to protect people whose abilities are still developing. They have to organize shared life, educate, act in emergencies, and sometimes carry legal responsibility for children. But those functions do not automatically create unlimited authority over every dimension of the child's life.

The next chapter returns to the starting point with explicit criteria in hand. It will not simply ask whether children should be "more free." It will ask,

domain by domain, what adults actually decide for them, which justifications are strong, which rely mostly on age or convenience, how participation can become effective rather than symbolic, and how authority should narrow as the child becomes more able to decide.

CHAPTER 3 - THE CHILD: PROTECT WITHOUT TAKING OVER AN ENTIRE LIFE

Childhood is the clearest case in which one person must often decide for another. A newborn cannot secure food, shelter, medical care, transportation, or physical safety. A young child cannot be expected to evaluate every danger or organize every condition of daily life. Parents and other caregivers therefore exercise extensive authority, and American law strongly protects a sphere of parental care, custody, upbringing, and control. That starting point is real. The difficulty begins when a necessary power in some domains is allowed to become a presumed power over the whole person.

In the United States, parental authority has constitutional weight. The Supreme Court has repeatedly treated parental direction of a child's upbringing as a protected liberty interest. Troxel v. Granville is one of the clearest modern statements of that principle. But American constitutional law has never reduced the child to an extension of the parent. Students have First Amendment interests. Juveniles in delinquency proceedings have due-process protections. Children facing psychiatric confinement have liberty interests that cannot simply be erased by parental preference. The law therefore contains a tension that this chapter takes seriously: parents possess real authority and responsibility, while children remain persons whose own freedom matters.

This tension should not be resolved by pretending that parent and child are legal equals in every respect. They are not. Nor should it be resolved by treating parental responsibility as a general title over the child's will. The useful question is functional: what is the authority for?

Feeding a child, arranging medical care, preventing immediate danger, ensuring education, establishing routines, and managing a household are not interchangeable acts. Some are responses to incapacity. Some are responses to dependency. Some protect the rights of other household members. Some are legal duties. Some are matters of family culture. Some are exercises of convenience. The same adult may perform all of them in one day, but the justification for each is different.

A parent who stops a five-year-old from running into traffic acts because the child cannot reliably manage an immediate catastrophic risk. A parent who requires a bedtime may be organizing a household and protecting sleep. A parent who refuses to let a teenager drive without a license is enforcing a legal and safety boundary. A parent who reads every private message, selects every friendship, or decides every future aspiration claims a much broader kind of power. Calling all of these "parenting" hides the differences.

The first task is therefore to separate protection from governance.

Protection is tied to a function: preventing a serious harm, meeting a need the child cannot meet alone, fulfilling a legal responsibility, or creating conditions in which development remains possible. Governance goes further. It appears when authority begins to define the child's harmless preferences, identity, relationships, values, private spaces, or future choices simply because the adult is the adult.

The line is not always obvious. A harmful friendship can look harmless at first. Online privacy can create both developmental space and exposure to exploitation. Clothing may be a matter of identity, safety, school rules, family resources, or conflict about values. Religious upbringing can involve both parental liberty and the child's emerging conscience. There is no formula that settles every case. But uncertainty does not eliminate the need to distinguish functions. It makes the burden of explanation more important.

American law already reveals this plurality of functions. Parents have strong authority over upbringing, but schools also exercise authority during the school day. The state imposes compulsory education requirements through state law. Courts recognize student rights, but those rights are shaped by the special characteristics of the school environment. Tinker v. Des Moines protected student expression against suppression absent a sufficient school justification, while later cases such as Hazelwood School District v. Kuhlmeier allowed greater school control over school-sponsored expressive activities under specific conditions. The child therefore moves among overlapping authorities—parent, school, court, medical institution, state—none of which should be mistaken for unlimited sovereignty.

That overlap can produce a practical problem: when several adults are responsible, the child may be the only person whose view can be treated as optional by everyone.

Participation is often offered as the solution. But "being heard" can mean almost anything. A child may be invited to speak after the real decision has already been made. A teenager may be asked for a preference only so adults can say they consulted them. A student may be allowed to choose between two options selected entirely by others. A patient may be told what will happen and then asked whether they understand. These forms of participation are not worthless, but they are not the same as decision-making power.

A useful distinction is between expression, influence, and control. Expression means the child can state a view. Influence means that view can actually change the decision. Control means the child has the final say.

Development does not require that all three expand at the same pace in every domain. But if expression never becomes influence and influence never becomes control anywhere, the promise of increasing autonomy is mostly rhetorical.

This matters because freedom is learned through practice. A young person who is never permitted to make meaningful decisions does not magically acquire decision-making experience at eighteen. The general age of majority may transfer legal authority quickly, but judgment develops through repeated cycles of choosing, acting, seeing consequences, correcting, and trying again.

Protection can support this process. It can also interrupt it. A parent can help a child compare options, explain consequences, set a temporary boundary, or create a safe trial. Or the parent can solve every problem, remove every risk, and make every important decision. The first model may build capacity. The second can preserve dependence beyond what the child's actual abilities require.

This is why the right to make tolerable mistakes matters in childhood. Not every error should be prevented. Some mistakes are part of learning. A child spends allowance badly. A teenager chooses an extracurricular activity and later regrets it. A young person dresses in a way that produces embarrassment. These costs can be real without justifying total prevention.

The harder cases involve risks whose consequences are severe or irreversible. Here adults may have stronger reasons to intervene. But even then, the intervention should be connected to the risk. Preventing a minor from making a legally invalid or dangerously irreversible commitment does not justify controlling unrelated friendships, beliefs, or private communications.

The medical setting makes this especially clear because U.S. law does not use one nationwide rule for minors' consent. The legal age of adulthood is primarily a matter of state law, and states create different exceptions in which minors may consent to particular forms of care. HHS guidance on informed consent expressly notes that state law may authorize minors to consent in specific circumstances and that the age at which an individual may legally consent can vary by jurisdiction and by the intervention involved. In practice, state statutes commonly create exceptions for areas such as sexual and reproductive health, sexually transmitted infection services, substance-use treatment, mental-health care, pregnancy-related care, or care for emancipated minors, but the details vary substantially.

This variation teaches an important conceptual lesson. The law itself does not always treat "minor" as equivalent to "incapable of medical choice." It

often recognizes that a young person may have sufficient authority in one health domain while parental involvement remains required in another. That is domain-specific legal authority, not a declaration that the young person is globally mature.

The distinction between consent and assent is also useful. In pediatric care and research, adults may hold formal legal consent authority while clinicians or researchers seek the child's affirmative agreement when the child is capable of understanding at an appropriate level. Assent is not the same as legal consent. Yet the practice acknowledges that a child can possess relevant understanding and preferences even when final legal authority lies elsewhere.

A child's refusal raises the problem more sharply. Suppose a young patient understands a nonemergency procedure and strongly resists it. If the procedure is necessary to prevent grave harm, parental and medical authority may be strong. If the benefit is modest, the burden high, and the matter nonurgent, the child's refusal may deserve much greater weight. The fact that the parent possesses formal authority does not answer the ethical question of how that authority should be exercised.

Emancipation offers another example of partial transition. U.S. emancipation law varies by state. Cornell's Legal Information Institute catalogs state approaches and notes that emancipation can release minors from parental authority for important legal purposes before the ordinary age of majority. Some states have explicit statutory procedures; others rely more heavily on judicial doctrines or particular legal consequences. Emancipation may also be partial rather than a universal transformation of status.

The existence of emancipation is significant for this book not because it provides a simple alternative to parental authority, but because it exposes the conventional structure of that authority. If legal systems can recognize circumstances in which a minor assumes some adult powers before the general threshold, then age alone cannot be the complete justification for parental control. The real questions include dependence, responsibility, ability, risk, and the practical conditions of self-support.

Emancipation also reveals a limit. Formal legal independence without material means can be largely fictional. A teenager may possess more legal authority while still lacking housing, income, health insurance, transportation, or a safe adult network. Freedom on paper can coexist with severe dependence. This is why a serious account of children's autonomy cannot simply demand earlier legal adulthood. The conditions that make a choice real matter as much as the formal right to choose.

Education produces the same tension. The state requires schooling or its lawful equivalent through state compulsory-attendance regimes. Parents generally hold substantial authority over educational direction, and the Supreme Court's parental-rights cases include classic disputes over schooling and upbringing. Yet students are not without rights inside schools. The school may restrict speech, movement, privacy, and conduct for institutional purposes, but those restrictions remain subject to constitutional and statutory limits. The child therefore experiences not a single authority but a chain of institutions that can each claim to be acting for development or protection.

This chain becomes dangerous when responsibility is used to erase accountability. A parent says the school required it. The school says the parent requested it. A clinician says the parent consented. An institution says policy requires it. The child can then encounter a restriction with no clear author. Everyone is responsible enough to impose it, but no one is responsible enough to explain or reconsider it.

A protective structure should do the opposite. It should make authority legible. Who made this decision? Under what rule? For what purpose? For how long? What would justify changing it? Can the child ask for review? Can another adult hear the child without being dependent on the same authority?

These questions do not imply that every family must become a miniature court. Ordinary parenting depends on trust, informality, affection, habit, and rapid judgment. Turning every disagreement into a formal procedure would itself be destructive. The point is not bureaucratization. It is that serious restrictions should remain explainable and revisable rather than resting only on status.

The child's increasing capacity should therefore have practical consequences. An authority that remains identical from early childhood to late adolescence has failed to respond to development. The form of the change may differ by domain. More privacy. More control over money. More weight in medical choices. More freedom of movement. More say over education, work, relationships, clothing, online life, religion, or future plans. The exact timing is disputable; the direction should not be.

This is what a progressive transfer of decision-making power means in practice. It does not require a single new legal age. It can occur through domain-specific rights, parental practices, school procedures, medical consent rules, court hearing rights, emancipation, and supported participation. The central idea is that authority should track function and capacity rather than remain global until a birthday removes it all at once.

But progressive transfer has to be protected against arbitrary reversal. A teenager who has competently managed a domain for years should not lose that authority merely because the adult dislikes one decision. A new restriction may be justified by a new risk, a crisis, deception, harm to others, or a genuine change in capacity. It should not be justified simply by disobedience.

This distinction between disobedience and incapacity is one of the most important in childhood. A child can understand a rule and reject it. A teenager can appreciate consequences and disagree with a parent's values. Conflict is not evidence that the young person failed to understand. If every refusal becomes proof of immaturity, parental authority can never be challenged on its own terms.

The same problem appears in schools. A student who protests a policy may be disruptive, mistaken, or disrespectful. None of those facts by itself means the student lacks the ability to form a view. Tinker remains important not because student speech is absolute—it is not—but because the case rejects the idea that school status eliminates constitutional personhood. Institutional order has functions. Those functions need reasons.

Privacy is another domain where the balance changes with age. Young children require extensive supervision. Older children increasingly need spaces in which identity, friendship, reflection, and responsibility can develop without constant adult observation. Digital technology makes this difficult because surveillance can now be nearly total. Location tracking, message access, browser histories, school monitoring software, parental-control systems, and shared accounts can make continuous oversight easy.

Ease is not justification. The fact that adults can monitor everything does not show that they should. Monitoring may be proportionate to a concrete danger. It may also become a substitute for trust and a way of preventing the very independence the child must learn. A surveillance measure should therefore be judged by the same questions as other forms of substitute power: what harm is it preventing, how serious is that harm, what narrower method exists, how transparent is the monitoring, and when will it end?

Money offers a similar progression. A young child may need an adult to control nearly all resources. Later, allowance, wages, bank access, or budgeting can become training grounds for real decision-making. If adults prevent every financial error, they preserve safety at the cost of experience. If they hand over unlimited resources before relevant abilities exist, they may create avoidable harm. The useful middle is graduated responsibility.

Work introduces another layer because labor law, school obligations, parental responsibility, and economic dependence intersect. Federal and state child-labor laws limit certain work by minors, and state law determines many other details. The purpose is not simply to deny young people economic agency; it is also to prevent exploitation and protect education and health. Yet employment can increase autonomy by providing income, competence, social experience, and a path toward partial independence. The same activity can therefore be both a site of protection and a site of emancipation.

Relationships and intimate life are among the most sensitive domains because protection against exploitation can easily become control over identity and attachment. Age-of-consent laws, mandatory-reporting rules, parental authority, school policies, and criminal law create serious boundaries that vary by jurisdiction. This book does not attempt to summarize fifty state criminal codes. Its narrower point is that protection from coercion or abuse should not be converted into a general adult ownership of the young person's emotional life.

The same caution applies to religion and belief. Parents have broad rights to direct upbringing. Children also develop beliefs, doubts, identities, and convictions of their own. A family can transmit a tradition without assuming that disagreement proves defect. The more a young person can understand the meaning of a commitment, the harder it becomes to justify treating conscience as merely parental property.

A useful test across all these domains is to ask whether adult authority is building the child's future capacity to act without that authority. Protection that never creates conditions for its own reduction is at risk of becoming governance for its own sake.

That does not mean every good parent should seek to become irrelevant. Relationships continue after adulthood. Advice, emotional support, financial help, and interdependence may remain strong for life. What should disappear is the presumption that support gives one person a unilateral right to decide for another.

The child case therefore sharpens the framework from Chapter 2. Concrete harm matters. Capacity must be specific. Support should precede substitution when possible. Restrictions should be proportionate. The child's views should gain practical weight as abilities develop. Serious decisions should remain explainable and revisable. And authority should be oriented toward transfer rather than permanence.

These principles will never produce identical answers in every family or state. American law is deliberately plural in many of these areas, and families vary in culture, religion, resources, risk, and structure. The framework is not a disguised national family code. It is a way to ask whether the amount of power exercised over a child still corresponds to the function that justifies it.

The importance of this question becomes clearer at majority. If the law transfers broad authority to the individual at eighteen in most states, it creates a dramatic formal change. Yet adults do not become perfectly capable at that moment. Some remain materially dependent. Some have disabilities. Some experience illness, psychiatric crisis, addiction, cognitive impairment, or temporary loss of consciousness. Some will later age into new forms of dependence.

The child therefore cannot remain the only case. Childhood reveals the problem because asymmetry is so visible there. Adulthood reveals it in a more difficult form: when a person possesses full legal status, under what conditions may others begin taking decisions away again?

The next chapter turns to that question. It will show why legal adulthood must create a strong presumption of self-direction without turning the fiction of universal competence into another mistake.

CHAPTER 4 - ADULTHOOD DOES NOT MEAN CAPABLE OF EVERYTHING

Legal adulthood changes the presumption. A child is normally embedded in a structure in which others possess broad authority to act for the child. An adult, by contrast, is generally presumed to direct their own life. That presumption is one of the foundations of civil freedom. It would be intolerable if every adult had to prove competence before voting, choosing relationships, signing ordinary agreements, refusing advice, deciding where to live, or making routine medical choices.

But a strong presumption is not the same thing as a claim that every adult can make every decision at every moment. Illness, intoxication, delirium, brain injury, dementia, psychiatric crisis, medication, shock, severe pain, unconsciousness, communication barriers, or temporary confusion can all affect decision-making. Some impairments are short-lived. Some are progressive. Some are specific to a particular domain. Some do not impair decision-making at all.

The mistake would be to respond to this complexity by turning adulthood itself into a competence test. Adult freedom should not depend on passing repeated examinations of rationality. People are allowed to be eccentric, mistaken, impulsive, stubborn, unconventional, and difficult. A society that withdrew legal authority whenever someone made a decision others considered foolish would destroy ordinary liberty in the name of protecting it.

The important distinction is therefore between legal status and decision-specific ability. An adult can retain full legal personhood while being unable to make one particular decision at one particular time. The converse matters too: a person who needs substantial assistance in one area may remain fully able to make decisions in many others.

American medical law offers a useful illustration because informed consent is built around the patient's own authority. In Cruzan v. Director, Missouri Department of Health, the Supreme Court recognized a competent person's liberty interest in refusing unwanted medical treatment. The case involved life-sustaining treatment and an incapacitated patient, and the Court allowed Missouri to require clear and convincing evidence of the patient's prior wishes before treatment could be withdrawn. The decision did not create one nationwide health-care code, but it made a central principle explicit: competent adults have a protected interest in deciding what happens to their own bodies.

That principle does not mean every refusal must be accepted without inquiry. A person must be capable of making the decision in the relevant sense, and the exact legal standards vary by jurisdiction and setting. But disagreement with medical advice is not itself evidence of incapacity. A patient may understand the diagnosis, the recommended treatment, the risks of refusal, and the alternatives, and still reject the clinician's recommendation.

This point is essential because medicine easily confuses expertise with authority. Clinicians may know far more about prognosis, treatment, risk, and physiology. That expertise gives them strong reasons to advise, explain, warn, and recommend. It does not automatically give them the right to substitute their values for the patient's values.

A person can rationally prioritize things medicine does not maximize: alertness over pain control, mobility over longevity, home over institutional safety, fertility over treatment effectiveness, avoiding a particular side effect over a statistical survival benefit, or religious commitment over a recommended intervention. These choices may be hard for professionals or relatives to accept. They remain choices rather than symptoms unless the person cannot understand or appreciate the relevant information, cannot communicate a decision, or is otherwise legally unable to decide in the applicable framework.

The federal Veterans Health Administration regulation on informed consent provides a concrete example of decision-making capacity defined for health care. It describes capacity as the ability to understand and appreciate the nature and consequences of health-care treatment decisions and to formulate a judgment and communicate a clear decision. That definition applies within the VA system, not as a universal national standard. But it illustrates why "capacity" should be linked to an actual decision rather than treated as a global label.

The same regulation also shows how temporary incapacity should work. Patients receiving VA care ordinarily have the right to accept or refuse treatment. If a patient lacks decision-making capacity, a surrogate may act. If an emergency requires immediate care to preserve life or prevent serious impairment, the patient cannot consent, and waiting for a surrogate would increase the danger, necessary treatment may proceed without express consent. The authority is tied to the emergency. It does not create a permanent transfer of control.

Temporary incapacity is especially revealing because it strips away the illusion that substitute decision-making must always be attached to a permanent identity. A person under anesthesia, unconscious after an accident,

delirious with a severe infection, or temporarily cognitively impaired by medication may be unable to decide now and fully able to decide later. If power is justified by the inability, it should recede when the inability recedes.

This makes timing part of capacity assessment. A nonurgent decision should not always be forced at the person's worst moment. If delirium is likely to clear in hours, if pain can be controlled, if a medication can be adjusted, if an interpreter can be found, or if a calmer setting would allow meaningful communication, delay may itself be a form of support.

The principle is simple: before replacing a person's decision, ask whether the conditions of decision-making can be improved.

This is not always possible. Some emergencies cannot wait. Some impairments do not improve. Some decisions are time-sensitive. But the possibility of improvement should be part of the inquiry rather than an afterthought.

Advance directives exist because adults can anticipate that future problem. Under American law, the details are largely state-based, but federal law reinforces the importance of advance-directive information in health-care institutions. Federal regulations implementing the Patient Self-Determination Act require covered providers to inform adult patients about rights under state law to make decisions concerning medical care and to formulate advance directives. The regulations also recognize that when an adult is incapacitated at admission, information may initially be provided to family or a surrogate, but the institution must provide it directly to the individual once the person is no longer incapacitated.

That last requirement contains a profound principle: incapacity today does not erase the person tomorrow. Institutions must be able to return to the individual when the individual can again participate.

Advance directives also allow a person to project their own values into periods when present expression may become impossible. A living will can record treatment preferences. A durable power of attorney for health care can appoint an agent. Psychiatric advance directives can address future mental-health treatment in jurisdictions that recognize them. The details differ by state, and federal systems such as the VA have their own rules, but the general function is consistent: reduce the amount of future decision-making that has to be invented by others.

A health-care agent is therefore not simply someone empowered to do what they personally think is best. In the VA framework, the surrogate should use substituted judgment based on what the patient would have wanted when that

is known, and best interest when the patient's values and wishes are unknown. Other jurisdictions formulate the hierarchy differently, but the distinction matters. The substitute is ideally preserving the person's authorship, not replacing it with a new one.

This is one of the deepest tensions in substitute decision-making. Suppose an adult can no longer communicate. The family knows that the person repeatedly rejected a particular treatment while competent. The family now believes the treatment would be better. Whose values should control? The answer cannot be "the family's" simply because the family has become the practical decision-maker. Substitute authority is not ownership of the decision. Its legitimacy depends partly on fidelity to the person whose decision can no longer be directly expressed.

The same logic applies outside medicine. A power of attorney for finances, a representative payee arrangement, or a limited guardianship may give someone authority in a defined area without transferring all authority over the person's life. The exact legal mechanisms and terminology vary by state and federal program. The conceptual point is stable: needing representation for one function does not entail needing representation for every function.

Guardianship makes the stakes larger because it can transfer substantial civil authority. In the United States, adult guardianship is primarily state law, and terminology varies. Some states distinguish guardianship of the person from conservatorship of property; others use different terms. Modern reform efforts, including the Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act, emphasize person-centered planning and the least-restrictive means necessary for protection.

That orientation rejects the old habit of treating incapacity as a total condition. A court may need to address financial exploitation without deciding residence. It may need to authorize help with complex contracts without controlling intimate relationships. It may need to create a temporary arrangement during crisis rather than a lifelong plenary guardianship. The more precisely the problem is defined, the harder it becomes to justify global power.

This does not mean limited guardianship is automatically benign. A narrow legal order can still produce broad informal control. A guardian with authority over housing may indirectly control social life. A person who controls money may make travel or relationships practically impossible. Formal scope and effective power are not identical. Later chapters will return to this distinction.

The adult case therefore forces us to distinguish at least three things: legal capacity, functional decision-making ability, and practical ability to carry out a decision. A person may have the legal right to choose, understand the decision, and still be physically unable to execute it without help. Someone who cannot drive can still decide where they want to go. Someone who cannot physically sign can still direct a transaction. Someone who needs personal assistance can still decide who enters their home and when.

Confusing execution with decision-making is a common source of unnecessary substitution. If a person cannot perform the act alone, others may start deciding whether the act should happen at all. Assistance then quietly becomes governance.

Communication is another major source of error. Speech disability, aphasia, hearing loss, intellectual disability, limited English proficiency, or unfamiliar communication style can make a person appear less capable than they are. The question is not whether communication is easy for the evaluator. It is whether the person can understand, form, and communicate a decision with reasonable support.

This is why accommodations are not cosmetic. An interpreter, communication device, simplified explanation, extra time, visual support, or trusted facilitator can change the apparent capacity of the same person. If decision-making becomes possible after accommodation, the original problem was partly environmental.

Again, this does not make every incapacity reversible. Some people remain unable to make particular decisions even after excellent support. The point is that incapacity should be established after asking what support can make the decision possible, not before.

The adult case also exposes the danger of value judgments disguised as capacity judgments. An evaluator may conclude that a person “does not appreciate the consequences” when the person does appreciate them but assigns them different weight. An older adult may value staying home over avoiding all fall risk. A patient may value consciousness over aggressive pain treatment. A disabled adult may value privacy over constant safety monitoring. A person with limited income may spend money on something a professional considers frivolous because it has social or personal meaning.

A genuine inability to appreciate consequences exists. But evaluators must distinguish inability from disagreement. The test cannot become “Would a reasonable person make the choice I prefer?”

The right to refuse treatment is a particularly strong reminder. In Cruzan, the Supreme Court treated a competent person's interest in refusing unwanted treatment as constitutionally significant even where the consequences could be death. The state can have legitimate interests, and the exact balance varies by context. But the seriousness of the outcome does not automatically transfer the decision to physicians or family when the adult is capable of deciding.

This is the opposite of a safety-maximizing model. Freedom includes choices that others would not make.

At the same time, the law becomes more cautious when the person cannot decide. Cruzan allowed Missouri to require strong evidence of the incapacitated patient's prior wishes before withdrawal of life-sustaining treatment. Whatever one thinks of the specific rule, the structure is important: when the person's present decision disappears, procedures become more important because substitute decision-makers may be wrong about what the person would have chosen.

That is why advance planning, prior statements, durable powers of attorney, and documented values matter. They reduce epistemic uncertainty. They help answer the question: whose choice is this supposed to be?

The principle extends to fluctuating capacity. Some psychiatric, neurological, metabolic, and medication-related conditions produce periods of greater and lesser decision-making ability. A system that evaluates the person only during crisis may convert an intermittent limitation into a permanent identity. Whenever the decision is not urgent, assessment should consider whether there is a better time for the person to decide.

This is especially important because timing can be manipulated. Institutions may schedule important decisions when staffing is convenient, not when the person is most capable. Families may wait until a crisis to seek broad authority. Professionals may rely on old evaluations long after circumstances have changed. A static record can become more powerful than the living person.

Review is therefore not optional. If substitute authority was justified by a condition that can change, the authority must be capable of changing too.

The National Center for State Courts and modern guardianship reform efforts emphasize monitoring and restoration of rights. That language matters. A protective system should not treat termination of guardianship as an exceptional failure of the original order. Restoration can be evidence that the system worked: power was used while needed and returned when no longer justified.

The same idea should guide informal relationships. A spouse who handles everything during illness should not automatically keep handling everything after recovery. Adult children helping a parent after surgery should not assume the temporary role has become permanent. A professional who obtained consent from a surrogate during incapacity should return to the patient once the patient can decide again.

Federal advance-directive regulations make this temporal logic explicit in institutional care. When an adult was too incapacitated at admission to receive advance-directive information, covered providers are not relieved of the duty to give that information to the person later once the person can receive it. The person re-enters the decision structure.

This should be a general aspiration of substitute power: the person should re-enter as soon as possible.

There is also a difference between present wishes and past wishes. Suppose a person with progressive dementia previously wrote an advance directive refusing a treatment, but later appears content and expresses a contrary present preference in a way that is difficult to interpret. Which expression should control? American law does not provide one answer across all states and settings. The conflict exposes a deeper philosophical problem about personal continuity, prior autonomy, current experience, and substituted judgment. This book will not solve it by pretending the law already has one theory.

What it can do is insist on clarity. Are we following a binding advance directive? A state surrogate statute? A guardian's court-defined authority? A prior statement of values? A current preference? A best-interest standard? These are not interchangeable sources of authority.

The same discipline is needed with sexual and relational decisions. Capacity in intimate life cannot be inferred from financial capacity, nor can financial incapacity automatically justify control of friendships, sexuality, or family relationships. State criminal and guardianship laws vary, and safety concerns can be serious. But the conceptual error remains the same: one limitation should not silently colonize unrelated domains.

This chapter therefore leaves adulthood in a deliberately unstable position. Adult legal status must create a strong presumption of self-direction. Without that presumption, ordinary freedom disappears. Yet adult status cannot prove universal decision-making ability. Without the possibility of specific, temporary, and supported intervention, protection becomes impossible when genuine incapacity exists.

The task is to hold both truths at once.

The next chapter will test that balance in domains where societies have historically made the opposite mistake: disability and psychiatry. There, diagnosis has too often been treated as a shortcut from difference to incapacity, and incapacity as a shortcut from incapacity to broad substitute power. The question will be how to protect people from real harms without making disability or psychiatric status into a general license for others to decide.

CHAPTER 5 - DISABILITY, PSYCHIATRY, AND SUPPORTED DECISION-MAKING

Disability is one of the places where societies have most often collapsed difference into incapacity. A diagnosis, a communication difficulty, an intellectual disability, a psychiatric history, a need for assistance, or an unusual way of reasoning can become a shortcut from “this person needs support” to “someone else should decide.” The shortcut is tempting because some people with disabilities do face real decision-making limitations. But a category that includes real limitations does not justify treating every member of the category as globally incapable.

The first rule of this chapter is therefore negative: disability is not incapacity by default.

That statement is not a denial of impairment. Some disabilities can affect memory, comprehension, judgment, impulse control, communication, planning, or appreciation of consequences. Some psychiatric states can temporarily make meaningful consent impossible. Some people may require extensive assistance throughout life. The point is narrower and more demanding: the existence of a disability does not tell us, by itself, which decisions the person can make, which supports would help, or which powers another person may legitimately exercise.

American disability law strongly reinforces this individualized approach, although it does so through civil-rights law rather than through one national law of legal capacity. Title II of the Americans with Disabilities Act prohibits disability discrimination by state and local governments. The Department of Justice’s implementing rules require public entities to make reasonable modifications to policies, practices, and procedures when necessary to avoid discrimination, unless the modification would fundamentally alter the nature of the service, program, or activity. The rules also require effective communication with people with disabilities.

These requirements matter for decision-making because capacity can be distorted by inaccessible conditions. A person who cannot hear the explanation may appear not to understand. A person with aphasia may know what they want but be unable to express it in the evaluator’s preferred form. Someone with an intellectual disability may understand a decision when information is presented in plain language but fail when confronted with technical jargon. A person with autism may communicate atypically under pressure. A person in psychiatric distress may need time, a quieter environment, or a trusted supporter before they can participate meaningfully.

In such cases, accommodation is not charity added after the real decision. It can be part of determining whether substitution is needed at all.

Section 504 of the Rehabilitation Act reaches a different but overlapping set of institutions. It prohibits disability discrimination in programs and activities receiving federal financial assistance. In health and human services, the 2024 HHS Section 504 rule strengthened protections in areas that include medical treatment, accessible communication, web and mobile accessibility, and access to services. For this book, the practical implication is straightforward: a disability-related barrier created by an institution should not be mistaken for incapacity located entirely inside the person.

This distinction becomes especially important in guardianship. Adult guardianship is still primarily state law. Some states recognize supported decision-making explicitly; others use different arrangements or rely on less-restrictive alternatives without a specific supported-decision-making statute. The National Center for State Courts describes supported decision-making as an alternative to guardianship in which a person keeps decision-making authority while receiving help from trusted supporters. It also notes a broader reform movement away from plenary guardianship toward limited orders and less-restrictive alternatives.

Supported decision-making is not magic. A supporter can manipulate. Family pressure can be disguised as assistance. A person may choose supporters who have conflicts of interest. Some decisions may remain impossible even with excellent support. And some people may genuinely need substitute decision-making in particular domains. The value of supported decision-making is not that it abolishes every hard case. It is that it asks a different first question: what support would allow this person to make the decision themselves?

That question changes the burden of proof. Under a substitution-first model, the evaluator identifies impairment and then asks who should decide. Under a support-first model, the evaluator identifies the decision, the barrier, the person’s abilities, and the available supports before concluding that decision-making authority must be transferred.

The Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act reflects part of this reform logic. It is a uniform act drafted for state enactment, not federal law. Where enacted or adapted, it promotes person-centered planning and requires the least-restrictive means necessary for protection. The Conference of Chief Justices and Conference of State Court Administrators have likewise endorsed increasing the use of less-restrictive options where appropriate and explicitly referred to supportive services,

technological assistance, and supported decision-making when evaluating whether guardianship is necessary.

These developments do not create a uniform American doctrine. They show a direction: before removing rights, courts and institutions should ask whether the person's needs can be met while preserving more of the person's own authority.

The reason is not only moral. It is epistemic. Substitute decision-makers can be wrong about the person. They can misunderstand preferences, underestimate ability, confuse unconventional choices with incapacity, or rely on stereotypes. A person with cerebral palsy may communicate slowly and be assumed to have an intellectual disability. A person with an intellectual disability may understand a familiar choice better than a professional who has met them for twenty minutes. A person with schizophrenia may have a psychiatric diagnosis while making a clear and stable decision unrelated to any acute psychotic symptom.

Individualized assessment is therefore essential. The ADA itself is built against categorical stereotyping. In contexts such as parental rights, federal disability guidance emphasizes individualized assessment rather than assumptions based on disability. The same principle belongs here conceptually: what can this person actually understand, communicate, and decide in this domain, under accessible conditions?

Psychiatry presents a harder problem because the possibility of coercion is explicit. Involuntary civil commitment allows the state to confine a person who has not been convicted of a crime. The substantive standards are largely matters of state law, and they vary. But federal constitutional law places important limits on that power.

In O'Connor v. Donaldson, the Supreme Court held that mental illness alone does not provide a constitutional basis for confining a person who is dangerous to no one and can live safely in freedom, either alone or with the help of willing family or friends. That principle directly rejects one of the most dangerous shortcuts in this field: diagnosis does not equal a general license to confine.

The decision also exposes a recurring confusion between care and captivity. A state may sincerely believe that an institution offers better shelter, supervision, food, medication, or safety. But a supposedly superior living standard does not by itself justify confinement of a person capable of living safely outside. Protection can become domination precisely when "what would be better for you" replaces a more demanding justification for coercion.

Addington v. Texas addressed a different question: how certain must the state be before imposing indefinite involuntary civil commitment? The Supreme Court held that due process requires at least a clear-and-convincing-evidence standard, rather than an ordinary preponderance standard. The Court emphasized the individual's weighty liberty interest while also recognizing legitimate state interests in care and public safety. It left substantive commitment standards to state law within constitutional limits.

The combination of O'Connor and Addington matters for this book. Psychiatry can justify coercive intervention in some circumstances, but neither diagnosis nor ordinary uncertainty is enough. Liberty loss is serious enough to require a stronger justification and procedural protection.

This does not settle what counts as danger, grave disability, inability to care for basic needs, or a qualifying psychiatric condition. State statutes answer those questions differently. Some include danger to self or others. Some include grave disability or inability to meet basic needs. Emergency-hold procedures and durations differ. Judicial review differs. Treatment authority after commitment can also be legally distinct from authority to confine. A U.S. adaptation must therefore resist the temptation to write as though "involuntary commitment law" were one national statute.

The conceptual separation is crucial: authority to hospitalize is not automatically authority to make every treatment decision, and authority to make a treatment decision is not automatically authority to control finances, relationships, housing after discharge, or unrelated civil choices. Each power requires its own legal and factual basis.

This is where the idea of local incapacity becomes especially important. A person in an acute psychotic episode may be unable to make one high-stakes treatment decision today and still retain meaningful preferences about who may be contacted, what belongings matter, which language or cultural practices should be respected, or what should happen once the crisis passes. Crisis does not erase the entire person.

Psychiatric settings also show why timing matters. Capacity can fluctuate dramatically. A decision made at the height of panic, intoxication, mania, psychosis, severe depression, medication effects, sleep deprivation, or restraint may not reflect the person's ability hours or days later. When a decision can safely wait, waiting for a better moment can be a form of support rather than neglect.

The reverse problem also exists: systems may treat a person as fully capable because they appear calm during a brief interview even when severe

symptoms impair appreciation of consequences. Support-first does not mean pretending that every expressed preference is always competent. It means assessing the relevant ability carefully rather than deciding from diagnosis alone.

Advance planning can reduce coercion. Psychiatric advance directives, where recognized by state law, can allow a person to record treatment preferences, crisis plans, medication concerns, preferred facilities, people to contact, and people not to contact before a crisis occurs. Their legal force varies by jurisdiction. Even when not fully binding in every circumstance, they can preserve evidence of the person's own values when present communication becomes difficult.

The same principle applies to wellness plans, crisis plans, supported decision-making agreements, and powers of attorney. These tools differ legally. Their common function is to keep more of the person's authorship inside the decision process before a crisis transfers power to others.

Institutionalization raises another dimension of disability power: where a person receives services can determine how much freedom they have in practice. A person may technically retain legal rights while living in a setting where meals, schedules, visitors, transportation, money, privacy, employment, and community access are controlled by institutional rules.

The Americans with Disabilities Act addresses part of this through its integration mandate. In Olmstead v. L.C., the Supreme Court held that unjustified segregation of people with disabilities can constitute discrimination under Title II. The Court required community-based services when such services are appropriate, the person does not oppose community placement, and the public entity can reasonably accommodate the placement while taking account of available resources and the needs of others receiving disability services.

This holding is especially important because it links disability rights to actual life conditions rather than formal status alone. A person may retain theoretical rights while segregation sharply reduces ordinary opportunities for family relationships, social contact, work, education, economic independence, cultural life, and control of daily routines. The Department of Justice's Olmstead guidance therefore treats the "most integrated setting" as one that allows interaction with nondisabled people to the fullest extent possible and describes institutional features such as regimentation, lack of privacy, limits on visitors, and reduced control over daily life as indicators of segregation.

The principle is not that every person must live independently or that all congregate settings are unlawful. Some people choose group settings. Some require intensive support. Some community placements may be inappropriate or unavailable. Olmstead itself includes limits involving appropriateness, the person's own opposition, reasonable accommodation, resources, and the needs of others. The crucial point is that disability does not justify segregation by default.

This changes the meaning of support. A personal assistant, community mental-health team, supported housing, communication technology, job coach, accessible transportation, or home modification can increase freedom by making community life possible. Dependence on support is therefore not the opposite of autonomy. Support can be the infrastructure of autonomy.

The next chapter will examine this paradox in depth. Here it is enough to see that the same resource can be either integrative or controlling depending on how power is arranged. A personal assistant can enable someone to leave home, work, and maintain relationships. The same assistant can become a gatekeeper if the person cannot replace them, complain safely, or access alternatives. A guardian can prevent catastrophic exploitation. The same guardianship can become unnecessarily broad if courts fail to review its scope or if less-restrictive alternatives are ignored.

This is why supported decision-making needs safeguards. The supporter should help the person understand, communicate, compare, remember, and implement choices without quietly becoming the decision-maker. Conflicts of interest should be visible. The person should be able to change supporters. Important decisions should not depend entirely on one relationship when an independent check is feasible. Abuse, undue influence, and exploitation remain possible even in systems designed around autonomy.

There is a temptation to treat this as a dispute between two camps: autonomy versus protection. That framing is too crude. Some people need substantial protection from exploitation, self-neglect, or acute psychiatric danger. Some people have historically lost enormous amounts of freedom through systems justified as protective. Both facts are true.

The real conflict is between forms of protection. One form protects by replacing the person as decision-maker. Another protects by increasing the conditions under which the person can decide. Sometimes only the first will work. But if the second can work, it usually preserves more of what protection is supposed to protect: the person's life as their own.

The international disability-rights debate pushes this issue even further. The Convention on the Rights of Persons with Disabilities treats equal recognition before the law and access to support in exercising legal capacity as central principles. Its Committee has developed a strong critique of substitute decision-making. The United States signed the Convention in 2009 but has not ratified it, so the Convention is not binding U.S. treaty law in the same way it is for ratifying states. It can still be discussed as an international normative reference, but it must not be presented as controlling American law.

This difference in status is important because legal sources should not be blended into a single moral authority. The ADA and Section 504 are binding federal civil-rights laws in their respective domains. Supreme Court cases establish constitutional rules within the questions they decide. State guardianship and commitment statutes govern much of the concrete procedure. Uniform acts are proposed state legislation designed for enactment across jurisdictions; they are not federal law merely because the Uniform Law Commission approved them. The CRPD is an international treaty the United States has signed but not ratified. Supported decision-making as a general priority is partly legal reform, partly practice, and partly normative argument.

Keeping these levels separate allows the book to make a stronger claim, not a weaker one. We do not need to pretend that one source already contains the full theory. The pattern emerges across different sources: avoid categorical assumptions; make communication accessible; prefer less-restrictive arrangements where they can work; treat segregation as a serious loss of liberty; require stronger justification for coercive confinement; preserve the person's preferences and participation; review transferred power rather than letting it become permanent.

The difficult cases remain. A person may reject all help while facing severe exploitation. A supporter may be manipulative. A psychiatric crisis may create immediate danger. A community placement may require resources that are genuinely unavailable without harming others who also need services. A person's current preference may conflict with a prior directive. A guardian may be necessary despite every effort to avoid one.

No principle should erase these conflicts. "Support before substitution" is not "support instead of substitution in every case." "Community integration" is not "independent living without support." "Disability is not incapacity" is not "incapacity never occurs in people with disabilities." The point is to make every escalation of power earn its justification.

A useful test is to imagine the same decision without the diagnostic label. What exactly would worry us? What evidence of inability would remain?

What support would we offer? What danger would justify coercion? What rights would we hesitate to remove? The label may provide relevant information, but it should not do the reasoning for us.

This is particularly important because power can become self-confirming. A person placed under broad guardianship may have fewer chances to practice decisions. A person segregated in an institution may lose community skills. Someone whose communication is ignored may speak less. A patient whose preferences never affect treatment may stop expressing them. Later, the resulting dependence can be cited as proof that the original control was necessary.

A protective system should instead ask whether its own structure is increasing or reducing the person's capacity to participate. That question turns protection into a dynamic responsibility rather than a permanent status.

The chapter can now state its main conclusion. Disability, psychiatric diagnosis, and support needs may be relevant to decision-making, but they do not by themselves justify global substitute power. The legitimate scope of intervention depends on the decision, the person's actual abilities under accessible conditions, the concrete risk, the availability of support, the rights of others, the proportionality of the intervention, the possibility of review, and the ability to restore authority.

The next chapter leaves diagnosis behind and turns to a quieter source of power: dependence itself. A person may be fully capable of deciding and still be practically governed by whoever controls housing, money, transportation, care, communication, or access to institutions. Formal legal capacity can coexist with very little real freedom.

That is where the problem becomes less visible—and, in some ways, more pervasive.

CHAPTER 6 - DEPENDENCE, PROTECTION, AND INFORMAL POWER

A person can possess full legal capacity and still have very little practical freedom. The reason is simple: decisions require conditions. Housing, transportation, money, communication, personal assistance, health care, access to food, digital accounts, mobility devices, and help with daily tasks can all determine whether a choice can actually be carried out. Whoever controls those conditions can acquire power without ever being appointed a guardian.

This is one of the central problems of dependence. Dependence is not incapacity. It is a relationship in which access to something necessary passes through another person, organization, institution, or system. Every human being is dependent in this broad sense. We rely on infrastructures, employers, markets, public institutions, relatives, professionals, technologies, and one another. The issue is not whether dependence exists. The issue is how much power it gives to whoever controls what we need.

That power can be legitimate, illegitimate, or mixed. A personal care attendant may make independent living possible. A family member may provide transportation that dramatically expands a person's world. A nursing facility may deliver skilled care that cannot be reproduced safely at home. Medicaid may finance services without which a person could not remain in the community. Each of these supports can increase freedom.

The same support can also become a lever. If one person is the only available driver, that person may effectively decide where the dependent person goes. If one family member controls online banking, the family member may become the practical gatekeeper for every purchase. If housing depends on obedience, "choice" may become nominal. If a care worker can threaten to stop coming, refusing the worker may carry a cost the person cannot realistically bear.

Informal power matters precisely because it may not look like legal power. There may be no court order, no diagnosis, no formal declaration of incapacity. The person may legally retain every right and yet have to ask permission for ordinary life because the resources needed to exercise those rights are controlled by others.

This is why the distinction between legal authority and effective power must remain visible. The law can say that a person chooses where to live while the available service system offers only one viable placement. A person can retain the right to leave while having no accessible transportation. A resident

can have the right to visitors while staffing practices make visits difficult. A person can control their own money while another person possesses every password and card.

Freedom cannot be measured only by formal entitlement. It must also be measured by whether exit, refusal, communication, and alternative arrangements are realistically possible.

The American long-term-services system makes this especially clear. Medicaid is a major payer of long-term services and supports, and Home and Community-Based Services programs can fund assistance that allows older adults and people with disabilities to live outside institutions. Federal Medicaid rules for certain HCBS programs include a settings framework intended to protect autonomy and community integration. The rules require settings to support access to the greater community, opportunities to seek employment and engage in community life, control of personal resources, and individual choice among setting options.

For provider-owned or controlled residential settings, the federal rule goes further. It includes expectations involving privacy, lockable doors, choice of roommates when applicable, freedom to furnish and decorate living space, control over schedules and activities, access to food at any time, and visitors at any time, subject to individualized modifications that must themselves be justified through the person-centered planning process. These are not abstract niceties. They are attempts to prevent a service setting from becoming a total government of everyday life.

The structure of that rule is important. A limitation cannot simply be justified because “this is how the house works.” Where the rule permits an individualized modification to certain residential freedoms, it requires a specific assessed need, prior interventions and supports, proportionality, monitoring, informed consent, and documentation in the person-centered service plan. The function of the safeguard is recognizable from the earlier chapters: local risk should produce local restriction, not automatic institutional control.

The HCBS framework does not eliminate coercion or guarantee genuine choice. A state may have waiting lists. Rural areas may have few providers. A person may technically choose among settings while all realistic options are similar. Workers may be underpaid and difficult to recruit. Family members may provide unpaid care because no formal service is available. Administrative rules may preserve rights that staffing shortages make hard to exercise. A legal choice can therefore coexist with severe practical constraint.

This is why resource scarcity must be named rather than translated into incapacity. If a person cannot remain at home because no accessible housing or paid assistance is available, the problem is not necessarily that the person is incapable of choosing community living. The problem may be that the system has not made that choice materially possible.

Olmstead v. L.C. and the ADA integration mandate address part of this structural issue. Unjustified segregation of people with disabilities can constitute discrimination. Public entities may have to provide services in community settings when community-based services are appropriate, the person does not oppose them, and the arrangement can be reasonably accommodated. Current DOJ guidance also recognizes that the integration mandate can apply to people already institutionalized and to people at serious risk of institutionalization because they are not receiving the services needed to remain in the community.

This moves the question beyond “Can this person survive outside an institution alone?” That is often the wrong test. Many people cannot live safely without support. The relevant comparison is between institutional support and community support. Dependence on assistance does not by itself justify dependence on an institution.

Community living, however, should not be romanticized. A badly designed community service can reproduce institutional power inside a private apartment. If the same agency controls housing, staffing, transportation, money management, and complaint channels, the person may live behind an ordinary front door while remaining deeply dependent on one system. Integration is not merely geographic.

The Department of Justice describes integrated settings in terms that include access to ordinary community activities, opportunities to interact with nondisabled people, and meaningful choice in daily life. That is important because a setting can be physically located in a neighborhood while still organizing the person’s life through segregated schedules and limited choice.

Dependence therefore has several dimensions: how many essential resources pass through the same gatekeeper; how replaceable that gatekeeper is; what happens if the person says no; whether alternatives are known and accessible; whether complaints can be made safely; whether the person has independent relationships outside the care structure; and whether support is designed around the person’s aims or the provider’s routines.

Concentration matters. The same amount of assistance becomes more dangerous when one actor controls everything. If a parent provides housing,

money, transport, communication access, and personal care, disagreement in one domain may jeopardize all the others. If an institution controls room, medication, meals, social contacts, transportation, and discharge planning, the resident may face the same concentration at a larger scale.

This does not mean concentrated support is always avoidable. Some people need highly coordinated services. A rural household may have only one available provider. Family care can be the only realistic option. The point is not to condemn concentration by itself. It is to recognize the power created by concentration and add counterweights where possible.

The most important counterweight is real exit. Exit does not mean that every person must be able to leave instantly at no cost. That standard would make almost every human relationship unfree. Real exit means that leaving, changing providers, replacing a representative, moving settings, or refusing a service is possible without catastrophic retaliation or impossible practical barriers.

A person who can legally discharge themselves from a facility but has nowhere accessible to live does not possess the same practical exit as someone with housing and home-care options. A person who may fire an attendant but would then go without essential care for weeks faces a constrained choice. A resident who fears that complaining will lead to poorer treatment does not have an effective complaint right merely because a poster lists a telephone number.

Nursing facilities offer a concrete legal framework for examining these tensions. Federal regulations for Medicare- and Medicaid-certified nursing facilities require respect for resident rights, dignity, self-determination, participation in care, privacy, choice, visitors, grievances, and protections around transfer and discharge. These federal rules are significant because they reject the idea that entering a nursing home transfers ordinary personhood to the institution.

A resident does not become a guest in someone else’s organization in the ordinary sense. The facility is also the resident’s home. That changes the meaning of routines. Staff efficiency matters. Infection control matters. Safety matters. Other residents’ rights matter. But those institutional functions do not create a general entitlement to organize every detail of the resident’s life for operational convenience.

Consider waking, meals, bathing, clothing, visitors, bedtime, and activities. Each may involve staffing and safety constraints. Yet if all of them are scheduled solely around the institution’s workflow, a formally protected resident can live under a highly controlled regime. The question is not whether

routines exist. Shared institutions need routines. The question is whether routines remain responsive to individual preferences when doing so is reasonably possible.

Federal nursing-home rights explicitly include participation in care and independent choices consistent with the resident's interests, assessments, and plan of care. They include privacy and communication protections. They include visitation rights subject to reasonable clinical and safety restrictions. They include grievance mechanisms and requirements related to transfer and discharge. These rights do not remove all facility authority. They define boundaries around that authority.

Complaint systems matter because dependence can make direct confrontation risky. A resident may rely on the same staff for toileting, medication, food, mobility, and protection from pain. Complaining to those staff can feel very different from complaining to an ordinary business. Retaliation may be prohibited and still be feared.

The federal Long-Term Care Ombudsman Program exists partly because of this asymmetry. Every state and several U.S. jurisdictions have Ombudsman programs that advocate for residents of nursing homes and other long-term care settings. Ombudsmen identify, investigate, and work to resolve complaints affecting residents' health, safety, welfare, and rights. They are not the same as licensing agencies, Adult Protective Services, prosecutors, or facility management. Their role is resident-centered advocacy and complaint resolution.

That distinction is valuable. An appeal mechanism controlled entirely by the same institution whose conduct is being challenged is weaker than an independent channel. Independence does not guarantee success, but it changes the structure of power. It gives the resident somewhere else to speak.

Independent channels are especially important when a guardian, representative, family member, or provider claims to speak for the resident. ACL guidance makes clear that Ombudsman programs can work on complaints affecting residents who have guardians or other representatives as well. Formal representation does not erase the resident's own interests.

The same principle should apply more broadly: having a representative should not make the represented person invisible.

Money is another source of informal power. A representative payee, family member, fiduciary, trustee, guardian, or informal helper may be necessary to prevent exploitation or manage complex finances. But whoever controls money can indirectly control housing, transportation, relationships, food,

technology, and leisure. Financial authority is therefore rarely only financial in its effects.

This is why scope matters twice: legal scope and practical spillover. A limited financial role can have broad consequences when every form of participation costs money. Safeguards should therefore ask not only what authority the helper formally possesses, but what other choices become impossible because of that authority.

Information creates similar dependence. People often rely on professionals to explain benefits, care options, eligibility rules, medical choices, housing alternatives, and appeal rights. If the person receives only one option, they may "choose" it without knowing alternatives exist. Information asymmetry can therefore become a form of soft substitution.

A person-centered planning process is supposed to counter some of this by organizing services around the individual's preferences, strengths, goals, and chosen outcomes rather than around available slots alone. The federal HCBS regulations require person-centered planning in relevant Medicaid programs. But person-centered language can become ceremonial if every proposed goal must fit what the provider already offers.

The test is practical: can the person's stated goal alter the plan? Can the person choose who participates? Can disagreement be documented? Can the plan identify risks without turning every risk into prohibition? Can supports be rearranged when the current arrangement is not working?

This returns us to the distinction between assistance and government. Assistance adds capacity. Government substitutes another actor's final authority. Many services contain both elements. A case manager can help navigate a system and also control access to approvals. A family caregiver can enable daily life and also impose household rules. A residential provider can supply essential care and also regulate ordinary choices.

The objective cannot be to remove all asymmetry. Some roles inherently include power. A nurse controls access to medications in certain settings. A landlord controls aspects of property. A Medicaid agency administers eligibility rules. A guardian may possess court-authorized decision-making power. The task is to prevent functional authority from spreading into unrelated domains simply because the person is dependent.

That requires transparency. Which restrictions come from law? Which come from medical necessity? Which come from staffing limits? Which come from a provider's policy? Which come from family preference? Which are

merely habits that nobody has reconsidered? Very different claims can sound identical when expressed as “we have to do it this way.”

Naming the source of a restriction changes the conversation. A legal requirement can be challenged through legal channels. A medical judgment can be reassessed. A staffing constraint can become a resource problem rather than a claim about the resident’s capacity. A family value can be recognized as a value conflict. A habit can simply be changed.

Dependence also makes time important. A restriction may be tolerable during a short recovery and oppressive when made permanent. Intensive supervision after a dangerous fall may be justified for days while mobility is reassessed. The same surveillance months later may need a new justification. Temporary financial control during illness may become unnecessary after recovery. A service plan should therefore record not only what support exists but what conditions would permit its reduction.

This is the same restoration principle developed in guardianship, now applied to informal power. Good support should be able to become less necessary.

Some dependencies will never disappear. A person may always need assistance with dressing, communication, transportation, or medication. The goal is not independence in the sense of doing everything alone. It is preserving authorship inside dependence: the ability to direct support, express preferences, refuse, change arrangements, maintain relationships outside the support system, and participate in decisions that structure daily life.

This is why the disability-rights tradition has often distinguished independence from self-determination. A person can require extensive physical assistance while retaining strong control over how that assistance is provided. Conversely, someone who performs every physical task alone may be economically or institutionally constrained in other ways.

Dependence is therefore not the opposite of freedom. Unanswerable dependence is.

A dependency becomes especially dangerous when three conditions combine: the resource is essential, the gatekeeper is difficult to replace, and the person cannot safely challenge the gatekeeper. Housing plus care plus no alternative provider is one example. Money plus family pressure plus social isolation is another. Institutional residence plus fear of retaliation is a third.

The response should be structural. Increase alternatives where possible. Separate roles that do not need to be concentrated. Preserve direct access to communication and information. Protect complaint channels. Make provider

changes possible. Keep contact with independent people and advocates. Ensure that restrictions are documented rather than informal and invisible. Reassess them.

None of this eliminates resource constraints. It is easier to say “choose your provider” than to create a workforce. It is easier to say “live in the community” than to create accessible housing. It is easier to promise self-direction than to fund enough hours of assistance. A rights framework that ignores material capacity can become performative.

That is why cost and scarcity must appear openly in the analysis. Sometimes a preferred arrangement cannot be provided immediately. Sometimes resources must be allocated among people with competing needs. Sometimes a rural service system cannot offer the same choices as a dense city. These realities are not moral failures by definition. But they should not be hidden behind claims that the person “needs” the only arrangement the system happens to fund.

A resource constraint and an incapacity are different facts.

The distinction matters ethically and politically. If a person is placed in a more restrictive setting because no community service is funded, the remedy is different from a case in which community living is genuinely unsafe even with reasonable support. Confusing the two turns institutional scarcity into a judgment about the person.

This chapter therefore extends the book’s central framework. We began with formal substitute decision-making. We now see that power can arise before any formal substitution occurs. Whoever controls the conditions of action can shape the action itself.

The legitimate response is not to pretend dependence can be abolished. It is to design dependence so that it remains answerable: limited in scope, transparent, contestable, replaceable where possible, reviewed over time, and oriented toward the person’s own aims rather than the convenience of whoever provides the support.

The next chapter turns to the stage of life where these issues often converge at once. Aging can bring illness, sensory loss, cognitive change, financial dependence, family intervention, driving restrictions, housing transitions, and pressure toward institutional care. It can also bring a dangerous social presumption: that needing more help means gradually losing the right to decide.

The question will be whether protection in old age can expand without allowing the person’s own authority to disappear.

CHAPTER 7 - AGING: WHEN POWER SHIFTS BACK TO OTHERS

Aging often makes the central problem of this book reappear in reverse. Childhood begins with broad dependence and, ideally, moves toward increasing self-direction. Old age can move the other way: a person who has spent decades directing their own life may gradually need more help with mobility, health care, finances, housing, transportation, communication, or daily tasks. The danger is that assistance expands faster than incapacity and that a need for help is interpreted as a return to governability.

There is no legal principle in the United States under which old age, by itself, cancels adult self-direction. Being eighty, ninety, or one hundred years old does not create guardianship. It does not automatically transfer medical authority to children. It does not make a person incapable of choosing where to live, whom to see, how to spend money, whether to accept treatment, or which risks are worth taking. Age may correlate with some impairments. It is not a substitute for evidence about the actual decision.

Yet age can function socially as if it were a diagnosis. A younger adult who forgets an appointment is distracted. An older adult who forgets one may be described as declining. A younger person who takes a financial risk is adventurous or reckless. An older person who does the same may be treated as incompetent. A younger adult may live in a messy home without intervention; an older adult may trigger questions about whether they can continue living independently.

Sometimes those questions are necessary. Cognitive decline can be real. Falls can become frequent. Driving can become unsafe. Medication regimens can become complex. Fraud and financial exploitation can target older adults aggressively. But the fact that age makes some risks more common does not justify replacing individual assessment with age-based suspicion.

The first distinction is therefore familiar: aging is not incapacity.

The second is less obvious: protection in old age often arrives through family before it arrives through law. Adult children begin paying bills, driving to appointments, speaking to doctors, arranging medications, monitoring a parent’s location, cleaning the home, ordering groceries, managing passwords, or answering calls from institutions. None of these acts necessarily requires guardianship. Most begin as help.

Because family help is informal, its growth can be difficult to see. A daughter who starts accompanying her father to medical visits may gradually

become the person doctors address. A son who helps with online banking may become the only person who knows the password. A relative who provides all transportation may acquire veto power over social life. A family member who installs fall-detection or location-tracking technology may begin monitoring movement continuously.

The practical result can be broad substitute power without any legal transfer of authority.

This is why the question “Who is the legal decision-maker?” is not enough. We also have to ask who controls the conditions under which the older adult can act.

Residence is one of the largest examples. An older adult may want to remain at home. Family members may believe home is unsafe. A hospital may be reluctant to discharge without support. A nursing facility may be recommended. A Medicaid program may cover some services but not others. Accessible housing may be unavailable. Home-care staffing may be insufficient. The resulting “choice” may be heavily structured by what services exist.

A person may therefore enter a nursing facility not because they prefer institutional life and not because they are incapable of choosing, but because no realistic community alternative has been organized. That is a service-system constraint, not a conclusion about capacity.

Federal law partly recognizes this distinction. The ADA integration mandate and Olmstead framework apply to older people with disabilities as they do to younger people. Medicaid Home and Community-Based Services can support community living. The legal and funding landscape is complex and state implementation varies, but the conceptual point is direct: needing substantial care does not itself prove that institutional residence is necessary.

Nursing facilities, when they are used, are not supposed to erase residents’ ordinary rights. Federal regulations for Medicare- and Medicaid-certified nursing facilities protect dignity, self-determination, participation in care, privacy, communication, visitors, grievances, and protections concerning transfer and discharge. These rules matter because residential care can otherwise transform practical dependence into comprehensive institutional control.

Residence decisions also expose the role of risk. Families often say they want an older person to be safe. The desire is understandable. But safety is not a single variable. Moving to a facility may reduce some risks—falls, medication errors, missed meals, delayed emergency response—while

increasing others: isolation, loss of familiar routines, reduced mobility, depression, loss of privacy, institutional infection, or loss of control over daily life.

Protection redistributes risk.

This means “safer” should never be treated as self-explanatory. Safer from what? At what cost? According to whose priorities? A person may rationally prefer a higher risk of falling at home to a lower risk of falling in an institution if staying home preserves independence, relationships, pets, neighborhood, habits, and meaning.

This is not a romantic defense of home at any price. Some homes are genuinely dangerous. Some people need twenty-four-hour care. Some families cannot safely provide the support required. Some community services are unavailable. But the decision should name these facts rather than translate them into “she cannot decide anymore.”

Driving creates the same tension in a concentrated form. For many older adults, driving is not merely transportation. It is access to groceries, friends, worship, medical care, volunteering, work, family, and ordinary spontaneity. Losing the ability to drive can therefore remove far more than a vehicle.

At the same time, unsafe driving can seriously harm other people. Unlike many private risks, driving involves strangers who have not consented to the danger. This makes intervention easier to justify when functional impairment is real.

The relevant question should still be functional rather than purely chronological. Vision, reaction time, cognition, motor control, medication effects, seizure risk, and actual driving performance matter more than age by itself. State licensing rules differ. Some states impose additional renewal requirements on older drivers, such as shorter renewal periods, vision testing, or in-person renewal. Those rules are state-specific and should not be treated as one national standard.

Family members may face a difficult transition when driving becomes unsafe. Taking away keys without explanation can feel like confiscating adulthood. Ignoring serious impairment can endanger the driver and others. A better process uses evidence, medical and driving evaluation when appropriate, discussion of alternatives, and a plan for mobility after driving ends. Removing driving without replacing transportation can turn a safety intervention into social confinement.

That last point generalizes. A restriction should be accompanied by the support needed to preserve the underlying function whenever possible. If

driving stops, mobility should not stop. If online banking becomes risky, access to money should not disappear. If medication self-management becomes unsafe, the person should not lose all say over treatment. If independent bathing becomes dangerous, privacy should not become irrelevant.

Finances are another major area because older adults are frequent targets of fraud, scams, coercion, and exploitation. Concern may be entirely justified. But financial protection can also become a route to domination. A child gains access to accounts “to help” and then decides what purchases are allowed. A power of attorney becomes a practical license to override preferences. A family conflict about inheritance is reframed as concern about capacity.

The United States has multiple legal mechanisms for addressing financial risk: powers of attorney, trusts, representative payees for specific federal benefits, conservatorship or guardianship under state law, protective-services interventions, and criminal or civil remedies for exploitation. The exact mechanisms vary. Their existence reinforces the principle of fit: different problems call for different tools.

A Social Security representative payee, for example, manages Social Security or SSI benefits for a beneficiary whom the Social Security Administration determines cannot manage or direct the management of those benefits. That authority concerns those federal benefits. It does not automatically make the payee the person’s guardian or give authority over every other financial or personal decision.

This distinction is easy to lose in practice. Families and institutions may treat any formal representative role as evidence that the person no longer decides. The role should instead be read narrowly according to its actual legal scope.

Powers of attorney raise a different issue. An older adult may voluntarily appoint an agent to manage finances or health care. That can preserve autonomy by allowing the person to choose who will help before a crisis. But agency can become dominating if the agent ignores instructions, hides information, isolates the principal, or treats convenience as authority. The fact that power was voluntarily granted does not make its exercise immune from abuse.

This is why independent review and complaint mechanisms matter. Adult Protective Services, courts, banks, law enforcement, ombudsman programs, health-care institutions, and state agencies can all play different roles when exploitation or abuse is suspected. No single channel replaces the others, and

jurisdiction differs. The important structural point is that the person should not be forced to challenge a powerful helper only through that helper.

Surveillance deserves special attention because technology makes it easy to intensify control while describing the result as safety. Cameras, door sensors, GPS trackers, smart watches, fall detectors, medication dispensers, motion sensors, and shared phone accounts can all reduce real risk. They can also turn a private home into a monitored environment.

The ethical question is not whether technology is good or bad. It is whether the monitoring is proportionate, transparent, consented to when consent is possible, limited to the relevant risk, secure against misuse, and capable of being reduced when circumstances change.

A camera in a common area during a short recovery is not the same as permanent video monitoring of private life. A fall detector is not the same as continuous location tracking. A medication reminder is not the same as remote control over all daily routines. Technologies that are grouped together as "safety tools" can involve very different invasions of privacy.

The right to privacy does not disappear because privacy can make supervision harder.

Intimate and sexual life is another domain where old age can produce a troubling double standard. Older adults in long-term care may encounter restrictions on relationships, overnight visits, privacy, sexuality, or remarriage. Cognitive impairment can create serious consent questions. But concern about capacity in intimate life should be assessed in that domain rather than inferred automatically from financial or medical impairment.

A person can be unable to manage a complex investment portfolio and still understand affection, intimacy, and consent. Conversely, apparent willingness does not settle every concern when coercion, cognitive impairment, or exploitation is present. The difficulty should produce careful assessment, not automatic desexualization.

The same principle applies to medical treatment. Older adults often face multiple chronic conditions and complex recommendations. Family members may increasingly participate in visits. Participation can be extremely helpful. It becomes substitute power when clinicians stop addressing the patient directly despite the patient's ability to participate.

Advance directives and health-care agents are especially important here because cognitive capacity can decline over time. The Patient Self-Determination Act framework requires covered institutions to provide information about state-law rights concerning medical decisions and advance

directives. State laws govern the details of living wills, health-care powers of attorney, surrogate hierarchies, and decision standards.

Advance planning can preserve authorship, but it does not eliminate every conflict. Prior directives may be unclear. Present preferences may differ from earlier statements. Family members may disagree about what the person wanted. A health-care agent may have different values. The legal hierarchy varies by state. These conflicts need to be named rather than hidden under the phrase “best interest.”

“Best interest” is one of the most powerful and dangerous phrases in substitute decision-making because it sounds neutral. It often contains value judgments. Is independence more important than avoiding falls? Is longevity more important than alertness? Is remaining at home worth more than easier supervision? Is a familiar relationship worth a risk of exploitation? People can disagree about these questions without one side being irrational.

Where the person can decide, the person’s values should govern. Where the person cannot decide, prior wishes and values should remain central where law permits and evidence exists. Where those wishes cannot be known, best-interest reasoning becomes more necessary—but also more vulnerable to projection.

Guardianship in old age requires the same discipline developed earlier in the book. The fact that a person has dementia does not answer which decisions they can still make. Early-stage cognitive impairment may affect complex finances before it affects ordinary preferences, residence choices, or personal relationships. Later stages may involve broader loss. Capacity can also fluctuate with infection, medication, fatigue, stress, and time of day.

A guardianship assessment that captures a person during delirium may become obsolete after treatment. A restriction justified during hospitalization may be inappropriate months later. Review and restoration are therefore essential even when the underlying condition is progressive, because the exact scope of needed authority can still change.

Progressive disease does not mean every decline is linear. And even where abilities diminish, areas of preference can remain meaningful long after complex decision-making is impaired.

This is why the person should continue to be asked.

Asking does not mean pretending the answer always controls. A person may no longer understand a high-stakes financial transfer. But asking what the person wants can still reveal values, fears, relationships, and priorities that

should shape the substitute decision. Excluding the person because they cannot exercise full legal authority wastes information and diminishes status.

Family pressure can be especially difficult to evaluate because it operates through love, history, dependency, guilt, and inheritance at the same time. Adult children may be exhausted caregivers. They may also have financial interests. A spouse may be devoted and controlling. A sibling may be protective and resentful. None of these mixed motives prove abuse. They show why good intentions should not substitute for structure.

When one family member controls information, access, money, transportation, and communication with professionals, other relatives or outsiders may have difficulty knowing whether the older person's preferences are being represented accurately. Concentration of roles therefore deserves attention even where everyone appears benevolent.

Independent contact protects both the older adult and the caregiver. Ombudsman programs, legal services, health professionals, social workers, advocates, courts, banks, and trusted friends can provide outside reference points. The purpose is not to create suspicion around every family. It is to avoid a closed system in which one person's account becomes the only account.

The problem of isolation deserves separate treatment because isolation both increases dependence and makes abuse harder to detect. An older adult who no longer drives, rarely leaves home, and relies on one caregiver may become practically invisible. The caregiver may then control not only daily life but the information others receive about that life.

Reducing isolation can therefore be protective without transferring decision-making. Transportation, community programs, home visits, digital access, social networks, and independent services can all reduce the concentration of power.

Fall risk is another example of how a legitimate concern can expand into excessive control. Falls are a major source of injury among older adults. Clinicians and families may reasonably respond with mobility aids, physical therapy, medication review, home modifications, supervision, or changes in activity.

But eliminating all fall risk would require eliminating much of ordinary movement. Restricting walking can itself reduce strength and balance. Bed or chair alarms can protect and also surveil. Physical restraints can prevent one harm while creating others and are heavily regulated in nursing facilities. The

correct objective is not zero risk. It is proportionate risk reduction consistent with the person's values and rights.

This is where the phrase dignity of risk becomes useful, provided it is not romanticized. People need room to accept meaningful risk. But dignity of risk should not become an excuse for withholding support, abandoning someone in dangerous conditions, or ignoring impaired decision-making. It means that safety should not automatically outrank every other value.

Aging also reveals the importance of transition planning. People often lose autonomy not in one dramatic legal event but through a series of small handovers: first the car, then the checkbook, then the medications, then the keys, then the phone, then the home. Each transfer may have a reason. Together they can remove nearly all self-direction.

A serious protective process should therefore look not only at each transfer separately but at the cumulative structure. How much authority remains with the person after all the "small" protections are combined?

This cumulative question is central to the entire book. A local restriction can be proportionate in isolation and still contribute to global domination when combined with many others.

The answer is not to forbid cumulative support. Many people genuinely need extensive help. The answer is to make the overall pattern visible and ask whether the person still has meaningful domains of control, effective ways to express preferences, access to independent relationships, and realistic avenues to challenge or change arrangements.

Old age therefore completes the life-course symmetry introduced in the first chapter. Childhood tempts adults to say: "You are not yet capable, so we decide." Aging tempts families and institutions to say: "You are no longer capable, so we decide." In both cases, the same error is possible: using a broad category to replace decision-specific inquiry.

The better principle is continuity. A person's authority over their own life should not vanish simply because the amount of support changes. Where capacity is retained, support should serve decision-making. Where capacity is impaired, substitute power should remain tied to the affected decisions. Where emergency requires temporary control, that control should end when the emergency ends. Where broad authority is genuinely necessary, the person should still be included to the greatest extent possible.

The final chapter will ask what follows institutionally from everything developed so far. If legitimate authority must be specific, proportionate, contestable, reviewable, and oriented toward its own reduction, then good

protective power has an unusual property: it must be designed not only to act, but to disappear.

CHAPTER 8 - AUTHORITY THAT MUST BE ABLE TO END

The most revealing test of protective authority is not whether it can act. It is whether it can stop.

Every institution knows how to expand authority in the face of danger. Parents tighten rules after a serious incident. Hospitals restrict movement during crisis. Courts appoint guardians when a person cannot protect important interests. Families take over bills when finances become chaotic. Facilities increase supervision after falls. These responses may be justified. But authority has inertia. Once a system has learned to decide for someone, it often becomes easier to continue deciding than to return power.

This is the final problem of the book. A legitimate protective intervention must contain not only a reason to begin but a reason to end.

The principle applies across the life course. Parental authority should contract as children become capable of deciding. Emergency medical authority should end when the patient can consent again. A temporary financial arrangement should shrink when the crisis passes. A guardianship should be modified or terminated when it is no longer necessary. Institutional restrictions should be reconsidered when the risk changes. Surveillance should stop when the reason for surveillance is gone.

Without an exit condition, protection easily becomes status.

Status is dangerous because it detaches power from the specific function that originally justified it. “Minor.” “Incapacitated.” “Disabled.” “Psychiatric patient.” “Resident.” “Ward.” “High fall risk.” “Needs supervision.” A label that once described one relevant fact can become a durable explanation for broad authority. The person then has to prove that the label no longer applies before ordinary freedom returns.

A better system reverses that burden. The person should not have to prove perfect competence in every domain to recover authority. The actor exercising substitute power should be able to explain why the restriction is still necessary now.

This is what review is for. Review is not administrative housekeeping. It is the point at which the system asks whether yesterday’s justification still exists today.

American guardianship reform gives this idea a legal form. Adult guardianship remains primarily state law, but modern reform materials

emphasize limited orders, periodic review, monitoring, less-restrictive alternatives, and restoration of rights. The Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act is a uniform act drafted for state enactment rather than national law, yet its structure is instructive: protective arrangements should be tailored to demonstrated needs, and guardianship should not extend further than necessary.

Restoration is particularly important because guardianship has historically been treated as a one-way door. Once a court declares incapacity and transfers authority, the practical barriers to reversing that decision can be substantial. The person may lack money, counsel, access to records, transportation, or even knowledge of the procedure for seeking termination. The guardian may control the very resources needed to challenge the guardianship.

A right to restoration that cannot realistically be used is a weak safeguard.

That is why contestability and review must be designed together. The person needs to know that review is possible, have a way to request it, have access to evidence and independent assistance, and be able to participate in the process. Courts also need information about the person as they are now rather than relying indefinitely on the evaluation that justified the original order.

This principle should extend beyond courts. A family rule should be revisable. A school restriction should be reconsidered as the student matures. A hospital should reassess decision-making capacity when conditions change. A nursing facility should revisit individualized restrictions instead of letting them become permanent house rules. A service plan should record not only what limitation exists but what would permit it to be reduced.

The idea is simple enough to state: every significant restriction should have an identifiable path back.

That path may be immediate, gradual, conditional, or uncertain. It may require recovery, new support, a period of demonstrated stability, a safer environment, additional skills, or a change in resources. Sometimes the path will never fully open. A person with profound lifelong impairment may always need substantial substitute decision-making in certain domains. Even then, the scope of authority should remain open to revision.

The fact that some power must remain does not justify freezing all power.

This is where the difference between support and sovereignty becomes most visible. Support is defined by the function it performs for the person. Sovereignty is authority that no longer has to explain itself to the person. A guardian, parent, clinician, institution, or family member becomes sovereign in practice when their judgment is final simply because of who they are.

Good protective authority should therefore be anti-sovereign. It should be bounded by purpose, evidence, scope, time, review, and the continuing status of the person as someone whose own reasons matter.

This does not mean the protected person always gets the outcome they want. Children can be stopped from dangerous conduct. Adults who lack capacity may have decisions made for them. A person can be involuntarily committed under lawful state standards and constitutional protections. A nursing facility can impose clinical restrictions. A court can authorize a guardian. Anti-sovereign authority is not powerless authority. It is authority that remains answerable.

Answerable to what? First, to the concrete harm it is meant to prevent. Second, to the person's actual abilities. Third, to less-restrictive alternatives. Fourth, to the rights of other people. Fifth, to the costs created by the intervention itself. Sixth, to the person's prior and present wishes. Seventh, to changing conditions over time.

These are not seven numbers to be added into a score. They are seven forms of explanation. Their function is to prevent one broad label from doing all the work.

The need for explanation is particularly important in emergencies. Emergencies justify speed. They do not justify conceptual laziness. "Emergency" should describe a real temporal condition in which delay would materially increase serious harm. It should not become a permanent category attached to a person who once experienced crisis.

The same is true of risk. "High risk" should not mean "subject to whatever restrictions make staff or family most comfortable." Risk must be tied to a specific danger and weighed against the harms of restriction. The goal is not maximum safety. It is justified protection.

The same is true of incapacity. "Lacks capacity" should not mean "has no authority." It should mean that a relevant decision cannot presently be made by the person, even with reasonable support, according to the applicable legal and clinical framework. That conclusion may justify substitution in that decision. It does not erase the rest of the person.

This book has therefore resisted global categories throughout. Children develop unevenly. Adults can lose capacity temporarily. Disabled people may need support without substitute decision-making. Psychiatric crisis may justify coercion in limited circumstances without authorizing control of unrelated life choices. Dependence can create power even when legal capacity remains intact. Aging can increase the need for assistance without canceling adulthood.

Across all these cases, one pattern appears: power tends to spread.

It spreads from one domain to another. From money to housing. From housing to visitors. From medical treatment to daily routine. From one psychiatric crisis to permanent distrust. From one fall to continuous surveillance. From one bad decision to a presumption of general incompetence.

The institutional challenge is therefore not only to justify each intervention at the beginning. It is to prevent spillover.

One way to do this is explicit scope. A legal order, care plan, family agreement, or institutional decision should identify what the authority covers and what it does not cover. Ambiguity favors the more powerful actor because the person subject to authority is usually the one who bears the cost of clarification.

A second way is separation of roles. The same person does not always need to control money, housing, health care, transportation, communication, and complaints. Some concentration may be unavoidable, but distributing roles can reduce the risk that one conflict becomes total dependence.

A third way is independent contact. The person should have access, where feasible, to someone who is not controlled by the same authority: counsel, an ombudsman, advocate, clinician, social worker, trusted friend, another relative, or review body. Independent contact creates a second channel of reality when one relationship becomes closed.

A fourth way is documentation. Informal restrictions are often harder to challenge because nobody admits that a restriction exists. “We just do it this way.” “It is safer.” “The doctor said so.” “That is facility policy.” Written reasons make the source of authority visible and make later review possible.

A fifth way is temporal design. A restriction can have an expiration date, a review date, a trigger for reassessment, or a specified condition for reduction. Permanent power should not be the default when the reason for power is temporary or uncertain.

A sixth way is restoration practice. Systems should not wait passively for the person to prove they deserve rights back. Where the law and resources allow, institutions should actively look for opportunities to restore decision-making: reassess capacity, reduce guardianship scope, add supports, modify environments, or transfer control back to the person.

This is not only protective of liberty. It can improve accuracy. A person’s abilities are easier to see when they are allowed to exercise them. A system

that never returns decisions cannot know whether the person could have resumed them.

There is a paradox here. Protective authority often seeks certainty. It wants to know that the person will not fall, lose money, refuse care, relapse, be exploited, or make a disastrous choice. But no ordinary adult life is protected against all of those possibilities. The attempt to eliminate uncertainty can therefore eliminate adulthood itself.

A legitimate protective system has to tolerate some residual risk.

The amount of tolerable risk will vary. A small avoidable loss and a life-threatening danger are not equivalent. Risk to the person and risk to others are not identical. A reversible mistake and an irreversible harm deserve different treatment. But the presence of any risk cannot be enough to justify substitution, because self-direction always includes exposure to risk.

This is why the least-restrictive principle is so important. It accepts that protection may be necessary while refusing the idea that the strongest available intervention is automatically the best one. The question is not “What would make the bad outcome impossible?” but “What is the least transfer of power that can address the relevant danger adequately?”

Adequately is the difficult word. It refuses both perfection and neglect.

A system that demands zero risk will over-control. A system that treats every restriction as paternalism will under-protect. The work lies in the middle: identifying the actual harm, the actual capacity, the available supports, the person’s values, the rights of others, and the costs of each intervention.

This middle cannot be automated. A score can assist with screening, but it cannot convert all these dimensions into one morally neutral answer. Two cases with similar risk scores may involve different values, histories, alternatives, relationships, and consequences. Judgment remains necessary.

Human judgment, however, is not self-validating. It must remain open to challenge. This is why procedure matters even when everyone involved is benevolent. Notice, reasons, participation, review, appeal, second opinions, independent advocates, and restoration processes are not signs of distrust in every protector. They are ways of protecting everyone from the limits of judgment.

The person exercising authority also benefits from this structure. Family caregivers may be exhausted and frightened. Clinicians may face liability and time pressure. Guardians may be responsible for difficult decisions with incomplete information. Facilities may operate under staffing constraints.

Clear scope and review can prevent every burden from becoming a private moral crisis for the person in charge.

Institutions should therefore distinguish three questions that are often collapsed. What is legally authorized? What is practically necessary? What is ethically justified? These questions overlap but are not identical.

A court order can be legally valid and still be broader than necessary in practice. A facility policy can be lawful and still be ethically excessive. A family intervention can be practically understandable and still need limits. A person may ethically deserve more participation than the minimum legal procedure guarantees.

Keeping the questions separate prevents law from becoming a moral shortcut and ethics from pretending it is law.

This distinction is especially important in the United States because so much of substitute decision-making is state-specific. Guardianship standards vary. Supported decision-making statutes vary. Civil commitment standards vary. Health-care surrogate hierarchies vary. Driver licensing rules vary. Assisted-living regulation varies. A national book cannot honestly convert these systems into one code.

What can be national is the method of analysis.

The method begins with the person, the decision, and the function of the proposed intervention. It asks what harm is at stake, what capacity is relevant, what support is possible, what rights others have, what costs the restriction creates, how broad and how long the authority would be, how it can be challenged, and how it can end.

This method also requires source discipline. A federal constitutional holding should not be presented as a complete state-law rule. A federal regulation should not be generalized beyond the program it governs. A uniform or model act is not binding law unless enacted by a jurisdiction. An international treaty the United States has not ratified is not controlling federal law. A normative principle of this book should be identified as a normative principle.

That discipline is not a technical detail. It is the same ethical demand applied to knowledge: do not claim more authority than the source can justify.

The central principle of the book can now be stated in its strongest form: substitute power is legitimate only to the extent that it remains connected to a specific protective function and does not become a general right to govern the person.

This principle has consequences. A need for assistance does not erase authorship. A diagnosis does not erase personhood. A legal status does not erase decision-specific ability. A temporary crisis does not justify permanent control. A family relationship does not create ownership. A care setting does not create sovereignty. Safety does not automatically outrank every other value.

And a justified authority should be able to become smaller.

Sometimes it should disappear entirely. Sometimes it should contract to one domain. Sometimes it should become support instead of substitution. Sometimes it should remain substantial because the underlying inability remains substantial. The measure is not ideological purity. It is correspondence between power and need.

This final test is demanding because it requires protectors to accept their own dispensability. Parents must raise children toward increasing authority over their own lives. Guardians should accept restoration when possible. Professionals should welcome the patient's return to decision-making. Institutions should prefer supports that make their own control less necessary.

Power rarely volunteers to become unnecessary. Good protective design has to require it.

That requirement is the book's answer to the question with which we began: when may one person legitimately decide for another? Not because they are older, more educated, a parent, a clinician, a guardian, or a professional. Not because the other person belongs to a category. Not because the safer option is always the better option.

The justification appears only when a concrete decision involves a relevant inability, serious enough harm or the rights of others, support is insufficient or unavailable, the intervention is proportionate and as limited as reasonably possible, the person remains included to the greatest extent possible, the authority can be challenged and reviewed, and there is a path for reducing or ending it when the justification weakens.

That is a demanding standard.

It should be.

Deciding for another person is one of the most consequential powers ordinary human beings exercise over one another. It can protect life, prevent exploitation, preserve health, and make care possible. It can also erase privacy, relationships, judgment, identity, and the experience of being the author of one's own life.

The aim is not to abolish protective authority. It is to keep protection from becoming government.

And the clearest sign that protection has remained protection is this: when the reason for power disappears, the power can disappear too.

SOURCES AND LEGAL AUTHORITIES

This apparatus consolidates the chapter-level source notes used during the U.S. adaptation. Source status is kept explicit: federal constitutional authority, federal statute or regulation, state-law framework, Uniform Law Commission act, international reference, empirical source, or normative principle of this book.

Chapter 1 - There Is No Magic Age

— U.S. Constitution, Twenty-Sixth Amendment: citizens eighteen years of age or older may not be denied or abridged the right to vote by the United States or any State on account of age.

— Legal Information Institute, Wex, “age of majority”: most U.S. states use eighteen as the general age of majority; specific legal thresholds do not necessarily coincide with the general age of majority.

— Troxel v. Granville, 530 U.S. 57 (2000): the Supreme Court recognized the interest of parents in the care, custody, and control of their children as a fundamental liberty interest under the Fourteenth Amendment.

— Tinker v. Des Moines Independent Community School District, 393 U.S. 503 (1969): students do not shed constitutional rights to freedom of speech or expression at the schoolhouse gate, subject to the special characteristics of the school environment.

— In re Gault, 387 U.S. 1 (1967): juveniles in delinquency proceedings possess substantial due-process protections; juvenile status does not erase constitutional personhood.

— Parham v. J. R., 442 U.S. 584 (1979): in the specific context of admission of minors to state mental hospitals, parents retain a substantial role, but the child has a liberty interest in avoiding unnecessary confinement and parental discretion is not treated as absolute and unreviewable.

— Icenogle, G. et al. (2019), Law and Human Behavior, 43(1), 69–85, DOI 10.1037/lhb0000315: multinational cross-sectional study of 5,227 participants ages 10–30 in 11 countries; deliberative cognitive capacity and psychosocial maturity follow different developmental trajectories.

— Source-level note: age of majority and family-law rules are largely state law; the Twenty-Sixth Amendment and Supreme Court cases cited above are federal constitutional authorities; the developmental findings are empirical; the chapter’s principles about localized capacity, support, substitution, and power are normative analyses of this book.

Chapter 2 - Deciding For Someone Else: What Could Justify It?

— Uniform Law Commission, Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act (2017, with technical revisions through 2020): uniform act promoting person-centered planning and the least-restrictive means necessary for protection. It is not federal law and applies only where enacted or adapted by a state.

— National Center for State Courts, guardianship and conservatorship resources (current in 2026): guardianship significantly limits civil rights; courts should consider less-restrictive alternatives, tailor authority to specific areas of incapacity, monitor guardianships, respond to complaints, and support restoration of rights where guardianship is no longer necessary.

— Legal Information Institute, Wex, “informed consent” and “implied consent”: American medical treatment generally requires informed consent; emergency circumstances can permit treatment when the patient cannot provide express consent and delay would endanger life or health, subject to applicable law.

— 38 C.F.R. § 17.32 (VA informed consent and advance directives): in the federal Veterans Health Administration context, patients have the right to accept or refuse treatment; surrogates may act for patients who lack decision-making capacity; necessary emergency treatment may proceed without express consent when regulatory conditions are met.

— Uniform Law Commission, Uniform Health-Care Decisions Act (2023): uniform act enabling individuals to appoint health-care agents, state treatment instructions and values, and authorize surrogate decision-making for incapable patients in specified circumstances without requiring guardianship. It is drafted for state enactment, not nationwide federal law.

— Source-level note: adult guardianship, health-care surrogate authority, powers of attorney, supported decision-making, and restoration procedures are primarily matters of state law. Uniform acts and NCSC materials are reform benchmarks, not a single binding national code. The chapter’s criteria—decision-specific capacity, support before substitution, proportionality, contestability, review, and restoration—are normative principles of this book.

Chapter 3 - The Child: Protect Without Taking Over An Entire Life

— Troxel v. Granville, 530 U.S. 57 (2000): parental care, custody, and control are protected by the Due Process Clause; the case does not make parental authority absolute.

— Tinker v. Des Moines Independent Community School District, 393 U.S. 503 (1969): students retain First Amendment rights in school, subject to the special characteristics of the school environment and legitimate school functions.

— Hazelwood School District v. Kuhlmeier, 484 U.S. 260 (1988): schools may exercise greater editorial control over school-sponsored student expression under the standards stated by the Court.

— In re Gault, 387 U.S. 1 (1967): juveniles in delinquency proceedings possess substantial due-process protections.

— Parham v. J. R., 442 U.S. 584 (1979): in the specific context of voluntary admission of minors to state mental hospitals by parents, the Court recognized both a substantial parental role and the child's liberty interest in avoiding unnecessary confinement, requiring an independent medical decision process.

— U.S. Department of Health and Human Services, Office for Human Research Protections, Informed Consent FAQs: legal adulthood is determined by state/local law; state law may authorize minors to consent to particular medical interventions or interactions in specified circumstances.

— Legal Information Institute, "Emancipation of minors - laws" and "emancipation of minors": emancipation and age-of-majority rules vary substantially by state; emancipation may be statutory, judicial, or partial depending on the jurisdiction.

— Source-level note: parental authority, compulsory education, medical-consent exceptions, emancipation, age-of-consent rules, and many other childhood legal thresholds are largely state-law matters. The federal cases cited above establish constitutional principles in particular contexts, not a comprehensive national child-autonomy code. The chapter's principles of progressive transfer, non-retrogradation without new reason, and support before substitution are normative analyses of this book.

Chapter 4 - Adulthood Does Not Mean Capable Of Everything

— Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990): the Supreme Court recognized a competent person's liberty interest in refusing unwanted medical treatment and held that Missouri could require clear and convincing evidence of an incapacitated patient's wishes regarding withdrawal of life-sustaining treatment.

— 38 C.F.R. § 17.32 (VA informed consent and advance directives): within the Veterans Health Administration, patients generally have the right to accept or refuse treatment; decision-making capacity is defined in relation to understanding, appreciation, judgment, and communication; surrogates may act when capacity is lacking; emergency care may proceed without express consent under specified conditions; advance directives and substituted judgment are recognized.

— 42 C.F.R. §§ 489.100–489.102 (Patient Self-Determination Act regulations): covered providers must give adult patients information about rights under state law concerning medical decisions and advance directives; when an adult is incapacitated at admission, information may initially be provided to family or a surrogate, but must later be provided directly to the individual when the individual can receive it.

— Uniform Law Commission, Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act: uniform act promoting person-centered planning and least-restrictive protective arrangements. It is not nationwide federal law and applies only where enacted or adapted by a state.

— Source-level note: guardianship, health-care proxy law, advance directives, surrogate hierarchies, capacity standards, and many restoration procedures are primarily matters of state law. Federal authorities cited above apply only in their respective constitutional or regulatory domains. The chapter's principles of decision-specific capacity, timing as support, assistance before substitution, and restoration of authority are normative analyses of this book.

Chapter 5 - Disability, Psychiatry, And Supported Decision-Making

— Americans with Disabilities Act, Title II, and U.S. Department of Justice Title II regulations (28 C.F.R. Part 35): state and local governments may not discriminate on the basis of disability; public entities must make reasonable modifications when necessary to avoid discrimination unless doing so would fundamentally alter the service, program, or activity; effective communication requirements also apply.

— Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, and HHS 2024 Part 84 rule: disability discrimination is prohibited in covered federally funded programs and activities; HHS rules strengthen protections in health and human services, including medical treatment and accessibility.

— O'Connor v. Donaldson, 422 U.S. 563 (1975): mental illness alone does not constitutionally justify involuntary confinement of a person who is dangerous to no one and can live safely in freedom, alone or with willing assistance.

— Addington v. Texas, 441 U.S. 418 (1979): due process requires at least clear and convincing evidence in a state civil proceeding seeking indefinite involuntary commitment; substantive commitment criteria otherwise vary by state within constitutional limits.

— Olmstead v. L.C., 527 U.S. 581 (1999), and U.S. Department of Justice Olmstead guidance: Title II prohibits unjustified segregation; community-based services are required when appropriate, not opposed by the person, and reasonably accommodable considering available resources and the needs of others receiving disability services.

— Uniform Law Commission, Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act (2017, technical revisions through 2020): uniform act promoting person-centered planning and least-restrictive protective arrangements. It is not federal law and applies only where enacted or adapted.

— National Center for State Courts / Conference of Chief Justices materials on supported decision-making and guardianship reform: less-restrictive alternatives, supported decision-making, ongoing monitoring, and restoration of rights are emphasized as important guardianship reforms.

— Convention on the Rights of Persons with Disabilities, Article 12, and U.N. treaty-status records: the United States signed the CRPD in 2009 but has not ratified it. The Convention may therefore be used here as an international normative reference, not as binding U.S. treaty law.

— Source-level note: guardianship, supported decision-making statutes, psychiatric advance directives, involuntary-commitment standards, emergency-hold procedures, and treatment-over-objection rules vary substantially by state. The chapter's broader principles—diagnosis ≠ incapacity, support before substitution, local incapacity → local power, contestability, and restoration—are normative analyses of this book.

Chapter 6 - Dependence, Protection, And Informal Power

— 42 C.F.R. § 441.301(c)(4): federal Medicaid Home and Community-Based Services settings requirements include access to the greater community, opportunities for community participation and employment, control of personal resources, and individual choice among setting options; additional conditions apply to provider-owned or controlled residential settings.

— 42 C.F.R. § 441.301(c)(4)(vi): in provider-owned or controlled residential settings, federal HCBS rules address privacy, lockable doors, roommate choice where applicable, furnishing and decorating living space, control of schedules and activities, access to food, and visitors; individualized modifications must be supported by a specific assessed need and documented through the person-centered service plan.

— Americans with Disabilities Act Title II / Olmstead v. L.C., 527 U.S. 581 (1999), and current U.S. Department of Justice community-integration guidance: unjustified segregation can constitute disability discrimination; the integration mandate also applies to people at serious risk of institutionalization when needed community services are not provided.

— 42 C.F.R. § 483.10 and related federal nursing-facility regulations: Medicare- and Medicaid-certified nursing facilities must protect resident rights including dignity, self-determination, participation in care, privacy, choice, communication and visitation, grievances, and protections concerning transfer and discharge.

— Administration for Community Living, Long-Term Care Ombudsman Program: every state and several U.S. jurisdictions maintain Ombudsman programs that advocate for residents of nursing homes and other long-term care settings and work to identify, investigate, and resolve complaints affecting health, safety, welfare, and rights.

— ACL Long-Term Care Ombudsman guidance: Ombudsman complaint-resolution authority extends to residents who have guardians or other resident representatives; Ombudsman programs represent residents' interests rather than serving as the state's official abuse substantiator.

— Source-level note: Medicaid HCBS rules and certified nursing-facility rules are federal frameworks with defined program scopes; assisted-living regulation, many complaint and discharge details, guardianship, landlord-tenant law, and service availability vary by state. The chapter's concepts of effective power, real exit, concentration of gatekeeping, and answerable dependence are normative analyses of this book.

Chapter 7 - Aging: When Power Shifts Back To Others

— 42 C.F.R. § 483.10 and related federal nursing-facility regulations: residents of Medicare- and Medicaid-certified nursing facilities retain rights involving dignity, self-determination, participation in care, privacy, communication, visitation, grievances, and protections regarding transfer and discharge.

— Americans with Disabilities Act Title II / Olmstead v. L.C., 527 U.S. 581 (1999), and U.S. Department of Justice community-integration guidance: unjustified segregation can constitute disability discrimination; the integration mandate can apply to older people with disabilities and to people at serious risk of institutionalization.

— 42 C.F.R. § 441.301(c)(4): Medicaid HCBS settings rules protect community access, choice, control of personal resources, and, in provider-controlled residential settings, privacy and other daily-life rights subject to individualized documented modifications.

— 42 C.F.R. §§ 489.100–489.102: Patient Self-Determination Act regulations require covered providers to inform adult patients about rights under state law concerning medical decisions and advance directives; the substantive details remain state-law matters.

— Social Security Administration, representative payee framework: a representative payee manages Social Security or SSI benefits for a beneficiary whom SSA determines cannot manage or direct the management of those benefits; representative-payee authority does not by itself confer general guardianship over unrelated domains.

— Administration for Community Living, Long-Term Care Ombudsman Program: state and territorial Ombudsman programs advocate for long-term-care residents and address complaints involving health, safety, welfare, and rights.

— National Center for State Courts / guardianship-reform materials: adult guardianship is primarily state law; modern reform emphasizes limited orders, less-restrictive alternatives, monitoring, and restoration of rights where appropriate.

— Source-level note: driver licensing, guardianship, powers of attorney, assisted-living regulation, health-care surrogate law, advance directives, exploitation procedures, consent standards, and many elder-law remedies vary by state. The chapter's claims that age ≠ incapacity, safety must be balanced against other values, and cumulative restrictions can become global domination are normative analyses of this book.

Chapter 8 - Authority That Must Be Able To End

— Uniform Law Commission, Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act (2017, technical revisions through 2020): uniform act emphasizing person-centered planning, limited authority, and the least-restrictive means necessary for protection. It is not federal law and applies only where enacted or adapted by a state.

— National Center for State Courts guardianship-reform resources: modern guardianship practice emphasizes monitoring, limited guardianship, less-restrictive alternatives, complaint mechanisms, review, and restoration of rights when guardianship is no longer necessary.

— 42 C.F.R. § 441.301(c)(4): Medicaid HCBS settings rules require person-centered planning and protect choice, community access, control of personal resources, and individualized justification for certain restrictions in provider-controlled residential settings.

— 42 C.F.R. § 483.10 and related nursing-facility regulations: residents retain rights to dignity, self-determination, participation, privacy, communication, grievances, and protections concerning transfer and discharge; institutional residence does not erase personhood or ordinary civil interests.

— 38 C.F.R. § 17.32 and 42 C.F.R. §§ 489.100–489.102: federal health-care rules in their respective domains illustrate the temporal character of substitute authority by requiring return to the patient's own decision-making when capacity is present or restored.

— Americans with Disabilities Act Title II / Olmstead v. L.C., 527 U.S. 581 (1999): disability-related support should not default to unjustified segregation; community integration and reasonable modification are part of preserving autonomy in actual living conditions.

— Source-level note: guardianship review, restoration procedures, supported decision-making, civil commitment, health-care surrogacy, and many protective arrangements remain state-law matters. The chapter's general requirements—specificity, proportionality, contestability, temporal limits, restoration, and anti-spillover design—are normative principles of this book.

ABOUT NOOSOPHIE

Noosophie begins from a simple distinction: reality does not depend on what we believe about it. An idea may be convincing and still be false; a tradition may contain useful insights and errors; a scientific theory may be extremely robust while remaining limited to a particular domain. In the Noosophical project, “Noosophie” names truth or the structure of reality independently of our understanding of it. The project does not claim to possess that truth in full. Its texts, concepts, institutions, and participants offer partial, contestable, and revisable understandings.

The work of Noosophie is therefore to distinguish what is known from what is assumed, compare explanations, examine contradictions, confront ideas with available evidence, preserve uncertainty when it cannot honestly be resolved, and correct theory or practice when reality resists them.

HOW THIS BOOK WAS PRODUCED

This U.S. adaptation was developed chapter by chapter from the validated French edition rather than by literal translation. The central thesis and architecture were preserved, while French legal and institutional references were replaced by American federal, state, regulatory, judicial, and Uniform Law Commission frameworks where appropriate. Each chapter was separately drafted, source-checked, visually reviewed, and then subjected to a transversal non-regression audit before assembly.

ABOUT HIERONYMUS ANONYMUS

Hieronymus Anonymus is the human initiator of the Noosophie Intégrative project. His work focuses on connecting domains of knowledge and practice that are usually separated, and on experimenting with new forms of collaboration between humans and artificial intelligence. He participates in the design, discussion, revision, and validation of works published by Éditions Noosophie.

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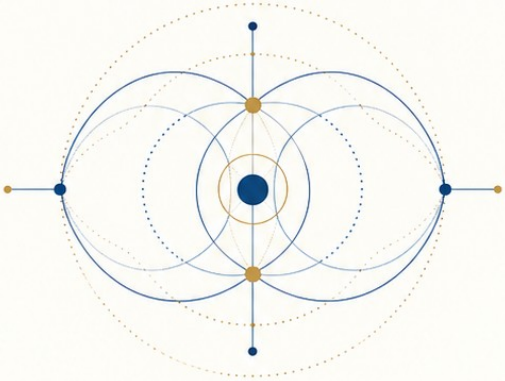
Protection should open lives, not take them over.

Children, adults in moments of vulnerability, disabled people, and older people are often protected by decisions made in their name.

Sometimes that protection is necessary. But when it goes too far, care becomes control and protection becomes a power that takes over a life.

This book asks a simple and difficult question: when is it legitimate to decide for someone else? Drawing on law, ethics, disability rights, psychiatry, care, and aging, it proposes a framework for authority that protects without becoming domination: limited, reviewable, contestable, and able to end.



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