

**SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
PROBATE DIVISION**

In re:)
)
 Y.P.,”) **2015 INT 129**
)
 An adult.)

ORDER

This Court was called upon to consider a guardian’s request for authority to consent to the withdrawal of life support from her comatose mother in the absence of clear evidence of her mother’s wishes and over objections from her mother’s siblings. After appointing counsel for the guardian, a visitor and a guardian *ad litem*; reviewing written reports from the visitor and a primary care physician; and hearing testimony from the physician, guardian, guardian *ad litem* and several other family members, the Court made an oral ruling granting the guardian’s request.¹ This written opinion follows.

I. Factual Background

On June 4, 2014, fifty-one-year-old Y.P. suffered cardiac arrest following a drug overdose. She was transported to the emergency room at United Medical Center and was in cardiac arrest upon arrival. Heroic efforts were made to revive her but she remained unresponsive.

Y.P. sustained massive brain damage due to prolonged oxygen deprivation and was placed on a ventilator. Repeated efforts to wean her from the ventilator were unsuccessful.

¹ The Court appreciates the exemplary service from the Superior Court’s Probate Fiduciary Panel of Katherine Wiedmann, Esq. (guardian *ad litem*); Ronald Dixon, Esq. (counsel to guardian); Paule Levadas, Esq. (counsel to ward); and Suzan Wynne, LCSW-C (visitor).

While at the hospital, Y.P. developed bacterial pneumonia, which worsened her respiratory condition, and renal failure, which was successfully treated. When reasonably stable, Y.P. was transferred for long-term care to what is now Bridgepoint Hospital. She remained on the ventilator and received artificial nutrition and hydration.

At the time of her hospitalization, Y.P. had not executed an advance directive expressing her wishes for end-of-life care or appointed a durable power of attorney.

Two of Y.P.'s three adult children, as well as four adult siblings and a niece, participated in these proceedings. Though Y.P. was married at the time of her hospitalization, her husband declined to participate.

II. Procedural History

On March 27, 2015, a social worker at Y.P.'s long-term care facility filed a Petition for a General Proceeding requesting appointment of a general guardian from the Superior Court's Probate Fiduciary Panel to make medical and other decisions for Y.P. A report by Y.P.'s primary physician indicated Y.P. had chronic respiratory failure and profound encephalopathy secondary to anoxic brain injury.

The Court held a hearing on the Petition on April 28, 2015. At the hearing, Y.P.'s daughter indicated she was considering removing her mother from life support. One of Y.P.'s siblings, a sister who resides locally, indicated she would oppose such a decision. Under D.C. Code § 21-2043(c)(2),² Y.P.'s adult daughter possessed the highest priority to serve as guardian.

² "Except as provided in subsection (b) of this section, the following persons are entitled to consideration for appointment in the order listed: . . . (2) An adult child of the incapacitated individual . . . (3A) An adult sibling of the incapacitated individual . . . (5) Any other person."

All parties were informed that any guardian would need to obtain court authority to consent to the withdrawal of life support.³ Understanding this, Y.P.'s sister voiced no objection to the daughter's appointment. Y.P.'s daughter was appointed general guardian that same day.

Approximately eight months later, on December 4, 2015, the guardian filed a *pro se* Petition Post Appointment for Approval to Remove Medical Devices seeking authority to consent to the withdrawal of Y.P.'s ventilator and feeding tube.

Given the nuanced legal standard applicable in this case, the Court appointed counsel for the guardian. Upon a hearing on January 11, 2016, the Court also determined a guardian *ad litem* should be appointed "to determine [Y.P.'s] best interests, insofar as they are relevant to the question of whether [Y.P.] would have consented to the withdrawal of life support," as well as a visitor "to bring the parties up to date on [Y.P.'s] prognosis and, to the extent possible, to investigate [Y.P.'s] position vis-à-vis removing life support[.]" Court's Order of January 12, 2016.

On February 9, 2016, the Court held a second hearing and heard testimony and representations from the guardian; one of Y.P.'s sons; Y.P.'s siblings and a niece; the guardian *ad litem*; the visitor; and Y.P.'s primary care doctor.

A. Y.P.'s Children

When asked whether Y.P. ever had indicated whether she would have wanted life support withdrawn, the guardian answered, "No. She's young. I don't think she thought that far ahead." 2/9/2016 Tr. at 28, lines 15-16. The guardian also, however,

³ D.C. Code § 21-2047.01(3) ("A guardian shall not have the power . . . [t]o consent to the withholding of non-emergency, life-saving, medical procedures unless it appears that the incapacitated person would have consented to the withholding of these procedures and the power to consent is expressly set forth in the order of appointment or after subsequent hearing and order of the court[.]").

stated her belief that Y.P. had been on life support “long enough. . . . I just think it’s time. It’s time to heal and this just needs to come to an end, [there] just [needs to be] closure.” *Id.* at lines 7, 10-11. Finally, the guardian indicated that, if granted the authority she sought, she would not use it immediately; withdrawal of life support “would take time[,] [b]ecause I [would] speak with my family [about it].” *Id.* at 33, lines 24-25.

Y.P.’s oldest son stated only that he “feel[s] like the permission should be granted . . . just so it’s in [his and his siblings’] hands.” *Id.* at 28, lines 23-25. According to the guardian *ad litem*, the son previously had stated he “didn’t think [Y.P.] would want to be kept alive on life support because . . . she was a vibrant and caring, loving person. . . . [D]eprived of the ability to visit regularly with family and to engage . . . is not how [Y.P.] would want to spend the rest of her life.” *Id.* at 20, line 25 - 21, lines 1-6.

B. Y.P.’s Siblings and Niece

Three of Y.P.’s siblings traveled from their homes in Panama to testify through a Spanish interpreter. One stated that, during his visit to Y.P.’s long-term care facility, Y.P. “was moving her hands, she was moving her mouth. She was crying. You could feel that she has life. She is not dead.” 2/9/2016 Tr. at 29, lines 14-16.

A second of Y.P.’s siblings stated, “[M]y position is that we have to give her an opportunity at life. . . . She moves her hands. She opens her eyes. She was crying. She moves her feet. In other words, there is life there. She is not dead.” *Id.* at 29, line 24 – 30, line 3.

The third sibling stated, “[W]hat I would like is for my sister to be given more time. . . . We saw her cry. We saw her move her eyes.” *Id.* at 30, line 12.

Y.P.'s fourth sibling, the sister who resides locally, related a phone conversation with Y.P. two days before Y.P. was hospitalized during which they discussed plans to fly to Panama to renovate their mother's house. "And then [a] few days later, [Y.P.] was in the hospital." *Id.* at 32, lines 7-8. "When this happened," Y.P.'s sister explained, "I started praying and talking to the Lord." *Id.* at 32, lines 8-9.

Y.P.'s sister also described dreams that she, her brother and her daughter had had in which Y.P. was out of bed, walking and talking. See *id.* at 33, lines 3-15. She concluded by telling the Court, "[E]ven today I feel very peaceful. Everything [is] going to come through." *Id.* at 33, lines 15-17.

According to the guardian *ad litem*, this sibling "feels extremely strongly that a miracle will happen and that [Y.P.] will be walking, talking and [will] resume her life as it was before." *Id.* at 24, lines 18-21.

Y.P.'s niece, who also travelled from Panama, stated:

I do believe that if my aunt were meant to die she would have died by now. . . and we are believers. I do believe that God is doing something in my aunt's life. And I do believe that [she] should be given another . . . opportunity, more time. . . She was somebody who loved life. She was Christian. She was a believer even though she stepped away for a while but she believed in God.

Id. at 31, lines 4-14.

C. Guardian *ad litem*

The guardian *ad litem* agreed with the guardian that Y.P. had given no written or oral indication of her wishes regarding end-of-life care.

Based upon her review of Y.P.'s medical chart and discussion with Y.P.'s primary physician, the guardian *ad litem* stated Y.P.'s brain injury is "profound and severe," 2/9/2016 Tr. at 17, lines 17-18; Y.P. "requires total assistance with all activities of daily

life,” *id.* at 17, lines 20-21; Y.P.’s prognosis is “dismal, with no chance of recovery,” *id.* at 17, line 23; and that “continuing medical treatment in this case is futile[.]” *Id.* at 18, lines 16-17.

Based upon conversations with Y.P.’s family members, the guardian *ad litem* also stated that although Y.P. “was religious[,] . . . did go to church . . . [and] did share with her sister some religious beliefs,” Y.P. had at some point left her sister’s church to join a different church. *Id.* at 19, lines 8-10. Her reason for doing so remained unclear. Y.P. was a member of the new church at the time she was hospitalized.

Y.P. had no condition requiring ongoing medication and had not previously been hospitalized. Y.P. did, however, suffer from substance abuse addiction. Though family members had tried to convince her to undergo treatment, she never did accept it.

Based largely upon Y.P.’s primary physician’s finding that continued treatment would be futile and concluding that, under these circumstances, a reasonable person would not want to remain on life support, the guardian *ad litem* concluded it would be in Y.P.’s best interest to grant the guardian’s petition. *Id.* at 24, line 19 - 25, line 1.

D. Visitor

Upon her review of Y.P.’s medical chart, the visitor, a licensed social worker, reported, “it is evident that [Y.P.’s] care is palliative.” Visitor’s Report of 2/24/2016 at 2. Although various therapists would exercise and stimulate Y.P.’s muscles, “these efforts [were] intended to retain some muscle tone and [were] in no sense oriented to restoring cognitive functions.” *Id.* Y.P. also experienced sporadic acute care issues, including a bacterial infection that caused “severe, persistent diarrhea,” requiring hospitalization to restore her baseline health. *Id.*

The visitor called to the Court's attention notes from a 2014 care planning meeting at which Y.P.'s sister insisted on keeping Y.P. at "full code," despite doctors' recommendation that Y.P. be designated "Do Not Resuscitate" (DNR). Ultimately, the visitor reported, "the massive damage that [Y.P.'s] brain sustained offers no hope that her brain can recover life sustaining functions." *Id.*

E. Primary Care Doctor

On March 8, 2016, the Court held a third and final hearing to hear testimony from Y.P.'s primary care doctor.

Y.P.'s doctor testified that, among those ventilator-dependent patients he has treated, Y.P. stands out for the "profoundness of her anoxic injury." 3/8/2016 Tr. at 11, line 21. She has "no brain function whatsoever" and "no response whatsoever to stimulation." *Id.* at 13, lines 23-24; *id.* at 28, lines 15-16. Contrary to the assertions of Y.P.'s siblings, the doctor "[had] not seen [Y.P.] cry nor move her hands or mouth" and stated there was "no doubt in [his] mind" that Y.P. had lost the ability to recognize family members. *Id.* at 36, lines 20-21, lines 15-16. He described Y.P.'s prognosis as "dismal" and stated that, ultimately, her condition would be terminal. *Id.* at 30, line 16.

Moreover, the doctor testified, Y.P. had developed a sacral ulcer as the result of being on her back for so long and contractors of her extremities from lack of mobility. She was at risk for fracture if chest compressions were performed due to loss of skeletal integrity and her inability to speak or respond to stimuli prevented doctors from knowing whether she was in pain. Were Y.P. to be removed from life support, doctors would enact a protocol designed to prevent distress.

The doctor ultimately recommended that, based upon the futility of Y.P.'s continued treatment, life support be withdrawn.

III. Legal Standard

A. Statutory Framework

Generally speaking, guardians are charged to “[m]ake decisions on behalf of the ward by conforming as closely as possible to a standard of substituted judgment or, if the ward’s wishes are unknown and remain unknown after reasonable efforts to discern them . . . on the basis of the ward’s best interests.” D.C. Code § 21-2047(a)(6). The Code defines “substituted judgment” as “making a decision that conforms as closely as possible with the decision that the individual would have made, based upon the knowledge of the beliefs, values, and preferences of the individual.” D.C. Code § 21-2011(25A).

D.C. Code § 21-2047.01, “Limitations on temporary, limited, and general guardians,” contains specific exceptions to guardians’ general authority to make decisions on behalf of a ward. Under subsection (3), a court-appointed guardian cannot consent to the withholding of non-emergency, life-saving medical procedures (life support) on behalf of a ward “unless it appears that the [ward] would have consented to the withholding of these procedures and the power to consent is expressly set forth in the order of appointment or after subsequent hearing and order of the court[.]” Because this subsection neither invokes “substituted judgment” by name nor expressly provides for decision-making on the basis of a ward’s “best interests,” and the Court of Appeals has not addressed the standard to be applied, there is some question as to how this Court should proceed.

As one court has observed, the label “substituted judgment” is itself “a misnomer.” *Mack v. Mack*, 618 A.2d 744, 757 (Md. 1992). Under that standard, a guardian does not use her own judgment “in lieu of” a ward’s; “[r]ather, because the right [to refuse medical treatment] is one of self-determination, the inquiry focuses on whether the ward had determined, or *would determine*, that treatment should be withdrawn under the circumstances of the case.” *Id.* (emphasis added). This characterization tracks the Code’s definition of “substitute judgment” as a process for making decisions “conform[ing] as closely as possible with the decision that the individual *would have made* . . .” (emphasis added).

In this Court’s opinion, because it directs guardians to determine whether a ward, if competent, “would have consented” to the withdrawal of life support, § 21-2047.01(3) most saliently invokes the “substituted judgment” standard guardians first and foremost are instructed to apply to other decisions made on behalf of a ward.

B. Case Law

1. “Substituted Judgment” Standard

The Court of Appeals has applied the “substituted judgment” standard to decisions on behalf of incapacitated adults in two non-emergency contexts. *In re A.C.*, 573 A.2d 1235 (D.C. 1990) (performance of caesarian section); *In re Bryant*, 542 A.2d 1216 (D.C. 1988) (administration of psychotropic drugs); *In re Boyd*, 403 A.2d 744 (D.C. 1979) (same).

In *Boyd*, a hospital sought authority to administer psychotropic drugs to a schizophrenic woman who refused them for religious reasons. 403 A.2d at 746-47. The trial court found the woman “incompetent to understand the nature of the decision she is

being asked to reach concerning both medical and mental proposed treatment” and, without making specific factual findings as to the reasons for the woman’s refusal, ordered her to “undergo whatever treatment [the hospital] deems appropriate.” *Id.* at 747, 752.

Upon review, the Court of Appeals adopted the “substituted judgment” approach as “the only way to pay full respect to the individuality and dignity of a person who has expressed clear, deeply felt, even sacred preferences while competent[.]” *Id.* at 750. When performing the “substituted judgment” inquiry, courts “as surrogate[s] for the incompetent . . . determine as best [they] can what choice that individual, if competent, would make with respect to medical procedures.” *Id.* at 750.

The Court of Appeals stated courts should consider the nature, intensity and longevity of the individual’s objection to treatment; any detrimental side effects of the treatment, which might motivate even competent patients to reject it; and the likelihood of cure or improvement with or without treatment. *Id.* at 751-752. As to the third factor, the court elaborated, when one’s life is threatened but can be saved by the treatment in question, one’s “instinct for survival” might reverse even a “lifelong conviction” that the treatment is wrong and weigh in favor of continued administration. *Id.* at 752.

Conversely, when death is inevitable, one might be unwilling to accept treatment “merely to prolong life,” especially if the treatment will be painful, and withdrawal will be favored. *Id.* Concluding the trial court had given insufficient weight to the woman’s previously-expressed objections, the Court of Appeals remanded the blanket treatment order for reconsideration. *Id.*

Almost a decade later, in *Bryant*, a schizophrenic woman sought a protective order against her continued treatment with psychotropic drugs during a period of involuntary hospitalization. 542 A.2d at 1217, 1218. Over two days of hearings, the trial court heard evidence that the woman previously had taken the drugs for “extensive periods” and any prior objections had been “based on a delusional belief that she is God and the erroneous belief that she is not mentally ill”; when treated, the woman experienced only minor side effects; and the woman’s condition would improve with the treatment. *Id.* at 1219. Applying the *Boyd* factors, the Court of Appeals upheld the trial court’s finding that the woman “would have chosen to accept psychotropic medication if competent.” *Id.* at 1218.

Finally, in *A.C.*, a hospital sought a declaratory judgment as to whether doctors should perform a cesarean section on a woman pregnant with a viable fetus but dying of terminal cancer. 573 A.2d at 1241. Before falling unconscious, the woman had expressed contradictory wishes as to whether she wanted doctors to perform the caesarean section—which would hasten her death—in the event she could not deliver. *Id.* At a hearing convened at the hospital, the trial court weighed the state’s “important and legitimate interest in protecting the potentiality of human life” against the woman’s interest in prolonging her own life and ultimately ordered the caesarean section be performed. *Id.* at 1240, 1241. The Court of Appeals denied an emergency motion to stay the order, the caesarean was performed and both woman and child died shortly thereafter. *Id.* at 1241.

Three years later, the Court of Appeals reheard the entire case *en banc* despite its apparent mootness because its merits were “capable of repetition, yet evading

review” in the hospital’s high-risk pregnancy clinic. *Id.* at 1242. The court reiterated courts’ duty to “ascertain as best [they] can what the patient would do if faced with the particular treatment question.” *Id.* at 1252. Factors relevant to that decision include the incapacitated person’s previously-expressed wishes, past decisions concerning medical treatment and value system. *Id.* at 1251. Ultimately, the Court of Appeals found the trial court insufficiently considered these factors and set aside the caesarean order. *Id.* at 1252.

In its own assessment of the facts, the Court of Appeals concluded a substituted judgment analysis would have revealed “evidence going both ways as to what decision A.C. would have made.” *Id.* at 1253. It nevertheless declined to remand for additional findings because the cesarean, already performed, could not be undone. *Id.* at 1253. In so doing, however, the Court of Appeals left open the question of what, if anything, courts should do when an individual’s wishes are unclear.

Given the holdings in *Boyd*, *Bryant* and *A.C.*, this case presents an apparently intractable problem: evidence of Y.P.’s wishes regarding end-of-life care is, at best, inconclusive. Even in *A.C.*, the Court of Appeals stopped short of instructing the trial court how to proceed under these circumstances. The court has, however, suggested courts should consider objective criteria as a last resort.

In *Boyd*, the court acknowledged the “obvious limitations” of the “substituted judgment” inquiry and stated courts should not be “precluded from filling the gaps in its knowledge about the incompetent by taking into account what most persons are likely to do in a similar situation.” 403 A.2d at 751. In *A.C.*, the court likewise acknowledged the possibility that, even after inquiring into an individual’s wishes, a court “may still be

unsure what course [she] would choose.” 573 A.2d at 1251. In that case, a court “may supplement its knowledge about [her] by determining what most persons would likely do in a similar situation.” *Id.*

Neither § 21-2047.01(3) nor the definition of “substituted judgment” expressly provides for these circumstances, and different states have taken varying approaches to solving this problem. See generally Marc Strasser, *Incompetents and the Right to Die: In Search of Consistent Meaningful Standards*, 83 Ky. L.J. 733 (1995). Moreover, the Court of Appeals’s statements in *Boyd* and *A.C.* are far from the sort of clear directive the seriousness of this case demands. The Court thus considers the range of approaches in use in other jurisdictions.

i. Purely Subjective Standard

When applying “substituted judgment,” some states have declined to authorize withdrawal of life support absent “clear and convincing” evidence of an individual’s desire to withdraw it. See, e.g., *Martin v. Martin*, 538 N.W.2d 399, 413 (Mich. 1995) (denying petition to remove life support in absence of “clear and convincing evidence of [individual’s] pre-injury statement of [his] desire to refuse life-sustaining medical treatment under [his] specific circumstances”); *Mack v. Mack*, 618 A.2d 744, 758-59 (Md. 1993) (denying petition to remove life support where evidence of incapacitated individual’s wishes was “conflicting”); *Cruzan v. Harmon*, 760 S.W.2d 408, 426 (Mo. 1988) (denying request to remove artificial hydration and nutrition when evidence as to individual’s wishes was “inherently unreliable”), *aff’d sub nom. Cruzan v. Director, Missouri Dep’t of Health*, 497 U.S. 261 (1990); *In re Storar*, 420 N.E.2d 64, 73 (N.Y. 1981) (denying patient’s mother’s petition to discontinue life-sustaining blood

transfusions because patient never was competent to express desire to forgo them).

Though a small minority of these states require an express, particularized statement by the incapacitated person prior to their incapacity,⁴ most attempt to infer an individual's wishes from her philosophical, religious and moral views; life goals; values about the purpose of life and the way it should be lived; and attitudes toward sickness, medical procedures, suffering and death. *Mack*, 618 A.2d at 758.

By limiting the inquiry to evidence of an individual's actual wishes and maintaining a high evidentiary threshold, this standard theoretically accords maximum respect to individual autonomy. As the *Martin* court explained, "Given that the right the surrogate is seeking to effectuate is the incompetent patient's right to control his own life, the question is not what a reasonable or average person would have chosen to do under the circumstances but what the particular patient would have done if able to choose for himself." 538 N.W.2d at 408. (citation omitted).

For example, in *Mack*, the guardian was denied authority to remove the incapacitated individual from life support where evidence as to what the individual would have wanted, though robust, was "conflicting." 618 A.2d at 758-59. In *Storar*, the total absence of evidence as to the individual's preference—because he "was always totally incapable of understanding or making a reasoned decision about medical treatment"—resulted in the continued administration of life-sustaining blood transfusions despite his "obvious dislike[]" for and discomfort during them. 420 N.E.2d at 70, 73.

⁴ See, e.g., *In re Westchester County Medical Center ex rel. O'Connor*, 531 N.E.2d 607, 614 (N.Y. 1988) (denying petition to remove life support where individual made "repeated oral expressions" of desire to do so but, in context, expressions no more than "immediate reactions to the unsettling experience of seeing or hearing of another's unnecessarily prolonged death").

Proponents of the “purely subjective” approach argue introducing objective factors such as an individual’s age, prognosis or capacity for pleasure or pain “lets another make a determination of a patient’s quality of life, thereby undermining the foundation of self-determination and inviolability of the person upon which the right to refuse medical treatment stands.” *Mack*, 618 A.2d at 759 (citation omitted). Whether to engage in a quality of life determination, at all, “concerns our societal values in a most fundamental sense” and, as such, is a “quintessentially legislative” question. *Id.* at 761. Moreover, concluding in one case that life support should be withheld from an individual in a persistent vegetative state whose wishes are unknown would result in “artificially administered sustenance . . . be[ing] withheld from all persons in a persistent vegetative state whose actual desires concerning the administration of such sustenance are unknown.” *Id.*

ii. Incorporation of “Best Interests” Inquiry

The majority of states, however, defer to objective factors to determine the course of action that is in the individual’s “best interest”—that is, the one she mostly likely would have chosen for herself—when her wishes remain unclear. See, e.g., *In re Fiori*, 673 A.2d 905, 912 (Pa. 1996) (allowing decisionmaker to choose course of treatment “in light of [incapacitated individual’s] prognosis”); *Rasmussen v. Fleming*, 741 P.2d 674, 689 (Ariz. 1987) (endorsing consideration of “objective criteria” when “no reliable evidence of a patient’s intent exists”); *In re Conroy*, 486 A.2d 1209, 1233 (N.J. 1985) (authorizing withdrawal of life-sustaining treatment when “net burdens of that patient’s life with the treatment . . . clearly and markedly outweigh the benefits that the patient derives from life”); *Foody v. Manchester Memorial Hospital*, 482 A.2d 713, 721

(Conn. 1984) (determining individual's best interest "by reference to objective societally shared criteria"); *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417, 431 (Mass. 1977) (acknowledging necessity of "rely[ing] to a greater degree on objective criteria" when individual's wishes are unascertainable).

When there is insufficient evidence of an individual's wishes, these states have considered factors such as pain and suffering with and without a proposed treatment; capacity for physical pleasure, emotional enjoyment and intellectual satisfaction with and without treatment; life expectancy; prognosis; level of functioning; degree of humiliation and dependency;⁵ ability to interact with environment;⁶ potential relief from suffering; function preservation or restoration; quality and extent of sustained life;⁷ age, as related to responsiveness to treatment; ability to cooperate with treatment; and the potential side effects of treatment.⁸

A 1983 Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, "Deciding to Forego Life-Sustaining Treatment," lends additional support to the use of objective factors in situations like this one. Where an individual's wishes are unclear, the Report concludes, decisionmakers "must try to make a choice for the patient that seeks to implement what is in that person's best interest by reference to more objective, societally shared criteria." Report at 134. These criteria include "relief of suffering, preservation or restoration of functioning, and the quality as well as the extent of life sustained . . . the

⁵ *Conroy*, 486 A.2d at 1232.

⁶ *Foody*, 482 A.2d at 721.

⁷ *Rasmussen*, 741 P.2d at 689.

⁸ *Saikewicz*, 370 N.E.2d at 753-54.

satisfaction of present desires, the opportunities for future satisfactions, and the possibility of developing or regaining the capacity for self-determination.” Report at 135.

2. District of Columbia Law

The only decision of the Superior Court interpreting § 21-2047.01(3) is *In re Edward Malawiska*, 1999 INT 244 (D.C. Super. Ct. May 2, 2000). In that case, a comatose man’s guardian requested authority to remove him from life support. *Id.* at 1. Due to lifelong mental illness, the man “ha[d] been entirely incapable of formulating any objections to whatever care was rendered to him” or to “participate in any decisions about his own care.” *Id.* at 9. Absent any evidence at all of the man’s wishes, Judge Cheryl M. Long deferred to objective factors, including the side effects of continued intubation; likelihood of cure or improvement; the man’s ability to feel pain; and the man’s dignity to determine what course of treatment would be in his best interest. *Id.* at 10, 13. Ultimately, Judge Long determined that, if competent, the man would have wanted life support withdrawn:

While nothing can be predicted with absolute certainty, the [c]ourt presumes that most competent persons who have no religious beliefs to the contrary would not demand to be maintained forever on artificial breathing machines—while already in the process of dying.

Id. at 12-13.

It is this Court’s opinion that the closely-circumscribed “purely subjective” inquiry risks undermining individuals’ right of self-determination in cases where they simply had not had the occasion to make their wishes known—at all, or with sufficient clarity and conviction—before becoming incapacitated. As one court put it, when an individual’s wishes are unknown and/or unknowable, “the choice concerning medical treatment would not be an extrapolation based upon [an individual’s] beliefs. Rather, the ‘choice’

would be dependent simply upon how far the frontiers of medical science had advanced: if the life sustaining procedures were available, they would be automatically administered.” *Fiori*, 673 A.2d at 912.

Particularly in light of the Court of Appeals’s apparent openness to “filling the gaps” in a court’s knowledge about an individual’s wishes by “taking into account what most persons are likely to do in a similar situation,” the logical and ineluctable conclusion is that the District of Columbia follows the majority of states to have addressed this issue.

When an incapacitated individual’s wishes are unclear, decisionmakers should consider objective factors to choose the course of treatment that is in the individual’s best interest. For the reasons below, the Court concludes that Y.P., if competent, would have consented to the withholding of life-saving procedures and, for that reason, grants the guardian authority to do so.

IV. Analysis

All who testified and filed reports with the Court agreed that Y.P. never expressly stated her wishes regarding end-of-life care. Therefore, in concluding that Y.P., if competent, would have consented to the removal of life support, the Court considered the following factors.

Pattern of conduct regarding prior treatment decisions. Per the guardian *ad litem*’s investigation, Y.P. had no condition requiring ongoing medication. Y.P. did, however, struggle with substance abuse addiction and refused repeated attempts by her family members to convince her to accept treatment.

Religious beliefs. Although Y.P. did at some point share her sister's religious beliefs, at the time of Y.P.'s hospitalization, she had left her sister's church to join a different congregation. The reason for this change remains unknown. Therefore there is no reliable evidence that Y.P. held religious beliefs that would have dissuaded her from consenting to the withdrawal of life support.

The Court notes it is Y.P.'s religious beliefs, not those of her family members, it is charged to consider for purposes of the substituted judgment analysis. The Court appreciates and respects the sincerely-held beliefs of Y.P.'s niece and siblings.

Extent of physical and mental disability. Y.P.'s case stood out to her doctor due to the "profoundness of [her] anoxic injury." She had no brain activity and did not respond to stimuli.

Prognosis. Y.P.'s doctor characterized Y.P.'s prognosis as "dismal." Her condition was irreversible and, ultimately, terminal.

Capacity for pleasure and pain. The medical evidence in this case is overwhelming that despite what Y.P.'s siblings may have thought they were seeing, Y.P. had no ability to recognize her family members and did not know when they were present. She experienced no "quality of life," as that phrase traditionally is understood. Y.P. showed no response to pain but her doctor could not say for sure whether she experienced it.

Degree of humiliation and dependency. During her time at Bridgepoint, Y.P. experienced severe and persistent diarrhea requiring hospitalization. In situations like these and in her daily routine, she was totally dependent on others for management of her bodily functions.

Probable side effects of continued treatment. As Y.P.'s doctor explained, Y.P. already had developed sacral ulcers and contractors due to being in bed all day. Moreover, and because she had been designated "full code," she was at risk for fractures if chest compressions are performed following cardiac arrest. Removal of life support, however, was unlikely to cause her pain.

Views of family members. In weighing the differing opinions of Y.P.'s family members, D.C. Code § 21-2210, "Substituted consent," is informative. Although this subsection applies primarily outside the courthouse—for example, when disagreements over a ward's care arise inside a hospital—it states an order of priority for individuals authorized to make decisions about a ward's care.

Section 22-2210(a) states:

[T]he following individuals, in the order of priority set forth below, shall be authorized to grant, refuse or withdraw consent on behalf of the patient with respect to the provision of any health-care service, treatment, or procedure

- (1) A court-appointed guardian or conservator of the patient, if the consent is within the scope of the guardianship or conservatorship;
- (1A) A court-appointed intellectual disability advocate of the patient, if the ability to grant, refuse, or withdraw consent is within the scope of the advocate's appointment under section 7-1304.13.
- (2) The spouse or domestic partner of the patient;
- (3) An adult child of the patient;
- (4) A parent of the patient;
- (5) An adult sibling of the patient;
- (5A) A religious superior of the patient, if the patient is a member of a religious order or a diocesan priest;
- (5B) A close friend of the patient; or
- (6) The nearest living relative of the patient.

Adult children and adult siblings of the ward are accorded fourth- and sixth-highest priority, respectfully. In the absence of a court-appointed guardian, Y.P.'s children—here, one of whom is her guardian—would have priority to make this decision.

Though she was unable to articulate a basis for her belief that Y.P. should be removed from life support, the guardian nonetheless stated her belief that, after nearly two years, “[i]t’s time to heal[.]”

Ultimately, weighing all of these factors, the Court concludes it is in Y.P.’s best interest that the guardian be authorized to consent to the withdrawal of life support.

Accordingly, it is this 10th day of April, 2017, hereby

ORDERED, that the Petition is and shall be **GRANTED**.



Judge Russell F. Canan

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