



Making End-of-Life and Medical Decisions for Your Ward: Legal & Bioethical Considerations

2010 Guardianship Conference

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I. What are the Duties and Responsibilities of a Guardian in Making Health Decisions for Wards?

A. Legal Guardian.

A Legal Guardian is an agent acting on behalf of the Court for a person who has been determined to be incapacitated. The Court takes the individual under its protection and the Guardian is the agent of the Court. A finding of incapacity does not mean that a person loses any rights to participate in their health care decisions. The law of the District of Columbia is very clear that all Legal Guardians must exercise Substituted Consent, meaning any decision you make as a Guardian must be based on the known wishes of the ward. As a guardian, you also need to try to ascertain your ward's wishes. In addition, you must include your ward in the making of health care decisions to the maximum extent possible.

B. Rights of Ward to Participate in Decision-Making Under D.C. Law

D.C. Code Section	Title	Summary
21-2004	Guardianship Proceeding: Effect of Finding of Incapacity	A ward who is found to be incapacitated retains all legal rights and abilities unless limited in the Order appointing a Guardian. A finding of incapacity does not constitute a finding of legal incompetence.
21-2210(a)	Substituted Consent Surrogate Decision-making Health Care Decisions Act	A decision to grant, refuse or withdraw consent shall be based on the known wishes of the patient, ... or if unknown, then on a good faith belief as to the best interests of the patient.
21-2047 (a)(1)	Powers and Duties of Guardian ¹	Must become personally acquainted with the ward
21-2047 (a)(6)	Powers and Duties of Guardian	Must make decisions based on standard of substituted judgment, or if the ward's wishes are unknown after reasonable efforts to discern them, make the decision based on the ward's best interest.

¹ There are corresponding duties for Emergency and Health Care Guardians pursuant to D.C. Code § 21-2047.02.

D.C. Code Section	Title	Summary
21-2011(25A)	Definition: Substituted Judgment	Substituted Judgment means 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.
21-2047 (a)(7)	Powers and Duties of Guardian	Include the ward in the decision-making process to the maximum extent of the ward's ability
21-2047 (a)(8)	Powers and Duties of Guardian	Encourage the ward to act on his or her behalf and to develop capacity to make decisions to the maximum extent possible
21-2047(b)(6)	Powers and Duties of Guardian	If reasonable under all of the circumstances, delegate to the ward certain responsibilities for decisions affecting the ward's well-being.

C. Durable Power of Attorney for Health Care.

A Durable Power of Attorney for Health Care is an Agent designated by an individual (and not the Court) to make health care decisions. The individual must have the competency to name a health care agent. The document naming a power of attorney for health care must provide that the power is durable and "shall continue during incapacity."²

* Note: The Court must consider any Power of Attorney as evidence of the ward's wishes in appointing a Guardian. In an intervention proceeding, the Court's failure to consider the ward's wishes stated in a Durable Power of Attorney document and appointment of a Guardian from the fiduciary list constituted an abuse of discretion requiring reversal.³

² See D.C. Code § 21-2207 for Statutory Sample Form.

³ In re Orshansky, 804 A.2d 1077, 1098 (D.C. 2002).

D. The Right to Control Health Care Decisions Under D.C. Law.

D.C. Code Section	Title	Summary
7-621	Advance Directive Law Living Will (1989)	Every person over the age of 18 may sign a "Declaration" directing the withholding or withdrawal of life-sustaining procedures in the event of a "terminal condition."
7-651.01 to 7-651.17	EMS – DNR Law (implemented 2006) ***SEE TAB 1 [App 01 – 07]	Any competent person, who is 18 years of age or older, or the Guardian may request a DNR/Comfort Care Order from the physician and may wear a distinctive bracelet or necklace indicating their wishes to EMS (Emergency Medical Services),
21-2201 to 2213	Durable Power of Attorney for Health Care (2000) & Surrogate Decision Making	All competent adults have the right to control decision relating to their own health care and to have their rights and intention in health care matters respected and implemented by others if they become incapable of making or communicating decision for themselves. See § 21-2201.

II. How to Make Decisions as a Guardian?

A. Substituted Judgment Governs All Decisions Made On Behalf Of Your Ward.

1. Subjective Inquiry: What does the ward want?

If a ward is not competent to make a particular decision, the guardian has a duty to determine subjectively, to the extent possible, the course the ward would have taken if competent and apply a substituted judgment or subjective test.⁴

⁴ In Re A.C., 573 A. 2d 1235, 1249 (D.C. 1990) (finding Court erred in forcing a mother to undergo a Caesarian Section, when mother was not competent, was dying of cancer, and the Court did not inquire as to what the mother would have done had she been competent)

2. **Limited-Objective Test: What would most persons likely do in a similar situation?**

If there is some evidence of what the ward would want, but not enough to know the ward's intent, then ask what would most persons likely do in a similar situation.⁵ If some trustworthy evidence of an incompetent's intent can be found, but not enough to fully determine subjective intent, this can be taken into account in determining the incompetent's best interests, and a limited-objective test should be used.

3. **Objective test: What course of treatment is in the best interest of the ward?**

If no reliable evidence of an incompetent's subjective intent exists, the decision maker should use a pure-objective test, or best interests test. As, as in the limited-objective test, a Guardian applying the objective test, may deny or withdraw treatment, if the net burdens of the patient's life with the treatment clearly outweigh the benefits that the patient derives from life.⁶

B. Self-Determination: Same Goal for All Decisions

The substituted judgment test and the best interests test "represent points on a continuum of subjective and objective information leading to a reliable decision that gives as much weight as possible to the right of self-determination."⁷

III. Advance Directives

A. Under the Substituted Judgment Standard, a Guardian must follow the ward's wishes as expressed verbally or set forth in an Advance Directive.

If the ward cannot communicate his/her wishes, look to the ward's written or oral directions concerning treatment to family, friends, and health-care professionals. Also take into account the ward's past decisions regarding medical treatment, and attempt to ascertain the ward's value system, goals, and desires in determining what the ward would decide if competent.⁸

⁵ In Re A.C., 573 A.2d 1235, 1249 (D.C. 1990) (defining the test as "determining what most persons would likely do in a similar situation).

⁶ In re Conroy, 486 A.2d 1209, 1232 (N.J. 1985).

⁷ In Re M.R., 638 A.2d 1274, 1280 (N.J. 1994)

⁸ In re A.C., 573 A.2d 1235, 1251 (D.C. 1990)

B. Start Now: First Steps to Ascertaining Your Ward's Wishes

1. Investigate whether the ward already has an advance directive. Check with prior attorney, if known.
2. Discuss the ward's wishes as soon as practicable.
3. If the ward is able, complete an advance directive form.

****Note, the Court revised the Guardianship Report in July 2007. Number 13 states: Does the ward have a current health care directive? If yes, attach a copy if not previously filed (copy will be kept in a confidential location). If no, explain...**

C. What are Advance Directives?

Advance Directives set forth your wishes for life-sustaining medical treatment. Because you cannot anticipate what may happen in the future, the Advance Directive sets forth your basic wishes with regard to medical treatment if you are unable to communicate your wishes. An Advance Directives form is a legal document which governs how your medical treatment team, your Guardian, or the Court will decide how to proceed should you be unable to communicate your wishes yourself. Advance Directives, Living Will Declaration § 7-622.

D. Can an Individual Who Has a Guardian or a Conservator Execute an Advance Directive Form?

YES. Individuals who have mental health, mental retardation or other incapacities are presumed to have the competency to make health care decisions for themselves. § 21-2203.

E. Advance Directive Forms – Samples. **See TABS 2 & 3**

1. Five Wishes Form [<http://www.agingwithdignity.org/five-wishes.php>]
2. Washington Hospital Center Form [App 13 – 16]
3. Thinking Ahead Workbook [App 17 – 21]
4. Advance Directive – (Incorrectly Completed) [App 31 – 33]

F. General Wishes – the 3 Basic Options.

1. I wish to receive all medical treatment, even if I am in a vegetative state or have a terminal condition.
2. I do not want life-sustaining treatments to be started. If they have been started I want them to be withdrawn.
3. I want treatment started for a period of time. If I show no signs of recovery, I wish all treatment to cease or be withdrawn.

**** Note,** Encourage your wards to the extent possible to provide details regarding their wishes. Many persons designate a specific time period for which they wish to have life-sustaining treatments performed and if no signs of recovery withdrawn (i.e two weeks, two months, one year)

**** Also,** pay attention to the particular wishes of your client regarding the definitions and the scope of the treatments they wish to receive or not receive. An individual may modify any definition and is not limited to the treatments set forth in the document. Often a person's view is shaped by experience. If they saw a parent struggle with Alzheimers, they may include the advanced stage of the disease in the definition of a "terminal condition." They may wish to receive dialysis or not receive dialysis. Explore fully the ward's opinions. *****See TAB 3 [App 34 – 39] [Example of an advance directive tailored for individual client].**

G. How to Discuss Advance Directives with your ward.

1. **Emphasize that the discussion is hypothetical and that you are not talking about any current medical decisions.**

As long as the patient can communicate his/her wishes, you will discuss every treatment, as well as the risks and benefits with them. Explain that you are asking questions about their wishes so that if something were to happen in the future and the patient was unable to communicate, you will understand what he/she would want you to do.

2. **Explore the ward's understanding of key terms**
 - a. Do you know what I mean when I say "life-sustaining treatment"
 - b. Do you know what CPR means? Have you ever seen on TV when the doctors apply pressure with their hands to a patient's chest? They breathe into the patient's mouth and the patient's heart begins to beat?
 - c. Do you know what a coma is?
 - d. Do you know what cancer is?

**** See Glossary, Section XI, Below

3. **Simplify the questions:**
 - a. If you're heart were to stop, and you were in a terminal condition, would you want your doctors to bring you back?
 - b. If you could not eat on your own, would you want your doctors to insert a feeding tube?
4. **Use the Five Wishes Form as a means to work through the ward's wishes.** [<http://www.agingwithdignity.org/five-wishes.php>]

H. What to Do If Your Ward Cannot Express Own Wishes.

1. **Contact Family.**
 - a. Did you ever discuss with the ward what his/her wishes would be if he were in a terminal condition?
 - b. What do you believe the ward's wishes would be if he could express them?
 - c. What is the basis for your opinions?⁹
2. **If No Family and the Ward Cannot State Wishes, then you need to investigate what the ward would have wanted. Factors to consider are:**
 - a. Did the ward consent to intrusive or dangerous medical treatments in the past?
 - b. What is the patient's value system?
 - c. What cultural considerations would inform the ward?
 - d. What religious beliefs would inform the ward?
 - e. What were the goals of the ward?
 - f. What are the medical diagnoses?
 - g. Age?
 - h. Is the patient's condition terminal?

⁹ The Court of Appeals for the District of Columbia cautioned that while family members are in the best position to know the wishes of the ward, "sometimes family members will rely on their own judgments or predilections rather than serving as conduits for expressing the patient's wishes." In Re A.C., supra 573 A.2d at 1250.

IV. DNR – Do Not Resuscitate

A. Forms

For each facility the procedure is slightly different. Usually, this is not a document that the Guardian signs, rather it is something the Guardian requests or authorizes the ward's doctors to sign. ****See TAB 4, App 51-52. (Examples of DNR Orders in the District of Columbia). A DNR is a separate document from the Advance Directive and must be placed in the ward's chart at the medical facility.

B. Can a Guardian Request a DNR Without the Court's Approval?

Yes. A guardian may authorize and execute a DNR Order without seeking a Court Order.¹⁰

C. When is it appropriate for a Guardian to Request a DNR?

1. First, try to discuss with the ward, family, & treating doctors.
2. Other guidelines to consider¹¹:
 - a. The ward is terminally ill; or
 - b. The ward is permanently unconscious; or
 - c. CPR will not work (would be medically futile); or
 - d. CPR would impose an extraordinary burden on the ward given his/her medical condition and the expected outcome of CPR.

*** Note the District of Columbia allows an individual to wear a bracelet or necklace indicating their DNR wishes so that EMS (Emergency Medical Services) will know their wishes regarding emergency resuscitation. ****See TAB 1 [App 01-07].

V. Do Guardians have the right to authorize life-sustaining treatment?

Yes. Guardians may authorize life sustaining treatment without a Court Order, IF the incapacitated individual would have wanted to receive such treatment.

¹⁰ In re N., 406 A.2d 1275, 1282 (D.C. 1979) (No legal authority is cited or appears to exist that requires the courts to intervene when extraordinary life support methods are threatened with withdrawal pursuant to a so called "living will" or as done here).

¹¹ DECIDING ABOUT CPR: DO-NOT-RESUSCITATE (DNR) ORDERS. A Guide for Patients and Families. Courtesy of NYS Department of Health <<
<http://www.health.state.ny.us/publications/1441/>>>

VI. Do Guardians have the right to order the withdrawal of life-sustaining treatment

No. Guardians may not consent to the withholding or withdrawal 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. §21-2047.01(3). You must petition the Court for a hearing and receive Court authority before withdrawing life-sustaining treatment.

VII. Other limitations

Guardians may not consent to an abortion, sterilization, psycho-surgery or removal of a bodily organ except to preserve the life or prevent immediate serious impairment of the physical health of the incapacitated individual. D.C. Code § 20-2047.01.

In addition, a Guardian cannot consent to convulsive therapy, experimental treatment or research, behavior modification programs involving aversive stimuli or involuntary or voluntary civil commitment for a mentally ill ward. D.C. Code § 20-2047.01.

You must petition the Court for a hearing and receive Court authority before consenting to such treatment. D.C. Code § 20-2047.01.

VIII. Can A Guardian Force a Ward to Submit to Treatment, When the Ward's Refusal Is Based on Impaired Judgment?

No. Even if the ward's refusal to undergo treatment is clouded by his/her impaired thinking, only a Court can make the determination that the individual must undergo the proposed treatment. The Court must find that the patient, if competent, would choose to undergo the procedure.

A. Psychotropic Drugs:

If the drugs are not necessary to save the patient's life, the Court will look at the substituted judgment method to decide whether to force a patient to take psychotropic drugs against their will. A guardian must raise the question to the Court, and the Court must make findings of fact as to what choice that individual if competent would make

with respect to medical procedures.¹² In the Boyd case, a woman who was a practicing Christian Scientist was admitted to St. Elizabeth's Hospital and refused psychotropic drugs on religious grounds. The Court remanded the case and ordered the Court to determine whether the patient, if competent would have refused the treatment. The Court advised that an individual's right to refuse treatment may be upheld under the substituted judgment method where (1) an individual, prior to incompetence, objected, absolutely to medical care on religious grounds, (2) there was a strong adherence to the tenets of religious faith, and (3) there was no evidence of vacillation.

IX. Practical Considerations

A. Contact Family

Again, the question centers on the patient. You should ask, If the patient did not have this disability, would the patient undergo the treatment?

B. Contact Treating Doctors

If there is no family, then consider discussing the treatment options with the ward's attending doctor, especially advance directives. It has been my experience that if a patient cannot express his wishes and no family is involved, the ward's treating doctor will discuss the advisability of the ward's code status and other decisions.

C. Factors to Consider

Take into account the age of the ward, all medical diagnoses, whether any diagnoses is "terminal," prognosis, etc. In cases, where the ward cannot communicate and has no family, I set up a time to discuss advance directives with the ward's treating doctor. Issues that may arise include whether to place a feeding tube when a ward is unable to eat, whether to subject a 100 year-old patient to aggressive testing, whether to enter a DNR Order for a patient hospitalized on multiple occasions for heart failure. I find the doctors are the most helpful persons to assess the benefits of treatment or nontreatment as they arise.

X. Right to Refuse Medical Treatment – Legal Fundamentals

A. Supreme Court - Constitutional Right to Refuse Medical Treatment

Liberty Interest. The Supreme Court has framed the right to refuse medical treatment as a right arising out of the Fourteenth Amendment liberty interest.¹³ The

¹² In re Boyd, App. D.C., 403 A.2d 744, 1979 D.C. App. LEXIS 404 (June 21, 1979).

¹³ Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 279 (U.S. 1990).

Fourteenth Amendment prohibits a State from depriving any person of life, liberty, or property, without due process of law.¹⁴

Informed Consent. In 1891, the Supreme Court noted that "no right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."¹⁵

Bodily Integrity. An individual is liable for "battery" if he touches another without consent.¹⁶ "[A] surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."¹⁷

Right to Refuse Treatment. The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment. Until 1976 when the NJ Supreme Court decided the seminal case, In re Quinlan,¹⁸ there were relatively few cases involving the right-to-refuse-treatment. The number of cases has greatly increased, thanks in large part to advances in medical treatment which allow an individual to sustain life longer than what was possible in the past.¹⁹

Limitations. No Constitutional Right to Assisted Suicide.²⁰ In addition, a Court in very rare and unusual circumstances may override a competent patient's right to refuse treatment in the interest of protecting society's interest in (1) the preservation of human life; (2) the protection of third parties; and (3) the protection of the ethical integrity of the medical profession.²¹

XI. Glossary

"Advance Directive" means a legal document that puts into writing a person's wishes regarding medical treatment in the future should the person be unable to express his/her wishes.

"Artificial Nutrition and Hydration" means food and water administered by tube. This can be done nasal-gastrically (NG-Tube – tube from the nose to stomach) or directly into the stomach (PEG-Tube – tube through abdomen wall to stomach).

¹⁴ USCS Const. Amend. 14, § 1

¹⁵ Union Pacific R. Co. v. Botsford, 141 U.S. 250, 251, 35 L. Ed. 734, 11 S. Ct. 1000 (1891).

¹⁶ See W. KEETON, D. DOBBS, R. KEETON, & D. OWEN, PROSSER AND KEETON ON LAW OF TORTS § 9, pp. 39-42 (5th ed. 1984).

¹⁷ Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 129-130, 105 N.E. 92, 93 (1914).

¹⁸ 70 N.J. 10, 355 A.2d 647 (N.J. 1976).

¹⁹ Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 269-270 (U.S. 1990)

²⁰ Washington v. Glucksberg & Vacco v. Quill (U.S. 1991).

²¹ Cruzan, 497 U.S. at 271.

“Comfort Care” means measures to keep a person comfortable and at ease in the end of life, but does not intend to cure. Examples include, turning, keeping a person’s lips and mouth moist, and gentle massage.

“CPR” is a treatment performed when a person’s heart and breathing stops. CPR is designed to try and restart a person’s breathing or heartbeat. CPR may be done by applying pressure to the chest, placing a tube down the throat and electric shocks.

“DNR” means Do Not Resuscitate. The form varies from facility to facility, but is usually signed by the treating physician after consulting with the patient, guardian or surrogate decision-maker for the ward.

“Durable Power of Attorney for Health Care” is a legal document which appoints a person to make medical decisions for a person in the future if he/she can’t make his/her own decisions due to incapacity.

“Life-sustaining procedure” (DC Statutory Definition) means any medical procedure or intervention, which, when applied to a qualified patient, would serve only to artificially prolong the dying process and where, in the judgment of the attending physician and a second physician, death will occur whether or not such procedure or intervention is utilized. The term “life-sustaining procedure” shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain. D.C. Code § 7-621 (2009)

“Life-sustaining procedure” includes medicines, breathing machines, tube feeding and drinking, CPR, dialysis and surgeries.

“Living Will” means the same thing as Advance Directive (see above).

“Persistent Vegetative State” means a state of unconsciousness with no reasonable expectation of regaining consciousness. A person in such state may move or open his/her eyes, but is unable to communicate or think.

“Substituted Judgment” means 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. This is the standard to which Guardians must adhere in making decisions on behalf of a ward.

“Terminal condition” means an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serve only to postpone the moment of death of the patient. D.C. Code § 7-621 (2009)

GLOSSARY

ADVANCE DIRECTIVE

A set of instructions, usually written, intended to allow a patient's current preferences to shape medical decisions during a future period of incompetence.

BEREAVEMENT

The time it takes for the survivor to feel the pain of loss, mourn, grieve and adjust to world without the physical, psychological and social presence of the deceased; an acute state of intense psychological sadness and suffering experienced after the tragic loss of a loved one.

CHRONIC DISEASE

An illness marked by long duration or frequent recurrence.

CHRONIC PAIN

Pain that may exist for months or years, rarely causing changes in heart rate or blood pressure but often causing loss of appetite, sleep disturbance, and depression.

CURATIVE

Having healing or curative properties.

DO NOT RESUSCITATE ORDER

An order dictating that an individual does not desire resuscitative measures in case of failed breathing or cardiac arrest.

EMS COMFORT CARE ORDER

A document developed and approved for use by the DC Department of Health. This document authorizes DC Emergency Medical Services personnel to honor "do not resuscitate" orders for persons medically diagnosed with a specific terminal condition.

END OF LIFE

The period of time marked by disability or disease that is progressively worse until death.

GRIEF

A normal emotional response to an external loss; distinguished from a depressive disorder since it usually subsides after a reasonable time. The individualized and personalized feelings and responses that an individual makes to real, perceived, or anticipated loss.

HOSPICE

A care program that provides a centralized program of palliative and supportive services to dying persons and their families, in the form of physical, psychological, social, and spiritual care; such services are provided by an interdisciplinary team of professionals and volunteers who are available at home and in specialized inpatient settings.

HOSPITAL

An institution for the treatment, care, and cure of the sick and wounded, for the study of disease, and for the training of physicians, nurses, and allied health personnel.

INPATIENT RESPITE CARE

Admission of a patient to a hospital, nursing facility, or inpatient hospice to allow the family to have a period without direct care giving. Also, a payment rate for this service in the Medicare hospice benefit.

INPATIENT SYMPTOM MANAGEMENT CARE

Admission of a patient to a hospital, nursing facility or inpatient hospice to control symptoms. Also, a payment rate for this service in the Medicare hospice benefit.

INTRACTABLE PAIN

Pain that is not easily managed, governed, or alleviated.

LONG TERM CARE FACILITY

A facility that provides a range of health, personal care, social, and housing services to people who are unable to care for themselves independently as a result of chronic illness or mental/physical disabilities.

LOSS

The absence of a possession or a future possession.

MEDICAID

A program of medical aid designed for those unable to afford regular medical service and financed by the state and federal governments in the United States.

MEDICAL POWER OF ATTORNEY

Authority to act for another regarding medical decisions.

MEDICARE

A U.S. government program of medical care especially for the aged and disabled.

MOURNING

The outward, social expression of a loss.

NURSE PRACTITIONER

A registered nurse with at least a master's degree in nursing and advanced education in the primary care of particular groups of clients, capable of independent practice in a variety of settings.

NURSING HOME

A facility for the care of individuals who do not require hospitalization and who cannot be cared for at home.

ONCOLOGIST

A specialist in the study of the physical, chemical, and biological properties and features of cancers, including causation, pathogenesis, and treatment.

PAIN

An unpleasant sensation associated with actual or potential tissue damage. Pain is whatever the person says it is; experienced whenever they say they are experiencing it.

PALLIATIVE

Relief of symptoms that interfere with quality of life when treatments won't change the course of the illness.

PATIENT SELF DETERMINATION ACT (PSDA)

A federal statute requiring patients to be informed of their authority to make certain medical decisions, under state law.

PROGRAMS FOR ALL-INCLUSIVE CARE OF THE ELDERLY (PACE)

A federal program offering elderly clients a range of health care services, transportation, food, and social activities, as well as physical, recreational, and occupational therapy.

PROXY

An individual who has been granted the authority or power to act on another's behalf.

ROUTINE HOME CARE

A daily rate in the Medicare hospice benefit; at least 80 percent of the Medicare beneficiary payment days must be at this rate.

SUPPORTIVE SERVICES

Care services designed to help patient and family cope with the effects of illness and disability, rather than to alter the course of disease.

VENTILATOR

A machine that takes over breathing for the patient, controlling the intake and expiration of air.

What is Cardiopulmonary Resuscitation (CPR)?

- CPR includes medical treatments used by healthcare providers to restart the heart and/or restore the breathing of someone who suffers a cardiac or respiratory arrest. CPR involves a group of procedures that may include artificial respiration and intubation to support or restore breathing and chest compression or the use of electric stimulation or medication to support or restore heart function.

Purpose of CPR

- When CPR was developed, the purpose was to restore heart function for individuals experiencing sudden cardiac death resulting from accidents such as drowning or electrocution.

CPR Effectiveness

- A study published in the Journal of the American Medical Association reported that 305 individuals received effective bystander CPR, and of those 305, 14 (4.6%) survived.
- A study of 300 elderly people in nursing homes who had CPR performed showed a survival rate of just 2%. In that study, of the six people who survived CPR, only one would choose to have CPR performed again.
- American Heart Association research shows only 10-15% of hospital patients who have cardiac arrest and receive CPR live long enough to leave the hospital and survive for a period of time.

What is Comfort Care?

- Comfort care focuses on achieving the best possible quality of life for patients and their families regardless of the stage of the disease.
- Comfort care focuses on aggressively controlling pain and other distressing symptoms such as shortness of breath, nausea, vomiting, and anxiety or agitation.
- It addresses personal and spiritual concerns, helping with decision making and providing opportunities for personal growth.
- Respect for the patient's culture, beliefs and values is an essential component.

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Tab 4 DNR Forms (GWUH and Howard Univ. Hosp.	App 51 – 52
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Tab 6 D.C. Code Sections	
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DC EMS Comfort Care Orders

Prepared by The
Greater Washington
Partnership for
Palliative and End-of-Life Care

The Emergency Medical Services Non-Resuscitation Procedures Act of 2000

- D.C. Law 13-224
- Implemented in August 2006
- Enacted so that an individual with a life-limiting terminal illness has the right to experience a natural death at home or at other "out of the hospital" locations.

The Emergency Medical Services Non-Resuscitation Procedures legislation

- Establishes a formal DC protocol to allow physicians to write orders to not perform cardiopulmonary resuscitation for their patients living in the District and being cared for at home. This legislation establishes the out-of-hospital DNR and names it a *Comfort Care Order*.

The Comfort Care Order (CCO)

- Authorizes Emergency Medical Services personnel to withhold cardiopulmonary resuscitation from a person if the person experiences cardiac arrest (no palpable pulse) or respiratory arrest (no spontaneous breathing) as the result of a specified medical or terminal condition and to administer comfort care.

Who is eligible to execute a Comfort Care Order?

- Competent persons 18 years of age or older.
- An authorized decision-maker on behalf of an incapacitated person.
- A surrogate on behalf of a minor.

Under District of Columbia law, authorized decision-makers include:

- A person whom the patient has authorized under a Durable Power of Attorney for Health Care.
- A family member recognized under DC law or a guardian authorized to make health care decisions if there is no Power of Attorney.
- Natural or adoptive parents or legal guardian of a minor child authorized to make health care decisions are recognized as the surrogate of the minor child.

Circumstances for DNR with a Comfort Care Order

- Standard Do Not Resuscitate orders issued by a physician are only valid in the hospital or other medical facility.
- The Comfort Care Order allows the patient to extend the physician's DNR order outside the confines of the medical setting.
- The Comfort Care Order allows the EMS personnel to honor the wishes of the patient, authorized decision-maker or surrogate to allow a natural death should it occur while the patient is in an ambulance or otherwise under their care.
- EMS personnel and other care providers honor specially designed Comfort Care bracelets or necklaces that confirm the existence of a properly executed Comfort Care Order.

How does one get a Comfort Care Order?

- Physicians and others can order the forms by calling the Department of Health Call Center at 202-671-5000 and asking for the EMS Comfort Care forms.
- The forms are individually numbered. They will be sent with the temporary plastic bracelets and instructions for ordering a stainless steel ID type bracelet for a cost of \$21.95 each.
- If ordered, the permanent bracelet/necklace will be engraved with
 - Patient name/identification number
 - Attending MD name/telephone number
 - Comfort Care Order number

The following information is required on the form:

- **Name, Identification Number**
- **Patient Signature**
 - if the patient is able to sign;
 - otherwise refer to the decision-maker or surrogate name/signature
- **Attending MD**
 - signature
 - date
 - license number
 - telephone number
- **Authorized decision-maker or surrogate name/signature/Social Security number**
 - If the patient has designated a decision-maker or surrogate, that person's name, signature and social security number should be on the form.

The Comfort Care Order is valid only when signed by a physician.

- Once completed, one copy of the form must be faxed or mailed to the Department of Health as designated on the form. We recommend sending them by fax and, if possible, keeping a log of the registration numbers.

Revocation of CCO

- The Comfort Care Order may be revoked at any time by the patient, his/her authorized decision maker, or surrogate.
- Consider the order revoked if:
 - bracelet or necklace is removed, cut, destroyed, defaced or discarded
 - patient or his or her authorized surrogate directs another person to remove or destroy the bracelet in the presence of the patient, authorized decision maker or surrogate
 - the patient, authorized decision maker or surrogate communicates directly to EMS provider the intent to revoke the order

- Please report any problems securing forms or bracelets or in other aspects of the program to Sally White, 202-895-0246 or swhite@gwpartnership.org.
- We'd love to hear success stories too!



EMS Comfort Care Order

FORM MUST BE FULLY COMPLETED TO BE VALID

A. Patient Information

Name (Print legibly):

Last

First

M.I.

Patient's DOB:

Month / Date / Year

Gender:

Male:

Female:

Signature of (Check one)

☐ Patient

☐ Authorized Decision-Maker

☐ Surrogate

I consent to this Order.

Name:

Signature:

SSN:

B. Physician's Certification and Order

- I certify that this patient has the following specified medical or terminal condition:
- If the patient's heart or breathing stops as a result of the above medical or terminal condition, I direct that the Patient receive all necessary comfort care as listed on the back of this form. Cardiopulmonary resuscitation (CPR) and advanced life support are inappropriate measures for this patient and are not to be used.
- I have explained to the patient or authorized decision-maker or surrogate, if applicable, the effect of this Comfort Care Order as explained on the back of this form, the medical alternatives to it, and the other forms of health care advance directives.
- I have also explained how this Order may be revoked, as described on the back of this form.

Signature of Attending Physician

Date

Physician's Name (printed)

Physician's License Number

Physician's Phone Number

C. EMS provider check all that are applicable

☐ Patient Transported

☐ CCO Implemented

☐ CCO Revoked

This form is an EMS Comfort Care Order authorized by D.C. Law 13-224, and is printed on security paper.
Photocopies are not Valid

Form Copies:
WHITE
Patient's Copy

YELLOW
Patient's medical record

BLUE
Physicians mail to:
DC DOH/EHMSA/DNR
64 New York Ave NE Suite 5000
Washington, DC 20001
or fax to: 202-671-0846

MANILLA
For ordering metal bracelet

Physician signing EMS Comfort Care Order must sign ALL IDENTIFICATION INSERTS

EHMSA-DNR-0000 1/04

IMPORTANT: Type or print information clearly, detach identification insert, fold strip then insert into plastic bracelet. Physician must affix bracelet to patient.

IMPORTANT: Type or print information clearly, detach identification insert, fold strip then insert into plastic bracelet. Physician must affix bracelet to patient.

IMPORTANT: Type or print information clearly, detach identification insert, fold strip then insert into plastic bracelet. Physician must affix bracelet to patient.

District of Columbia
EMS Comfort Care Order

Patient Name:

MD Name:

MD Phone:

CCO/Patient I.D. #

District of Columbia
EMS Comfort Care Order

Patient Name:

MD Name:

MD Phone:

CCO/Patient I.D. #

District of Columbia
EMS Comfort Care Order

Patient Name:

MD Name:

MD Phone:

CCO/Patient I.D. #

APP 07

Your Durable Power of Attorney for Health Care, Living Will & Other Wishes

This document has been prepared and distributed as an informational service of the District of Columbia Hospital Association.

INSTRUCTIONS AND DEFINITIONS

Introduction

This form is a combined Durable Power of Attorney for Health Care and Living Will for use in D.C., Maryland and Virginia.

With this form, you can:

- ◆ Appoint someone to make medical decisions for you if, in the future, you are unable to make medical decisions for yourself

And/or

- ◆ Indicate what medical treatment you do or do not want if in the future you are unable to make your wishes known.

Directions

- ◆ Read each section carefully.
- ◆ Talk to the person you plan to appoint to make sure that he/she understands your wishes, and is willing to take the responsibility.
- ◆ Place the initials of your name in the blank before those choices you want to make.
- ◆ Fill in only those choices that you want under Parts 1, 2, and 3. Your advance directive should be valid for whatever part(s) you fill in, as long as it is properly signed (part 4).
- ◆ Add any special instructions in the blank spaces provided. You can write additional comments on a separate sheet of paper, but you should indicate on the form that there are additional pages to your advance directive.
- ◆ Sign the form and have it witnessed.
- ◆ Give your doctor, your nurse, the person you appoint to make your medical decisions for you, your family, and anyone else who might be involved in your care, a copy of your advance directive and discuss it with each person.
- ◆ Understand that you may change or cancel this document at any time.

For more information call:

Social Work Department
202.877.6286

or

The Center for Ethics
202.877.0246

Words You Need To Know

Advance Directive

A written document that tells what a person wants or does not want if, in the future, he/she can't make his/her wishes known about medical treatment.

Artificial Nutrition and Hydration

When food and water are given to a person through a tube.

Autopsy

An examination done on a dead body to find the cause of death.

Comfort Care

Care that helps to keep a person comfortable but does not intend to cure. Bathing, turning, keeping a person's lips moist are types of comfort care.

CPR (Cardiopulmonary Resuscitation)

Treatment to try and restart a person's breathing or heartbeat. CPR may be done by pushing on the chest, by putting a tube down the throat, or by other treatments.

Durable Power of Attorney for Health Care:

An advance directive that appoints someone to make medical decisions for a person if in the future he/she can't make his/her own medical decisions.

Life-Sustaining Treatment

Any medical treatment that is used to keep a person from dying. A breathing machine, CPR, and artificial nutrition and hydration are examples of life-sustaining treatments.

Living Will

An advance directive that tells what medical treatment a person does or does not want if he/she is not able to make his/her wishes known.

Organ and Tissue Donation

When a person permits his/her organs (such as eyes or kidneys) and other parts of the body (such as skin) to be removed after death to be transplanted for use by another person or to be used for experimental purposes.

Persistent Vegetative State

When a person is unconscious with no reasonable expectation of regaining consciousness even with medical treatment. The body may move and eyes may be open but as far as anyone can tell, the person can't think or respond.

Terminal Condition

An on-going condition caused by injury or illness that has no cure and from which doctors expect the person to die even with medical treatment.

This form is to be completed by a patient **who has** an Advance Directive, but **does not have an available** copy upon admittance to Washington Hospital Center. This form will serve as a substitute verification of the patient's wishes until the original Advance Directive is presented.

☐ I have an ADVANCE DIRECTIVE that has **NOT BEEN** provided to the Washington Hospital Center.

I understand that to protect the right I have already demonstrated through an advance directive, I need to communicate my wishes in regards to my future medical care to my healthcare providers.

As such, the intent of my advance directive is as follows:

	YES	NO
If I am in a terminal condition, I want medically appropriate methods used to keep me alive.	<input type="checkbox"/>	<input type="checkbox"/>
IF YOU ANSWERED NO, COMPLETE THE FOLLOWING SIX QUESTIONS		
DO YOU WANT:		
1. To be kept on a ventilator (a mechanical device to assist with breathing)?	<input type="checkbox"/>	<input type="checkbox"/>
2. CPR (Cardiopulmonary Resuscitation...Emergency medical procedures to stimulate heart and/or provide air into the lungs)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Antibiotics (medication to fight infection)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Pain medication (providing pain medication to relieve pain even if it may lead to reduced consciousness and/or shorten life)?	<input type="checkbox"/>	<input type="checkbox"/>
5. To be fed by a tube to your stomach if you cannot eat?	<input type="checkbox"/>	<input type="checkbox"/>
6. To be medically fed and hydrated?	<input type="checkbox"/>	<input type="checkbox"/>

☐ I cannot remember any of the content of my advance directive and wish to fill out another one.

I have appointed a Durable Power of Attorney or Healthcare Surrogate: ☐ Yes ☐ No

If you have not appointed a Durable Power of Attorney or healthcare surrogate, is there someone you want to make decisions for you if you are not able to speak for yourself?

Name:

Phone:

At any time, you may change your mind about any of the answers given to any of these questions by informing your nurse attending physician.

Comments you would like to make:

I understand and agree that this document will serve as a recording of the substance of my existing Advance Directive until I provide a copy to the Washington Hospital Center.

Signature of Patient:

Date:

Witness:

Date:

My Durable Power of Attorney for Health Care, Living Will and Other Wishes

I, _____, write this document as a directive regarding my future medical care.

Put the initials of your name by the choices you want.

PART 1. MY DURABLE POWER OF ATTORNEY FOR HEALTH CARE

☐ I appoint this person to make decisions about my medical care if there ever comes a time when I cannot make those decisions myself:

☐ If the person I appointed first cannot or will not make decisions for me, I appoint this person:

Name

Name

Home phone

Home phone

Work phone

Work phone

Address

Address

☐ I have not appointed anyone to make health care decisions for me in any other document.

I want the person I have appointed, my doctors, my family, and others to be guided by the decisions I have made below:

PART 2. MY LIVING WILL

These are my wishes for my future medical care if there ever comes a time when I can't make these decisions for myself.

A. These are my wishes if I have a **terminal condition**:

B. These are my wishes if I am ever in a **persistent vegetative state**:

Life-Sustaining Treatments

Life-Sustaining Treatments

☐ I do not want life-sustaining treatments (including CPR) started. If life-sustaining treatments are started, I want them stopped.

☐ I do not want life-sustaining treatments (including CPR) started. If life-sustaining treatments are started, I want them stopped.

☐ I want life-sustaining treatments that my doctors think are best for me.

☐ I want life-sustaining treatments that my doctors think are best for me.

☐ Other wishes:

☐ Other wishes:

Artificial Nutrition and Hydration

Artificial Nutrition and Hydration

☐ I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration is started, I want it stopped.

☐ I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration is started, I want it stopped.

☐ I want artificial nutrition and hydration even if it is the main treatment keeping me alive

☐ I want artificial nutrition and hydration even if it is the main treatment keeping me alive

☐ Other wishes:

☐ Other wishes:

Comfort Care

Comfort Care

☐ I want to be kept as comfortable and free of pain as possible, even if such care speeds up my dying or shortens my life.

☐ I want to be kept as comfortable and free of pain as possible, even if such care speeds up my dying or shortens my life.

☐ Other wishes:

☐ Other wishes:

Other Directions

You have the right to be involved in all decisions about your medical care, even those not dealing with terminal conditions or persistent vegetative states. If you have wishes not covered in other parts of this document, please indicate them here.

PART 3. OTHER WISHES**Organ Donation**

☐ I want to donate all of my organs and tissues.

☐ I only want to donate these organs and tissues:

☐ I do not wish to donate any of my organs or tissues.

☐ Other wishes:

Autopsy

☐ I agree to an autopsy if my doctors wish it.

☐ I do not want an autopsy.

☐ Other wishes:

If you wish to say more about any of the above choices, or if you have any other statements to make about your medical care, you may do so on a separate sheet of paper. If you do so, put the number of pages you are adding here:

PART 4. SIGNATURES

You and two witnesses must sign this document in order for it to be legal.

Your Signature

By my signature below I show that I understand the purpose and the effect of this document.

Date

Print Name

Signature

Address

Your Witnesses' Signature

I believe the person who has signed this advance directive to be of sound mind, that he/she signed or acknowledged this advance directive in my presence, and that he/she appears not to be acting under pressure, duress, fraud, or undue influence. I am not related to the person making this advance directive by blood, marriage or adoption, nor, to the best of my knowledge, am I named in his/her will. I am not the person appointed in this advance directive. I am not a health care provider or an employee of a health care provider who is now, or has been in the past, responsible for the care of the person making this advance directive.

Witness #1

Print Name

Signature

Date

Address

Witness #2

Print Name

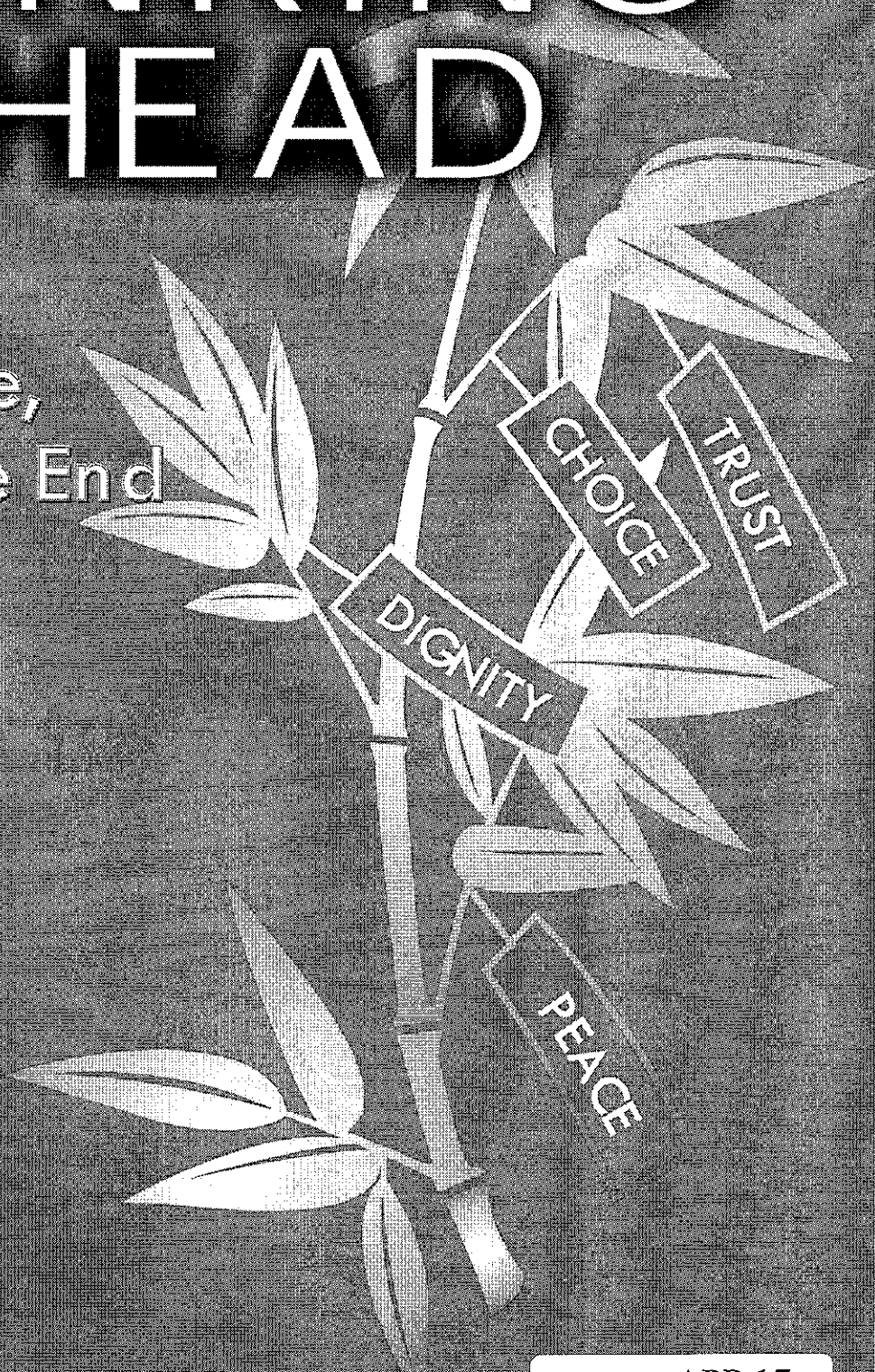
Signature

Date

Address

THINKING AHEAD

My Way,
My Choice,
My Life at the End



APP 17

"There is life, and there is death. You don't know what's going to happen today or tomorrow so you have to be prepared."

Connie Martinez, 2008



Personal Requests

These are my personal requests, but it is not a Will.

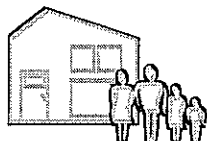
Name: _____

(1) Where I want to be

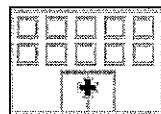
This is my choice about where I want to spend my final days.



☐ My Home



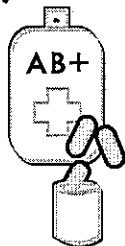
☐ With My Family



☐ Hospital

☐ Other Place

(2) How I want to be cared for



? Have my family and friends near.

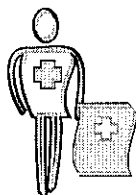
? Have personal care that helps me feel comfortable.

? Have my favorite things around me.

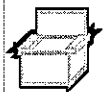
? Have my favorite music playing.

? Have my religion respected.

? Other ways I want to be cared for:



(3) Where I want my things to go



Money

Clothing



Furniture

Equipment



Pet

Other



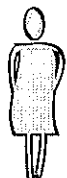
Personal Requests



(4) Gifts I want to give

Item: _____ To: _____

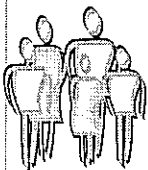
Item: _____ To: _____



(5) My body

? I want to be buried. Where: _____

? I want to be cremated. Where I want my ashes to go: _____



(6) Being remembered

I want a funeral service ? Yes ? No

? At my place of worship _____

? At a funeral home _____

? Other place _____

? I want people to remember me by doing this: _____

abc

Sign Your Name

Date

Street Address

City

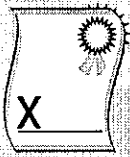
State

Zip Code

Home Phone

Work Phone

Email



Advance Directive

(Name) _____ is my
End-of-Life Advocate (Health Care Agent).

Street Address City State Zip Code

Home Phone Work Phone Email

My End-of-Life Advocate will make decisions for me only if I cannot make my own decisions.



My End-of-Life Choices

 **During my final days, my quality of life means:**

- ? Being awake and thinking for myself.
- ? Communicating with family or friends.
- ? Being free from constant and severe pain.
- ? Not being connected to a machine all the time.
- ? _____

 **During my final days, my life support treatment decision is:**

- ? I want life support treatment as long as possible.
- ? I do not want any life support treatment.
- ? I want life support treatment **only** if my doctor thinks it could help.
- ? I want my End-of-Life Advocate to decide for me.



Advance Directive

abc

Sign Your Name

Date

abc

Print Your Name

Date

Address

City

State

Zip Code

For Witnesses:

As a witness, I promise that (person) _____,
signed this form while I watched. He/she was **not** forced to sign it.

I also promise that:

- I know this person and he/she can confirm their identity.
- I am 18 years or older.
- I am **not** this person's End-of-Life Advocate (Health Care Agent).
- I am **not** this person's health care provider or work for this person's health care provider.
- I do **not** work where this person lives.

abc

Witness Signature

Date

abc

Witness Signature

Date

One witness must not be related by blood, marriage or adoption and not receive any money or property from this person after he/she dies.

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
Probate Division

In re:

EUNICE WARE:

Adult Ward

Intervention Proceeding
No. 05-01

RECEIVED
PROBATE DIVISION
2006 APR 21 2:30 PM
LH 24

**EMERGENCY PETITION POST APPOINTMENT FOR
THE APPOINTMENT OF A BIO-ETHICS PANEL**

Comes now, Katherine M. Wiedmann, Successor Guardian of Eunice Ware, an Adult, and hereby submits the following in support of her Emergency Petition Post-Appointment for the Appointment of a Bio-Ethics Panel:

I. Introduction

1. Petitioner was appointed Successor Guardian by Court Order dated August 3, 2004.
2. Archie Blacknall is the only surviving child of the ward and previously served as the ward's guardian. *See* Court Order dated March 8, 2001.
3. On May 12, 2004, Mr. Blacknall was removed as guardian for reasons including his relocation to North Carolina.
4. The ward is currently 92 years old, having been born on April 9, 1914 and she resides at the Washington Center for Aging Services, 2601 Eighteenth Street N.E., Washington D.C. 20018.
5. The ward has been diagnosed with Alzheimer's disease, Stage-two dementia, and has a history of gastritis. She is unable to speak, is non-responsive to attempts to communicate with her, is unable to walk or feed herself, and requires assistance with all activities of daily life. Prior to Petitioner's appointment, she had a g-tube placed through which she receives all sustenance.

6. Her feeding tube has become detached and Petitioner has questions as to whether the feeding tube should be replaced under the provisions of her living will. Since the ward's feeding tube has become detached, she is receiving short-term sustenance intravenously and cannot subsist for many days without additional nutrition. For this reason, Petitioner respectfully requests the immediate appointment of a Bioethics Panel and an emergency hearing to take place on Monday, May 1, 2006.

II. The Ward's Living Will

7. Soon after her appointment Petitioner visited the ward at the nursing home and reviewed her chart. She obtained a copy of the ward's Advance Health Care Directive, signed by Mr. Blacknall and dated August 20, 2000. See, Advance Health-Care Directive for an Incapacitated Resident, attached hereto as Exhibit A. The form is incorrectly filled out so that it both directs health care providers that life-sustaining treatments (including CPR) **should not** be started and that life-sustaining treatments **should** be provided.

8. Petitioner made several attempts to contact Mr. Blacknall, but the information on file at the nursing home was outdated and the telephone number was non-working. Petitioner was told by the nursing home that they believed he no longer lived in the area.

9. On March 23, 2005, Petitioner spoke with Dr. Shelly McDonald-Pinkett, the ward's attending physician at the nursing home who has treated the ward since her admission in 1998. Dr. Pinkett explained that she has advanced Alzheimer's and that she does not expect any improvement. She also requested that Petitioner "update" the ward's advanced directives because the current document contradicts itself and for that reason the ward would be treated as "full code."

10. On June 2, 2005, Petitioner received a telephone message from Dr. Lamming-Lee, the

ward's attending physician at Providence Hospital, who informed her that the ward had been admitted to the ER after experiencing trouble breathing and gastro-intestinal bleeding. Dr. Lamming-Lee indicated that there was a DNR on the chart although the records were unclear. She referred to the Advance Directive signed by Mr. Blacknall in 2000. Petitioner immediately called back Dr. Lamming-Lee and both agreed that the ward should remain "full-code" until Petitioner could investigate further the ward's wishes.

11. On June 6, 2005, Petitioner received a telephone call from Mr. Blacknall, who explained that he currently lives in North Carolina and that he had been contacted by Providence Hospital regarding the hospitalization of his mother. Petitioner explained that she wished to discuss the ward's advance directives with him and he responded that he had copies of her will and living will which named him power of attorney to act on her behalf. Petitioner arranged to meet with Mr. Blacknall and requested he bring any documentation he had to the meeting.

12. On June 7, 2005 and June 21, Petitioner met with Mr. Blacknall, who presented a copy of the ward's Living Will and her Last Will and Testament, both signed by the ward and dated March 4, 1991. See, Living Will of Eunice Ware, attached hereto as Exhibit B. He stated that he had never seen the original documents and did not know where his mother may have kept them. The documents were prepared by Paul L. Wershals, an attorney with offices in Great Neck, New York.

13. When Petitioner asked him why he had been appointed guardian originally, when he had the power of attorney, he stated that he tried to raise this issue to the Court but, as far as he understood, it was never addressed.

14. During the meeting on June 21, 2005, Petitioner asked Mr. Blacknall how he felt about

the wishes his mother expressed in the Living Will, that should her doctors determine that she is in a state of permanent unconsciousness, that all health care be withheld or withdrawn.

Petitioner pointed out that the definition expressly refers to the advanced stages of Alzheimer's disease. He responded that he felt the document left some room for interpretation, and he stated he believed that his mother still recognized him when he visits. He mentioned the Terri Schiavo case and questioned Petitioner as to whether the feeding tube would be removed. He stated that he would strongly object to any decision to remove her feeding tube.

15. On June 21, 2005, Petitioner telephoned the offices of the drafting attorney, who located the forms and sent them to her office. She is now in possession of the original last will and testament and living will of the ward.

16. The living will document provides in Section A, entitled "Declaration," that "If I should be in a state of permanent unconsciousness, I direct that all health care be withheld or withdrawn." Exhibit B at 1. The ward defines "permanent unconsciousness" as "a lasting

condition, indefinitely without change in which thought, feeling, sensations and awareness of self or environment are absent in the opinion of my attending physician or other physician requested by any proxy of mine to render an opinion. It includes a persistent vegetative state such as in an advanced stage of Alzheimer's disease, or a similar senile condition, in which recognition of family members is absent, in the opinion of such physician." Id. at 3, Para. 1(b).

17. The ward further provides that "If I should be in a terminal condition and am unable to make decisions regarding my medical treatment, I direct that all life sustaining treatment be withheld or withdrawn, including resuscitation, medication, respiration, nutrition and hydration, excepting only if and to the extent needed to relieve suffering, unduly severe discomfort or unduly severe pain." Id. at 1.

18. For many months, Petitioner has been trying to work with Mr. Blacknall and the ward's physicians to prepare an advance directives form which complies with the ward's wishes as set forth in her living will.
19. On July 14, 2005, Petitioner spoke with Dr. Pinkett at the nursing home, and explained to her that we have been able to locate the ward's Living Will. After discussing the specific provisions in the document, Dr. Pinkett stated that she believes the document supports the directive that no advance cardiac life support or cardio pulmonary resuscitation should be performed. She stated that the ward is not currently on many medications and that these medications are palliative and improve the ward's comfort. Finally, she stated that based on the language provided in the living will, she believes that the ward should continue to receive nutrition through the g-tube.
20. On July 21, 2005, Petitioner sent a letter to Dr. Pinkett to follow up on the issues and to seek additional medical guidance in the interpretation of the living will. Exhibit C. However, it was not until February, 2006 that Petitioner was able to have a conference call with the doctors and staff at the Home to discuss, from a medical perspective, how the living will should be interpreted given the ward's medical condition.
21. On March 1, 2006, Petitioner spoke with the head of physicians at the Home, Dr. Obesessan, and he opined that according to the definition in the living will, she is in a persistent vegetative state. However, Petitioner was unable to ascertain whether the feeding tube is "health care" under the living will, Part A, Paragraph 1. The doctor advised that he felt the feeding tube should remain in place, which is consistent with the opinion of Dr. Pinkett and Mr. Blacknall.

III. Emergency Request for Appointment of Bio-Ethics Committee

22. On April 12, 2006, Petitioner received a telephone call from the Washington Center For Aging Services explaining that the ward had been transferred to Providence Hospital because her feeding tube had become detached.

23. During that week, the ward was seen by doctors in the surgical unit, as well in the gastroenterology unit. Dr. Brownlee, the ward's attending physician and Dr. Williams, her gastroenterologist, explained to Petitioner that the feeding tube could not be re-placed at the same site. The feeding tube was removed and the doctors advised that the site would have to be left to heal and the feeding tube would have to be re-inserted at a different site. She is currently being fed intravenously through peripheral parenteral nutrition (PPN), which provides adequate nutrition only for the short term.

24. Petitioner now seeks the appointment of an Emergency Bioethics Committee to address the question of whether the feeding tube should be replaced per the directions of the ward set forth in her living will.

IV. Legal Issues Presented

The District of Columbia recognizes the right to make advanced decisions for medical care in a Living Will. See, D.C. Sec. 21-2201 et seq. The purpose of the section is to "affirm the right of all competent adults to control decisions relating to their own health care and to have their rights and intentions in health care matters respected and implemented by others if they become incapable of making or communicating decisions for themselves." D.C. Sec. 22-2201. It is also well established that the patient, and not the physician, ultimately decides if treatment – any treatment – is to be given at all. Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972).

However, Petitioner seeks guidance as to the express wishes of the ward as stated in her living will and whether her medical condition fits into the definition of "permanent unconsciousness." The ward defines "permanent unconsciousness" as:

a lasting condition, indefinitely without change in which, thought, feeling, sensations and awareness of self or environment are absent in the opinion my attending physician . . . It includes a persistent vegetative state such as in an advanced stage of Alzheimer's disease, or a similar senile condition, in which recognition of family members is absent, in the opinion of such physician.

Here, the ward combines the concept of a persistent vegetative state with the advanced stages of Alzheimer's disease. In addition, Petitioner has discussed this matter with several doctors who have differing opinions as to whether the feeding tube is "health care."

The Court of Appeal of Florida considered a similar issue in In re Guardianship of Estelle M. Browning et al v. State of Florida & Sunset Point Nursing Ctr, 543 So.2d 258 (Fla. 1960). In that case, the court appointed guardian petitioned the Court for authority to exercise the ward's self-determination as expressed in her living will to withdraw a nasogastric tube. Id. at 262. The ward in that case was 89 years old and she had been confined to a nursing home following a massive stroke which caused major, permanent and irreversible damage to her brain. She was fully dependent on others for her activities of daily living and received nutrition and hydration through a feeding tube. Eventually the feeding tube became dislodged and the ward received feeding through a nasogastric tube. The ward was totally unresponsive except that she would respond to deep pain by moving.

Prior to her incapacity, the ward had prepared a living will stating that she desired that "nutrition and hydration (food and water)" not be provided and that she desired that all life sustaining procedures be withdrawn when her death was "imminent." Her doctors testified that the ward was in a persistent vegetative state with little or no neurological activity above the

brain stem. Id. at 263.

The Court considered the guardian's request under various legal theories. The Court first found that under Florida's Living Will statute, the guardian could not direct the nursing home to remove the feeding tube. Florida's statute, much like D.C.'s, provides "any competent adult may . . . make a written declaration directing the withholding or withdrawal of *life-prolonging* procedures in the event such person should have a *terminal condition*."¹ Id. (emphasis provided in original). The Court determined that an artificial feeding device involved the "provision of sustenance" and was not a life-prolonging procedure for purposes of the statute.

After deciding that no other statute, including the power of attorney statute, provided a remedy to the guardian, the court went on to discuss the patient's right to refuse medical treatment. The Court explained that the right to refuse medical treatment is based on the individual's right of self-determination guaranteed by the Florida constitutional right to privacy. Id. at 267. Further, when a person is no longer competent to exercise his or her own right of self-determination, the right still exists, but the decision must be delegated to a surrogate decision-maker. Id. The Court affirmed the right of the legal guardian to withdraw the feeding tube under the doctrine of "substituted judgment" where the evidence establishes the patient would have made the decision to withdraw treatment under these circumstances. Id. at 272-73.

WHEREFORE, Petitioner respectfully requests that the Court grant this Petition, appoint an emergency Bio-Ethics Panel and schedule a hearing for Monday, May 1, 22006.

¹ D.C. Code Section 7-622(a) provides "Any persons 18 years of age or older may execute a declaration directing the withholding or withdrawal of life-sustaining procedures from themselves should they be in a terminal condition"

Respectfully submitted,

Katherine M. Wiedmann

Katherine M. Wiedmann

Successor Guardian of Eunice Ware

D.C. Bar No. 481795

Crowley, Hoge & Fein, P.C.

1710 Rhode Island Avenue, N.W.

7th Floor

Washington, D.C. 20036

(202) 483-2900

I, Katherine M. Wiedmann, being first duly sworn, on oath, depose and say that I have read the foregoing pleadings by me subscribed, and that the facts therein stated are true to the best of my knowledge, information and belief.

Katherine M. Wiedmann

Katherine M. Wiedmann

Crowley, Hoge & Fein, P.C.

1710 Rhode Island Ave., NW 7th Floor

Washington, D.C. 20036

(202) 483-2900

DISTRICT OF COLUMBIA, SS:

Subscribed and sworn to before me by Katherine M. Wiedmann this 21st day of April 2006.

Denise M. Nealy
Notary Public, D.C.

My commission expires 8-14-2010

CERTIFICATE OF SERVICE

I hereby certify that on the 21st day of April, 2006, I mailed copies of the foregoing Petition to the following individuals entitled to notice in this matter:

Eunice Ware

Providence Hospital

1150 Varnum St Ne

Washington, DC 20017

ADVANCE HEALTH-CARE DIRECTIVE
FOR AN INCAPACITATED RESIDENT

Note: INCORRECTLY COMPLETED

I/we have agreed to make health-care decisions for Mr. Eunice, an incapacitated adult resident currently residing at the Washington Center for Aging Services.

I am/we are related by blood to Mr. Eunice Lane and request that the following health-care directives be observed.

INDICATE YOUR CHOICE BY PLACING YOUR INITIALS BY THE APPROPRIATE RESPONSES.

Directions Regarding Terminal Conditions

If the resident is ever in a terminal condition, that is, the resident has an incurable or irreversible medical condition and the resident's doctors conclude that the resident has no chance of recovery, or that the resident is dying, and/or that the use of life-sustaining procedures would only prolong the resident's dying,

1. Life-Sustaining Treatment in General.

A) APB I/we do not want life-sustaining treatments (including CPR) started. If life-sustaining treatments have been started, I want them stopped.

B) APB I/we want medically indicated life-sustaining treatments.

C) APB I/we want resident to be transferred to an acute-care hospital.

D) _____ I/we do not want resident to be transferred to an acute-care hospital.

E) _____ My/our wishes are as follows: As per requested in Residing Will. Available upon request

2. Nutrition and Hydration in Particular.

A) _____ I/we do not want artificial nutrition and hydration started if it would be the primary treatment keeping the resident alive. If artificial nutrition and hydration has been started, I/we want it stopped.

B) APB I/we want medically indicated artificial nutrition and hydration.

C) _____ My/our wishes are as follows: to make the resident as comfortable as possible

3. Comfort Measures.

A) APB I/we want the resident to be kept as comfortable and as pain-free as possible even if doing so might either prolong the resident's dying or shorten the resident's life.

Directions Regarding Persistent Vegetative State and Other Irreversible Comas

If the resident is ever in a persistent vegetative state, or other form of irreversible coma, that is, the resident has such severe brain damage that his/her doctors conclude that to the best of their knowledge the resident has lost the ability to think or respond to people,

1. Life-Sustaining Treatment in General.

- A) _____ I/we do not want life-sustaining treatments (including CPR) started. If life-sustaining treatments have been started, I/we want them stopped.
- B) _____ I/we want medically indicated life-sustaining treatments.
- C) _____ I/we want resident to be transferred to an acute-care hospital.
- D) _____ I/we do not want resident to be transferred to an acute-care hospital.
- E) _____ My/our wishes are as follows: _____

2. Nutrition and Hydration in Particular.

- A) _____ I/we do not want artificial nutrition and hydration started if it would be the primary treatment keeping the resident alive. If artificial nutrition and hydration has been started, I/we want it stopped.
- B) _____ I/we want medically indicated artificial nutrition and hydration.
- C) _____ My/our wishes are as follows: _____

Comfort Measures.

- A) _____ I/we want the resident to be kept as comfortable and as pain-free as possible even if doing so might either prolong the resident's dying or shorten his/her life.
- B) _____ My/our wishes are as follows: _____

OTHER IMPORTANT DECISIONS

* Issues Regarding Organ Donation

- A) Yes (9/9/93) If the resident is ever a candidate for organ donation, I/we wish to donate all usable organs and/or tissues.

B) OK

If the resident is ever a candidate for organ donation, I/we do not wish to donate any of his/her organs or tissues.

C) _____

My/our wishes are as follows: that she be released to appropriate authority

Wishes Regarding Autopsy

A) _____

I/we have no objections to a post-mortem (after death) examination.

B) OK

I/we do not wish to have a post-mortem (after death) examination.

C) _____

My/our wishes are as follows: _____

SIGNATURES

(This section must be completed for your advance health-care directive to be valid.)

BY THE SIGNATURE(S) BELOW, I/WE INDICATE THAT I/WE UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

Signature: [Signature]

Address: 5330 4th St. SE, Washington, DC 20032

Date: 08/20/00

Signature: _____

Address: _____

Date: _____

Signature: _____

Address: _____

Date: _____

THE ABOVE NAME INDIVIDUAL APPEARED BEFORE ME PERSONALLY, IN WASHINGTON, D.C., SIGNED IN MY PRESENCE THIS DOCUMENT, AND AFFIRMED IT PROPERLY.

DATED: 08/20/00

[Signature]
NOTARY PUBLIC

Subscribed and sworn to before me in my presence.

this 23rd day of August, 2000, a Notary Public

in and for the P. G. County of Maryland.

[Signature]
Notary Public

My commission expires January 1, 2001

COPY

LIVING WILL OF
EUNICE WARE

PAUL L. WERSHALS
ATTORNEY AT LAW
10 CUTTER MILL ROAD
GREAT NECK, N. Y. 11021
(516) 466-6120

EXHIBIT

B

APP 34

MY LIVING WILL

KNOW ALL MEN BY THESE PRESENTS which are intended to constitute a POWER OF ATTORNEY (Proxy) and DECLARATION pursuant to law as now or hereafter in effect,

THAT, I, the principal, EUNICE WARE, presently residing at 3330 4th Street SE, Apt. 205, Washington, D.C., being now of sound mind and able to make health care decisions for myself but realizing that I may become unable to do so and desiring to provide for that contingency, whether such contingency be temporary or of indefinite duration or otherwise,

A. DECLARATION

DO HEREBY DECLARE:

If I should be in a state of permanent unconsciousness, I direct that all health care be withheld or withdrawn.

If I should be in a terminal condition and am unable to make decisions regarding my medical treatment, I direct that all life sustaining treatment be withheld or withdrawn, including resuscitation, medication, respiration, nutrition and hydration, excepting only if and to the extent needed to relieve suffering, unduly severe discomfort or unduly severe pain.

Insofar as consistent with the above, I request my attending physician to administer medication to alleviate pain. I wish to die with whatever dignity is possible.

I also request that every one be perfectly honest and fully candid with me about my condition at all times. Insofar as I am able to do anything, knowledge may be essential so that I may act accordingly.

It is my preference that I live out my last days at home if that is feasible and does not impose an undue burden on my family, emotionally or financially. Indeed the avoidance of

such a burden on my family or myself is a motivating force in executing this document.

B. POWER OF ATTORNEY

AND I DO HEREBY APPOINT my son, ARCHIE JAMES BLACKNALL, residing at 3330 4th Street SE, Apt. 104, Washington, D.C. my attorney-in-fact and Proxy TO ACT in my name, place and stead, to the fullest extent possible, in any way which I myself could do, if I were personally present and able to act. In the event my son, ARCHIE JAMES BLACKNALL, cannot act, my daughter, PATRICIA BLACKNALL, residing at 901 6th Street SW, Washington, D.C., may act in his stead. They are authorized to act in the following capacities:

To make all health care decisions for me and on my behalf (if and so long as I should be unable to make such decisions), to give all such directions and execute and deliver all such documents and do all such further acts as such proxy may deem desirable in connection therewith, including the following:

To implement and give directions to carry out the provisions of my Declaration and this Power of Attorney, among other things; to have access to and disclose medical records and other personal information; to give or refuse, withhold or withdraw consent to medical care, medical (including surgical) procedures and other care or treatment of any kind and whether general or specific; to direct the withholding or withdrawal of all life sustaining treatment including resuscitation, medication, respiration, nutrition and hydration excepting only if and to the extent needed to relieve suffering unduly severe discomfort or unduly severe pain; to grant releases; to employ and discharge and to select and change physicians, caregivers, health care providers and facilities, and enter into agreements therefor, authorize and arrange for admission into facilities and discharge therefrom; to resort to the courts; to expend (or

withhold) funds.

C. GENERAL

1. As used in this instrument:

(a) "Life-sustaining treatment" means any medical procedure or intervention that will serve only to prolong the process of dying in the opinion of my attending physician or other physician requested by any proxy of mine to render an opinion.

(b) "Permanent unconsciousness" means a lasting condition, indefinitely without change in which thought, feeling, sensations and awareness of self or environment are absent in the opinion of my attending physician or other physician requested by any proxy of mine to render an opinion. It includes a persistent vegetative state such as in an advanced stage of Alzheimer's disease, or a similar senile condition, in which recognition of family members is absent, in the opinion of such physician.

(c) "Terminal condition" means an incurable or irreversible condition that, without the administration of life-sustaining treatment, may reasonably be expected to result in death within a relatively short time in the opinion of my attending physician or other physician requested by any proxy of mine to render an opinion.

(d) "Including" and words of like import mean without being limited thereto.

2. This Power of Attorney and the other contents of this instrument shall not be affected by the subsequent disability or incompetence of the principal (namely, myself).

3. To induce any third party to act hereunder, I hereby agree that any third party receiving an executed copy or a photocopy of this instrument may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such

revocation or termination shall have been received by such third party, and I for myself and for my heirs, executors, legal representatives and assigns, hereby release and agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied on the provisions of this instrument, including compliance with my declaration above or any direction of my proxy.

4. I am executing this document after due consideration and after consulting counsel. It sets forth my wishes that I have over the years expressed orally. Whether or not there is any specific statute authorizing this, it should, I trust, be a valid exercise of my legal rights as a human being; in any event I expect all concerned to honor it. Though it may be repetitious, let me emphasize that all directions hereunder are to be carried out promptly and fully even though my remaining life will thereby be shortened. I do not want heroic or other measures that merely prolong my dying.

5. This instrument shall be construed broadly and liberally to enable my intent to be carried out.

IN WITNESS WHEREOF, I have hereunto signed my name and affixed my seal this 4th day of March, 1991 at 10 Cutter Mill Road, Great Neck, New York.

WITNESSED:

Eunice M. Ware Seal)
EUNICE WARE, a/k/a
EUNICE M. WARE

The above person, whom I know, voluntarily signed this instrument in my presence.

Paul Whelan residing at 19 Old Elm Lane

Shirley Green residing at 28-22 215 Ave.
Bayshore, N.Y. 11360

STATE OF NEW YORK, COUNTY OF NASSAU ss.s:

On the 4th day of March, 1991, before me personally came EUNICE WARE to me known, and known to me to be the individual described in, and who executed the foregoing instrument, and she acknowledged to me that she executed the same.

Lisa A. Falco
Notary Public

LISA A. FALCO
Notary Public, State of New York
No. 4976796
Qualified in Suffolk County
Commission Expires Dec. 26, 1992

CROWLEY, HOGE & FEIN, P.C.

ATTORNEYS AT LAW

1710 RHODE ISLAND AVENUE, NW

SEVENTH FLOOR

WASHINGTON, D.C. 20036-3125

(202) 483-2900

FAX (202) 483-1365

WWW.CHF-LAW.COM

DANIEL H. CROWLEY (DC, MD)
CHRISTOPHER B. HOGE (DC, MD)
LESLIE G. FEIN (DC, MD, TN)
KATHERINE M. WIEDMANN (DC, NY)

4604 LANGDRUM LANE
CHEVY CHASE, MD 20815

KWIEDMANN@CHF-LAW.COM

July 21, 2005

Shelly McDonald-Pinkett, M.D.
Washington Center for Aging Services
2601 Eighteenth Street N.E.
Washington D.C. 20018

Re: Eunice Ware

Dear Dr. Pinkett:

This letter is to follow-up on our conversation on July 14, 2005 concerning your patient Eunice Ware. As I explained, I am in the process of preparing a petition to submit to the Court in light of the confusion surrounding the advanced directives for Eunice Ware. As we agreed, at this time, Ms. Ware should continue to be treated as a full-code patient until I am able to clarify certain issues relating to her wishes and my authority to sign a DNR order.

I intend to seek clarification from the Court as to whether the proper decision-maker for the ward is Mr. Blacknall, who is the ward's only surviving child and holds a power of attorney for medical decisions, or me under my authority as court-appointed guardian. Once, that decision is made, however, we still face important questions in giving full effect to the ward's living will which provides that:

If I should be in a state of permanent unconsciousness, I direct that all health care be withheld or withdrawn.

"Permanent unconsciousness" means a lasting condition, indefinitely without change in which thought, feeling, sensations and awareness of self or environment are absent in the opinion of my attending physician or other physician requested by any proxy of mine to render an opinion. It includes a persistent vegetative state such as in an advanced stage of Alzheimer's disease, or a similar senile condition, in which recognition of family members is absent, in the opinion of such physician.

I am writing to request that you respond to a number of questions and that I may discuss your responses with Mr. Blacknall and the Court in resolving this matter. The questions are as follows:

EXHIBIT

1. Do you believe that the ward is in a state of "permanent unconsciousness" meaning a lasting condition, indefinitely without change in which thought, feeling, sensations and awareness of self or environment are absent?
2. Do you believe the ward is in a "persistent vegetative state"?
3. What are the indicators of a "persistent vegetative state"?
4. Do you believe the ward is in "an advanced stage of Alzheimer's disease, or a similar senile condition, in which recognition of family members is absent"?
5. From the medical perspective, is a persistent vegetative state different from the advanced stages of Alzheimer's disease in which recognition of family members is absent?
6. What are the indicators that a person suffering from advanced stages of Alzheimer's disease has reached a point where that person is in a persistent vegetative state?
7. Do you agree with the following statement:

The ward has been diagnosed with Alzheimer's disease, Stage-two dementia, and has a history of gastrointestinal disease. She is unable to speak, is non-responsive to attempts to communicate with her, is unable to walk or feed herself, and requires assistance with all activities of daily life. She has a g-tube through which she receives all sustenance. In the past two month she has been hospitalized twice for problems with breathing, anemia and gastro-intestinal bleeding. While hospitalized, the ward received several blood transfusions and also underwent a gastro-intestinal endoscopy test. She has been discharged from the hospital and her condition is stable.

8. Do you wish to add any further information to describe the ward's current diagnosis or condition?
9. Please confirm that the following is a complete list of the medications which Ms. Ware is currently receiving or update accordingly:
 - a. Prosource for low albumin, 30 cc liquid
 - b. Ferrous sulfate, for _____, 220mg/5mL Elixir (RP Feosol)
 - c. Folic Acid, 1mg tablet via g-tube
 - d. Multivitamin Liquid
10. Please explain whether any of these medications increase the comfort of the ward and alleviate pain?
11. What is your prognosis of the ward?
12. When we talked you stated that you have treated Ms. Ware since she was first admitted at the Washington Center for the Aging, in 1998. Please confirm this information.

S. Pinkett, M.D.

July 21, 2005

Page 3 of 3

As time is of the essence, please provide responses to these questions as soon as possible and send your response by fax to (202) 483-1365. Thank you very much for your cooperation. Feel free to contact me if you have any questions.

Sincerely,

Katherine Wiedmann
Guardian of Eunice Ware

Cc:

Archie Blacknall

P.O. Box 761

Garysburg, NC 27831

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
Probate Division

In re: :
EUNICE WARE: : Intervention Proceeding
Adult Ward : No. 05-01

ORDER

UPON CONSIDERATION of the Emergency Petition Post-Appointment for the Appointment of a Bio-Ethics Visitor of Katherine M. Wiedmann, Court-appointed Successor Conservator for Eunice Ware, an Adult and for an emergency hearing pursuant to D.C. Code Section 21-2033, it is by the Court, this _____ day of _____, 2006, hereby

ORDERED, that the said Petition be, and it is hereby, GRANTED; and it is further,

ORDERED, that _____

be appointed Bioethics Visitors, pursuant to D.C. Code Section 21-2033,

ORDERED, that _____

Be appointed Counsel for the Subject, and it is further,

JUDGE

Copies to:

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
Probate Division

In re: :
EUNICE WARE: : Intervention Proceeding
Adult Ward : No. 05-01

**NOTICE OF HEARING ON EMERGENCY PETITION POST-APPOINTMENT FOR
THE APPOINTMENT OF A BIO-ETHICS PANEL**

NOTICE IS HEREBY GIVEN that a Petition for the Appointment of a Bio-Ethics Panel has been filed by Katherine M. Wiedmann, Successor Guardian for Eunice Ware.

Hearing has been set to consider the Petition on the _____ day of _____,
2006, before _____ in court room _____,
in the District of Columbia Superior Court, 500 Indiana Avenue, N.W.

JUDGE

Copies to:

Katherine M. Wiedmann
1710 Rhode Island Ave. NW
7th Floor
Washington D.C. 20036

Eunice Ware
Providence Hospital
1150 Varnum St Ne
Washington, DC 20017

Archie Blacknall
P.O. Box 761
Garysburg, NC 27831

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
Probate Division

In re:

EUNICE WARE

Adult Ward

Intervention Proceeding
No. 05-01

CERTIFICATION OF INCAPACITY

I, Asim Hargovic MD, hereby certify, that I am a
physician licensed to practice in the District and am qualified to make a determination of
mental incapacity. I further certify that:

☒ I am ~~am not~~ a psychiatrist or psychologist (cross out any part that is inapplicable)

The date of my last examination of the subject, Eunice Ware was
4/26/06

Eunice Ware is incapable of understanding the health-care choice, making decisions
concerning the particular treatment or services in question or communicating a decision even if
capable of making it.

The cause and nature of the mental incapacity:

Severe global cognitive impairment
due to Severe Dementia Alzheimer's V.
Vascular type

The extent and probable duration of the mental capacity:

Permanent and severe cognitive
deficit / Progressive

[Signature]
Signature

4/27/06
Date

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
Probate Division

In re:

EUNICE WARE:

Adult Ward

Intervention Proceeding
No. 05-01CERTIFICATION OF INCAPACITY

I, William James Browlee II MD, hereby certify, that I am a physician licensed to practice in the District and am qualified to make a determination of mental incapacity. I further certify that:

I ~~am~~ am not a psychiatrist or psychologist. (cross out any part that is inapplicable)

The date of my last examination of the subject, Eunice Ware was

May 1, 2006

Eunice Ware is incapable of understanding the health-care choice, making decisions concerning the particular treatment or services in question or communicating a decision even if capable of making it.

The cause and nature of the mental incapacity:

Severe Dementia due to peripartum Vascular Disease
Global Impairment,

The extent and probable duration of the mental capacity:

Permanent Severe Cognitive Dysfunction

William J. Browlee II MD
Signature

May 1, 2006
Date

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
Probate Division

In re: :
EUNICE WARE: : Intervention Proceeding
Adult Ward : No. 05-01

FINDINGS OF FACT, CONCLUSIONS OF LAW & ORDER

This matter came on for hearing on the 24th day of April, 2006, on the Emergency Petition Post-Appointment for the Appointment of a Bio-Ethics Visitor of Katherine M. Wiedmann, Court-appointed Successor Guardian for Eunice Ware.

The following were present at the hearing: the Petitioner, Katherine M. Wiedmann, Successor Guardian for Ms. Ware; Anne Meister, the Court-appointed Guardian Ad Litem; Archie Blacknall, Ms. Ware's son; and Dr. William James Brownlee III, Ms. Ware's attending physician at Providence Hospital.

Testimony was taken from Dr. Brownlee and Mr. Blacknall, as well as from Dr. Shelly McDonald-Pinkett, the ward's attending physician at the Washington Center for Aging Services, by telephone.

FINDINGS OF FACT & CONCLUSIONS OF LAW

After consideration of the Emergency Petition and the testimony and evidence adduced at the hearing, the Court makes the following findings of fact and conclusions of law:

Eunice Ware, an adult, was admitted to Providence Hospital on April 12, 2006 due to the dislodgement of her gastrostomy tube.

In consideration of the written certifications pursuant to D.C. Code Section 21-2204, of William James Brownlee III M.D. and Asim Haracic M.D., a psychiatrist at Providence Hospital, the Court finds that Eunice Ware is incapacitated and is incapable of understanding

the health-care choice, making a decision concerning the particular treatment or services in question, or communicating a decision even if capable of making it.

On March 4, 1991, the ward executed a durable power of attorney for health care appointing her son, Archie James Blacknall, her attorney-in-fact and a declaration concerning life-sustaining treatment designated as "My Living Will." [Hereinafter "Living Will"]. Having been validly executed in the state of New York pursuant to N.Y. Pub. Health Law Section 2981 (McKinney 2006), the Living Will complies with D.C. Code Sections 7-622 and 21-2202(3), and is VALID and BINDING;

Under the terms of the Living Will, Part C, General (Definitions), Paragraph 2, the Power of Attorney and the other contents of the Living Will are not affected by the incapacity of Eunice Ware.

In the opinion of her attending physicians, Dr. Brownlee and Dr. McDonald-Pinkett, Eunice Ware is in a state of permanent unconsciousness as that term is defined in the Living Will, Part C, General (Definitions), Paragraph 1(b).

Under the terms of the Living will, the replacement of a gastrostomy tube constitutes health care per Part A, Declaration, Paragraph 1.

Under the terms of the Living Will, Part A, Declaration, Paragraph 1, Eunice Ware directs that should she be in a state of permanent unconsciousness, all health care shall be withheld or withdrawn.

Under the terms of the Living Will, Part A, Declaration, Paragraph 3, Eunice Ware directs her attending physician to administer pain medication to alleviate pain so that she may die with whatever dignity is possible.

Eunice Ware, therefore, by her Living Will consented to the withholding or withdrawal

of the gastrostomy tube and all further health care, except the administering of medication to alleviate pain, and directed her attorney-in-fact to carry out her directions promptly and fully even though her remaining life may thereby be shortened.

Based on the testimony of Mr. Blacknall, he is unable to exercise his authority under D.C. Code Section 21-2206 in accordance with the wishes of the principal as expressed in her Living Will.

On consideration of the foregoing, the Court this 2 day of May 2006 makes the following Order:

ORDER

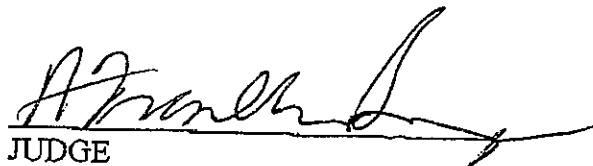
The Successor Guardian, Katherine Wiedmann, shall have the power to consent to the withdrawal or withholding of the replacement of the gastrostomy tube, as well as the withdrawal or withholding of all health care treatment, in accordance with D.C. Code Section 21-2047, and it is further,

ORDERED that in exercising her power to consent to the withdrawal or withholding of the replacement of the gastrostomy tube, that Successor Guardian shall direct the ward's health care providers to withdraw or withhold the replacement of the gastrostomy tube in accordance with the ward's wishes as expressed in her Living Will, and it is further,

ORDERED that Successor Guardian shall direct the ward's health care providers to withdraw or withhold all health care, except the administering of medication to alleviate pain per Living Will, Part A, Declaration, Paragraph 3, and it is further,

ORDERED that Successor Guardian may authorize the ward's health care providers and health benefits providers to provide hospice care in accordance with the ward's wishes as expressed in her Living Will, Part A, Declaration, Paragraph 3, and it is further,

ORDERED that the ward's health care providers shall comply with the directions of the Successor Guardian, even if the ward's remaining life will thereby be shortened.


JUDGE

Copies to:

Katherine M. Wiedmann
1710 Rhode Island Ave. NW
7th Floor
Washington D.C. 20036

Archie Blacknall
P.O. Box 761
Garysburg, NC 27831

Eunice Ware
Providence Hospital
1150 Varnum St Ne
Washington, DC 20017

Anne Meister
700 E Street SE
Washington DC 20003

William Brownlee III, M.D.
Eunice Ware
Providence Hospital
1150 Varnum St Ne
Washington, DC 20017

Shelly McDonald-Pinkett M.D.
Washington Center for Aging Services
2601 Eighteenth Street N.E.
Washington D.C. 20018

DOCKETED In Chambers MAY 02 2006

MAILED From Chambers MAY 02 2006

ADVANCE DIRECTIVES:

****Must be completed within 24 hours of admission****

TO BE COMPLETED BY ADMITTING DEPARTMENT

Patient has an Advance Directive

☐ Yes ☐ No ☐ Unknown

Copy provided by patient

☐ Yes ☐ No ☐ N/A **IF NO THEN**

Placed in Medical Record

☐ Yes ☐ No ☐ N/A

Admitting Representative Signature/Date

☐ I was informed of my right to formulate an Advance Directive and given information

☐ I have the information and wish to speak with someone about formulating an Advance Directive.

☐ I do not have an Advance Directive and I do not wish to formulate one.

Patient Signature/date

TO BE COMPLETED BY HEALTH CARE TEAM

HAS AN ADVANCE DIRECTIVE BUT DID NOT BRING

◆ Location

☐ Home/Requested ☐ On Chart
☐ Family/Friend/Requested ☐ On Chart
☐ Doctor's Office/Requested ☐ On Chart
☐ Med Records/Requested ☐ On Chart

◆ Patient given opportunity to prepare new Advance Directive

☐ Patient Declines
☐ Referred to Case Mgmt. ☐ Seen by Case Mgmt. ☐ On Chart

◆ Offered to record patient statement about content of Advance Directive:

☐ Patient Declines
☐ Patient's statement in patient's words are as follows:

Healthcare Provider's or Patient's Signature/Date

CODE STATUS ORDER SHEET

****TO BE COMPLETED BY PATIENT'S PHYSICIAN IF PATIENT IS *NOT* A FULL CODE**

****To Be Renewed Every 7 Days****

In the event of Cardiopulmonary Arrest and patient is NOT a **FULL CODE**:

☐ **NO CODE:** Do Not Resuscitate (No basic or advanced life support measures)

☐ **Limit Advanced Life Support Measures.** Do not perform or initiate the following:

_____ Vasopressors
 _____ Antiarrhythmics
 _____ Defibrillation/Cardioversion
 _____ Intubation/Mechanical Ventilation
 _____ Chest Compression
 _____ Other (Specify:)

Order Renewed:

Date: _____ MD Signature: _____

Time: _____

Date: _____ MD Signature: _____

Time: _____

Date: _____ MD Signature: _____

Time: _____

Date: _____ MD Signature: _____

Time: _____

Resident Physician Signature

Date/Time

Attending Physician Signature

Date/Time

Registered Nurse Signature

Date/Time

☐ This Code Status Was Revised

Date: _____

RN Initials: _____

Physician Initials: _____

See next A.D. order for specifics

☐ WRTC called if appropriate

(Glasgow Coma Scale \leq 5 and on ventilator, or withdrawal of support)

Signature/Title/Date/T

DO NOT THIN FROM CHART

DO NOT THIN FROM

DOCTOR'S ORDERS (sign all orders)

DO NOT RESUSCITATE (DNR) ORDER

() Do Not Attempt to Resuscitate (DNR). In the event of a cardiopulmonary arrest, do not initiate any of the following resuscitative measures:

- Mechanical Ventilation
- Endotracheal Intubation
- Chest Compression
- Rapid Fluid Infusions
- Electrical Cardioversion
- External Pacemakers
- Emergency Medication

() Continue all ordered diagnostic and therapeutic interventions unless crossed out below:

- Antiarrhythmics
- Blood Drawing
- IV Fluids
- Dialysis
- Ventilation by Positive Pressure Mask
- Antibiotics
- Tube Feeding
- Intravenous Vasoactive Drugs
- P.O. Feeding

(√) Continue all Pain Control and Hygiene Measures

I have discussed this with the patient/patient's surrogate _____

(Name of Surrogate who understands the order) (Relationship to Patient)

Attending Physician Signature Printed Name Date Time

Nurse's Signature Printed Name Date Time

(Complete this section to discontinue DNR order or to change any order above)

Date _____ Time _____ (DISCONTINUE THE ABOVE ORDER (S) IMMEDIATELY)

Attending Physician must also write "DISCONTINUE DNR" on standard order sheet

Physician's Signature Printed Name Date Time

Nurse's Signature Printed Name Date Time

DO NOT REMOVE FROM CHART IF THINNED



DO NOT
RESUSCITATE
DOCTOR'S
ORDERS

HUH

217

APP 52



Conversation Scripts: Getting Past the Resistance

WHY TALK ABOUT MEDICAL PREFERENCES IN ADVANCE?

Communication is the single most important step in health care planning. Talk about your wishes with the people who may be called upon to speak or decide for you. Why is this important?

1. No matter what your advance directive says, others will not fully understand your wishes. The more thoroughly you communicate, the easier it will be for everyone to respect your wishes.
2. It will help you think about what you want. Others will ask you questions or tell you things that will make you think about your wishes in another way.
3. It will help your loved ones make difficult decisions with less pain, doubt, and anxiety.
4. It may save money. Sometimes families continue medical treatments long past the point where they are helpful, simply because they are unsure what their loved one would have wanted. This is emotionally and financially costly ... and unnecessary.
5. It may even bring your family closer together.

STARTING THE DISCUSSION

There's no "right" way to start. Nor is there a "right" time. Nor does the discussion necessarily have to be somber and mournful. Here are some suggestions for getting started:

- Start with a story of someone else's experience:

"Do you remember what happened to so-and-so and what his family went through? I don't want you to have to go through that with me. That's why I want to talk about this now, while we can."

"Neither Richard Nixon nor Jackie Kennedy was placed on life support. I wonder if they had living wills and made what they wanted clear in advance."

- Blame it on your attorney:

"Mr. Darrow, my lawyer, says that before I complete some legal documents, I need to talk over with you some plans about end-of-life medical care."

- Use the worksheets provided in this packet to guide the discussion. A variety of other workbooks are also available. (See Tool #10 – Resources: Advance Planning.)

- Use a letter, tape, or video recording as a starting point. At first, it may be easier for people to hear what you have to say if you are not there. Afterwards they may be more ready to sit down and talk with you.

RESISTANCE TO THE DISCUSSION IS COMMON, FOR EXAMPLE...

"Mom, I don't see what good it does to talk about such things. It's all in God's hands anyway."

"Dad, I already know you don't want any heroic measures if things are really bad. There's nothing more we need to discuss about it. We'll do the right thing if the situation arises."

"I just can't talk about this. It's too painful, and talking about it just makes it more likely that it will happen."

IN RESPONSE...

- Be firm and straightforward.

"I know this makes you feel uncomfortable, but I need you to listen, to hear what I have to say. It's very important to me."

"Yes, death is in God's hands, but how we live until that moment is in our hands, and that's what I need to talk to you about."

"If it is too overwhelming for you right now, I understand. But let's make an appointment for a specific time to sit down together to discuss this. All right?"

- Point out the possible consequences of not talking now.

"If we don't talk about this now, we could both end up in a situation that is even more uncomfortable. I'd really like to avoid that if I could."

- Ask someone to be your spokesperson.

If you are able to connect well with one family member or friend, ask this person to initiate and lead the discussion with other family members or your doctor. This may make your job of explaining, clarifying, and answering questions easier.



D.C. Council Home

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DC ST § 7-622

Formerly cited as DC ST 1981 § 6-2422

DC ST § 7-622

Formerly cited as DC ST 1981 § 6-2422

District of Columbia Official Code 2001 Edition Currentness

Division I. Government of District.

Title 7. Human Health Care and Safety. (Refs & Annos)

Subtitle A. General.

Chapter 6. Death.

Subchapter II. Natural Death. (Refs & Annos)

➔§ 7-622. Declaration--Execution; form.

(a) Any persons 18 years of age or older may execute a declaration directing the withholding or withdrawal of life-sustaining procedures from themselves should they be in a terminal condition. The declaration made pursuant to this subchapter shall be:

- (1) In writing;
- (2) Signed by the person making the declaration or by another person in the declarant's presence at the declarant's express direction;
- (3) Dated; and
- (4) Signed in the presence of 2 or more witnesses at least 18 years of age.

In addition, a witness shall not be:

- (A) The person who signed the declaration on behalf of and at the direction of the declarant;
- (B) Related to the declarant by blood, marriage, or domestic partnership;
- (C) Entitled to any portion of the estate of the declarant according to the laws of intestate succession of the District of Columbia or under any will of the declarant or codicil thereto;
- (D) Directly financially responsible for declarant's medical care; or
- (E) The attending physician, an employee of the attending physician, or an employee of the health facility in which the declarant is a patient.

(b) It shall be the responsibility of the declarant to provide for notification to his or her attending physician of the existence of the declaration. An attending physician, when presented with the declaration, shall make the declaration or a copy of the declaration a part of the declarant's medical records.

(c) The declaration shall be substantially in the following form, but in addition may include other specific directions not inconsistent with other provisions of this subchapter. Should any of the other specific directions be held to be invalid, such invalidity shall not affect other directions of the declaration which can be given effect without the invalid direction, and to this end the directions in the declaration are severable.

Declaration

Declaration made this ... day of (month, year).

I,, being of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, do declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by 2 physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Signed
Address

I believe the declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am at least 18 years of age and am not related to the declarant by blood, marriage, or domestic partnership, entitled to any portion of the estate of the declarant according to the laws of intestate succession of the District of Columbia or under any will of the declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not the declarant's attending physician, an employee of the attending physician, or an employee of the health facility in which the declarant is a patient.

Witness
Witness

CREDIT(S)

(Feb. 25, 1982, D.C. Law 4-69, § 3, 28 DCR 5047; Sept. 12, 2008, D.C. Law 17-231, § 16(b), 55 DCR 6758.)

HISTORICAL AND STATUTORY NOTES

Prior Codifications

1981 Ed., § 6-2422.

Effect of Amendments

D.C. Law 17-231 substituted "blood, marriage, or domestic partnership" for "blood or marriage".

Legislative History of Laws

For legislative history of D.C. Law 4-69, see Historical and Statutory Notes following § 7-621.

For Law 17-231, see notes following § 7-621.

DC CODE § 7-622

Current through January 3, 2010



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DC ST § 7-651.02

§ 7-651.02. Execution and issuance of comfort care order.

DC ST § 7-651.02

District of Columbia Official Code 2001 Edition Currentness

Division I. Government of District.

Title 7. Human Health Care and Safety. (Refs & Annos)

Subtitle A. General.

Chapter 6A. Non-Resuscitation Procedures for Emergency Medical Services.

➔§ 7-651.02. Execution and issuance of comfort care order.

(a) The following persons may execute a comfort care order to communicate the decision that the person who is the subject of the order shall not be resuscitated if the person experiences cardiac arrest or respiratory arrest as a result of a specified medical or terminal condition:

- (1) Any competent person, who is 18 years of age or older, on behalf of the competent person;
- (2) An authorized decision-maker on behalf of an incapacitated person; or
- (3) A surrogate on behalf of a minor.

(b) A comfort care order may be issued only by the attending physician of a person who is the subject of the Order. The attending physician shall explain to the person who does not wish to be resuscitated and the person's authorized decision-maker or surrogate, as appropriate, the effect of the Order and the alternatives, including medical treatment and the issuance of another form of advanced directive. If the person, after reviewing the alternatives, wishes to execute an Order, the attending physician shall:

- (1) Issue the Order and a comfort care bracelet or necklace;
- (2) Place the bracelet or necklace on the person;
- (3) Explain to the person, authorized decision-maker, or surrogate how the Order may be revoked; and
- (4) Submit a copy of the comfort care order to the Mayor.

(c) The Mayor shall keep confidential any records containing patient social security numbers.

CREDIT(S)

(Apr. 3, 2001, D.C. Law 13-224, § 3, 48 DCR 27.)

HISTORICAL AND STATUTORY NOTES

Legislative History of Laws

For D.C. Law 13-224, see notes following § 7-651.01.

DC CODE § 7-651.02`

Current through January 3, 2010

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END OF DOCUMENT

LEXIS DISTRICT OF COLUMBIA CODE

ANNOTATED

2001 EDITION

With Provision for Subsequent Pocket Parts

INCLUDING ALL EMERGENCY, PERMANENT, AND TEMPORARY ACTS
THROUGH D.C. ACT 17-503, AND ANNOTATIONS POSTED TO LEXIS-NEXIS
FOR THE D.C. COURT OF APPEALS THROUGH AUGUST 7, 2008, AND
THROUGH AUGUST 8, 2008, FOR OPINIONS THAT WILL APPEAR IN THE
FOLLOWING TRADITIONAL REPORTERS: SUPREME COURT REPORTER,
FEDERAL REPORTER, FEDERAL SUPPLEMENT, AND BANKRUPTCY
REPORTER.

2008 REPLACEMENT
VOLUME 6

TITLE 11 — ORGANIZATION AND JURISDICTION OF THE COURTS
TITLE 12 — RIGHT TO REMEDY
TITLE 13 — PROCEDURE GENERALLY
TITLE 14 — PROOF
TITLE 15 — JUDGMENTS AND EXECUTIONS; FEES AND COSTS
TITLE 16 — PARTICULAR ACTIONS, PROCEEDINGS AND MATTERS
TITLE 17 — REVIEW
TITLE 18 — WILLS
TITLE 19 — DESCENT AND DISTRIBUTION
TITLE 20 — PROBATE AND ADMINISTRATION OF DECEDENTS' ESTATES
TITLE 21 — FIDUCIARY RELATIONS AND THE MENTALLY ILL

Edited and Annotated by the Editorial Staff of the Publisher.



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CHAPTER 20. GUARDIANSHIP, PROTECTIVE PROCEEDINGS, AND DURABLE POWER OF ATTORNEY

Subchapter I. General Provisions

- Sec.
21-2001. Rule of construction; purposes.
21-2002. Supplementary general principles of law applicable.
21-2003. Standard of proof.
21-2004. Effect of a finding of incapacity.

Subchapter II. Definitions

- 21-2011. Definitions.

Subchapter III. Scope

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21-2022. Practice in court.
21-2023. [Repealed].
21-2024. Appeals.

Subchapter IV. Notice, Parties, and Representation in Guardianship and Protective Proceedings.

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21-2032. Notice; waiver.
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21-2047.02. Powers and duties of emergency and health-care guardians.
21-2048. Termination of guardianship for incapacitated individual.
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Subchapter VI. Protection of Property of Incapacitated, Disappeared or Detained Individuals

- 21-2051. Protective proceedings.
21-2052. Original petition for appointment or protective order.

- Sec.
21-2053. Notice.
21-2054. Procedure concerning hearing and order on original petition.
21-2055. Permissible court orders.
21-2056. Protective arrangements and single transactions authorized.
21-2057. Who may be appointed conservator; priorities.
21-2058. Bond.
21-2059. Effect of acceptance of appointment.
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21-2061. Death, resignation, or removal of conservator.
21-2062. Petitions for orders subsequent to appointment.
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21-2065. Accounts.
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21-2067. Recording of conservator's letters.
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21-2070. Powers of conservator in administration.
21-2071. Distributive duties and powers of conservator.
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21-2073. Preservation of estate plan; right to examine.
21-2074. Personal liability of conservator.
21-2075. Termination of proceedings.
21-2076. Payment of debt and delivery of property to foreign conservator without local proceedings.
21-2077. Foreign conservator; proof of authority; bond; powers.

Subchapter VII. Durable Power of Attorney

- 21-2081. Definition.
21-2082. Durable power of attorney not affected by incapacity.
21-2083. Relation of attorney in fact to court-appointed fiduciary.
21-2084. Power of attorney not revoked until notice.
21-2085. Proof of continuance of durable and other powers of attorney by affidavit.

Subchapter VIII. Uniform Disclaimer of Property Interests

- 21-2091 to 21-2098. [Repealed].

Subchapter I. General Provisions

§ 21-2001. Rule of construction; purposes.

- (a) This chapter shall be liberally construed and applied to promote its underlying purposes and policies.
(b) The underlying purposes and policies of this chapter are to:

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§ 21-200

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§ 21-2003, the allegedly incapacitated woman's brother to present clear and convincing evidence that appointment of a guardian or conservator was warranted or, pursuant to D.C. Code § 21-2054(e), entitled the woman to a hearing at which she could present evidence and cross-examine witnesses, the probate court lacked the necessary firm factual

foundation to make the findings that could have justified its rulings in appointing a conservator. *In re Penning*, 930 A.2d 144, 2007 D.C. App. LEXIS 403 (2007).

Applied in *In re Penning*, — A.2d —, 2007 D.C. App. LEXIS 491 (July 12, 2007).

§ 21-2004. Effect of a finding of incapacity.

A finding under this chapter that an individual is incapacitated shall not constitute a finding of legal incompetence. An individual found to be incapacitated shall retain all legal rights and abilities other than those expressly limited or curtailed in the order of appointment of a guardian or in a protective proceeding, or subsequent order of the court. (1981 Ed., § 21-2004; Feb. 28, 1987, D.C. Law 6-204, § 2(a), 34 DCR 632.)

Legislative history of Law 6-204. — See note to § 21-2001.

Subchapter II. Definitions

§ 21-2011. Definitions.

For the purposes of this chapter, the term:

- (1) "Best interests" means promoting personal well-being by assessing:
 - (A) The reason for the proposed action, its risks and benefits, and any alternatives considered and rejected; and
 - (B) The least intrusive, least restrictive, and most normalizing course of action possible to provide for the needs of the individual.
- (1A) "Claims" in respect to a protected individual, means liabilities of the protected individual, whether arising in contract, tort, or otherwise, and liabilities of the estate that arise at or after the appointment of a conservator, including expenses of administration.
- (2) "Court" means the Superior Court of the District of Columbia.
- (3) "Conservator" means a person who is appointed by a court to manage the estate of a protected individual and includes a limited conservator described in section 21-2066(a).
- (4) "Counsel" means an attorney admitted to the practice of law in the District.
- (5) "District" means District of Columbia.
- (5A) "Domestic partner" shall have the same meaning as provided in § 32-701(3).
- (5B) "Domestic partnership" shall have the same meaning as provided in § 32-701(4).
- (5C) "Emergency care" means immediate treatment, including diagnostic treatment, provided in response to a sudden and acute medical crisis in order to avoid injury, extreme pain, impairment, or death.
- (6) "Estate" means the property of the individual whose affairs are subject to this chapter.
- (7) "Examiner" means an individual qualified by training or experience in the diagnosis, care, or treatment of the causes and conditions giving rise to the alleged incapacity, such as a gerontologist, psychiatrist, or qualified mental retardation professional.
- (8) "Guardian" means a person who has qualified as a guardian of an incapacitated individual pursuant to court appointment, not including a guardian ad litem, but including:
 - (A) A temporary guardian appointed as described in section 21-2046 for a finite period of time to serve as:
 - (i) An emergency guardian whose authority may not extend beyond 21 days and who may exercise any powers granted by court order and not prohibited by law;
 - (ii) A health-care guardian whose authority is granted for up to 90 days and may be extended for up to an additional 90 days to provide substituted consent

in accordance with section 21-2210 for an individual certified as incapacitated for a health-care decision; or

(iii) A provisional guardian whose authority is granted for a specified period not to exceed 6 months, upon the court's finding that any guardian is not effectively performing duties and that the welfare of the incapacitated individual requires immediate action;

(B) A general guardian not limited by the court in scope as described in section 21-2044(c) or in time as described in section 21-2046; and

(C) A limited guardian whose powers are limited by the court as described in section 21-2044(c) and who is appointed for a finite period of time as described in section 21-2046 or for an indeterminate period of time.

(9) "Guardian ad litem" means an individual appointed by the court to assist the subject of an intervention proceeding to determine his or her interests in regard to the guardianship or protective proceeding or to make that determination if the subject of the intervention proceeding is unconscious or otherwise wholly incapable of determining his or her interest in the proceeding even with assistance.

(10) "Habilitation" means the process by which an individual is assisted to acquire and maintain those life skills that enable him or her to cope more effectively with the demands of his or her own person and of his or her own environment and to raise the level of his or her physical, intellectual, social, emotional, and economic efficiency.

(11) "Incapacitated individual" means an adult whose ability to receive and evaluate information effectively or to communicate decisions is impaired to such an extent that he or she lacks the capacity to manage all or some of his or her financial resources or to meet all or some essential requirements for his or her physical health, safety, habilitation, or therapeutic needs without court-ordered assistance or the appointment of a guardian or conservator.

(11A) "Incapacitated individual for health-care decisions" means an adult individual who lacks sufficient mental capacity to:

(A) Appreciate the nature and implications of a health-care decision;

(B) Make a choice regarding the alternatives presented; or

(C) Communicate that choice in an unambiguous manner.

(12) "Intervention proceeding" means any proceeding under this chapter.

(13) "Lease" means an oil, gas, or other mineral lease.

(14) "Letters" means letters of guardianship and letters of conservatorship.

(15) "Manage financial resources" means those actions necessary to obtain, administer, and dispose of real and personal property, intangible property, business property, benefits, and income.

(16) "Meet essential requirements for physical health or safety" means those actions necessary to provide health care, food, shelter, clothing, personal hygiene, and other care without which serious physical injury or illness is more likely than not to occur.

(17) "Mortgage" means any conveyance, agreement, or arrangement in which property is used as collateral.

(18) "Organization" includes a corporation, business trust, estate, trust, partnership, association, 2 or more persons having a joint or common interest, government, governmental subdivision or agency, or any other legal entity.

(19) "Person" means an individual or an organization.

(20) "Petition" means a written request to the court for an order after notice.

(21) "Property" means anything that may be the subject of ownership, and includes both real and personal property and any interest in real or personal property.

(22) "Protected individual" means an individual for whom a conservator has been appointed or other protective order has been made as provided in sections 21-2055 and 21-2056.

(23) "Protective proceeding" means a proceeding under the provisions of subchapter VI of this chapter.

(24) "Qualified mental retardation professional" means:

(A) A psychologist with at least a master's degree from an accredited program and with specialized training or 1 year of experience in mental retardation;

(B) A physician licensed to practice medicine in the District and with specialized training in mental retardation or with 1 year of experience in treating individuals with mental retardation;

(C) An educator with a degree in education from an accredited program and with specialized training or 1 year of experience in working with individuals with mental retardation;

(D) A social worker with:

(i) A master's degree from a school of social work accredited by the Council on Social Work Education (New York, New York), and with specialized training in mental retardation or with 1 year of experience in working with individuals with mental retardation; or

(ii) A bachelor's degree from an undergraduate social work program accredited by the Council on Social Work Education who is currently working and continues to work under the supervision of a social worker as defined in subparagraph (D)(i) and who has specialized training in mental retardation or 1 year of experience in working with individuals with mental retardation;

(E) A rehabilitation counselor who is certified by the Commission on Rehabilitation Counselor Certification (Chicago, Illinois) and who has specialized training in mental retardation or 1 year of experience in working with individuals with mental retardation;

(F) A physical or occupational therapist with a bachelor's degree from an accredited program in physical or occupational therapy and who has specialized training or 1 year of experience in working with individuals with mental retardation; or

(G) A therapeutic recreation specialist who is a graduate of an accredited program and who has specialized training or 1 year of experience in working with individuals with mental retardation.

(25) "Security" means any:

(A) Note;

(B) Stock;

(C) Treasury stock;

(D) Bond debenture;

(E) Evidence of indebtedness;

(F) Certificate of interest or participation in an oil, gas, or mining title or lease or in payments out of production under such a title or lease;

(G) Collateral trust certificate;

(H) Transferable share;

(I) Voting trust certificate; or

(J) Interest or instrument commonly known as a security, certificate of interest or participation, temporary or interim certificate, receipt, certificate of deposit for, or any warrant or right to subscribe to or purchase any of the foregoing.

(25A) "Substituted judgment" means 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.

(26) "Visitor" means a person appointed in a guardianship or protective proceeding who is an officer, employee, or special appointee of the court and who has no personal interest in the proceeding.

(27) "Ward" means an individual for whom a guardian has been appointed. (1981 Ed., § 21-2011; Feb. 28, 1987, D.C. Law 6-204, § 2(a), 34 DCR 632; Mar. 24, 1998, D.C. Law 12-81, § 14(r), 45 DCR 745; Apr. 4, 2006, D.C. Law 16-79, § 7(a), 53 DCR 1035; Apr. 24, 2007, D.C. Law 16-305, § 35(c)(1), 53 DCR 6198; Oct. 22, 2008, D.C. Law 17-249, § 2(b), 55 DCR 9206.)

Section references. — This section is referenced in § 7-1901 and § 21-2051.

Effect of amendments. — D.C. Law 16-79 inserted (5A) and (5B).

D.C. Law 16-305 substituted "individuals with mental retardation" for "mentally retarded individuals" in (24)(B), (C), (D)(i) and (ii), (E), (F), and (G).

D.C. Law 17-249 redesignated former (1) as (1A); added present (1); added (5C), (11A), and (25A); and rewrote (8).

Temporary legislation. — Section 2(a) of D.C. Law 15-98 added (5A) to read as follows:

"For the purposes of this chapter, the term:

"(5A) 'Emergency care' means immediate treatment, including diagnostic treatment, provided in response to a sudden, acute, and unanticipated medical crisis in order to avoid injury, extreme pain, impairment, or death."

Section 5(b) of D.C. Law 15-98 provides that the act shall expire after 225 days of its having taken effect.

Section 2(a) of D.C. Law 15-245 added (5A) to read as follows:

porary Amendment Act of 2003," was introduced in Council and assigned Bill No. 15-557. The Bill was adopted on first and second readings on Nov. 4, 2003, and Dec. 2, 2003, respectively. Signed by the Mayor on Dec. 18, 2003, it was assigned Act No. 15-268 and transmitted to Congress for its review. D.C. Law 15-98 became effective on Mar. 10, 2004, and expires on Oct. 21, 2004.

Legislative history of Law 15-245. — See note § 21-2011.

Legislative history of Law 16-46. — See note to § 21-2011.

Legislative history of Law 16-194. — See note to § 21-2002.

Legislative history of Law 17-100. — See note to § 21-2002.

Legislative history of Law 17-249. — See note to § 21-2002.

§ 21-2047. Powers and duties of general guardian and limited guardian.

Except as limited pursuant to section 21-2044, a general guardian or a limited guardian of an incapacitated individual is responsible for care, custody, and control of the ward, but is not personally liable to third persons by reason of that responsibility for acts of the ward.

(a) In particular and without qualifying the foregoing, a general guardian or a limited guardian shall:

(1) Become or remain personally acquainted with the ward and maintain sufficient contact with the ward to know of the ward's capacities, limitations, needs, opportunities, and physical and mental health;

(2) Take reasonable care of the ward's personal effects and commence protective proceedings, if necessary, to protect other property of the ward;

(3) Apply any available money of the ward to the ward's current needs for support, care, habilitation, and treatment;

(4) Conserve any excess money of the ward for the ward's future needs, but if a conservator has been appointed for the estate of the ward, the guardian, at least quarterly, shall pay to the conservator money of the ward to be conserved for the ward's future needs;

(5) Report in writing the condition of the ward and of the ward's estate that has been subject to the guardian's possession or control, as ordered by the court on petition of any person interested in the ward's welfare or on any order of the court, but at least semiannually;

(6) Make 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, make the decision on the basis of the ward's best interests;

(7) Include the ward in the decision-making process to the maximum extent of the ward's ability; and

(8) Encourage the ward to act on his or her own behalf whenever he or she is able to do so, and to develop or regain capacity to make decisions in those areas in which he or she is in need of decision-making assistance, to the maximum extent possible.

(b) A general guardian or limited guardian may:

(1) Receive money payable for the support of the ward under the terms of any statutory benefit or insurance system or any private contract, devise, trust, conservatorship, or custodianship;

(2) Take custody of the person of the ward and establish the ward's place of abode within or without the District, if consistent with the terms of any order by a court of competent jurisdiction relating to detention or commitment of the ward;

(3) Institute proceedings, including administrative proceedings, or take other appropriate action to compel the performance by any person of a duty to support the ward or to pay sums for the welfare of the ward, if no conservator for the estate of the ward has been appointed;

(4) Consent to medical examination and medical or other professional care, treatment, or advice for the ward, without liability, by reason of the consent for injury to the ward resulting from the negligence or acts of third persons, unless the guardian fails to act in good faith;

(5) Obtain medical records for the purpose of applying for government entitlements or private benefits and have the status of a legal representative under the District of Columbia Mental Health Information Act of 1978, effective March 3, 1979 (D.C. Law 2-136; § 7-1201.01 et seq.); and

(6) If reasonable under all of the circumstances, delegate to the ward certain responsibilities for decisions affecting the ward's well-being.

(c) Repealed.

(d) A guardian is entitled to reasonable compensation for services as guardian and to reimbursement for room, board, and clothing personally provided to the ward, but only as approved by order of the court pursuant to section 21-2060(a). (1981 Ed., § 21-2047; Feb. 28, 1987, D.C. Law 6-204, § 2(a), 34 DCR 632; May 10, 1989, D.C. Law 7-231, § 27, 36 DCR 492; Sept. 22, 1989, D.C. Law 8-34, § 2(h), 36 DCR 5035; Oct. 22, 2008, D.C. Law 17-249, § 2(g), 55 DCR 9206.)

Section references. — This section is referenced in § 7-1231.07 and § 21-2049.

Effect of amendments. — D.C. Law 17-249 substituted "general guardian and limited guardian" for "guardian" in the section heading and introductory language of (a) and (b); substituted "a general guardian or a limited guardian" for "guardian" in the introductory paragraph; and added (a)(6) through (8).

Temporary legislation. — Section 2(g) of D.C. Law 16-194 amended the section heading to read "Powers and duties of general guardian and limited guardian," amended (a) and (b) and repealed (c) as follows:

"Except as limited pursuant to section 21-2044, a general guardian or a limited guardian of an incapacitated individual is responsible for care, custody, and control of the ward, but is not personally liable to third persons by reason of that responsibility for acts of the ward.

"(a) In particular and without qualifying the foregoing, a general guardian or limited guardian shall:

"(4) Conserve any excess money of the ward for the ward's future needs, but if a conservator has been appointed for the estate of the ward, the guardian, at least quarterly, shall pay to the conservator money of the ward to be conserved for the ward's future needs;

"(5) Report in writing the condition of the ward and of the ward's estate that has been subject to the guardian's possession or control, as ordered by the court on petition of any person interested in the ward's welfare or on any order of the court, but at least semi-annually;

"(6) Make 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, make the decision on the basis of the ward's best interests; and

"(7) Encourage the ward to participate with the guardian in the decision-making process to the maximum extent of the ward's ability in order to encourage the ward to act on his or her own behalf whenever he or she is able to do so, and to develop or regain capacity to make decisions in those areas in which he or she is in need of decision-making assistance, to the maximum extent possible.

"(b) A general guardian or limited guardian may:

"(c) Repealed."

Section 6(b) of D.C. Law 16-194 provided that the act shall expire after 225 days of its having taken effect.

Section 2(g) of D.C. Law 17-100 amended the section heading, repealed (c), and amended portions of subsection (a) and the introductory language of (b) to read as follows:

"Powers and duties of general guardian and limited guardian.

"Except as limited pursuant to section 21-2044, a general guardian or a limited guardian of an incapacitated individual is responsible for care, custody, and control of the ward, but is not personally liable to third persons by reason of that responsibility for acts of the ward.

"(a) In particular and without qualifying the foregoing, a general guardian or limited guardian shall:

"(4) Conserve any excess money of the ward for the ward's future needs, but if a conservator has been appointed for the estate of the ward, the guardian, at least quarterly, shall pay to the conservator money of the ward to be conserved for the ward's future needs;

"(5) Report in writing the condition of the ward and of the ward's estate that has been subject to the guardian's possession or control, as ordered by the court on petition of any person interested in the ward's welfare or on any order of the court, but at least semiannually;

"(6) Make 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, make the decision on the basis of the ward's best interests;

"(7) Include the ward in the decision-making process to the maximum extent of the ward's ability; and

"(8) Encourage the individual to act on his or her own behalf whenever he or she is able to do so, and to develop or regain capacity to make decisions in those areas in which he or she is in need of decision-making assistance, to the maximum extent possible.

"(b) A general guardian or limited guardian may:

"(c) Repealed."

Section 6(b) of D.C. Law 17-100 provides that

CHAPTER 22. HEALTH-CARE DECISIONS

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§ 21-2201. Purpose.

The purpose of this chapter is to affirm the right of all competent adults to control decisions relating to their own health care and to have their rights and intentions in health care matters respected and implemented by others if they become incapable of making or communicating decisions for themselves. (1981 Ed., § 21-2201; Mar. 16, 1989, D.C. Law 7-189, § 2, 35 DCR 8653; Feb. 5, 1994, D.C. Law 10-68, § 23(b), 40 DCR 6311; Mar. 24, 1998, D.C. Law 12-81, § 14(y), 45 DCR 745.)

Legislative history of Law 7-189. — Law 7-189, the "Health-Care Decisions Act of 1988," was introduced in Council and assigned Bill No. 7-131. The Bill was adopted on first and second readings on October 25, 1988, and November 15, 1988, respectively. Signed by the Mayor on December 1, 1988, it was assigned Act No. 7-251 and transmitted to both Houses of Congress for its review.

Legislative history of Law 10-68. — D.C. Law 10-68, the "Technical Amendments Act of 1993," was introduced in Council and assigned Bill No. 10-166. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on August 23,

1993, it was assigned Act No. 10-107 and transmitted to both Houses of Congress for its review. D.C. Law 10-68 became effective on February 5, 1994.

Legislative history of Law 12-81. — Law 12-81, the "Technical Amendments Act of 1998," was introduced in Council and assigned Bill No. 12-408. The Bill was adopted on first and second readings on November 4, 1997, and December 4, 1997, respectively. Signed by the Mayor on December 22, 1997, it was assigned Act No. 12-246 and transmitted to both Houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

§ 21-2202. Definitions.

For the purposes of this chapter, the term:

(1) "Attorney in fact" means the person who receives the power of attorney for health-care decisions pursuant to the provisions of this chapter.

(1A) "Close friend" means any adult who has exhibited significant care and concern for the patient, and has maintained regular contact with the patient so as to be familiar with his or her activities, health, and religious and moral beliefs.

(2) "District" means the District of Columbia.

(2A) "Domestic partner" means an adult person living with, but not married to, another adult person in a committed, intimate relationship. The term "domestic partner" shall include any adult who has registered as a domestic partner under the Health Care Benefits Expansion Act of 1992, effective June 11, 1992 (D.C. Law 9-114; D.C. Code § 32-701 et seq.), as well as any adult who has registered as a domestic partner in a substantially equivalent program administered by another jurisdiction.

(2B) "Domestic partnership" means 2 adult persons living together, but not married, in a committed, intimate relationship. The term "domestic partnership" shall include any relationship registered under § 32-701(4), as well as any relation-

ship in another jurisdiction that includes a substantially equivalent registration requirement, including those relationships recognized under § 32-702(i).

(3) "Durable power of attorney for health care" means a legally enforceable document that:

(A) Is executed in the District in a manner consistent with this chapter or validly executed in another jurisdiction pursuant to similar provisions of the law of that jurisdiction; and

(B) Creates a power of attorney for health-care decisions, which is effective upon, and only during incapacitation and is unaffected by the subsequent disability or incapacity of the principal as defined in this chapter.

(4) "Health-care provider" means any person or organizational entity, including health care facilities as defined in § 44-501, licensed or otherwise authorized to provide health-care services in the District.

(5) "Incapacitated individual" means an adult individual who lacks sufficient mental capacity to appreciate the nature and implications of a health-care decision, make a choice regarding the alternatives presented or communicate that choice in an unambiguous manner.

(5A) "Member of a religious order or diocesan priest" means an unmarried adult who, by vow or other bond of commitment, voluntarily undertakes a style of living under the rule and direction of a religious order or community that has been established for religious purposes and has been recognized and approved as a religious order or community by a church.

(6) "Principal" means a person who is competent to make health-care decisions for his or her own benefit or on his or her own account.

(6A) "Qualified psychologist" means a person who is licensed pursuant to § 3-1205.01 and has:

(A) One year of formal training within a hospital setting; or

(B) Two years of supervised clinical experience in an organized health-care setting, one year of which must be post-doctoral.

(7) "Religious superior" means a bishop or a member of a religious order who, under the approved constitution, laws, statutes, bylaws, or rules of the religious order or community, exercises authority over the particular community or unit of the religious order to which the member of the religious order or community belongs. (1981 Ed., § 21-2202; Mar. 16, 1989, D.C. Law 7-189, § 3, 35 DCR 8653; Mar. 11, 1992, D.C. Law 9-67, § 2(a), 39 DCR 12; Feb. 5, 1994, D.C. Law 10-68, § 23(c), 40 DCR 6311; Mar. 24, 1998, D.C. Law 12-81, § 14(z), 45 DCR 745; Apr. 20, 1999, D.C. Law 12-264, § 57(c), 46 DCR 2118; June 21, 2003, D.C. Law 15-17, § 2(a), 50 DCR 3387; Sept. 12, 2008, D.C. Law 17-231, § 22(g), 55 DCR 6758; Oct. 22, 2008, D.C. Law 17-249, § 3(a), 55 DCR 9206.)

Effect of amendments. — D.C. Law 15-17 added (1A) and (2A).

D.C. Law 17-231 added (2B).

D.C. Law 17-249 added (6A).

Temporary legislation. — Section 3(a) of D.C. Law 16-46 added (6A) to read as follows:

"For the purposes of this chapter, the term:

"(6A) 'Qualified psychologist' means a person who is licensed pursuant to § 3-1205.01 and has:

"(A) One year of formal training within a hospital setting; or

"(B) Two years of supervised clinical experience in an organized health care setting, one year of which must be post-doctoral."

Section 6(b) of D.C. Law 16-46 provides that the act shall expire after 225 days of its having taken effect.

Section 3(a) of D.C. Law 17-100 added (6A) to read as follows:

"For the purposes of this chapter, the term:

"(6A) 'Qualified psychologist' means a person who is licensed pursuant to § 3-1205.01 and has:

"(A) One year of formal training within a hospital setting; or

"(B) Two years of supervised clinical experience in an organized health-care setting, one year of which must be post-doctoral."

Section 6(b) of D.C. Law 17-100 provides that the act shall expire after 225 days of its having taken effect.

Emergency legislation. — For temporary addition of (6A), see § 3(a) of the Health-Care Decisions for Persons with Mental Retardation and Developmental Disabilities Emergency Amendment Act of 2005 (D.C. Act 16-190, October 28, 2005, 52 DCR 10021).

For temporary addition of (6A), see § 3(a) of the Health-Care Decisions for Persons with Mental Retardation and Developmental Disabilities Congressional Review Emergency Amendment Act of 2006 (D.C. Act 16-262, January 26, 2006, 53 DCR 795), applicable as of January 26, 2006.

§ 21-2203. Presumption of capacity.

An individual shall be presumed capable of making health-care decisions unless certified otherwise under § 21-2204. Mental incapacity to make a health-care decision shall not be inferred from the fact that an individual:

(1) Has been voluntarily or involuntarily hospitalized for mental illness pursuant to § 21-501 et seq.;

(2) Has a diagnosis of mental retardation or has been determined by a court to be incompetent to refuse commitment under § 7-1301.01 et seq.; or

(3) Has a conservator or guardian appointed pursuant to § 21-1501 et seq. [repealed] or § 21-2001 et seq. (1981 Ed., § 21-2203; Mar. 16, 1989, D.C. Law 7-189, § 4, 35 DCR 8653; Feb. 5, 1994, D.C. Law 10-68, § 23(d), 40 DCR 6311; Apr. 24, 2007, D.C. Law 16-305, § 35(d), 53 DCR 6198.)

Effect of amendments. — D.C. Law 16-305 substituted "Has a diagnosis of mental retardation" for "Is mentally retarded" in (2).

Legislative history of Law 7-189. — See note to § 21-2201.

Legislative history of Law 10-68. — See note to § 21-2201.

Legislative history of Law 16-305. — Law 16-305, the "People First Respectful Language

Conforming Amendment Act of 2006," was introduced in Council and assigned Bill No. 16-664. The Bill was adopted on first and second readings on June 20, 2006, and July 11, 2006, respectively. Signed by the Mayor on July 18, 2006, it was assigned Act No. 16-437 and transmitted to Congress for its review. D.C. Law 16-305 became effective on Apr. 24, 2007.

CASE NOTES

Applied in *Doe v. District of Columbia*, 489 F.3d 376, 2007 U.S. App. LEXIS 13701 (D.C. Cir. 2007).

§ 21-2204. Certification of incapacity.

(a) Mental incapacity to make a health-care decision shall be certified by 2 professionals who are licensed to practice in the District and qualified to make a determination of mental incapacity. One of the 2 certifying professionals shall be a physician and one shall be a qualified psychologist or psychiatrist. Both certifying professionals shall give an opinion regarding the cause and nature of the mental incapacity as well as its extent and probable duration.

(b) All professional findings and opinions forming the basis of certification under subsection (a) of this section shall be expressed in writing, included in the patient-care records of the individual, and provide clear evidence that the person is incapable of understanding the health-care choice, making a decision concerning the particular treatment or services in question, or communicating a decision even if capable of making it.

(c) Certification of incapacity under this section shall be limited in its effect to the capacity to make health-care decisions and shall not be construed as a finding of incompetency for any other purpose. (1981 Ed., § 21-2204; Mar. 16, 1989, D.C. Law 7-189, § 5, 35 DCR 8653; Feb. 5, 1994, D.C. Law 10-68, § 23(e), 40 DCR 6311; Oct. 22, 2008, D.C. Law 17-249, § 3(b), 55 DCR 9206.)

Section references. — This section is referenced in § 7-1208.03, § 7-1231.07, § 7-1231.08, § 7-1305.06a, § 7-1305.07a, § 21-2002, § 21-2041, § 21-2046, § 21-2047.02, § 21-2203, § 21-2210, and § 21-2212.

Effect of amendments. — D.C. Law 17-249, in (a), substituted "professionals" for "physicians" throughout, and substituted "shall be a physician and one shall be a qualified psychologist or psychiatrist" for "shall be a psychiatrist" in the second sentence.

Temporary legislation. — Section 3(b) of D.C. Law 16-46 amended (a) to read as follows:

"(a) Mental incapacity to make a health-care decision shall be certified by 2 professionals who are licensed to practice in the District and quali-

fied to make a determination of mental incapacity. One of the 2 certifying professionals shall be a physician and one shall be a qualified psychologist or psychiatrist. At least 1 of the 2 certifying professionals shall examine the individual in question within 1 day preceding certification. Both certifying professionals shall give an opinion regarding the cause and nature of the mental incapacity as well as its extent and probable duration."

Section 6(b) of D.C. Law 16-46 provides that the act shall expire after 225 days of its having taken effect.

Section 3(b) of D.C. Law 16-194 amended (a) to read as follows:

"(a) Mental incapacity to make a health-care decision shall be certified by 2 professionals who

are licensed to practice in the District and qualified to make a determination of mental incapacity. One of the 2 certifying professionals shall be a physician and one shall be a qualified psychologist or psychiatrist. At least 1 of the 2 certifying professionals shall examine the individual in question within 1 day preceding certification. Both certifying professionals shall give an opinion regarding the cause and nature of the mental incapacity as well as its extent and probable duration."

Section 6(b) of D.C. Law 16-194 provided that the act shall expire after 225 days of its having taken effect.

Section 3(b) of D.C. Law 17-100 amended (a) to read as follows:

"(a) Mental incapacity to make a health-care decision shall be certified by 2 professionals who are licensed to practice in the District and qualified to make a determination of mental incapacity. One of the 2 certifying professionals shall be a physician and one shall be a qualified psychologist or psychiatrist."

Section 6(b) of D.C. Law 17-100 provides that the act shall expire after 225 days of its having taken effect.

Emergency legislation. — For temporary amendment of (a), see § 3(b) of the Health-Care Decisions for Persons with Mental Retardation and Developmental Disabilities Emergency Amendment Act of 2005 (D.C. Act 16-190, October 28, 2005, 52 DCR 10021).

For temporary amendment of (a), see § 3(b) of the Health-Care Decisions for Persons with Mental Retardation and Developmental Disabilities Congressional Review Emergency Amendment Act of 2006 (D.C. Act 16-262, January 26, 2006, 53 DCR 795), applicable as of January 26, 2006.

For temporary amendment of (a), see § 3(b) of the Health-Care Decisions for Persons with Developmental Disabilities Emergency Amendment Act

of 2006 (D.C. Act 16-480, September 25, 2006, 53 DCR 7940), applicable as of September 22, 2006.

For temporary amendment of (a), see § 3(b) of the Health-Care Decisions for Persons with Developmental Disabilities Congressional Review Emergency Amendment Act of 2006 (D.C. Act 16-566, December 19, 2006, 53 DCR 10272), applicable as of December 21, 2006.

For temporary amendment of (a), see § 3(b) of the Health-Care Decisions for Persons with Developmental Disabilities Congressional Review Emergency Amendment Act of 2006 (D.C. Act 16-566, December 19, 2006, 53 DCR 10272), applicable as of December 21, 2006.

For temporary amendment of (a), see § 3(b) of the Health-Care Decisions for Persons with Developmental Disabilities Emergency Amendment Act of 2007 (D.C. Act 17-161, October 18, 2007, 54 DCR 10932).

For temporary amendment of (a), see § 3(b) of the Health-Care Decisions for Persons with Developmental Disabilities Congressional Review Emergency Amendment (D.C. Act 17-245, January 23, 2008, 55 DCR 1230), applicable as of January 16, 2008.

For temporary amendment of (a), see § 3(b) of the Health-Care Decisions for Persons with Developmental Disabilities Emergency Amendment Act of 2008 (D.C. Act 17-492, August 4, 2008, 55 DCR 9167).

Legislative history of Law 7-189. — See note to § 21-2201.

Legislative history of Law 10-68. — See note to § 21-2201.

Legislative history of Law 16-46. — See note to § 21-2202.

Legislative history of Law 16-194. — See note to § 21-2202.

Legislative history of Law 17-100. — See note to § 21-2202.

Legislative history of Law 17-249. — See note to § 21-2202.

CASE NOTES

Applied in *Doe v. District of Columbia*, 489 F.3d 376, 2007 U.S. App. LEXIS 13701 (D.C. Cir. 2007).

§ 21-2205. Durable power of attorney for health care.

(a) A competent adult may designate, in writing, an individual who shall be empowered to make health-care decisions on behalf of the competent adult, if the competent adult becomes incapable, by reason of mental disability, of making or communicating a choice regarding a particular health-care decision.

(b) A durable power of attorney for health care shall include language which clearly communicates that the principal intends the attorney in fact to have the authority to make health-care decisions on behalf of the principal and shall include language identical or substantially similar to the following:

(1) "This power of attorney shall not be affected by the subsequent incapacity of the principal."; or

(2) "This power of attorney becomes effective upon the incapacity of the principal."

(c) A durable power of attorney for health care shall be dated and signed by the principal and 2 adult witnesses who affirm that the principal was of sound mind and free from duress at the time of signing. The 2 adult witnesses shall not include the principal, the health-care provider of the principal or an employee of the health-care provider of the principal.

attorney for health care subject to the limitations set forth in this chapter. The health care provider may not be named as the attorney in fact. (1981 Ed., § 21-2209; Mar. 16, 1989, D.C. Law 7-189, § 10, 35 DCR 8653; Feb. 5, 1994, D.C. Law 10-68, § 23(j), 40 DCR 6311.)

Legislative history of Law 7-189. — See note to § 21-2201.

Legislative history of Law 10-68. — See note to § 21-2201.

§ 21-2210. Substituted consent.

(a) In the absence of a durable power of attorney for health care and provided that the incapacity of the principal has been certified in accordance with § 21-2204, the 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.

(b) A decision to grant, refuse or withdraw consent made pursuant to subsection (a) of this section shall be based on the known wishes of the patient or, if the wishes of the patient are unknown and cannot be ascertained, on a good faith belief as to the best interests of the patient.

(c) There shall be at least 1 witness present whenever a person specified in subsection (a)(2) through (6) of this section grants, refuses or withdraws consent on behalf of the patient.

(d) If no individual in a prior class is reasonably available, mentally capable and willing to act, responsibility for decisionmaking shall rest with the next reasonably available, mentally capable, and willing person on the priority list.

(e) Any person listed in subsection (a) of this section shall have legal standing to challenge in the Superior Court of the District of Columbia any decision made by a person of higher priority as listed within that subsection.

(f) The order of priority established in subsection (a) of this section creates a presumption that may be rebutted if a person of lower priority is found to have better knowledge of the wishes of the patient, or, if the wishes of the patient are unknown and cannot be ascertained, is better able to demonstrate a good-faith belief as to the interests of the patient.

(g) An individual identified in subsection (a)(5B) of this section shall not be authorized to grant, refuse, or withdraw consent on behalf of the patient with respect to a decision regarding a health-care service, treatment, or procedure if the individual is:

(1) A health-care provider who is treating or providing services to the incapacitated patient at the time of the health-care decision; or

(2) An owner, operator, administrator, or employee of, or a person with decision-making authority for, a health-care provider treating or providing services to the incapacitated patient at the time of the health-care decision.

(h) If no person listed in subsection (a) of this section is reasonably available, mentally capable, and willing to act, the health-care provider, or the District of Columbia, for those persons committed or admitted to receive habilitation or other services pursuant to Chapter 13 of Title 7, or any interested person may petition the Superior Court of the District of Columbia for appointment of a guardian pursuant to section 21-2044 or section 21-2046.

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(i) The health-care provider who is treating or providing services to the incapacitated patient at the time of the health-care decision shall accept the decision of the individual authorized under this section to grant, refuse, or withdraw consent on behalf of the patient as the decision of the principal. (1981 Ed., § 21-2210; Mar. 16, 1989, D.C. Law 7-189, § 11, 35 DCR 8653; Mar. 11, 1992, D.C. Law 9-67, § 2(b), 39 DCR 12; Feb. 5, 1994, D.C. Law 10-68, § 23(k), 40 DCR 6311; June 21, 2003, D.C. Law 15-17, § 2(b), 50 DCR 3387; Mar. 13, 2004, D.C. Law 15-105, § 106, 51 DCR 881; Oct. 22, 2008, D.C. Law 17-249, § 3(c), 55 DCR 9206.)

Section references. — This section is referenced in § 7-651.01, § 7-1231.02, § 7-1231.06, § 7-1231.07, § 7-1301.03, § 7-1305.04, § 7-1305.06a, § 7-1305.06b, § 7-1305.06c, § 7-1305.07a, § 21-2011, § 21-2046, § 21-2047.02, and § 21-2211.

Effect of amendments. — D.C. Law 15-17 inserted "domestic partner" in (a)(2); inserted (a)(5B) and made a related change; and added (f) and (g).

D.C. Law 15-105 redesignated former (g)(1), (g)(1)(A) and (g)(1)(B) as present (g), (g)(1) and (g)(2), respectively.

D.C. Law 17-249 added (a)(1A), (h) and (i).

Temporary legislation. — Section 3(c) of D.C. Law 16-46 added (a)(1A) and (h) to read as follows:

"(a) In the absence of a durable power of attorney for health care and provided that the incapacity of the principal has been certified in accordance with § 21-2204, the 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:

"(1A) A court-appointed mental retardation advocate of the patient, if the ability to grant, refuse, or withdraw consent is within the scope of the advocate's appointment under § 7-1304.13.

"(h) If no person listed in subsection (a) of this section is reasonably available, mentally capable, and willing to act, the health-care provider, or the District of Columbia, for those persons committed or admitted to receive habilitation or other services pursuant to Chapter 13 of Title 7 of the District of Columbia Code, or any interested person may petition the Superior Court of the District of Columbia for appointment of a limited guardian for health care pursuant to § 21-2044(c)."

Section 6(b) of D.C. Law 16-46 provides that the act shall expire after 225 days of its having taken effect.

Section 3(c) of D.C. Law 16-194 added (a)(1A), and (h) to read as follows:

"(a) In the absence of a durable power of attorney for health care and provided that the incapacity of the principal has been certified in accordance with § 21-2204, the 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:

"(1A) A court-appointed mental retardation 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.

"(h) If no person listed in subsection (a) of this section is reasonably available, mentally capable, and willing to act, the health-care provider, or the District of Columbia, for those persons committed or admitted to receive habilitation or other services pursuant to Chapter 13 of Title 7, or any interested person may petition the Superior Court of the District of Columbia for appointment of a health-care guardian pursuant to section 21-2044 or section 21-2046."

Section 6(b) of D.C. Law 16-194 provided that the act shall expire after 225 days of its having taken effect.

Section 3(c) of D.C. Law 17-100 added (a)(1A), (h) and (i) to read as follows:

"(a) In the absence of a durable power of attorney for health care and provided that the incapacity of the principal has been certified in accordance with § 21-2204, the 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:

"(1A) A court-appointed mental retardation 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.

"(h) If no person listed in subsection (a) of this section is reasonably available, mentally capable, and willing to act, the health-care provider, or the District of Columbia, for those persons committed or admitted to receive habilitation or other services pursuant to Chapter 13 of Title 7, or any interested person may petition the Superior Court of the District of Columbia for appointment of a health-care guardian pursuant to section 21-2044 or section 21-2046.

"(i) The health-care provider who is treating or providing services to the incapacitated patient at the time of the health-care decision shall accept the decision of the individual authorized under this section to grant, refuse, or withdraw consent on behalf of the patient as the decision of the principal."

Section 6(b) of D.C. Law 17-100 provides that

the act shall expire after 225 days of its having taken effect.

Emergency legislation. — For temporary amendment of section, see § 2(g) of the Health-Care Decisions for Persons with Developmental Disabilities Emergency Amendment Act of 2006 (D.C. Act 16-480, September 25, 2006, 53 DCR 7940), applicable as of September 22, 2006.

For temporary amendment of section, see § 2(g) of the Health-Care Decisions for Persons with Developmental Disabilities Congressional Review Emergency Amendment Act of 2006 (D.C. Act 16-566, December 19, 2006, 53 DCR 10272), applicable as of December 21, 2006.

For temporary amendment of section, see § 2(g) of the Health-Care Decisions for Persons with Developmental Disabilities Emergency Amendment Act of 2007 (D.C. Act 17-161, October 18, 2007, 54 DCR 10932).

For temporary amendment of (a) and repeal of (c), see § 2(g) of the Health-Care Decisions for Persons with Developmental Disabilities Congressional Review Emergency Amendment (D.C. Act 17-245, January 23, 2008, 55 DCR 1230), applicable as of January 16, 2008.

For temporary amendment of section, see § 2(g) of the Health-Care Decisions for Persons with

Developmental Disabilities Emergency Amendment Act of 2008 (D.C. Act 17-492, August 4, 2008, 55 DCR 9167).

Legislative history of Law 6-204. — See note to § 21-2001.

Legislative history of Law 7-231. — Law 7-231, the "Technical Amendments Act of 1988," was introduced in Council and assigned Bill No. 7-586. The Bill was adopted on first and second readings on November 29, 1988, and December 13, 1988, respectively. Signed by the Mayor on January 6, 1989, it was assigned Act No. 7-285 and transmitted to both Houses of Congress for its review.

Legislative history of Law 8-34. — See note to § 21-2002.

Legislative history of Law 16-194. — See note to § 21-2002.

Legislative history of Law 17-100. — See note to § 21-2002.

Legislative history of Law 17-249. — See note to § 21-2002.

Editor's notes. — D.C. Law 17-249 substituted "a general guardian or a limited guardian" for "guardian" in the introductory paragraph, which would have resulted in the phrase "a a guardian"; LexisNexis edited out the extra indefinite article.

CASE NOTES

ANALYSIS

Guardian's discretion.
Intent.

Guardian's discretion.

Suitable guardian has considerable discretion in gauging how best to care for his or her ward, and this chapter does not call for judicial micromanagement and second-guessing. In re Orshansky, 804 A.2d 1077, 2002 D.C. App. LEXIS 488 (2002).

Intent.

Although District of Columbia law authorizes a guardian to change a ward's place of residence, it

does not authorize a guardian to establish the ward's intent with respect to residency; thus the guardian could move the ward to a different state, but the exercise of that authority did not change the legal effect of the change of residence under the Medicaid regulations. McKenzie v. D.C. Dep't of Human Servs., 802 A.2d 356, 2002 D.C. App. LEXIS 377 (2002).

Applied in In re Estate of Grealis, 902 A.2d 821, 2006 D.C. App. LEXIS 414 (2006); In re Randolph-Bray, 942 A.2d 1142, 2008 D.C. App. LEXIS 78 (2008); Snead v. Watkins (In re Estate of McDaniel), 953 A.2d 1021, 2008 D.C. App. LEXIS 286 (2008).

§ 21-2047.01. Limitations on temporary, limited, and general guardians.

A guardian shall not have the power:

(1) To consent to an abortion, sterilization, psycho-surgery, or removal of a bodily organ except to preserve the life or prevent the immediate serious impairment of the physical health of the incapacitated individual, unless the power to consent is expressly set forth in the order of appointment or after subsequent hearing and order of the court;

(2) To consent to convulsive therapy, experimental treatment or research, or behavior modification programs involving aversive stimuli, unless the power to consent is expressly set forth in the order of appointment or after subsequent hearing and order of the court;

(3) To 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;

(4) To consent to the involuntary or voluntary civil commitment of an incapacitated individual who is alleged to be mentally ill and dangerous under any provision or proceeding occurring under Chapter 5 of Title 21, except that a guardian may function as a petitioner for the commitment consistent with the requirements of Chapter 5 of Title 21 or Chapter 13 of Title 7;

(5) To consent to the waiver of any substantive or procedural right of the incapacitated individual in any proceeding arising from an insanity acquittal; or

(6) To prohibit the marriage or divorce, or consent to the termination of parental rights, unless the power is expressly set forth in the order of appointment or after subsequent hearing and order of the court. (Oct. 22, 2008, D.C. Law 17-249, § 2(h), 55 DCR 9206.)

Section references. — This section is referenced in § 21-2047.02.

Temporary legislation. — Section 2(h) of D.C. Law 16-194 added this section.

Section 6(b) of D.C. Law 16-194 provided that the act shall expire after 225 days of its having taken effect.

Section 2(h) of D.C. Law 17-100 added this section.

Section 6(b) of D.C. Law 17-100 provides that the act shall expire after 225 days of its having taken effect.

Emergency legislation. — For temporary addition of section, see § 2(h) of the Health-Care Decisions for Persons with Developmental Disabilities Emergency Amendment Act of 2006 (D.C. Act 16-480, September 25, 2006, 53 DCR 7940), applicable as of September 22, 2006.

For temporary addition of section, see § 2(h) of the Health-Care Decisions for Persons with Developmental Disabilities Congressional Review Emergency Amendment Act of 2006 (D.C. Act 16-566, December 19, 2006, 53 DCR 10272), applicable as of December 21, 2006.

For temporary addition of section, see § 2(h) of the Health-Care Decisions for Persons with Developmental Disabilities Congressional Review Emergency Amendment Act of 2006 (D.C. Act 16-566, December 19, 2006, 53 DCR 10272), applicable as of December 21, 2006.

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For temporary addition of section, see § 2(h) of the Health-Care Decisions for Persons with Developmental Disabilities Emergency Amendment Act of 2007 (D.C. Act 17-161, October 18, 2007, 54 DCR 10932).

For temporary addition of section, see § 2(h) of the Health-Care Decisions for Persons with Developmental Disabilities Congressional Review Emergency Amendment (D.C. Act 17-245, January 23, 2008, 55 DCR 1230), applicable as of January 16, 2008.

For temporary addition of section, see § 2(h) of the Health-Care Decisions for Persons with Developmental Disabilities Emergency Amendment Act of 2008 (D.C. Act 17-492, August 4, 2008, 55 DCR 9167).

Legislative history of Law 16-194. — See note to § 21-2002.

Legislative history of Law 17-100. — See note to § 21-2002.

Legislative history of Law 17-249. — See note to § 21-2002.

§ 21-2047.02. Powers and duties of emergency and health-care guardians.

(a) Except as limited by sections 21-2046 and 21-2047.01, an emergency guardian or health-care guardian is responsible for providing substituted consent for an incapacitated individual and for any other duties authorized by the court, but is not personally liable to third persons by reason of that responsibility or acts of the incapacitated individual.

(b) An emergency or health-care guardian shall:

(1) Become or remain personally acquainted with the ward and maintain sufficient contact with the ward to know of his or her capacities, limitations, needs, opportunities, and physical and mental health;

(2) Make 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, make the decision on the basis of the ward's best interests;

(3) Include the ward in the decision-making process to the maximum extent of the ward's ability.

(4) Encourage the individual to act on his or her own behalf whenever he or she is able to do so, and to develop or regain capacity to make decisions in those areas in which he or she is in need of decision-making assistance, to the maximum extent possible; and

(5) Make any report the court requires.

(c) An emergency or health-care guardian may:

(1) Grant, refuse, or withdraw consent to medical examination and health-care treatment for an individual who has been deemed incapacitated pursuant to section 21-2204;

(2) Obtain medical records for the purpose of providing substituted consent pursuant to section 21-2210; and

(3) Have the status of a legal representative under Chapter 12 of Title 7 (Oct. 22, 2008, D.C. Law 17-249, § 2(h), 55 DCR 9206.)

Katherine M. Wiedmann is an associate attorney at Crowley, Hoge & Fein PC. She has been practicing in the District of Columbia since 2002 and focuses on wills, estates, trusts and elder law. Ms. Wiedmann is a member of the Court's Probate Fiduciary Panel and the Probate, Trusts and Estates Section of the D.C. Bar. In her work as a Court-appointed guardian and conservator, she has encountered complex end-of-life decisions for wards and their families. In 2006, she initiated a petition to the Court for authority to withdraw life-supporting treatment for a ward, whose son refused to honor the ward's wishes set forth in her Living Will. She has also dealt with wards who have refused medical treatment against medical advice and has sought the Court's assistance to resolve those matters.

Ms. Wiedmann also assists clients to think through End-of-Life decisions in estate planning, including assisting clients to prepare advance directives, powers of attorney and special needs trusts. She has experience litigating fiduciary duties and obligations in intervention and estate matters. She is a member of the National Association of Consumer Advocates (NACA) and represents clients in real property matters as well. She is a graduate of Mercyhurst College, summa cum laude (B.A. 1994) and The Washington College of Law, American University, cum laude (J.D. 2001), where she was a member of the Administrative Law Journal. Before law school, she was a Peace Corps Volunteer in Cameroon, Africa. She is admitted to practice in Washington DC and New York.