
Disabilities Project Newsletter

End of Life Decisions

Whose Call?

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This is a confusing area of the law and the statutes and court decisions have not made it any simpler. Different rules apply to different surrogate decision makers. For example, the Estates and Protected Individuals Code (EPIC) does not provide the same level of explicit guidance for guardians in making these decisions as is provided to patient advocates.

I will try to bring some clarity to the question by examining the leading Michigan cases on the topic as well as Michigan's Do-Not-Resuscitate Act, the Dignified Death Act and the frequently cited Michigan Attorney General's opinion relative to the authority of a guardian to sign a do-not-resuscitate order on behalf of a developmentally disabled adult.

Before I do that, let me summarize my opinion as to the authority of guardians of legally incapacitated adults to make end of life decisions since this is the issue you are most likely to face. I will address minors and persons with developmental disabilities later.

First; I believe guardians have the authority to consent to DNR orders based on the common law and the saving language in the DNR Act which states that the Act is cumulative and does not impair the legal right of a guardian to refuse medical treatment.

Second; I do not think a court order is required. If a guardian consults with the treatment team and it is agreed that a DNR order is appropriate, and no one objects, we should not see that case.

Third; In the event of an objection, by anyone, a hearing will be held and a decision made as to whether the guardian will be prevented from consenting to a DNR order.

Fourth; at the hearing, the court would first determine whether there is an advance directive, or, using the subjective test, what the individual would have wanted based on previously expressed views. The evidentiary standard would be clear and convincing evidence to permit the guardian to consent to a DNR order.

Fifth, and finally; if the substituted judgment test fails to support the issuance of a DNR order, we would then move to the objective or best interest's analysis. The *Martin*¹ case, which I will discuss later, acknowledges that the objective analysis test may be appropriate if a person is terminally ill, permanently unconscious, in a persistent vegetative state or in great uncontrollable pain. However, *Martin* does not permit the use of the objective or best interest test if the patient is conscious and was formerly competent. *Martin* might permit the best interest test if the patient were terminally ill, in a persistent vegetative state or in great uncontrollable pain.

EPIC

So, how did I arrive at these conclusions? Let's start with EPIC. When it comes to patient advocates, EPIC provides explicit guidance. It provides that:

A patient advocate may make a decision to withhold or withdraw treatment that would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.²

It is not necessary that the patient be terminally ill, permanently unconscious, in a permanent vegetative state or in great uncontrollable pain to empower the patient advocate. All that is required for the patient advocate to withhold or withdraw treatment is the written consent of the patient.

On the other hand, guidance for guardians is limited to this: "the guardian must make provision for the ward's care, comfort, and maintenance" ... and "...secure services to restore the ward to the best possible state of mental and physical well-being so that the ward can return to self-management at the earliest possible time."³ Also, "A guardian may give the consent or approval that is necessary to enable the ward to receive medical or other professional care, counsel, treatment, or service."⁴ It can be argued that implicit in the use of the word "may" give consent is the discretion to decline to give consent. The Supreme Court in *Martin* explicitly found that a necessary corollary of the common-law right to informed consent is the right not to consent.

¹ *Martin v Martin (In re Martin)*, 450 Mich 204, 538 NW2d 399 (1995), *cert denied* 516 US 1113 (1996).

² MCL 700.5509(1)(e).

³ MCL 700.5314(b).

⁴ MCL 700.5314(c).

Do-Not-Resuscitate Act

The DNR Act provides express authority for a patient advocate to sign a DNR order.⁵ However, the DNR Act only applies to documents that take effect in the event a patient suffers cessation of both spontaneous respiration and circulation in a setting outside of a hospital, a nursing home, or a mental health facility owned or operated by the department of community health.⁶ The DNR order is not effective in these facilities. The purpose of these community DNR orders is to protect emergency personnel from lawsuits.

While the DNR Act does not give express authority to a guardian to sign that type of DNR order, the savings clause of the Act provides that: “The provisions of this act are cumulative and do not impair or supersede a legal right that a ... guardian ... may have to consent to or refuse medical treatment.”⁷ It can be argued that the legislature is acknowledging the authority of guardians to refuse treatment that may lead to death.

Michigan Dignified Death Act

In contrast, the Michigan Dignified Death Act⁸ provides explicit authority to guardians to withhold certain medical treatment, including, but not limited to, palliative care or a procedure, medication, surgery, a diagnostic test or a hospice plan of care that may be ordered, provided, or withheld by a health professional or a health care facility under generally accepted standards of medical practice that is not prohibited by law.⁹ The Act does not speak to DNR orders, resuscitation is a “procedure” and the Act permits withholding a “procedure”. However, the Act is limited in that it only permits the guardian the right to refuse medical treatment for a patient’s terminal illness.

Case law

The *Martin* case addresses the authority of a guardian to refuse life-sustaining treatment for an adult while the *Rosebush*¹⁰ case speaks to the authority of a surrogate decision maker to withhold life-sustaining treatment for a minor. Attorney General Opinion No. 7056 addresses the authority of the guardian of a developmentally disabled ward to execute a DNR order under the DNR Act and the Patient Advocate Act. I will address each of these separately.

Adult Guardianships

In *Martin*, the Michigan Supreme Court discussed the authority of a guardian to withhold life-sustaining treatment. The trial court, affirmed by the Court of Appeals following remand from the Court of Appeals, had found the evidence to be clear and convincing that the ward had expressed a preference to decline life-sustaining medical treatment under the circumstances presented.

Mary Martin and Michael Martin were married in 1972. They had three children. On January 16, 1987, Michael suffered a closed head injury in an automobile accident that left him unable to walk or talk. He had a colostomy and a gastrostomy tube for nutrition. Mary was appointed as his guardian. Michael lived in nursing

⁵ MCL 333.1052, *et seq.*

⁶ MCL 333.1055(5)

⁷ MCL 333.1066(1)

⁸ MCL 333.5651 *et seq.*

⁹ MCL 333.5653(1)(d).

¹⁰ *In re Rosebush*, 195 Mich App 675, 491 NW2d 633 (1992).

homes after that. Nearly 5 years later, on January 9, 1992, while Michael was in the hospital for an obstructed bowel, Mary contacted the hospital's bioethics committee to determine whether Michael's life-sustaining treatment should be withdrawn. After the bioethics committee consulted with Mary, a family friend, a social worker, Michael's treating physician and nurses at the hospital, the committee issued a report stating that withdrawal of treatment was appropriate, but, court authorization would be required.

Mary filed a petition with the probate court seeking authorization to withdraw treatment. Michael's mother and sister opposed the petition and asked that Mary be removed as Michael's guardian and conservator. Initially, the probate court denied the petition. The Court of Appeals then remanded the case for further findings. The trial court then found that Mary had presented clear and convincing evidence of her husband's wishes to decline life-sustaining treatment under these circumstances. The Court of Appeals affirmed.

The Supreme Court began its analysis by recognizing that the right to refuse treatment is an aspect of the common-law doctrine of informed consent. The Court then made it clear that it was "deciding only that to the extent the right to refuse medical treatment refers to decisions already made and communicated by the patient before losing capacity to make further choices, ...it is true that the patient's interest in having those choices honored must survive incapacity."¹¹

The Court then addressed the standard to be followed for guiding guardians in carrying out their responsibilities. In general, there are two approaches. First: The best interest standard, which is an objective analysis where the benefits and burdens to the patient of the treatment are assessed by the surrogate in conjunction with statements made by the patient, if such statements are available. It is generally a secondary approach when subjective evidence is lacking. This standard is grounded in the State's *parens patriae* power.¹² The Court found nothing that prevents the state from grounding any objective analysis on a threshold requirement of pain, terminal illness, foreseeable death, a persistent vegetative state, or affliction of a similar nature.¹³

The subjective analysis represents an effort to identify the wishes of the patient while the patient was competent. First, the surrogate looks to explicit statements made by the patient. If not available, the surrogate may look to what the patient might have decided, based on evidence of the patient's "value system".¹⁴ This approach has both subjective and objective features to it. This standard is based on a patient's right to self-determination.

The Court looked to the New Jersey Supreme Court's approach in its decision in the 1985 case of *In re Conroy*.¹⁵ That court created a hierarchical decision-making continuum which ranged from a purely subjective analysis to a purely objective analysis. The standard to be used in a given case would depend on the facts of the case.

¹¹ *Martin* at 406.

¹² *Martin* at 408.

¹³ *Martin* at 408.

¹⁴ *Martin* at 407.

¹⁵ *In re Conroy*, 98 NJ 321, 346-348, 486 A2d 1209 (1985).

In the *Martin* case the Supreme Court took great pains to explicitly state that the purely subjective analysis was the appropriate standard to apply under the circumstances of that case. The Court stated it expressed no opinion about the proper decision-making standard for patients who have never been competent (such as minors or persons with developmental disabilities), patients existing in a persistent vegetative state, patients who are experiencing great pain, or patients who are terminally ill. The Court stated if a patient has any of these conditions, or ailments of a similar nature, a more objective approach may be necessary and appropriate.¹⁶

The court added: “The facts of each case present unique circumstances, and it would be unrealistic for us to attempt to establish a rigid set of guidelines to be used in all cases requiring an evaluation of a now-incompetent patient’s previously expressed wishes. The number and variety of situations in which the problem of terminating artificial life support arises precludes any attempt to anticipate all of the possible permutations.”¹⁷

The guidance we get from *Martin* is limited, but useful. The stronger the evidence to support a finding that someone is in a persistent vegetative state, is suffering persistent unavoidable pain that outweighs any enjoyment of life or is terminally ill, the closer you will get to the ability to use an objective or best interest analysis.

However, if the patient is conscious and was formerly competent, the Supreme Court requires the use of the subjective analysis in the absence of a persistent vegetative state, terminal illness or persistent unavoidable pain. In its conclusion the Supreme Court used the term “conscious” 4 time. So how did this work for Michael Martin.

The Court acknowledged that conflicting testimony was presented regarding Michael. Dr. Joseph Fischhoff, who was head of the Department of Psychiatry at Wayne State University and chairman of the bioethics committee at Children’s Hospital in Detroit, testified that Michael had no voluntary control over any of his limbs, or any ability to function on a voluntary level, and therefore lacked any meaningful interaction with his environment. Dr. Robert Kreitsch, the director of the Brain Injury Rehabilitation Program at the Mary Free Bed Rehabilitation Center testified that Michael had some ability to carry out voluntary motor commands on his right side, including the ability to pinch and grasp, as well as the ability to recognize faces, respond emotionally, and communicate with others with head nods. It was agreed that Michael was not in a persistent vegetative state or terminally ill.

The Court found that Michael’s life and health were not threatened by his infirmities and he had been competent and able to express his wishes and desires at one time, therefore, it would apply a purely subjective standard. The court required the surrogate decision-maker to show by clear and convincing evidence that Michael’s prior statements regarding withholding life-sustaining treatment illustrated a serious, well thought out, consistent decision to refuse treatment under these exact circumstances or circumstances highly similar to the current situation.

¹⁶ *Martin* at FN 15.

¹⁷ *Martin* at FN 15.

The Court acknowledged that the trial court relied on the testimony of Michael's wife, including her affidavit. In her affidavit, she wrote as follows:

She said they had discussed what would happen if they ever had a serious accident or disabling or terminal illness about eight years earlier and that Mike's position was always the same: he did not want to be kept alive on machines and he made her promise that she would never permit it. In reference to movies they had watched depicting people who could not feed or dress themselves Mike would say: Please don't ever let me exist that way because those people don't even have their dignity. She recalled that after watching "Brian's Song" he said: "If I ever get sick don't put me on any machines to keep me going if there is no hope of getting better." He also said that if she put him on a machine he would come back to haunt her. The last conversation on the topic occurred on December 9, 1986, two months before the accident. She was having surgery on New Year's Day and they discussed their wishes if either became severely incapacitated. She told Mike she would not want to be maintained artificially. Mike's response was that he would respect her wishes and expected she would do the same for him. She opined that he would wish to be permitted to die in a dignified manner consistent with his explicit wishes expressed prior to the accident.

The appellants did not dispute these statements but argued that Mary's affidavit was uncorroborated, the comments were remote in time and his comments were general, vague and casual because he had never experienced this form of helplessness. They conceded that they had no reason to question the veracity of Mary's testimony or doubt those conversations took place. Mike's mother admitted that he would not have wanted to be helpless and dependent on others. However, she felt his prior wishes should not control. In addition, they argued that he changed his mind.

The Court, after reviewing Mary's testimony, commented, "This testimony and affidavit cannot be viewed in a vacuum."¹⁸ It is not clear what the Court meant by that comment. The Court cited testimony that the condition Mike was in was not the type of condition discussed prior to the accident. A doctor testified that he seemed content with his environment. The Court then observed that several witnesses testified that Mike could respond to simple yes or no questions by nodding his head and always indicated no when asked if did not want to go on living. The Court concluded that the testimony and affidavit of Mary did not constitute clear and convincing evidence of Mike's wishes in this type of situation.

The dissent was sharply critical observing that the majority became the first disinterested body to examine Michael's wishes without being convinced by the ample evidence of his prior wishes. The dissent charged the majority with failing to respect the trial court's role as fact finder.

The majority claimed it was not swayed by the witnesses who claimed to perceive that Michael had changed his mind and wanted to live. If that was the case, one might wonder why bother to point out in the opinion that several witnesses testified that Mike indicated a desire to continue living. If that language is deleted from the opinion all that is left is the testimony that he seemed content. In a footnote¹⁹, the dissent

¹⁸ *Martin* at 412.

¹⁹ *Martin* at FN 23.

cited evidence that Mike did not have the capacity to understand the question of whether he wanted to live or die. In a responding footnote²⁰, the majority stated they did not rely on that testimony.

Taking the petitioner's testimony as true, the majority simply held that the evidence was not sufficiently clear and convincing. In light of the evidence in this case, one might ask, just what would it take to find evidence that was clear and convincing? The dissent suggested the majority's treatment of the evidence would require a highly formal oral or written statement concerning the patient's specific medical condition.

The *Martin* case was hotly disputed with multiple amicus briefs filed by advocacy groups from around the country. A big problem with *Martin* is the lack of guidance on what constitutes clear and convincing evidence. The Court's comment that "Statements made in response to seeing or hearing about another's prolonged death, do not fulfill the clear and convincing standard"²¹ is troublesome. Is such a statement, evidence at all? The Court stated as follows: Only when the patient's prior statements clearly illustrate a serious, well thought out, consistent decision to refuse treatment under these exact circumstances, or circumstances highly similar to the current situation should treatment be refused or withdrawn."²²

The Court found that Mike's pre-accident statements expressed a desire not to live like a vegetable and he was not in a true persistent vegetative state. The dissent pointed out that the bioethics committee found that Mike's condition and level of functioning was equivalent to a persistent vegetative state.²³

The outcome in *Martin* seems perplexing. Even, Michael's mother, who opposed termination of life sustaining treatment, admitted her son would not want to live that way. So, if the Court found the evidence not clear and convincing as to his wishes, why not look at his value system, as suggested in the opinion? Just two months before his accident, Michael told his wife not to put him on a machine if there was no hope of getting better. If the Court was endorsing the *Conway* hierarchical approach, why not move along the hierarchy?

The Court drew a distinction between the formerly competent and the never competent in deciding which standard to use. However, when facing the question of withholding or withdrawing treatment, the former competent and never competent are in the same situation. They are not competent and we do not know their wishes.

Despite the protestations of the Court in *Martin*, reading the opinion, it is not difficult to conclude that the Court was troubled by the fact that Michael might be indicating a desire to live. Between that and the wide publicity the case had, it was safer to deny the petition to withhold treatment and limit the precedent of that case

So, what does *Martin* stand for? Keep in mind the Courts statement: "We cannot stress too strongly that the complexity and ramifications of any decision in this area cautions against moving too swiftly or adopting controversial decision-making standards in cases that do not present facts compelling such decision.

²⁰ *Martin* at FN 10.

²¹ *Martin* at 411.

²² *Martin* at 411.

²³ *Martin* at 415.

The right of informed consent extends only to the decisions this particular patient has made. As we noted at the outset, if we are to err, we must err in preserving life. Our first step in this area must be a careful one.”²⁴

Does this mean these cases will be addressed by the Supreme Court on a case-by-case basis? Still, I think *Martin* does give some useful guidance to work with. We know the analysis will range from the purely subjective (clear and convincing evidence of the patient’s wishes) to the purely objective (weighing the benefits and burdens of treatment). The court did not limit Michigan to one standard or the other.

The case can be read narrowly to require the purely subjective analysis in cases involving conscious persons who were formerly competent and not in a persistent vegetative state. On the other hand, other language in the opinion limiting the precedential value to this case while suggesting other approaches in other cases may be appropriate seems to permit a broader reading for others who were formerly competent.

I think the starting point for analysis is whether clear and convincing evidence exists using the subjective analysis. To the extent such evidence is insufficient you would then begin an objective analysis based on the presence of pain, terminal illness, foreseeable death, a persistent vegetative state, or affliction of a similar nature. The really challenging cases will be those where the existence of a vegetative state is at issue, the patient is conscious and was formerly competent. In limiting the application of *Martin*, I think the door is open to the use of the objective or best interest analysis for other formerly competent persons.

Minors

Minors present a different situation. Unlike legally incapacitated adults, minors have never had the legal capacity to make decisions concerning their medical treatment. Someone acting as a surrogate must exercise the right to refuse treatment on their behalf.

The Court of Appeals addressed this issue in *In re Rosebush*. Joelle Rosebush was born on May 20, 1976. A traffic accident on January 12, 1987, severed her spinal cord and she went into cardiac arrest. She was left completely and irreversibly paralyzed from the neck down and unable to breathe without a respirator. Most, if not all of her cerebral function had been destroyed and left her in a persistent vegetative state. It was uncontroverted that she would never regain consciousness and would never be able to breathe on her own.

Joelle was initially hospitalized until June, 1987. Her parents initially rejected discontinuing life-support and moved her to the Neurorehabilitation Center at the Georgian Bloomfield Nursing Home. By March of 1988, Joelle’s parents decided to authorize the removal of life-support systems. They made this decision after consulting with their daughter’s treating physicians, the staff, the family’s Catholic priest and the family’s attorney.

Joelle’s case manager sought the assistance of doctors at Children’s Hospital of Michigan in effectuating the decision to discontinue life-support. The bio-ethics committee at Children’s Hospital authorized Joelle’s transfer to that hospital for further evaluation. However, the transfer was blocked after staff members at the Neurorehabilitation Center contacted the Oakland County Prosecutor who obtained a temporary restraining order prohibiting Joelle’s transfer or the removal of life-support systems.

²⁴ *Martin* at 409.

Following seven days of trial, the court dissolved the injunction and authorized the parents to remove the ventilator. Joelle died on August 13, 1988.

The prosecutor appealed. The Court of Appeals decided to hear the appeal although it was technically moot with the death of Joelle. The Court found that appellate review was appropriate because the issue involved questions of public importance that may recur and evade review.

The Court of Appeals held that the right to refuse treatment is not lost because of the incompetence or youth of the patient. The Court held that parents are empowered to make decisions regarding withdrawal or withholding of lifesaving or life-prolonging measures on behalf of their children. The question for the Court was what restrictions, if any, should be placed on parents' decision-making authority and what role the courts should play.

The court held that the decision-making process should generally occur in the clinical setting without resort to the courts unless an impasse is reached. They further held that surrogate decision-makers should first act on the best approximation of the patient's preference; but, if that is not known, then act in the best interests of the patient. The court suggested that for a minor of mature judgment-the substituted judgment standard would be appropriate. But for immature minors, the best interest standard should be used.

The *Rosebush* court attempted to formulate an approach that applied to minors and incapacitated adults. This led to a partial dissent which suggested the court should limit its holding to the decision as it affected Joelle. In light of *Martin*, which is the standard for incompetent adults, I think the dissent has had its way.

In *Rosebush*, the county prosecutor also argued that termination of life-support for Joelle should subject Joelle's parents and doctors to criminal liability for homicide. The Court of Appeals held that the trial court did not err in refusing to impose criminal liability for the removal of Joelle's life-support systems.

Developmentally disabled

In 2000, the Attorney General issued her opinion on the authority of guardians for developmentally disabled adults to sign patient advocates under the Patient Advocate Act and the DNR Act.²⁵ The Attorney General concluded that a Guardian lacked the authority to sign a designation of patient advocate act on behalf of the ward since the Patient Advocate Act does not explicitly give that authorization to guardians. In addition, the developmentally disabled person may not sign the designation since a prerequisite to signing such a document is that the person be of sound mind. One could argue that the Attorney General's analysis should only apply to plenary guardianships. What about partial guardianships? Could the court reserve to the ward in a partial guardianship the right to execute a DNR order?

The Court of Appeals in *Martin*²⁶ observed that the fact a patient has been previously adjudicated incompetent is not controlling because a patient may not be competent to make some decisions, but still have the requisite capacity to make a decision regarding medical treatment. The Court cited the fact that this view

²⁵ OAG, 2000, No 7,056 (June 20, 2000)

²⁶ *In re Martin*, 200 Mich App 703 (1993).

was embodied in Michigan's patient advocacy statute which explicitly recognizes that an incompetent patient may express a desire not to have life-sustaining medical treatment withheld or withdrawn.²⁷

The test for whether a person has the requisite capacity to make a decision to withhold or withdraw treatment was described as "...whether the person (1) has sufficient mind to reasonably understand the condition, (2) is capable to understanding the nature and effect of the treatment choices, (3) is aware of the consequences associated with those choices, and (4) is able to make an informed choice that is voluntary and not coerced."²⁸ For most developmentally disabled persons, they will lack that capacity, however, for some, it may be reasonable to retain the power to designate a patient advocate.

In any event, the Attorney General applied the same analysis to the DNR Act, noting that the legislature did not provide authority for guardians to sign designations in the DNR Act, which is true; however, the Attorney General did not address the savings clause in the Act.

The Attorney General did not address the authority of guardians to sign DNR orders under the common law or the Michigan Dignified Death Act.

I would agree that neither Act cited by the Attorney General is the *source* of authority for a guardian to withdraw or withhold life-sustaining treatment. That authority exists at common law.

The issue of the authority to make end of life decisions for persons with developmental disabilities was addressed by one of our former colleagues, Judge Michael Mack, of the Montmorency County Probate Court, in 2005. In that case, Edith Shirley was 50 years old and developmentally disabled. The guardian sought an order permitted the discontinuance of life-sustaining treatment. The hospital and treating physicians were unsure of the authority of the guardian to consent to the withdrawal of treatment.

The court found that Edith was suffering from a terminal illness and that her suffering was unavoidable and would endure throughout her life time. The court found that the administration of CPR would leave her in a worse condition and would likely terrorize her since she would not know why treatment was being conferred and would only feel pain. The court found that the burdens of further treatment outweighed any substantial benefit.

The court found that the appropriate standard to be used would be the objective best interest standard as touched upon in *Martin* because Edith was never competent. As such, the guardian would be authorized to withhold treatment. The court went on to say that the physicians and guardian should, as they do in all other cases, consult with each other and they and they alone, make the decision when a device should be removed. The testimony revealed that there are no strict medical criteria for such a decision and it varies from patient to patient. The guardian was given the authority to make a medically based, informed decision as to the termination of a particular treatment.

The judge observed that the right to refuse treatment was sown in the common law. He could see no reason why persons with developmental disabilities should be denied that right, after all, the Mental Health

²⁷ Citing MCL 700.496(13), now known as MCL 700.5511(1).

²⁸ *In re Martin*, at 716.

Code goes to great lengths to protect and retain the rights of persons with developmental disabilities to make decisions, even minor ones like what color dress to wear.

I would suggest that guardians of developmentally disabled persons have the authority at common law to withdraw or withhold treatment. In the event of a dispute, the court would then apply the objective, best interest standard in deciding whether the guardian would be authorized to withdraw or withhold treatment.

Practical considerations

The murkiest area of the law involves cases where the conscious, formerly competent patient may not be in a vegetative state. Frankly, drawing a distinction between the formerly competent and the never competent seems hard to explain or justify. However, until the legislature speaks, it is not clear that the Supreme Court would authorize use of the objective or best interest analysis for a conscious, formerly competent person who is not in a persistent vegetative state, as defined by medical standards.

In the meantime, for those cases where we are called upon to decide the best interests, the Wisconsin Supreme Court has provided a useful checklist in the case of *In the Matter of Guardianship of L.W.*²⁹ That Court said where there is little or no evidence of a patient's wishes and the patient is in a persistent vegetative state, the guardian must determine what is presently in the patient's best interests. The court provided 12 criteria to guide the guardian's best-interest determination:

- (1) Whether the ward ever expressed any view regarding life-sustaining treatment.
- (2) The wishes of the family.
- (3) An independent medical opinion.
- (4) The recommendation, if any, of a bioethics committee.
- (5) The chances of physical recovery.
- (6) The chances of mental recovery.
- (7) The likelihood of physical, psychological, or emotional injury as a result of providing or not providing treatment.
- (8) The likelihood and duration of survival without treatment.
- (9) The physical effects of prolonged treatment.
- (10) The benefits of continued life with and without treatment.
- (11) The motives of those supporting withdrawal.
- (12) Any other factors bearing on the best interests of the ward.

Using these factors in making a best-interest assessment of withholding or withdrawing treatment is as good a guide as any. This test appears suitable for the never competent (minors and persons with developmental disabilities) and for the formerly competent in a persistent vegetative state, terminally ill or suffering great pain.

June 25, 2012

²⁹ *In the Matter of the Guardianship of L.W.*, 167 Wis2d 53, 482 NW2d 60 (1992).