

THE ALASKA HEALTH CARE DECISIONS ACT, ANALYZED

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This Article reviews and examines the Alaska Health Care Decisions Act (“AHCDA”), found at section 13.52 of the Alaska Statutes and effective January 1, 2005. The AHCDA is examined functionally, historically, philosophically, and by hypothetical application to well-known cases. The Article identifies a number of errors and ambiguities in the AHCDA and concludes that while the AHCDA expresses itself as an attempt to balance the societal concerns of sanctity of life and the right to self-determination, in practice it is likely to promote termination of life support in circumstances supported by neither of those two philosophical imperatives.

I. INTRODUCTION

After four years of debate, the 2004 Alaska Legislature finally passed the Alaska Health Care Decisions Act (“AHCDA”).¹ The AHCDA is an ambitious attempt to pull together a number of statutory schemes related to the end of life, including laws on advance directives (also known as “living wills”), termination of life support for those who are terminally ill or permanently unconscious, laws related to decision making for the mentally ill, and laws related to organ donation. The AHCDA also adds a section on surrogate decision making for those who have not filled out an advance medical directive and have no court-appointed guardian. The AHCDA includes an optional form called an advance healthcare directive, which can be used to appoint a decision maker for healthcare decisions in the event a person is incapacitated.² The advance healthcare directive also provides instructions for healthcare, including decisions to withdraw life

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1. ALASKA STAT. § 13.52 (2004).
2. § 13.52.300.

support (which includes feeding tubes); changes the system for making anatomical gifts at death; allows appointment of a surrogate decision maker for mental health treatment; and indicates the physician who will have the right, under certain circumstances, to make decisions on a patient's behalf.³

This Article will examine the AHCDA from several different perspectives. Part II reviews the AHCDA functionally, with an emphasis on what its various parts achieve and how well these parts fit together. Part III culls the legislative history to show how the bill evolved from a "Five Wishes" statement to its current form. Part IV examines the AHCDA from a philosophical perspective, showing how the various emphases on sanctity of life, right to self-determination, and quality of life have been factored, albeit somewhat unevenly, into the Act. Part V applies the AHCDA to the well-known cases involving Karen Ann Quinlan, Nancy Cruzan, Terri Schiavo, Sun Hudson, and Ora Mae Magouirk to see how those cases would likely have come out under the AHCDA. Finally, Part VI considers the likely practical effects of the AHCDA, analyzing whether the probable results are in fact consistent with the aims on which the AHCDA purports to be based.

II. FUNCTIONAL ANALYSIS

The Health Care Decisions Act is a hybrid enactment, covering a number of different areas relating to decision making on medical issues.

The AHCDA's most distinctive attribute is the new advance healthcare directive form, with the activating portion at the beginning of the statute,⁴ and the optional form itself at the conclusion (except for the definitions).⁵ Under the old living will statute,⁶ a terminally ill individual could direct that his attending physician withhold or withdraw procedures that merely prolonged the dying process and were not necessary to keep him comfortable and to relieve pain.⁷ The individual could also make an organ donation on the same document⁸ or separately. Under the new form, in a single document, the individual can designate an agent to make healthcare decisions if he or she becomes incapacitated; can

3. *Id.*

4. § 13.52.010.

5. § 13.52.300.

6. ALASKA STAT. §§ 18.12.010–.100 (2002) (repealed 2004).

7. § 18.12.010(a) (repealed 2004).

8. § 13.50.030 (repealed 2004).

limit that agent's authority; can indicate, when the person has a "qualifying condition,"⁹ whether life should be prolonged by artificial means, artificial nutrition or hydration, or whether pain relief should be provided; can direct an anatomical gift at death, and even what types of use to which the gift can be made; can delegate authority for mental health treatment; and can designate a primary physician for decision-making purposes.¹⁰ The AHCDCA provides details regarding how the form must be witnessed, when it is effective,¹¹ what the agent must consider in making decisions on the person's behalf, and how it may be revoked, among other limitations.

Noticeably, the statutes related to guardianship were not incorporated into the AHCDCA, but were instead left in Title 13.¹² However, several portions of the AHCDCA do relate to guardians. Under the guardianship statutes, a person nominated by the respondent has priority to be selected as guardian,¹³ and under the AHCDCA the form may include the individual's nomination of a guardian;¹⁴ thus, the AHCDCA provides a method for nominating the person who will be given priority under the guardianship statutes. The sample form, if left unaltered, simply nominates the person who is designated to make healthcare decisions as the guardian.¹⁵ Note, however, that under the guardianship statutes, a general guardian has a great deal of authority with regard to finances (assuming a separate conservator has not been appointed), and a different person might be better able to handle those duties. As a result, patients are advised to consider carefully the decision to designate a healthcare agent that will also act as the preferred guardian. Separating the functions of healthcare agent and guardian would require writing a separate instruction on the form, as the appointment of a guardian is otherwise automatic in the last paragraph of Part One of the statutory form.

Interestingly, absent a court order to the contrary, a healthcare decision made by an agent¹⁶ takes precedence over that of a

9. Defined as either a condition of permanent unconsciousness or a terminal condition. ALASKA STAT. § 13.52.300 (2004).

10. *Id.*

11. § 13.52.010(f). The form is only effective during the time the principal lacks capacity. *Id.*

12. §§ 13.26.090–.155.

13. § 13.26.145(d)(1).

14. § 13.52.010(j).

15. § 13.52.300 pt. 1(5).

16. An "agent" refers to one appointed under an advance healthcare directive.

guardian,¹⁷ and the guardian is required to comply with the ward's healthcare directive unless a court expressly authorizes the revocation. Attorneys who represent petitioners in guardianship cases have already noticed the potential malpractice trap; consequently, they now draft proposed orders for the court so that their guardians will be able to act according to their own perceptions of the ward's best interest and will not be overruled by an appointed agent. To understand the problem, imagine that you are the attorney for the petitioner in a guardianship case, and your client has asked you to secure guardianship over a relative with dementia, in part so that reasonable healthcare decisions can be made. In your proposed orders, which are ultimately adopted by the court, you neglect to state clearly that the guardian's decisions will overrule any decisions by an agent (probably because you are using the same forms you used in the past, when this was not an issue). On the eve of an important medical procedure, you discover that the ward has a pre-existing, valid healthcare directive, naming another individual as the agent. The agent will not consent to the medical procedure, so it cannot be performed. The malpractice risk in that scenario should be apparent.

In recognition of the fact that a significant portion of the population does not, and will not, have advance directives, the AHCDA includes a detailed provision allowing for the appointment of surrogates for individuals who do not have advance healthcare directives or guardians.¹⁸ A patient can designate such a surrogate by personally informing the supervising healthcare providers of the identity of the desired surrogate.¹⁹ If the patient fails to do so, a surrogate is appointed according to a priority list, beginning with the patient's spouse, then adult children, then parents, then adult siblings, and finally "an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, and who is reasonably available."²⁰ The surrogate is to act in accordance with the patient's individual instructions and wishes; otherwise, the surrogate may make the decision in accordance with his or her determination of the patient's best interest, considering the patient's personal values.²¹ The patient's primary healthcare provider may overrule the

17. § 13.52.040(b).

18. § 13.52.030.

19. § 13.52.030(c).

20. § 13.52.030(d).

21. § 13.52.030(g).

surrogate's decision if it appears that he or she is not abiding by the wishes, values, and best interests of the patient.²²

The AHCDCA has specific restrictions on when life support (including the withholding of artificial nutrition and hydration) may be withheld or withdrawn. The patient must have a "qualifying condition," which means either a terminal condition or a state of permanent unconsciousness.²³ However, the standards for do-not-resuscitate orders (commonly called "DNR" or "Comfort One" orders) are different under the AHCDCA. Specifically, the order must be entered by a physician and does not require the consent of the patient, agent, guardian, surrogate, or family.²⁴

The rules on anatomical gifts (also known as "organ donation") primarily involve two different sections of the AHCDCA. The first, section 13.52.170, allows the patient to make an anatomical gift in a variety of ways.²⁵ The second, section 13.52.180, allows other individuals (again, according to a priority list) to make anatomical gifts on the patient's behalf, unless the patient had previously and specifically objected.²⁶ The statute also provides a form for a third party to make the gift,²⁷ and other sections of the statute attempt to sort out the necessary details and prevent abuses.²⁸

Finally, there are the mental health provisions.²⁹ Part Four of the optional form directive allows an individual to make a variety of decisions about mental health treatment, including whether he or she consents to administration of psychotropic medications, electroconvulsive treatment, or mental health commitment.³⁰ The remaining mental health provisions, for the most part, carve out

22. § 13.52.030(h).

23. § 13.52.390(36).

24. § 13.52.065.

25. § 13.52.170.

26. § 13.52.180.

27. § 13.52.190.

28. §§ 13.52.200–.270.

29. Whether mental health treatment even falls within the AHCDCA depends on whether the AHCDCA is viewed as primarily related to medical care or to end-of-life issues. If the AHCDCA is aimed at medical care in general, including mental health treatment, this part of the statute makes sense. But, if one thinks of the AHCDCA as related primarily to questions surrounding the end-of-life, the section on mental health treatment does not fit at all.

30. § 13.52.300, pt. 4.

exceptions to the general rules applicable to other medical treatments.³¹

Most of the laws related to mental health commitments are not in the AHCDA, but rather in section 47.30³² of the Alaska Statutes, which covers involuntary mental health commitments. Under the involuntary commitment statute, an individual can be committed by a peace officer, a psychiatrist or other physician, or a psychologist;³³ the AHCDA adds the designated healthcare agent to the list of people who can initially order a commitment.³⁴ Additionally, under the AHCDA, the agent can commit the patient for up to seventeen days,³⁵ whereas the statute on involuntary commitments mandates a probable cause hearing within three days.³⁶

The mental health portion of the advance directive itself is nothing new; indeed, it is lifted word-for-word from the old statute, which was titled “Personal Declaration of Preference for Mental Health Treatment”³⁷ and was repealed effective the same day the AHCDA took effect.³⁸ Both forms allow the agent to make the decisions on psychotropic medication, electroconvulsive treatment, and involuntary commitment for up to seventeen days.³⁹

Curiously, under Part Four of the AHCDA’s form, the default rule is that the healthcare agent can make mental health decisions on behalf of the patient.⁴⁰ Consequently, there is a risk that those who do not read the form carefully or check off the boxes indicating non-consent will inadvertently give the agent the authority to consent to highly invasive and controversial mental

31. *E.g.*, § 13.52.020(a)–(c) (outlining exceptions to the general rules regarding revocation of a directive); § 13.52.030 (relating to surrogates); § 13.52.120(f) (regarding commitments to mental health facilities).

32. §§ 47.30.700–.815.

33. § 47.30.705.

34. § 13.52.300.

35. *Id.*

36. § 47.30.715.

37. ALASKA STAT. §§ 47.30.950–.980 (2002) (repealed 2004).

38. ALASKA STAT. § 13.52.300 (2004); ALASKA STAT. §§ 47.30.950–.980 (2002) (repealed 2004).

39. ALASKA STAT. § 13.52.300 (2004); ALASKA STAT. §§ 47.30.950–.980 (2002) (repealed 2004).

40. ALASKA STAT. § 13.52.300, pt. 4 (2004). The optional form directive reads as follows: “If you are satisfied to allow your agent to determine what is best for you in making these mental health decisions, you do not need to fill out this part of the form.” *Id.*

health treatments.⁴¹ Under the repealed mental health declaration, there was no such default.⁴² Rather, a patient who did not wish to give an agent those powers did not have to fill out the form in the first place.⁴³

Moreover, the witnessing requirements were more stringent under the prior statute. Under that statute, neither witness could be related to the patient,⁴⁴ and the agent was expected to accept the appointment in writing.⁴⁵ Under the AHCD, one witness may be a relative of the patient's.⁴⁶ As a result, it is easier to delegate important mental health decisions, and such delegation can even be done accidentally by leaving Part Four of the statutory form blank.

This puzzling default in the mental health section underscores a problem that surfaces throughout the AHCD: people are encouraged to fill out these forms as part of estate planning or general good stewardship, even if they do not have current medical problems; however, many parts of the statutory form seem designed for those with an existing major medical issue.

III. HISTORICAL ANALYSIS

The AHCD's history is unusual in that it took a full four years of work in various committees in order for the bill to become law. The bill was introduced in 2001, in the first session of the 22nd legislature, as House Bill 197.⁴⁷ After the House Health, Education and Social Services ("HESS") Committee and the Judiciary Committee made amendments, the bill passed the House during the second session of that legislature in 2002.⁴⁸ It did not pass the Senate (it was never even scheduled for a Senate hearing), and so, technically speaking, it died. However, in the following legislature,

41. Although some individuals with current psychological disorders may wish to give a trusted agent the authority to make these decisions on his or her behalf, it is unlikely that a person who has no current mental disorder would want to appoint someone to override his or her express wishes in this regard. After all, mental health treatment is generally recommended only for conscious patients. If the patient is conscious and agrees to the treatment, there is no need for the agent to be involved. So, presumably if the agent is acting, it is because the patient is not in agreement, at the time the decision must be made, with the proposed treatment.

42. See ALASKA STAT. §§ 47.30.950–980 (2002) (repealed 2004).

43. *Id.*

44. § 47.30.954 (repealed 2004).

45. § 47.30.970 (repealed 2004).

46. ALASKA STAT. § 13.52.010(e) (2004).

47. H.B. 197, 22d Leg., 1st Sess. (Alaska 2001).

48. H.B. 197, 22d Leg., 2d Sess. (Alaska 2002).

the bill was reintroduced in exactly the same form.⁴⁹ Finally, in 2004, after being amended numerous times by both the House and Senate committees, the bill received near-unanimous legislative approval and became law.⁵⁰

From the beginning, the bill was touted as being based on the “Five Wishes.”⁵¹ The Five Wishes is a document developed by the Aging With Dignity organization,⁵² which prompts the declarant to make choices regarding the following:

1. Comfort care (such as how much medicine should be provided, whether warm baths should be given, and whether religious readings or “well-loved poems” should be read aloud to the declarant when near death);
2. How people should treat the declarant (such as whether people should be around when death is near, whether members of a church or synagogue should be asked to pray for the declarant, and whether there is a preference to die in the home);
3. What loved ones should be told (including, for example, whether the declarant wishes forgiveness from family or friends, how the declarant wishes to be remembered, and instructions for memorial services);
4. Desired medical treatment (including especially the question of withdrawal of life support); and,
5. Which person should be named to make healthcare decisions if the declarant is no longer able to do so.

49. *Minutes, H. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 1st Sess. 6 (Alaska Feb. 13, 2003), available at <http://www.legis.state.ak.us/PDF/23/M/HHES2003-02-131507.pdf>.

50. H.B. 25, 23d Leg., 2d Sess. (Alaska 2004).

51. *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 6 (Alaska Mar. 8, 2004), available at <http://www.legis.state.ak.us/PDF/23/M/SHES2004-03-081333.pdf>; *Minutes, H. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 1st Sess. 11–13 (Alaska Feb. 13, 2003), available at <http://www.legis.state.ak.us/PDF/23/M/HHES2003-02-131507.pdf>; *Minutes, H. Judiciary Comm.*, 22d Leg., 2d Sess. 36–39 (Alaska Mar. 20, 2002), available at <http://www.legis.state.ak.us/PDF/22/M/HJUD2002-03-201315.pdf>; *Minutes, H. Health, Educ. and Soc. Serv. Comm.* 22d Leg., 1st Sess. 8–13 (Alaska Apr. 17, 2001), available at <http://www.legis.state.ak.us/PDF/22/M/HHES2001-04-171502.pdf>.

52. The Dying Process: Five Wishes Document, <http://www.learningplaceonline.com/stages/together/wishes/wishes-1.htm> (last visited Sept. 26, 2005) [hereinafter Five Wishes Document].

The 2001 version of the bill closely resembled the Five Wishes document, including the many details of comfort care.⁵³ However, by 2002, legislative committees had substantially rewritten the bill;⁵⁴ eventually, the finished product was merely “inspired by” the Five Wishes.⁵⁵

The Five Wishes document is a personal document not a legal document, and, as such, is written in lay language. By contrast, the AHCDA is more comforting to lawyers, as it is drafted in the style of a legal document and employs language and stylistic trends familiar to lawyers.⁵⁶

The legislature’s desire to provide something similar to the Five Wishes explains those portions of the AHCDA related to the healthcare directive, but those portions account for less than half of the total Act. The rest of the bill was explained as an attempt to bring together, under a single chapter, a variety of laws which previously had been scattered throughout the statutes.⁵⁷ The bill can be said to have accomplished this.⁵⁸

53. Compare H.B. 197, 22d Leg. 13, 1st Sess. (Alaska 2001) with Five Wishes Document, *supra* note 52, Part B, Wish 3.

54. Compare H.B. 197, 22d Leg., 1st Sess. (Alaska 2001) with H.B. 197, 22d Leg., 2d Sess. (Alaska 2002).

55. Minutes, S. Health, Educ. and Soc. Serv. Comm., 23d Leg., 1st Sess. 6 (Alaska May 16, 2003), available at <http://www.legis.state.ak.us/PDF/23/M/SHES2003-05-161351.pdf>.

56. Compare ALASKA STAT. § 13.52.300, pt. 2(6)(B)(i)–(ii) (2004) (defining “a condition of permanent unconsciousness” as “a condition that, to a high degree of medical certainty, will last permanently without improvement; in which, to a high degree of medical certainty, thought, sensation, purposeful action, social interaction, and awareness of myself and the environment are absent; and for which, to a high degree of medical certainty, initiating or continuing life sustaining procedures for me, in light of my medical outcome, will provide only minimal medical benefit for me”) with Five Wishes Document, *supra* note 52 (using terms such as being “close to death,” “in a coma and not expected to wake up or recover,” or “have permanent and severe brain damage and are not expected to recover”).

57. Minutes, H. Health, Educ. and Soc. Serv. Comm., 23d Leg., 1st Sess. 8 (Alaska Feb. 13, 2003), available at <http://www.legis.state.ak.us/PDF/23/M/HHES2003-02-131507.pdf>; Minutes, H. Judiciary. Comm., 22d Leg., 2d Sess. 9–10 (Alaska Apr. 10, 2002), available at <http://www.legis.state.ak.us/PDF/22/M/HJUD2002-04-101318.pdf>; Minutes, H. Judiciary Comm., 22d Leg., 2d Sess. 37 (Alaska Mar. 20, 2002), available at <http://www.legis.state.ak.us/PDF/22/M/HJUD2002-03-201315.pdf>.

58. See, e.g., ALASKA STAT. §§ 18.12.010–.100 (2002) (repealed 2004) (living wills and “Do Not Resuscitate” protocols), 13.50.010–.070 (repealed 2004) (organ donation), 47.30.950–.980 (mental health powers of attorney). Current versions at ALASKA STAT. § 13.52 (2004).

For the most part, philosophical discussions about end-of-life issues did not occur in the legislature until 2004, when the bill reached the Senate HESS Committee. The chairman, Senator Fred Dyson (R-Eagle River), raised a number of questions about life support termination, as did the Alaska Catholic Conference.⁵⁹ In addition to numerous committee meetings, a meeting was held off record and included the Alaska Catholic Conference's representative, the Lieutenant Governor's chief of staff, and a staff member of a legislator who advocated passage of the bill.⁶⁰ As a result of this meeting, a number of changes were made to the bill, including the addition of a broad statement that, in the absence of evidence to the contrary of the patient's intent, the AHCD A established a presumption in favor of life,⁶¹ and a clarification that the AHCD A does not authorize mercy killing, assisted suicide, or euthanasia.⁶² The changes did not entirely satisfy the Catholic Conference⁶³ but seemed to assuage the concerns of Senator Dyson, for when the bill moved to the Senate Judiciary Committee, Senator Dyson advocated its passage.⁶⁴

One of the more interesting exchanges in the Senate HESS Committee centered on the issue of pregnancy. Senator Dyson, who described himself as "irrevocably pro-life regarding the abortion issue" took the position that if a pregnant woman was in an unconscious state, efforts should be made to keep the child alive, even if that meant continuing life support past a point of physical benefit for the woman.⁶⁵ Senator Gretchen Guess (D-Anchorage) took the position that the statute should not overturn a healthcare directive and that the healthcare directive ought to have an option for a pregnant woman to determine whether she would want to be kept alive so that the child might be

59. *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 6, 18 (Alaska Mar. 8, 2004), available at <http://www.legis.state.ak.us/PDF/23/M/SHES2004-03-081333.pdf>.

60. *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 24 (Alaska Mar. 24, 2004), available at <http://www.legis.state.ak.us/PDF/23/M/SHES2004-03-241344.pdf>.

61. ALASKA STAT. § 13.52.120(a) (2004).

62. § 13.52.120(d).

63. *Minutes, S. Judiciary Comm.*, 23d Leg., 2d Sess. 16 (Alaska Apr. 29, 2004), available at <http://www.legis.state.ak.us/PDF/23/M/SJUD2004-04-290808.pdf>.

64. *Id.*

65. *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 11–12 (Alaska Mar. 8, 2004), available at <http://www.legis.state.ak.us/PDF/23/M/SHES2004-03-081333.pdf>.

born.⁶⁶ This seems to have led to an odd compromise under which the statute and the sample form say two different things. In the sample form⁶⁷ the declarant is to answer the question “should I become unconscious and I am pregnant, I direct that” (followed by several blank lines). However, a section of the AHCDA says that, if a pregnant woman lacks capacity, a directive or decision to withhold or withdraw life-sustaining procedures may not be given effect if it is probable that the fetus could develop to the point of live birth with the provision of such life-sustaining procedures.⁶⁸ In other words, if life support will enable the baby to be born alive, then life support must be continued, regardless of what the mother might have said in her directive. So the AHCDA itself would overrule a directive to discontinue life support. The resolution of any tension between a directive and the AHCDA may hinge on whether the doctor has actually read the statute or only the approved statutory form.

After four years of testimony, committee hearings, committee substitutes, and debate, the final version of House Bill 25 passed the Senate unanimously, and was then adopted by the House with only one dissenting House vote.⁶⁹ The governor signed the Act the following month, and it took effect on January 1, 2005.⁷⁰

IV. PHILOSOPHICAL ANALYSIS

A central premise of this article posits that people approach end-of-life issues from three different philosophical positions. This section of the Article will analyze how each of these positions ultimately influenced the adoption of the AHCDA.

A. Self-Determination

The first of these positions is an emphasis on self-determination, that is, the ability to make one’s own decisions about one’s own life. This is usually referenced as a “constitutional right” to self-determination. In *Cruzan v. Missouri Department of Health*,⁷¹ a case involving a woman in a vegetative state whose

66. *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 12, 29 (Alaska Apr. 14, 2004), available at <http://www.legis.state.ak.us/PDF/23/M/SHES2004-04-141341.pdf> (testimony of Sen. Gretchen Guess).

67. ALASKA STAT. 13.52.300, pt. 2(6)(E) (2004).

68. § 13.52.055(b).

69. H.J. 23, 2d Sess., at 4026 (Alaska 2004); S.J. 23, 2d Sess., at 3248 (Alaska 2004).

70. H.J. 23, 2d Sess., at 4508 (Alaska 2004).

71. 497 U.S. 261 (1990).

family wanted to remove her feeding tube, the United States Supreme Court held that the early common law rule that individuals are to be free from the restraint or interference of others⁷² and the requirement for informed consent to medical treatment⁷³ suggested that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment.⁷⁴ The Court noted in *Cruzan* that this right to self-determination may also extend to allowing others to exercise what it called a substituted judgment.⁷⁵ Substituted judgment involves informing the medical providers of what the patient, presumably unable to express his or her own wishes, would have wanted regarding cessation of medical treatment. Interestingly, Chief Justice Rehnquist's majority opinion does not actually find that there is a constitutional right to refuse medical treatment, but rather notes that such a right could be inferred from the Court's previous decisions.⁷⁶ In the subsequent case of *Washington v. Glucksberg*,⁷⁷ the Court, again in an opinion written by Chief Justice Rehnquist, noted that while that right could be inferred (since it had been "strongly suggested" by previous opinions), it had not actually been pronounced by the Court.⁷⁸

B. Sanctity of Life

The second significant philosophical position represents an emphasis on the sanctity of life. The Supreme Court has recognized this position, not as a constitutional right, but as a legitimate state interest,⁷⁹ which a state can consider in establishing laws. In *Cruzan*, it was this interest, among others, that justified allowing Missouri to require clear and convincing evidence that the individual would want life support terminated.⁸⁰ In *Glucksberg*, the state's interest in the preservation of life was a factor in upholding the state of Washington's prohibition of assisted suicide.⁸¹

72. *Id.* at 267 (citing *Union Pac. R.R. Co. v. Botsford*, 141 U.S. 250, 251 (1891)).

73. *Id.* at 269 (citing *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914)).

74. *Id.* at 278.

75. *Id.* at 284.

76. *See id.* at 278–79.

77. 521 U.S. 702 (1997).

78. *See id.* at 720.

79. *Id.* at 728–29; *Cruzan*, 497 U.S. at 280.

80. *Cruzan*, 497 U.S. at 281.

81. *Glucksberg*, 521 U.S. at 728–29.

C. Quality of Life

A patient's quality of life has never been specifically recognized as either a legitimate interest or a right by the Supreme Court. Nonetheless, concern for a patient's quality of life influenced the debate over the AHCD.

A moderate quality of life position may be defined as concern for the pain and misery that accompany the end of life. An extreme position suggests that once one is no longer able to do anything useful, productive, or interesting, one ought to die. Various courts and professional groups have taken diverging positions on this philosophical question.

In *In re Quinlan*,⁸² the New Jersey Supreme Court factored into its decision-making calculus the likelihood of the patient ever returning to "cognitive life," thus taking a position somewhere between the moderate and the extreme positions outlined above.⁸³

In one survey of doctors and medical administrators, a remarkable 89% believed it was ethical to withdraw nutrition and hydration from patients in a vegetative state, with a majority endorsing the view that patients in a vegetative state would be "better off dead."⁸⁴ One version of this philosophy was expressed in the legislative hearings on the AHCD by Dr. Maria Wallington, a medical ethicist.⁸⁵ She testified that the decision to terminate life support should hinge on whether "what is needed to keep the person alive actually allows him/her to go on with life" or the chance the person will become healthy again and not depend on medical care.⁸⁶

Remarkably, throughout the lengthy history of committee hearings and floor debates in 2001, 2002, and 2003, there was hardly any examination of the philosophical underpinnings of the law, which initially appeared to be strongly influenced by the right to self-determination. Throughout the committee minutes, legislators appeared to assume that people should be able to make their own choices regarding end-of-life decisions.⁸⁷ Examples, both

82. 355 A.2d 647 (N.J. 1976).

83. *Id.* at 664.

84. Kirk Payne et al., *Physicians' Attitudes about the Care of Patients in the Persistent Vegetative State: A National Survey*, 125 ANNALS OF INTERNAL MED. 104, 105 (1996).

85. *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 12-14 (Alaska Apr. 7, 2004), available at <http://www.legis.state.ak.us/PDF/23/M/SHES2004-04-071745.pdf>.

86. *Id.*

87. *See, e.g., Minutes, H. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 1st Sess. 17 (Alaska Feb. 27, 2003), available at <http://www.legis.state.ak.us/PDF/23/>

good and bad, were given from the personal experiences of witnesses and legislators.⁸⁸ However, no one raised much concern for the sanctity of life, until the bill reached the Senate HESS Committee in March 2004.⁸⁹ At that point, intertwined with the debate over the pregnancy provisions of the bill and the hammering out of various details, the concern for the sanctity of life finally surfaced.⁹⁰ Senator Dyson and the Alaska Catholic Conference raised the issue, and a few witnesses took opposing positions.⁹¹

Notably, a significant portion of the debate centered on the issue of withdrawal of artificial nutrition and hydration.⁹² Senator Dyson raised this as a main question about the bill in the opening

M/HHES2003-02-271504.pdf; *Minutes, H. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 1st Sess. 4 (Alaska Feb. 13, 2003), available at <http://www.legis.state.ak.us/PDF/23/M/HHES2003-02-131507.pdf>; *Minutes, H. Judiciary Comm.*, 22d Leg., 2d Sess. 12 (Alaska Apr. 10, 2002), available at <http://www.legis.state.ak.us/PDF/22/M/HJUD2002-04-101318.pdf>; *Minutes, H. Health, Educ. and Soc. Serv. Comm.*, 22d Leg., 1st Sess. 27 (Alaska Apr. 24, 2001), available at <http://www.legis.state.ak.us/PDF/22/M/HHES2001-04-241508.pdf>; *Minutes, H. Health, Educ. and Soc. Serv. Comm.*, 22d Leg., 1st Sess. 8 (Alaska Apr. 17, 2001), available at <http://www.legis.state.ak.us/PDF/22/M/HHES2001-04-171502.pdf>.

88. See, e.g., *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 1st Sess. 6 (Alaska May 16, 2003), available at <http://www.legis.state.ak.us/PDF/23/M/SHES2003-05-161351.pdf>; *Minutes, H. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 1st Sess. 20–21 (Alaska Feb. 27, 2003), available at <http://www.legis.state.ak.us/PDF/23/M/HHES2003-02-271504.pdf>; *Minutes, H. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 1st Sess. 3–4 (Alaska Feb. 13, 2003), available at <http://www.legis.state.ak.us/PDF/23/M/HHES2003-02-131507.pdf>; *Minutes, H. Judiciary Comm.*, 22d Leg., 2d Sess. 11 (Alaska Apr. 10, 2002), available at <http://www.legis.state.ak.us/PDF/22/M/HJUD2002-04-101318.pdf>; *Minutes, H. Health, Educ. and Soc. Serv. Comm.*, 22d Leg., 1st Sess. 11 (Alaska Apr. 17, 2001), available at <http://www.legis.state.ak.us/PDF/22/M/HHES2001-04-171502.pdf>.

89. See *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 18–19 (Alaska Mar. 8, 2004), available at <http://www.legis.state.ak.us/PDF/23/M/SHES2004-03-081333.pdf>.

90. See *id.*

91. Including, curiously, Dr. Maria Wallington, who purported to represent Providence Health Systems, which is owned by Sisters of Providence, a branch of the Roman Catholic Church. With the Alaska Catholic Conference (representing the Catholic bishops in Alaska) on one side of several issues, and Dr. Wallington of Providence Health Systems on the other, two different agencies of the Roman Catholic Church (sometimes thought to be “monolithic”) weighed in on opposite sides of the debate. See *id.* at 8.

92. *Id.* at 14–19.

of his committee's hearing.⁹³ A representative of the Alaska Nurses' Association argued that withholding fluid and nutrition actually allows a patient to die naturally.⁹⁴ Dr. Wallington argued that the law should safeguard the choices made in a person's advance directive.⁹⁵ On the other hand, the Alaska Catholic Conference representative argued that the law should have a strong presumption in favor of life, quoting the statement of then-Pope John Paul II that administration of water and food always represents a natural means of preserving life, not a medical act, even when provided by artificial means.⁹⁶

Ultimately, for the most part, the resulting bill is based on the right to self-determination, with a few specific overlays based on concern for the sanctity of life. Life support, including artificial nutrition and hydration, can be withdrawn only if the person is in a state of permanent unconsciousness (meaning a coma or a permanent vegetative state, depending on how one interprets the definitions) or has a terminal illness.⁹⁷ A surrogate, whether appointed by the patient or selected according to the statutory procedure, can make decisions for the patient; but in doing so, the surrogate must consider the patient's personal values, including any religious beliefs.⁹⁸ Life support may not be withdrawn for a pregnant woman if her child could survive to birth with the procedures in place.⁹⁹ Further, a healthcare provider may decline to provide "medically ineffective health care or healthcare contrary to generally accepted health care standards," but only after providing the family an opportunity to transfer the patient to another institution.¹⁰⁰ Finally, the AHCDCA explicitly states that, in the absence of evidence of the patient's intent to the contrary, the law establishes a presumption in favor of life, consistent with the patient's best interest.¹⁰¹

93. *Id.* at 7.

94. *Id.* at 9.

95. *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 12 (Alaska Apr. 7, 2004), available at <http://www.legis.state.ak.us/PDF/23/M/SHES2004-04-071745.pdf>.

96. *Id.* at 20.

97. ALASKA STAT. §§ 13.52.045, .390 (2004).

98. §§ 13.52.030(g), .390(6)(G).

99. § 13.52.055.

100. § 13.52.060(f)-(g).

101. § 13.52.120.

D. Distrust of Lawyers

A distrust for lawyers seems, if only speculatively, to have influenced the bill. Such distrust is evidenced by the fact that the AHCDA vests final decision-making authority in patients, their agents, or their surrogates, with some limited rights-of-refusal or review by their doctors.¹⁰² Further, doctors, not courts, decide whether a person lacks capacity.¹⁰³ A doctor may decline to comply with a surrogate's decisions if he or she believes that the surrogate is not abiding by the wishes, values, and best interest of the patient.¹⁰⁴ The doctor can otherwise refuse to comply with the individual instruction or decision for a variety of reasons, such as "reasons of conscience,"¹⁰⁵ or a belief that the proposed treatment would be ineffective or contrary to generally accepted healthcare standards.¹⁰⁶ It is the doctor who ultimately decides whether to issue a "Do Not Resuscitate" order.¹⁰⁷ The AHCDA grants healthcare providers fairly broad immunity in making these decisions.¹⁰⁸ The role of the judiciary receives only the briefest mention,¹⁰⁹ and an agent's healthcare decision can even overrule the decision of a court-appointed guardian (unless a court order specifically provides otherwise).¹¹⁰

In his book *Strangers at the Bedside*,¹¹¹ historian David Rothman chronicles how, beginning in the 1960s, the United States evolved from a society of unwavering acceptance of the decisions of doctors to a society in which lawyers, bioethicists, politicians, judges, and ethics committees are involved in the decision-making. He credits the shift in part to the fact that most Americans no longer have a trusted family doctor whom they know well enough to trust with end-of-life decisions.¹¹² Nonetheless, the AHCDA places some of the decision-making authority directly into the physician's hands.¹¹³ Thus, the AHCDA assumes that patients want

102. See §§ 13.52.010-.395.

103. § 13.52.010(g).

104. § 13.52.030(h).

105. § 13.52.060(e).

106. § 13.52.060 (f).

107. § 13.52.065.

108. § 13.52.080.

109. § 13.52.140.

110. § 13.52.040(b).

111. DAVID J. ROTHMAN, *STRANGERS AT THE BEDSIDE: A HISTORY OF HOW LAW AND BIOETHICS TRANSFORMED MEDICAL DECISION MAKING* (Walter de Gruyter 2003) (1991).

112. See *id.* at 128–31.

113. ALASKA STAT. § 13.52.300, pt. 5 (2004); see also § 13.52.030(h).

their primary physicians to make such decisions. This is a questionable assumption in an age when many people go to a clinic, family practice group, or emergency room for primary care. At no point did legislators discuss this issue in the many committee hearings on the bill. Therefore, whether the AHCDCA reflects an atavistic view of primary physicians or merely a general hesitancy to let lawyers make these decisions is uncertain.¹¹⁴

An emphasis on decision making by physicians may have also resulted from the drafters' focus on patients with pre-existing medical conditions, rather than on those who fill out the advance directive form as part of general estate planning.¹¹⁵ For instance, the designation of a primary physician will typically pose little problem for someone with cancer, who would likely designate his or her oncologist. Regardless, under the AHCDCA, nearly all end-of-life decisions will be made by doctors in consultation with family members, and very few decisions will be made by judges.

V. APPLICATION TO CASES

One rarely appreciates the implications of a statute until one applies the statute to a set of facts. This part of the Article will examine some of the best-known cases from recent memory to determine how they might have turned out under the AHCDCA.

A. Karen Ann Quinlan

In April of 1975, Karen Ann Quinlan, a twenty-one year old New Jersey woman, stopped breathing.¹¹⁶ She was revived, but suffered anoxia, or a loss of oxygen in the blood stream going to the brain.¹¹⁷ Quinlan ended up in a "chronic persistent vegetative state," which was explained as a "primitive reflex level" of neurological function, with the brain stem working, but other parts of the brain nonfunctional.¹¹⁸ She was sustained by a respirator and feeding tube, and it was assumed by the doctors (incorrectly, as it

114. The Alaska Legislature has invariably had fewer attorney members than most legislatures. In the current 24th Alaska Legislature, only eleven of sixty legislators hold law degrees, according to their legislative web sites. See Alaska Leg. State Senate, <http://w3.legis.state.ak.us/senate/24/senate.htm> (last visited Oct. 19, 2005); Alaska Leg. H. R., <http://w3.legis.state.ak.us/house/24/house.htm> (last visited Oct. 19, 2005).

115. See, e.g., *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 11–22 (Alaska Apr. 7, 2004), available at <http://www.legis.state.ak.us/PDF/23/M/SHES2004-04-071745.pdf>.

116. *In re Quinlan*, 355 A.2d 647, 653–54 (N.J. 1976).

117. *Id.* at 654.

118. *Id.* at 654–55.

turned out) that her primitive level of brain stem function would be insufficient for her to breathe on her own.¹¹⁹

Karen's father filed a petition, asking that he be appointed guardian and that the letters of guardianship contain an express power to authorize the discontinuance of all extraordinary medical procedures.¹²⁰ The hospital opposed the discontinuance, and the judge denied the father's request.¹²¹ On appeal, the Supreme Court of New Jersey found that if Karen were able to do so, she could decide to discontinue the life support apparatus.¹²² Addressing the question of substitution of judgment, the court determined that her guardian could "assert her right to privacy" on her behalf.¹²³ The court did not assert a broad right of guardians to make such decisions, but rather found such a right to be reasonable within the context of these particular facts.¹²⁴ In doing so, the court balanced the individual's right to privacy against the State's interest in the preservation and sanctity of human life and a physician's right to administer medical treatment according to his best judgment.¹²⁵ The court applied a sliding scale, finding that the State's interest weakened, and the individual's right to privacy grew, "as the degree of bodily invasion increase[d] and the prognosis dim[med]."¹²⁶ The court incorporated consideration of Karen's quality of life into the analysis.¹²⁷ It said that the "focal point of decision should be the prognosis as to the reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of that biological vegetative existence to which Karen seems to be doomed."¹²⁸ As the court's words indicate, the quality of life philosophical position is implicated whenever the focus is on the possibility of returning to a sapient or more productive level of life.¹²⁹

119. *See id.* at 655.

120. *Id.* at 651.

121. *Id.*

122. *Id.* at 663.

123. *Id.* at 664.

124. *Id.*

125. *Id.* at 663–64. The doctors in this case were opposed to the removal of life support. *Id.* at 663.

126. *Id.* at 664.

127. *Id.*

128. *Id.* at 669.

129. Conversely, the sanctity of life position would tend to consider any life as being valuable, even if it were sub-cognitive. The self-determination position would be neutral unless the patient had expressed her wishes in some way.

The court announced a rather curious requirement for termination of life support: although the father was appointed guardian, in order to terminate life support he had to obtain the concurrence of the rest of the family.¹³⁰ Furthermore, the attending physicians, in consultation with the hospital ethics committee, had to determine that there was no reasonable possibility of Karen ever emerging from her vegetative state.¹³¹

How would the Quinlan case be analyzed under the AHCD? Because Karen did not have an advance healthcare directive,¹³² her father would have turned to the surrogacy statute,¹³³ and because she had no spouse or adult child, her father would be next in line to be Karen's surrogate under the AHCD.¹³⁴ Therefore, he would have the authority to act, assuming Karen's mother did not object.¹³⁵

As surrogate, Mr. Quinlan would inform the attending physician that he wanted life support removed. The doctor would turn to section 13.52.045 and see that, because Karen did not sign a directive to the contrary, he would not be prohibited from removing the life support.¹³⁶

Next, the same section would direct him over to section 13.52.160 to see whether Karen had a "qualifying condition."¹³⁷ That section does not actually define "qualifying condition," but rather requires that the determination be made by the patient's primary physician and at least one other physician.¹³⁸ A "qualifying condition" is defined in section 13.52.390(36) as either a terminal condition or permanent unconsciousness.¹³⁹

The definition of "terminal condition" is "an incurable or irreversible illness or injury" that will result in imminent death, for which there is no reasonable prospect of cure or recovery, that imposes severe pain or an inhumane burden on the patient, and for which continuing life sustaining procedures will provide only

130. *See In re Quinlan*, 355 A.2d at 671–72.

131. *Id.*

132. *See id.* at 664.

133. ALASKA STAT. § 13.52.030 (2004).

134. § 13.52.030(c).

135. Karen's mother would have the same right as Karen's father to declare herself a surrogate. *See id.*

136. § 13.52.045.

137. *Id.*

138. § 13.52.160. In the case of permanent unconsciousness, the doctors must also consult with a neurologist. *Id.*

139. § 13.52.390(36).

minimal medical benefit.¹⁴⁰ The definition of “terminal condition” would be problematic here, because there was no guarantee that Karen would die within a “short period of time” if life-sustaining procedures were discontinued.¹⁴¹ Additionally, Karen’s family members did not request removal of the feeding tube, further casting doubt on whether removal of the respirator would result in death.¹⁴²

The doctor would next turn to the definition of “permanent unconsciousness”: a condition that will last “permanently without improvement,” in which thought, sensation, purposeful action, social interaction, and awareness of self and the environment are absent, and for which initiating or continuing life sustaining procedures provide only minimal medical benefit.¹⁴³ This definition is also problematic for a person in a vegetative state because it requires that sensation be absent.¹⁴⁴ Doctors seem to be in some disagreement as to whether a patient in a persistent vegetative state feels pain.¹⁴⁵ If Karen felt pain, one would assume sensation was not absent, and the definition of permanent unconsciousness could not legitimately be met.¹⁴⁶ There is no general consensus in neurology on this issue, probably due to the fact that although patients in a vegetative state react to painful stimuli,¹⁴⁷ they lack a connection to the “higher” parts of the brain that understand what pain is.¹⁴⁸ According to one survey of doctors, about 30% of the respondents believe that vegetative state patients experience pain,

140. § 13.52.390(42).

141. In fact, to everyone’s surprise, after the respirator was eventually removed, Karen Quinlan lived for another ten years. Ascension Health, Healthcare Ethics Cases: Quinlan, Karen Ann, <http://www.ascensionhealth.org/ethics/public/cases/case21.asp> (last visited Oct. 25, 2005).

142. The Quinlan family was strict Roman Catholic and made the decision to remove her from the respirator only after consultation with, and approval by, the church, which would not have approved removal of the feeding tube. *In re Quinlan*, 355 A.2d 647, 657–60 (N.J. 1976).

143. § 13.52.390(31).

144. *Id.*

145. Payne et al., *supra* note 84, at 105 tbl. 2.

146. For instance, the *Cruzan* decisions made several references to her responses to painful stimuli. *Cruzan v. Dir.*, Mo. Dep’t of Health, 497 U.S. 261, 266–67 n.1 (1990) (quoting *Cruzan v. Harmon*, 760 S.W.2d 408, 411 (Mo. 1989)).

147. Jan Kassubek et al., *Activation of a Residual Cortical Network During Painful Stimulation in Long-term Postanoxic Vegetative State*, 212 J. NEUROLOGICAL SCI. 85, 88 (2003).

148. See generally S. Laureys et al., *Cortical Processing of Noxious Somatosensory Stimuli in the Persistent Vegetative State*, 17 NEUROIMAGE 732 (2002).

and about 13% believe they experience hunger and thirst.¹⁴⁹ Given that the majority of doctors believe there is no sensation, combined with the possibility of “doctor shopping” by the family,¹⁵⁰ it is probably safe to assume that the Quinlans could, today, find a doctor who agrees that Karen meets the criteria for “permanent unconsciousness.” This is even further evident when considering that 88% of the doctors responding to the survey believed it was ethical to withdraw artificial nutrition and hydration from a patient in a vegetative state.¹⁵¹

The legislative history also yields some guidance. The definition of “permanent unconsciousness” was based on an Illinois statute,¹⁵² which includes the mandate that sensation be absent.¹⁵³ While the Illinois courts have not specifically addressed the question of whether reaction to painful stimuli constitutes sensation, several Illinois Supreme Court decisions have concluded that the condition of permanent unconsciousness covers the patient in a vegetative state.¹⁵⁴ Also, during legislative hearings in 2004, the Alaska legislative aide who had been shepherding the bill through the legislature specifically referenced “vegetative state” among the circumstances that would constitute a qualifying condition for purposes of removal of life support.¹⁵⁵

Let us assume that the primary physician and one other doctor, after consulting with the neurologist,¹⁵⁶ have informed the attending physician that at least one of the qualifying conditions has been met, either because they assume Karen will die within a short period of time without life support or because they believe she does not have sensation. The matter would then be back in the hands of the attending physician, who would return to section

149. See Payne et al., *supra* note 84, at 105.

150. Nothing in the AHCDA, or other Alaska laws, prohibit the surrogate from looking for another doctor who agrees with him or her. See ALASKA STAT. § 13.52 (2004).

151. Payne et al., *supra* note 84, at 107.

152. *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 25 (Alaska Mar. 24, 2004), available at <http://www.legis.state.ak.us/PDF/23/M/SHES2004-03-241344.pdf> (testimony of Linda Sylvester).

153. 755 ILL. COMP. STAT. 40/10 (2005).

154. See, e.g., *In re Estate of Greenspan*, 558 N.E.2d 1194, 1197 (Ill. 1990); *In re Estate of Longeway*, 549 N.E.2d 292, 298 (Ill. 1989).

155. *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 24 (Alaska Apr. 14, 2004), available at <http://www.legis.state.ak.us/PDF/23/M/SHES2004-04-141341.pdf> (testimony of Linda Sylvester).

156. The neurologist does not have to agree with the primary physician; he or she only needs to be consulted. ALASKA STAT. § 13.52.160 (2004).

13.52.045 and see that there must be an additional determination that withdrawing the life support would be consistent with the patient's best interest.¹⁵⁷ However, this decision is initially made by the surrogate.¹⁵⁸ The doctor would thus direct Mr. Quinlan to make the determination and, to the extent known to him, to consider Karen's wishes and personal values.¹⁵⁹ He would explain that "best interest" means that the benefits to the individual outweigh the burdens on the individual. In this decision, several factors should be considered: "the effect of treatment on the physical, emotional, and cognitive functions of the patient"; "the degree of pain or discomfort caused by either treatment or withdrawal of treatment"; the degree to which Karen's medical condition results in a severe and continuing impairment; the effect of treatment on her life expectancy; the prognosis for recovery; the risks, side effects, and benefits of treating or not treating; and Karen's religious beliefs and basic values.¹⁶⁰ Presumably, Mr. Quinlan would report back that he has considered all of those factors and still believes it to be in Karen's best interest to withdraw life support.

The decision would now go back to the medical professionals for several possible vetoes. First, the patient's primary healthcare provider may determine that the surrogate is not abiding by the wishes, values, and best interest of the patient, and may therefore decline to comply with the surrogate's decision.¹⁶¹ Alternatively, the healthcare provider may decline to comply for reasons of conscience.¹⁶² It is hard to say whether Karen's physicians would veto the surrogate's decision; they testified that "removal from the respirator would not conform to medical practices, standards and traditions,"¹⁶³ but that standard is not recognizably close to the standard under the AHCDCA.¹⁶⁴ Under the AHCDCA, a healthcare provider can refuse to provide healthcare contrary to generally accepted healthcare standards.¹⁶⁵ But here it would not be a question of providing healthcare, but rather of withdrawing it. As best as can be determined from the case law, the doctors never asserted an objection of conscience.¹⁶⁶ However, they might have

157. § 13.52.045.

158. *Id.*

159. § 13.52.030(g).

160. § 13.52.390(6).

161. § 13.52.030(h).

162. § 13.52.060(e).

163. *In re Quinlan*, 355 A.2d 647, 655 (N.J. 1976).

164. *See* § 13.52.060(f).

165. *Id.*

166. *See Quinlan*, 355 A.2d at 647-72.

argued that removal was not in Karen's best interest, especially in 1976.

If either side chose to go to court, they could do so under section 13.52.140, which provides that a court, through a guardianship proceeding, may enjoin or direct a healthcare decision.¹⁶⁷ A probate court judge adjudicating Karen's case would need to know what legal standard to apply, and immediately he or she would encounter a problem: there is an apparent error in the section on judicial relief. Section 13.52.140 says that a proceeding to enjoin or direct a healthcare decision is governed by sections 13.26.165–.320.¹⁶⁸ However, these statutory sections do not cover adult guardianships, but rather conservatorships.¹⁶⁹ In Alaska, conservators deal only with financial matters, not with medical decisions,¹⁷⁰ and the procedural protections are less than those for appointment of a guardian.¹⁷¹ The statute should have referenced sections 13.26.090–.155, for guardians of incapacitated adults. There is, within those sections, a specific provision as to what a guardian is or is not allowed to do:

A guardian may not . . . consent on behalf of the ward to the withholding of lifesaving medical procedures; however, a guardian is not required to oppose the cessation or withholding of lifesaving medical procedures when those procedures will serve only to prolong the dying process and offer no reasonable expectation of effecting a temporary or permanent cure of or relief from the illness or condition being treated unless the ward has clearly stated that lifesaving medical procedures not be withheld¹⁷²

Is the probate court to look only to this section of the guardianship statutes and determine whether a guardian is fulfilling that duty, or is the probate court to look at the AHCD and review all of its decision-making requirements (including whether the patient has a qualifying condition, and whether it is in the patient's best interest to withdraw life support)? That question will undoubtedly have to be answered in future litigation.

At any rate, the likely end result is that Karen Quinlan would still have her respirator removed, as she would be found to have met the standards of both the guardianship and healthcare decision laws related to removal of life support. In fact, Karen continued to

167. § 13.52.140.

168. *Id.*

169. §§ 13.26.165–.320.

170. § 13.26.280.

171. *See* §§ 13.26.165–.320.

172. § 13.26.150(e)(3).

breathe after removal of the respirator¹⁷³ and could survive for as long as she had the feeding tube inserted.¹⁷⁴ Under the AHCD, she could have the tube removed only upon her father's consent or if the doctors concluded that it was "medically ineffective health care,"¹⁷⁵ a problematic standard that will be examined in more detail in the Sun Hudson case below.

B. Nancy Beth Cruzan

In January 1983, a Missouri woman, Nancy Cruzan, was in a serious automobile accident.¹⁷⁶ Paramedics were able to restore her breathing and heart beat.¹⁷⁷ After three weeks in a coma, she progressed to a vegetative state.¹⁷⁸ She was able to take some food orally, but in order to ease the feeding and ensure that she had sufficient nutrition, a "gastrostomy feeding and hydration tube" was surgically inserted.¹⁷⁹ However, after several years with no improvement, Nancy's parents, who had already been appointed as co-guardians, petitioned in Missouri state court for authority to remove the feeding tube.¹⁸⁰

Initially, the only evidence as to Nancy's own wishes was testimony by a former roommate that Nancy once said that she would not wish to continue her life unless she could live at least halfway normally.¹⁸¹ The trial court authorized the withdrawal of life support, but the state appealed.¹⁸² The Missouri Supreme Court reversed, based on Missouri's living will statute, which had a policy strongly favoring preservation of life.¹⁸³ Specifically, Missouri required clear and convincing evidence of the patient's wishes for removal of life support when there was not a specific advance directive.¹⁸⁴ The Supreme Court affirmed, holding that Missouri had a legitimate interest in the protection and preservation of

173. Ascension Health, Healthcare Ethics Cases: Quinlan, Karen Ann, <http://www.ascensionhealth.org/ethics/public/cases/case21.asp> (last visited Sept. 21, 2005).

174. *Id.*

175. § 13.52.060 (f).

176. Cruzan v. Mo. Dep't of Health, 497 U.S. 261, 266 (1990).

177. *Id.*

178. *Id.*

179. *Id.*

180. *Id.* at 267–68.

181. *Id.* at 268.

182. *See id.*

183. *Id.*

184. *See id.* at 265.

human life, which it was entitled to safeguard with a statute designed to guard against potential abuses.¹⁸⁵

There, the case law ends, but not the case. The publicity surrounding *Cruzan* brought forward two new witnesses who had known Nancy before her accident and who learned about the case through the news coverage surrounding the appeal.¹⁸⁶ They both related conversations with Nancy, which supported the idea that she would not want to live in a vegetative state.¹⁸⁷ Aided by friendlier medical testimony the second time around, Mr. and Mrs. Cruzan prevailed in a new trial; third-party attempts to intervene and appeal were refused, and the feeding tube was removed, resulting in Nancy Cruzan's death twelve days later.¹⁸⁸

In many respects, Nancy Cruzan's situation was similar to that of Karen Quinlan. However, a significant difference is that Nancy Cruzan did not need a respirator.¹⁸⁹ However, she did need a feeding tube, and unlike the Quinlans, the Cruzan family wanted the feeding tube removed.¹⁹⁰ The AHCD makes no distinction between respirators and feeding tubes; they are all considered "life sustaining procedures" that may be withheld if the qualifying conditions are met.¹⁹¹ This distinction may make a big difference to the Roman Catholic Church and, judging by the number of protestors in both the Cruzan and Schiavo cases,¹⁹² to quite a lot of other people as well. However, it makes no legal difference in Alaska. It should be noted that defining artificial hydration and nutrition as medical care constitutes a significant philosophical choice on the legislature's part; the Catholic Church, among others,

185. *Id.* at 282.

186. WILLIAM H. COLBY, LONG GOODBYE: THE DEATHS OF NANCY CRUZAN 333–36 (2002).

187. *Id.*

188. *Id.* at 341–89.

189. *Cruzan v. Harmon*, 760 S.W.2d 408, 411 (Mo. 1988). Another potentially significant difference is that Cruzan was married at the time of her accident. However, Cruzan's husband agreed to dissolution of their marriage before the case reached the point of contested litigation. COLBY, *supra* note 187, at 29. Hence, Cruzan's marriage does not affect the outcome of the analysis.

190. *Cruzan*, 760 S.W.2d. at 410–11.

191. See ALASKA STAT. § 13.52.390(26) (2004).

192. COLBY, *supra* note 18, at 371–77; *All Things Considered: Protesters at Schiavo Hospice Grow Agitated* (NPR broadcast Mar. 27, 2005); Larry Copeland and Laura Parker, *Terri Schiavo's Case Doesn't End With Her Passing*, USA Today, Apr. 1, 2005, at A1.

would define it not as medical care but as feeding, and thus a basic responsibility which must not be withdrawn.¹⁹³

The next difference looks like a complication, but it actually leads to a simplification: Nancy Cruzan's parents were already her guardians when they decided to withhold artificial nutrition and hydration.¹⁹⁴ As her guardians, they would be surprised to discover that the AHCDA does not grant them any authority: it only allows an *agent or surrogate* to withhold or withdraw life sustaining procedures.¹⁹⁵ A guardian is not an agent or a surrogate. The definition of an agent requires that the declarant have executed a durable power of attorney for healthcare.¹⁹⁶ Furthermore, the definition of surrogate specifically excludes guardians.¹⁹⁷

The operation of these definitions, as they apply to the AHCDA, might be cause for consternation. However, not all of the laws related to end-of-life decision-making were included in Chapter 13.52. For example, under section 13.26.150(e)(3), which is part of the guardianship statutes, a guardian can oppose cessation of "life saving medical procedures" under a set of conditions similar to those in the AHCDA.¹⁹⁸ The guardian may consent to the withholding of such procedures when "[the procedures] will only serve to prolong the dying process, and offer no reasonable expectation of effecting a cure of or relief from the condition being treated if the ward has not clearly stated that the life sustaining medical procedures not be withheld"¹⁹⁹ While Nancy never prohibited such procedures from being withheld,²⁰⁰ another portion of that set of conditions is problematic. It refers to prolonging the dying process. Prior to the removal of the feeding tube, Nancy was not dying; the consensus was that she could possibly live for

193. *Minutes, S. Health, Educ. and Soc. Serv. Comm.*, 23d Leg., 2d Sess. 20 (Alaska Apr. 7, 2004), available at <http://www.legis.state.ak.us/PDF/23/M/SHES2004-04-071745.pdf> (testimony of Chip Wagoner, representing the Alaska Catholic Conference).

194. See *Cruzan*, 760 S.W.2d at 410.

195. The AHCDA states "an agent or a surrogate may determine that life-sustaining procedures may be withheld or withdrawn" § 13.52.045.

196. § 13.52.390(2).

197. § 13.52.390(40).

198. § 13.26.150(e)(3).

199. *Id.*

200. Ms. Cruzan had only made general statements to a roommate that she would not want to continue her life unless she could live "halfway normally." See *Cruzan v. Harmon*, 760 S.W.2d 408, 411, 424 (Mo. 1988).

another thirty years.²⁰¹ Unfortunately, this requirement in section 13.26.150(e)(3) seems to have been written for terminally ill patients, not patients in a coma or a vegetative state. However, technically speaking, the feeding tube prolongs the dying process.²⁰² Furthermore, the feeding tube appears to meet the other requirements of section 13.26.150(e) because it would offer no reasonable expectation of a cure or relief for Cruzan.²⁰³ Under these circumstances, the guardian would undoubtedly be legally justified in taking action.²⁰⁴ Nothing in the adult Guardianship Statutes or the AHEDA requires a guardian to seek specific court approval to withhold or withdraw life support.²⁰⁵ Under section 13.52.140, the superior court may enjoin or direct a healthcare decision, but an application to the superior court is not required.²⁰⁶ A healthcare decision made by a guardian is effective without judicial approval.²⁰⁷

A question remains as to the conscience clause in section 13.52.060(e), which allows a healthcare provider to decline to comply with an instruction for reasons of conscience.²⁰⁸ The state-run institution in which Nancy lived out her final years strongly opposed, on moral grounds, the removal of the feeding tube.²⁰⁹ However, the AHEDA's conscience clause has different standards for healthcare providers and healthcare institutions or facilities. The provider may decline to comply for reasons of conscience,²¹⁰ but another provider can easily be brought in to remove the tube. Under the statute, the healthcare facility can object to an instruction only if it is contrary to a written policy of the facility that is expressly based on reasons of conscience.²¹¹ Nothing in the case law or background materials suggests that the Missouri Rehabilitation Center had any such written policy. Therefore the facility would not have had the right to object.

201. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 266 n.1 (1990) (citing *Harmon*, 760 S.W.2d at 411).

202. Nancy Valko, *Of Living Wills and Butterfly Ballots*, LIFEISSUES.NET, http://www.lifeissues.net/writers/val/val_11_livingwills.html (last visited Oct. 19, 2005).

203. See § 13.26.150(e)(3).

204. See *id.*

205. §§ 13.26.090-.155; §§ 13.52.010-.395.

206. § 13.52.040(c).

207. *Id.*

208. § 13.52.060.

209. COLBY, *supra* note 18, at 188–96.

210. § 13.52.060(e).

211. *Id.*

The AHCDAs section on judicial relief allows the healthcare provider to petition the superior court for an injunction.²¹² In *Cruzan*, the facility may have sought this relief because the appeals featured the State of Missouri, representing its healthcare institution as a party, and the Cruzans as the opposing party.²¹³ After the appeals, the State of Missouri was dismissed from the guardianship case.²¹⁴ Even if the State of Missouri had continued to be involved with the guardianship case, the guardianship statute would have formed the substantive basis for the decision to withdraw life support, and the conditions of that statute appear to be easily met.²¹⁵

Analyzing Cruzan's case under the AHCDAs demonstrates that when a patient is in a terminal, comatose, or vegetative state, and has not executed an advance directive, a close family member who wants to remove life support should not claim the status of surrogate. Rather, the family member should petition to be appointed guardian first and then act under the guardianship statute. Because the guardianship statutes were not updated to be consistent with the AHCDAs, it is easier for a guardian to find sufficient legal justification to terminate life support.

C. Teresa Marie Schindler-Schiavo

In February of 1990, Terri Schiavo suffered a heart attack at the age of twenty-seven.²¹⁶ The heart attack caused her to enter into a vegetative state.²¹⁷ Her husband, Michael Schiavo, was appointed guardian without objection.²¹⁸ By 1993, however, serious disagreements between Terri's parents and Michael ensued.²¹⁹ The parents petitioned to have Michael removed as guardian,²²⁰ and Michael eventually petitioned the court to allow him to remove the feeding tube that kept Terri alive.²²¹ The trial court found clear and

212. § 13.52.140.

213. *See* *Cruzan v. Harmon*, 760 S.W.2d 408, 410 (Mo. 1988).

214. COLBY, *supra* note 18, at 330–31, 341.

215. § 13.26.150(e)(3).

216. *Schindler v. Schiavo*, 780 So.2d 176, 177 (Fla. Dist. Ct. App. 2001) [hereinafter *Schiavo I*].

217. *Id.*

218. *Id.*; *see also* Jay Wolfson, Guardian ad Litem, A Report to Governor Jeb Bush and the 6th Judicial Circuit in the Matter of Theresa Marie Schiavo 8 (Dec. 1, 2003), available at <http://www.miami.edu/ethics/schiavo/wolfson%27s%20report.pdf> [hereinafter *Wolfson Report*].

219. *Schiavo I*, 780 So.2d at 178; *see also* *Wolfson Report*, *supra* note 218, at 8.

220. *Schiavo I*, 780 So.2d at 177–78.

221. *Id.* at 177.

convincing evidence to support removal of the feeding tube.²²² Despite interventions by Terri's parents, the Florida governor and legislature, and the United States Congress and President, the courts sided with Michael Schiavo and allowed the feeding tube to be removed.²²³ Terri Schiavo died on March 31, 2005.²²⁴

The first court action in the Schiavo case was the uncontested petition by Michael Schiavo to be appointed guardian.²²⁵ Under Alaska law, a spouse has priority for appointment as guardian, unless the incapacitated person nominated someone else at a time when she had sufficient mental capacity to make an informed choice.²²⁶ A court may decline to appoint a person who has priority when it is in the best interest of the incapacitated person.²²⁷

In the Schiavo case, there was initially no reason for the court to consider that it might not be in Terri's best interest to appoint her husband as her guardian.²²⁸ When Terri's parents petitioned to remove Michael as the guardian, an Alaska court would have turned to section 13.26.125 and found that, while the court was clearly empowered to remove and replace a guardian, the statutes do not dictate the substantive standard for taking such action. Subsection (e) of that section states that a guardian may be removed if there is "probable cause to believe [he] is not performing [his] responsibilities effectively and there is an imminent danger that the physical health or safety of the ward will be seriously impaired"²²⁹ However, it is clear from the context of that subsection that there may be other bases.²³⁰ The Alaska

222. *Id.* at 179.

223. Schindler v. Schiavo, 403 F.3d 1223, 1226 (Fla. 11th Cir. 2005) [hereinafter Schiavo II].

224. Abby Goodnough, *Schiavo Dies, Ending Bitter Case over Feeding Tube*, N.Y. TIMES, Apr. 1, 2005, available at <http://www.nytimes.com>.

225. *Schiavo I*, 780 So. 2d at 177.

226. ALASKA STAT. § 13.26.145(d)(1)-(2) (2004).

227. § 13.26.145(f).

228. Later issues arose largely for two reasons. First, Michael Schiavo took the position that his wife should be allowed to die. Even before applying to the court for an order to terminate life support, he had entered a DNR order for her. Diana Lynne, *The Whole Terri Schiavo Story*, WORLD NET DAILY, Mar. 25, 2005, http://www.worldnetdaily.com/news/article.asp?ARTICLE_ID=43463; see also Wolfson Report, *supra* note 218, at 10. Second, Michael began to live with a woman he referred to as his fiancé and with whom he had two children. Jamie Thompson, *She's the Other Woman in Michael Schiavo's Heart*, ST. PETERSBURG TIMES, Mar. 26, 2005, available at http://www.sptimes.com/2005/03/26/Tampabay/She_s_the_other_woman.shtml.

229. § 13.26.125(e).

230. *See id.*

Supreme Court addressed this question recently in *H.C.S. v. Community Advocacy Project of Alaska, Inc.*²³¹ The court concluded that before removing or replacing a guardian, the trial court should first determine whether there has been a material change in circumstances since the guardian was originally appointed, and if there has been, whether the existing appointment is in the ward's best interest.²³² Terri's parents alleged abuse by Michael, but the judge found inadequate evidence of abuse.²³³ In all likelihood, the same judge who would later order removal of Terri's feeding tube would not have removed Michael from his position as guardian for proposing a DNR order.

This leaves the question of whether a conflict existed due to Michael's romantic interest in another woman. Nothing in the Alaska statutes or case law indicates whether such a conflict would have been sufficient, in and of itself, to justify removal. The priority section of the guardianship statutes states that the court may not appoint a person who has "interests that may conflict with those of the incapacitated person."²³⁴ However, this provision is included among several other bases for disqualification that relate to financial, not personal, interests.²³⁵ If the person is providing substantial services in a business or professional capacity,²³⁶ is a creditor of the incapacitated person,²³⁷ or is employed by someone else who would be disqualified,²³⁸ the person may not be appointed. Because the definition of a conflict of interest is unclear under this statute, Terri's parents could have argued that Michael's personal relationship warranted his removal. It is this very ambiguity, however, that makes it impossible to say how the judge might have ruled.

Note that the three cases examined thus far involved guardians rather than agents, and so the surrogacy section of the AHCDCA did not apply.²³⁹ Given that all three of these women were relatively young and healthy before a sudden trauma placed them in a vegetative state, it is hardly surprising that they did not have

231. 42 P.3d 1093 (Alaska 2002); *see also* Wolfson Report, *supra* note 218, at 11, 34 n.1.

232. *H.C.S.*, 42 P.3d at 1099.

233. *See* Schiavo I, 780 So. 2d 176, 177 (Fla. Dist. Ct. App. 2001).

234. ALASKA STAT. § 13.26.145(b)(3) (2004).

235. § 13.26.145.

236. § 13.26.145(b)(1).

237. § 13.26.145(b)(2).

238. § 13.26.145(b)(4).

239. *In re* Quinlan, 355 A.2d 647, 653–54 (N.J. 1976); *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988); *Schiavo I*, 780 So. 2d 176, 177 (Fla. Dist. Ct. App. 2001).

appointed healthcare agents. It should also not be surprising that at least two of them already had guardians,²⁴⁰ for the simple reason that in the *Cruzan* and *Schiavo* cases, the family members in question waited for a number of years before petitioning the court to remove life support.²⁴¹ In the meantime, a myriad of medical and other decisions had to be made, so that guardianship would have been a normal and expected action, even if the thought of removing life support was on no one's mind at the time. For instance, approximately 50% of patients who are diagnosed as being in a vegetative state one month after the injury will recover consciousness within a year.²⁴² Therefore, if the patient is in a vegetative or minimally conscious state, as opposed to being comatose, there will almost certainly be significant delays before the issue of removing life support comes to the fore.

There can be no surrogate under Alaska law if a guardian is already appointed and available.²⁴³ Thus, surrogates are unlikely to make life-support decisions for patients in a vegetative state because, by the time life support decisions are being made, the patient will likely have a guardian. A variety of non-medical decisions need to be made for someone in a vegetative or minimally conscious state, so a guardian would be appointed to make those decisions. A guardianship petition may be dismissed if there are feasible alternatives to guardianship,²⁴⁴ and a surrogate would be a feasible alternative to guardianship if only medical decisions need to be made.

Another potential problem with the AHCDCA exists. Assume hypothetically that no one, including Michael Schiavo, had been appointed Terri's guardian. Suppose instead he argued for surrogate status under the AHCDCA. In the absence of a designation by the patient as to whom she wanted as her surrogate, the first priority for appointment goes to the spouse, "unless legally separated."²⁴⁵ One might naturally assume that because he had moved in with another woman, fathered two children by her, and began referring to her as his fiancée, Michael Schiavo would be considered legally separated from his wife. That would be an incorrect assumption. Legal separation has a specific meaning in

240. In the *Quinlan* case, the issue of termination of life support came up in the initial litigation over the appointment of a guardian. *Quinlan*, 355 A.2d at 651.

241. *Cruzan*, 760 S.W.2d at 411, 413; *Schiavo I*, 780 So.2d at 177-78.

242. The Multi-Society Task Force on PVS, *Medical Aspects of the Persistent Vegetative State*, 330 NEW ENG. J. MED. 1572, 1572 (1994).

243. § 13.52.030(a).

244. § 13.26.113(d).

245. § 13.52.030(c)(1).

Alaska, and it is not based on the general facts of the case, but rather on whether a decree of legal separation has been entered under section 25.24.450.²⁴⁶ Because there was no legal separation decree between Michael and Terri Schiavo, Michael would still have been entitled to priority to be the surrogate, despite his conflicted circumstances. The primary healthcare provider could decline to comply with specific decisions made by Michael,²⁴⁷ but not with his right to be the surrogate. Of course the hospital, the parents, or any other interested person could petition for judicial relief under section 13.52.140 or guardianship under section 13.26.105.

Assuming Michael was able to maintain his position as guardian, we would again return to the statutes to determine his authority to consent to withdrawal of life-saving medical procedures. As in the *Cruzan* case, the question would be whether the procedures in question serve only to prolong the dying process and offer no reasonable expectation of effecting a temporary or permanent cure or relief from the illness or condition being treated.²⁴⁸ Suppose for the sake of argument no one had been appointed guardian, and Michael was seeking to act under surrogacy authority. He would have to establish, among other things, that his wife was in a state of permanent unconsciousness,²⁴⁹ and again there is the question of whether she experienced sensation.²⁵⁰ Terri's autopsy report indicated that, toward the end of her life, she was given acetaminophen,²⁵¹ but it is unclear whether this was for pain, fever, or inflammation. If the definition of permanent unconsciousness in the AHCDA is interpreted literally, surrogates will not be able to terminate life support for patients such as Nancy Cruzan and Terri Schiavo. The statute states that thought, sensation, purposeful action, social interaction, *and* awareness of self and the environment must be absent for the person to be found permanently unconscious.²⁵² A literal interpretation means that each of those five prongs must be absent, so that if the patient still experiences sensation, they are not

246. § 25.24.450.

247. § 13.52.030(h).

248. § 13.26.150(e)(3).

249. This state is known as a "qualifying condition." § 13.52.390(36).

250. See AUTOPSY REPORT OF THERESA SCHIAVO, CASE # 5050439 1 (June 13, 2005), <http://news.findlaw.com/hdocs/docs/schiavo/61305autopsyrpt.pdf>.

251. *Id.*

252. § 13.52.390(31)(b).

permanently unconscious.²⁵³ However, under Illinois law, sensation is interpreted as consciousness, and under this interpretation, a surrogate would be able to direct removal of a feeding tube for a person in a vegetative state.²⁵⁴ Furthermore, given that the majority of doctors believe it is appropriate to remove feeding tubes for patients in vegetative states²⁵⁵ and the possibility of “doctor shopping” by the guardian, there is little doubt that Terri Schiavo’s fate would not have changed under the AHFDA.

D. Sun Hudson

If the Quinlan, Cruzan, and Schiavo cases look remarkably similar from a factual viewpoint, the sad case of Sun Hudson is quite different.²⁵⁶ Sun was born with a genetic condition called thanatophoric dysplasia, a form of dwarfism, which includes a narrow chest, small ribs, and underdeveloped lungs.²⁵⁷ Infants born with this condition, if they are not stillborn, usually die shortly after birth from respiratory failure.²⁵⁸ This condition normally restricts the growth of the rib cage so that the baby slowly suffocates.²⁵⁹ Texas Children’s Hospital, where Sun was born, placed him on a ventilator, but informed his mother that further treatment would be futile, merely prolonging the inevitable, and that in their view he should be removed from the ventilator.²⁶⁰ His mother refused, and the matter ended up in probate court, where the judge eventually ruled that five-month old Sun could be taken off life support,

253. Sensation is defined as the activity of the sensors, or the immediate result of this activity before the combination with other data. THE NEW LEXICON WEBSTER’S DICTIONARY OF THE ENGLISH LANGUAGE, ENCYCLOPEDIA EDITION 907 (1989).

254. See *Keiner v. Cmty. Convalescent Ctr.*, 549 N.E.2d 292, 298 (Ill. 1998) (stating in part that a patient in a persistent vegetative state is unable to purposely interact with stimulation from his environment).

255. Payne, *supra* note 84, at 107, Table 4.

256. Associated Press, *Infant Born with Fatal Defect Dies After Being Taken Off Life Support*, ABC13.NET, Mar. 15, 2005, http://abclocal.go.com/ktrk/news/031405_local_baby1.html; Associated Press, *Houston Mother Loses Fight to Keep Baby on Life Support*, NBC5.COM, Mar. 15, 2005, <http://www.nbc5.com/health/428633/detail.html>; Rick Casey, *No Villains in This Sad Story*, HOUSTONCHRONICLE.COM, Feb. 23, 2005, <http://www.chron.com/cs/CDA/ssistory.mpl/metropolitan/casey/3047420>.

257. *Infant Born with Fatal Defect Dies After Being Taken Off Life Support*, *supra* note 256.

258. Rick Casey, *supra* note 256.

259. *Id.*

260. *Houston Mother Loses Fight to Keep Baby on Life Support*, *supra* note 256.

despite his mother's objections.²⁶¹ Under Texas law, the mother was allowed ten days to find another hospital willing to take over care.²⁶² When the mother was unable to find another hospital, Sun was removed from the ventilator, and he died a few breaths later, on March 15, 2005.²⁶³

The AHCDCA applies only to adults,²⁶⁴ so under Alaska law, Sun's mother would act on her baby's behalf under general parental rights rather than as a surrogate.²⁶⁵ Nonetheless, the hospital could have determined that keeping Sun on a respirator would constitute "medically ineffective health care," which is care that "cannot cure the illness, cannot diminish its progressive course, and cannot effectively alleviate severe discomfort and distress."²⁶⁶ This would have been a questionable determination, however, because the respirator diminished the progressive course of the malady by prolonging Sun's life.

Another way in which the Alaska and Texas procedures diverge is that under Alaska law, if the mother chose to seek a transfer, the hospital would have had to provide continuing care until the transfer was effected.²⁶⁷ By contrast, there is a ten-day time limit under Texas law.²⁶⁸ In Alaska, the search for a hospital willing to take the child could go on indefinitely.

Alternatively, the hospital could have turned to section 13.52.140, under which it could have requested the superior court to direct a healthcare decision. At that point, the court has the dilemma noted earlier: should it review the surrogate's decision under the standards provided in the AHCDCA or under the standards provided in the guardianship act? The judicial relief section of the AHCDCA appears to direct the court to the guardianship act.²⁶⁹ However, another question arises as to whether to consult the section on guardians of minors or guardians of incapacitated persons. The statute does not provide guidance

261. Casey, *supra* note 256.

262. *Id.*

263. *Infant Born with Fatal Defect Dies After Being Taken Off Life Support*, *supra* note 256.

264. See, e.g., Troxel v. Granville, 530 U.S. 57 (2000); Stanley v. Illinois, 405 U.S. 645 (1972); Evans v. Taggart, 88 P.3d 1078 (Alaska 2004).

265. ALASKA STAT. § 13.52.030(a) (2004).

266. § 13.52.060(f).

267. § 13.52.060(g)(2).

268. TEX. HEALTH & SAFETY CODE ANN. § 166.046(e) (Vernon 2002).

269. The AHCDCA states that "[a] proceeding under this section is governed by AS 13.26.165–13.26.320." § 13.52.140. These sections are a part of the guardianship statutes.

because it mistakenly directs that the statute on conservatorships be used.²⁷⁰ Understandably, the statute on minor guardianships does not address termination of life support beyond generally authorizing the guardian to facilitate medical care and treatment.²⁷¹ The article regarding incapacitated persons, which does address termination issues, is not limited to adults and can apply to any incapacitated person.²⁷² If the court turns to this article, it may hold that a guardian can consent to withholding life-saving medical procedures, as long as those procedures serve only to prolong the dying process, under section 13.26.150(e)(3). However, nothing in the guardianship statutes suggests that the judge may order the withholding of life-sustaining procedures if the guardian does not want them withheld.

On the other hand, if the judge interprets the section of the AHCDA which states that “[a] proceeding under this section is governed by” the guardianship statutes as merely referring to the procedure, then it would look to the AHCDA for the standards to be applied in determining whether life support should be terminated. However this is a stretch, not only because section 13.52.140 does not refer to *procedure*, but rather a *proceeding*, and the AHCDA does not appear to contemplate that the decisions be made by a judge.²⁷³ If a judge heard a case similar to that of baby Sun’s, the judge would have to determine whether the condition is “incurable or irreversible,” whether “without administration of life-sustaining procedures death would result in a short period of time,” whether “there is no reasonable prospect of cure or recovery,” and whether “the condition imposes severe pain or an inhumane burden on the patient.”²⁷⁴ Assuming the other conditions were met, the court might nonetheless have a difficult time finding that there would be an “inhumane burden” on the baby, who was apparently not in any particular pain and breathing reasonably well on the ventilator.

Assuming the judge would not find an inhumane burden, this would have left the hospital with one remaining alternative: it could petition the court to appoint someone other than the mother as the

270. Section 13.52.140 points to sections 13.26.165-.320, part of the guardianship statutes covering conservatorships.

271. § 13.26.070(3).

272. § 13.26.090.

273. See § 13.52.030(a).

274. This is the definition of a “terminal condition” under section 13.52.390(42). Life-sustaining procedures may be withheld or withdrawn from a patient with a “qualifying condition.” § 13.52.045. The definition of “qualifying condition” includes a “terminal condition.” § 13.52.390(36).

child's guardian, hoping that the appointee would be more likely to agree with its position. However, section 13.26.045 allows appointment of a guardian for a minor only if all parental rights of custody have been terminated or suspended by circumstances or a prior court order. None of those conditions occurred in this case. Therefore, regardless of the hospital's position, it is likely Sun Hudson would have lived a little while longer under the AHCD.

E. Ora Mae Magouirk

In April 2005, at the height of the Schiavo controversy, one of the hot topics of discussion on the Internet was the unusual case of a widow who was allegedly being starved to death in a hospice. Unlike the previous cases, it is not possible to conclusively state the facts of this case.²⁷⁵ However, for purposes of this Article, ascertaining the precise facts from among the multiple versions is unnecessary. Therefore, the following version has been pieced together by combining the various sources, with no representation of accuracy.

Ora Mae Magouirk was an eighty-one year old woman living in Alabama. Because she was a widow without any surviving children, her granddaughter helped take care of her by running errands and bringing her food. The granddaughter also had a general power of attorney. Magouirk had a living will, which said

275. Only a few articles appeared in the mainstream press, none of which were able to determine which side of the controversy gave the most accurate facts. Most of the information available on the case comes from Internet news sources that have a particular philosophical perspective and whose information, therefore, is necessarily suspect. See, e.g., Sarah Foster, *Closest Kin Prevented from Visiting 'Grandma,'* WORLDNETDAILY.COM, Apr. 12, 2005, http://www.worldnetdaily.com/news/article.asp?ARTICLE_ID=43763; Sarah Foster, *Granddaughter Yanks Grandma's Feeding Tube,* WORLDNETDAILY.COM, Apr. 7, 2005, http://www.worldnetdaily.com/news/article.asp?ARTICLE_ID=43688; Mark A. R. Kleiman, *Mae Magouirk: Is There a Reporter in the House?*, MARK A. R. KLEINMAN: A WEBLOG FOR THE REALITY-BASED COMMUNITY, Apr. 8, 2005, http://www.markarkleiman.com/archives/_/2005/04/mae_magouirk_is_there_a_reporter_in_the_house.php; Mark A. R. Kleiman, *Magouirk Update,* MARK A. R. KLEINMAN: A WEBLOG FOR THE REALITY-BASED COMMUNITY, Apr. 11, 2005, http://www.markarkleiman.com/archives/schiavo_/2005/04/magouirk_update.php; Denis O'Hayer, *Georgia Case Mirrors Schiavo Battle,* 11 ALIVE.COM, Apr. 8, 2005, http://www.11alive.com/help/search/search_article.aspx?storyid=61478; Charles Yoo, *Illness Splits Woman's Kin,* THE ATLANTA JOURNAL-CONSTITUTION, Apr. 12, 2005, <http://www.ajc.com/hp/content/metro/0405/12illness.html>; Maria Vitale Gallagher, *Woman's Starvation Stopped in a Terri Schiavo-Like Situation,* LIFE NEWS.COM, Apr. 11, 2005, <http://www.lifeneews.com/bio905.html>.

that nutrition and hydration were to be withheld only if she were either comatose or in a vegetative state. In March 2005, Magouirk was hospitalized for an aortic problem, reportedly lucid at the time. The granddaughter had her transferred to a hospice, telling other relatives they should let her pass away, and apparently not telling the hospice about the living will. Magouirk was only able to eat foods such as Jell-O and chips of ice. On learning of this, Magouirk's sister and brother insisted on placement of a feeding tube, and made arrangements for Magouirk to be transported to the hospital at the University of Alabama at Birmingham to begin the procedure. However, while they were at the hospice awaiting her transport to the hospital, the granddaughter went to court and obtained an emergency order appointing herself as guardian; she again refused to have the feeding tube inserted. A few days later, after hearing from Magouirk's siblings, the probate judge ordered that she be "adequately fed" pending a determination of her condition, which was to be based on the opinion of three mutually agreed-upon neurologists. There is no available record of the final decision. Magouirk reportedly died a few months later at a relative's home.

Perhaps the first and foremost lesson one can learn from the Magouirk case is that having an advance directive is useless if one's medical providers are unaware of it. In Alaska, most of the major hospitals have now set up directories that will store copies of advance directives for those who provide one.²⁷⁶ In addition, declarants should provide a copy to any physician they see on a regular basis and any surgeon or specialist who may be treating them for a particular problem (and to the declarant's lawyer, of course).

In the Magouirk case, the granddaughter's power of attorney did not include medical decision-making, and the living will apparently did not include appointment of an agent for health-care decisions. Therefore, under the AHCD, the hospice would have referred to section 13.52.030, the section on surrogates. The sources reflect conflicting information on Magouirk's ability to express herself at the time she arrived at the hospice. However, if she had been able to express an opinion, she could have designated a surrogate and informed her healthcare providers of her choice. Assuming that she could not express an opinion, the healthcare providers would have looked to the priority list to see who should

276. Confirmed by phone calls by author's staff to major hospitals in Alaska. Telephone interviews by author's staff with Providence Hospital, Alaska Regional Hospital, and Alaska Native Medical (July 19-22, 2005).

make decisions on her behalf.²⁷⁷ Magouirk did not have a surviving spouse, adult child, or parent, but the fourth priority is an adult sibling. Magouirk had two adult siblings. Either her sister or brother could have stepped forward and claimed the position of surrogate, or they could have both done so and would have had to reach consensus.²⁷⁸ Had they both stepped forward and not been able to agree on decisions, the doctor would have broken the tie.²⁷⁹ Either way, the sister and brother were both inclined to have a feeding tube inserted, and there is no reason to think that doing so would have been so far outside generally accepted healthcare standards that the provider would have been entitled to refuse. Presumably, the tube would have been inserted.

Could the granddaughter nonetheless have gone to probate court and received an emergency guardianship order? After all, a surrogate may make decisions only if a guardian has not been appointed,²⁸⁰ and while an *agent* may, in certain circumstances, be able to overrule a guardian,²⁸¹ there is nothing in the AHCD that suggests that a *surrogate* can overrule a guardian. The granddaughter could have applied for temporary guardianship under section 13.26.140, and if she convinced the court that an emergency order was necessary to protect the respondent from serious injury, illness, or disease, she could have obtained it.²⁸² The maneuver may or may not have worked. The granddaughter would have had to file a petition that provides the names and addresses of “the individuals most closely related to the respondent by blood or marriage.”²⁸³ This would have required her to provide the names of the brother and sister and take the risk that the court would contact them and learn that they were opposed to her guardianship.

The guardianship statutes also have a priority list, which is similar to, but not identical to, the list in the AHCD.²⁸⁴ One of the differences between the two lists could be absolutely critical in this case: the surrogate list begins with a spouse, then an adult child, then a parent, then an adult sibling, and finally an adult who has exhibited special care and concern for the patient.²⁸⁵ The

277. § 13.52.030(c).

278. See § 13.52.030(f).

279. See *id.*

280. See § 13.52.030(a).

281. § 13.52.040(b).

282. See § 13.26.140(d).

283. See § 13.26.105(b)(6).

284. The guardianship priority list is at section 13.26.145(d); the surrogate preference list is at section 13.52.030(c).

285. § 13.52.030(c).

guardianship list begins with the spouse, then an adult child or parent, then a relative with whom the incapacitated person has resided for more than six months, then a relative or friend who has demonstrated a sincere longstanding interest in the welfare of the incapacitated person.²⁸⁶ As adult siblings, the brother and sister would have had priority over the granddaughter for appointment as surrogates, but for guardianship appointment, the siblings would have been on the same priority level as relatives who had demonstrated a sincere, longstanding interest in the welfare of the incapacitated person. In fact, the granddaughter might have been considered higher on the list than the siblings, because while she was not actually living with Magouirk, she had apparently been helping to provide for her for some time.

Regardless of who was appointed as guardian (if the probate court even found a necessity for guardianship given the availability of a surrogate), the court would have still had the authority to review and amend a decision of the guardian²⁸⁷ and, therefore, could have directed the insertion or withholding of the feeding tube. The court would have considered whether the procedures in question would “serve only to prolong the dying process and offer no reasonable expectation of effecting a temporary or permanent cure of, or relief from, the illness or condition being treated”²⁸⁸ While Magouirk was elderly and had a potentially dangerous aortic condition, the information at hand suggests that she was not terminal, and, therefore, would probably not have qualified for cessation of life-sustaining treatment. She was also not in a vegetative state, so she would have experienced severe discomfort from being given inadequate nutrition and hydration, which would have unquestionably factored into a judge’s decision.

VI. CONCLUSION

In the spring of 2005, the news of the moment was the death of Terri Schiavo by dehydration. Congress passed legislation to stop this action in a late-night session,²⁸⁹ and numerous writs, cases, and appeals were filed. In the end, judicial authority won out over congressional dissent. Ms. Schiavo’s feeding tube was disconnected and she slowly died. In the meantime, the media and the internet buzzed with stories about a deformed baby in Houston and an

286. § 13.26.145(d).

287. *See* § 13.26.125(a)(1).

288. *See* § 13.26.150(e)(3).

289. Terry Schiavo Law, Pub. L. No. 109-3, 119 Stat. 15 (2005).

elderly woman in a hospice in Georgia. End-of-life decisions were the water-cooler topic of the season.

The majority public sentiment seems to have been that Ms. Schiavo should not have been “starved to death,”²⁹⁰ an observation supported by the legislative response. In the U.S. House of Representatives, where the vote was recorded, 203 representatives voted in favor of the bill to provide her with specific relief and only 58 representatives voted against the bill.²⁹¹ The U.S. Senate passed the same bill on a voice vote, and the President promptly signed it. Based on the overwhelming legislative response, one could assume that the majority of Americans seem to be opposed to removal of a feeding tube from a patient in a minimally conscious or vegetative state.

Nonetheless, in Alaska,²⁹² the recently passed AHCDCA would, in all likelihood, have resulted in Terri Schiavo’s death by dehydration, just as it actually happened in Florida. Despite the fact that the AHCDCA says that it establishes a presumption in favor of life,²⁹³ the specifics and the legislative history allow plenty of leeway to terminate life support, including removal of a feeding tube in circumstances in which most people believe it would be wrong to do so.²⁹⁴

The AHCDCA needs to be revisited, regardless of the philosophical position from which one approaches these issues. For example, the misdirection in section 13.52.140, in which the reader is referred to the conservatorship statutes instead of the guardianship statutes; the dichotomy between what the form suggests about the right to direct that life support be terminated even if one is pregnant²⁹⁵ and the statute that does not allow it,²⁹⁶

290. Ninette Sosa, et al., *Schiavo’s Feeding Tube Removed*, CNN.com, Mar. 18, 2005, <http://www.cnn.com/2005/LAW/03/18/schiavo.brain-damaged/>.

291. 151 CONG. REC. H1728 (daily ed. Mar. 20, 2005). One hundred seventy-four representatives did not vote. *Id.*

292. At present, the Senate is Republican-controlled by a margin of twelve to eight, and the House of Representatives by twenty-six to fourteen. Committee/Member Information of the Alaska State Legislature, http://www.legis.state.ak.us/basis/commbr_info.asp? session=24 (last visited Sept. 26, 2005). The Governor is Republican as well. Republican Governors Association, <http://www.rga.org/> (last visited Sept. 26, 2005).

293. See ALASKA STAT. § 13.52.120(a) (2004).

294. See *supra* notes 152–55 and accompanying text.

295. The sample Advance Health Directive given in the statutes has a section that seems to allow a person to enter end-of-life directives in case that person is unconscious and pregnant. § 13.52.300, pt. 2, item (6)(E).

296. § 13.52.055(b).

and the possible misconception as to what “legally separated” means in the context of a spouse taking control as a surrogate,²⁹⁷ all need to be clarified.

When it addresses these technical concerns, the legislature should also consider whether the actual effect of the AHCDA will accomplish its purpose. The AHCDA purports to be based on the right to self-determination, combined with a concern for the sanctity of life.²⁹⁸ Instead, it has been infused with enough loopholes such that doctors and surrogates can terminate lives, even of the unwilling, based on their own philosophical convictions. Although many people espouse the philosophy that those who cannot lead a productive life are “better off dead,” this is not the philosophy the legislature appears to have endorsed, at least explicitly, when it passed the AHCDA.²⁹⁹ If the legislature did not intend this result, it should consider a number of changes to the AHCDA, including a re-examination of whether the definition of “permanent unconsciousness” should include those in a vegetative state.

297. § 13.52.030(c)(1).

298. *See* § 13.52.010.

299. *See id.*