HB
485

COMMITTEE REPORT
SENATE

FURTHER: JUDICIARY

3/24/86

Date 4-1-86

Mr. President

The Committee on HESS considered CSHB 485(Jud) relating to powers and duties of guardians.

and (a majority of the committee) (the committee) reports it back with the following recommendations:

[X] do pass

[ ] do pass with attached amendment(s)

[ ] replace with/or adopt CS for
[ ] new title
[X] same title and recommends [crossed out]

[ ] and attached a "LETTER OF INTENT" [ ] NEW FISCAL NOTE

[ ] reports it back without recommendation

[ ] recommends referral to ________ Committee

MEMBERS SIGNING DO PASS	MEMBERS HAVING OTHER RECOMMENDATIONS
Joe Josephson	Paul Fischer N. Rec.
[signature]	
Edna DeVries	

Bettye Fahrenkamp Do Pass
Chairman

Chairman recommendation

Offered: 2/26/86
Referred: Rules

Original sponsors: Sund and Gruenberg

file

1 IN THE HOUSE BY THE JUDICIARY COMMITTEE

2 CS FOR HOUSE BILL NO. 485 (Judiciary)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FOURTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to powers and duties of guardians."

7 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

8 * Section 1. AS 13.26.150(e) is amended to read:

9 (e) A guardian may not

10 (1) place the ward in a facility or institution for
11 mentally ill other than through a formal commitment proceeding under
12 AS 47.30 in which the ward has a separate guardian ad litem;

13 (2) consent on behalf of the ward to an abortion, ster-
14 ilization, psychosurgery, or removal of bodily organs except when
15 necessary to preserve the life or prevent serious impairment of the
16 physical health of the ward;

17 (3) consent on behalf of the ward to the withholding of
18 <u>lifesaving</u> [LIFE-SAVING] medical procedures; <u>however, a guardian is</u>
19 <u>not required to oppose the cessation or withholding of lifesaving</u>
20 <u>medical procedures when those procedures will serve only to prolong</u>
21 <u>the dying process and offer no reasonable expectation of effecting a</u>
22 <u>temporary or permanent cure of or relief from the illness or condition</u>
23 <u>being treated unless the ward has clearly stated that lifesaving</u>
24 <u>medical procedures not be withheld; a guardian is not civilly liable</u>
25 <u>for acts or omissions under this paragraph unless the act or omission</u>
26 <u>constitutes gross negligence or reckless or intentional misconduct;</u>

27 (4) consent on behalf of the ward to the performance of an
28 experimental medical procedure or to participation in a medical ex-
29 periment not intended to preserve the life or prevent serious

1 impairment of the physical health of the ward;

2 (5) consent on behalf of the ward to termination of the

3 ward's parental rights;

4 (6) prohibit the ward from registering to vote or from

5 casting a ballot at public election;

6 (7) prohibit the ward from applying for and obtaining a

7 driver's license;

8 (8) prohibit the marriage or divorce of the ward.

STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: ______

REQUEST

Bill/Resolution No.: HB 485 #1
Title: "An Act relating to powers and duties of guardians."

Sponsor: Rep. Sund
Requestor: HESS & Judiciary
Date of Request: 1/28/86

FISCAL DETAIL

Agency Affected: Administration
BRU: Office of Public Advocacy

Components: Office of Public Advocacy

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES	-0-	-0-				
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-				
CAPITAL	-0-	-0-				
REVENUE	-0-	-0-				

FUNDING: (Thousands of Dollars)

	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
GENERAL FUND	-0-	-0-				
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	-0-				

POSITIONS:

	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
FULL-TIME	-0-	-0-				
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary

Prepared by: Brant McGee, Public Advocate [signature: Phillip J. McCarthy for]
Phone: 274-1684
Division: Office of Public Advocacy
Date: 2/4/86

Approved by Commissioner: Eleanor Andrews [signature]
Date: 2/4/86
Agency: Department of Administration

Distribution (by Agency preparing fiscal note):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

page ___ of ___

10/25/85

POSITION PAPER
Bill No. HB485

The Office of Public Advocacy in the Department of Administration performs the duties of the Public Guardian under A.S. 13.26.360-13.26.410. Guardians provide informed medical consents for incapacitated persons (wards) directly impacting the ward's health and safety according to A.S. 13.26.150(c)(5) except as limited by (e) of this section.

PRESENT STATUTE:

A.S. 13.25.150(e) "A guardian may not...(d) consent on behalf of the ward to the withholding of life-saving medical procedures."

PROPOSED AMENDMENT:

A.S. 13.25.150(e) "A guardian may not...(3) consent on behalf of the ward to the withholding of life-saving medical procedures; however, the guardian is not required to oppose the cessation or withholding of life-saving 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;"

RATIONALE:

The current law could be interpreted as requiring the guardian to insist upon the continuation of "life-saving medical procedures" regardless of the values such procedures might offer the patient in terms of benefits received. The question which needs to be considered is whether the procedure offers relief or cure, versus simply prolonging the dying process by the use of heroic means.

PROBLEM AREAS IN THE PRESENT STATUTE:

(1) A literal reading of the statute would mean that life-saving medical procedures cannot be stopped once they are started. Hence the possibility may arise that non-beneficial and even harmful procedures could not be withdrawn. A further possible effect might be that a different standard of care would be used for wards than for other patients. Also those with guardians might be either overtreated since the treatment could not be stopped or undertreated because the treatment was not begun lest it could not be withdrawn.

(2) the meaning of "life-saving medical procedures" is not clear nor is it defined. An attempt to define the phrase defies the enumeration process, as does a list of the exceptions. Moreover, such a task borders on the impossible because of the nature of the words. The phrase focuses on "procedures" instead of the "relationship" of the treatment to the ward in terms of the benefits received. E.G., chemotherapy or a respirator is life-saving if it is helpful in the restoration of health of the ward, but it would be counterindicated if it simply prolonged the dying process.

(3) An attempt to solve these problems by having the health care provider act independently of the guardian would defeat the purpose of guardianship. Further, such actions by the health care provider would be destructive of the informed consent process.

(4) The statute can create difficulties in the decision-making process for the guardian, ward, physician, health care institution and its personnel, and other health care providers. In addition, it would often conflict with the philosophy of medical ethics.

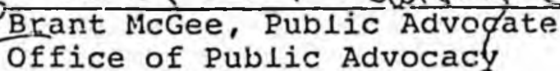
SUPPORT/HB485:

(1) The amendment more clearly delineates the different types of medical/nursing care involved, thus allowing the guardian to carry out more adequately his/her responsibilities toward the ward.

(2) The amendment allows the guardian to not oppose the cessation or withholding of life-saving medical procedures where they are clearly ineffective and not beneficial to the ward from the perspective of the ward.

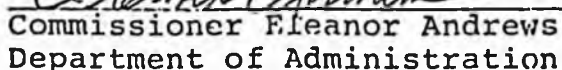
(3) The amendment facilitates and keeps open the communication process and dialogue among the guardian and health care providers at all times.

(4) There are no foreseen costs to the OPA with passage of HB485.



Brant McGee, Public Advocate
Office of Public Advocacy

2/3/86
Date



Commissioner Eleanor Andrews
Department of Administration

2/7/86
Date

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

HOUSE BILL NO. 485

For an Act entitled: "An Act relating to powers and duties of guardians."

House Bill No. 485 amends Alaska Statute 13.26.150(e) to clarify that a guardian is not required to oppose the cessation or withholding of life-saving 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.

It is the department's understanding that some guardians have a felt responsibility to oppose the withholding of medical treatment regardless of their beliefs or judgement. The change would allow the guardian to defer to a more appropriate party, such as a relative, to make critical decisions regarding life saving medical procedures. In addition, the bill is consistent with other federal and State policies requiring review of such decisions.

The department has no objection to the passage of HB 485.

RECOMMENDED: [signature]
Michael L. Price, Director
Division of Family
and Youth Services

DATE: February 4, 1986

APPROVED: [signature]
John R. Pugh, Commissioner
Department of Health
and Social Services

DATE: 2/5/86

STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: 2/3/86

REQUEST

Bill/Resolution No.: HB 485
Title: An Act relating to powers and duties of guardians.

Sponsor: Sund & Gruenberg
Requestor:
Date of Request: 2/3/86

FISCAL DETAIL

Agency Affected: Health & Social Services
BRU: Social Services
Youth Services

Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING		0	0	0	0	0
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
GENERAL FUND		0	0	0	0	0
FEDERAL FUNDS						
OTHER						
TOTAL		0	0	0	0	0

POSITIONS:

	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
FULL-TIME		0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary

n/a

Prepared by: Michael L. Price, Director
Phone: 465-3170
Division: Family and Youth Services
Date: February 4, 1986

Approved by Commissioner: John R. Pugh, Commissioner
Date: 2/5/86
Agency: Health and Social Services

Distribution (by Agency preparing fiscal note):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

10/25/85

health
association
of alaska

319 Seward St., Juneau, Alaska 99801 • (907) 586-1790
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FORMERLY
alaska state hospital association

POSITION PAPER

GUARDIANSHIP LAW: NO CODE ORDERS

POSITION:

Guardians should be permitted to consent to the withholding of medical procedures which offer no reasonable expectation of effecting a temporary or permanent cure of or relief from the illness or condition being treated. The current law, AS 13.26.150(e)(3) presently is being interpreted to require the continuation of "lifesaving medical procedures" no matter what value such procedures might offer the patient in terms of benefits received. The question which needs to be considered is whether the procedure offers relief or cure or rather is simply prolongation of the dying process by use of invasive and heroic means.

ACTION:

Amend AS 13.26.150(e)(3) to provide that 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.

December 6, 1985

health
association
of alaska

319 Seward St., Juneau, Alaska 99801

Mr. Chairman, I am Sister Barbara Haase, a member of the Sisters of St. Joseph of Peace, Administrator of Ketchikan General Hospital and former Chairman of the Health Association of Alaska. I am here today to speak on behalf of the Association as well as my own facility. The Health Association of Alaska represents hospitals and nursing homes in Alaska.

We support House Bill 485 by Representatives Sund and Gruenberg. This is a tightly drawn proposal which resolves a very specific and real problem. Under the current law "life saving procedures" may not be withheld from a ward under any circumstance. This is a substantial difference from the standard of medicine which is available to you and me. The guardianship law ought to work to protect the rights of an individual, not to deprive the person of rights.

The purpose of AS 13.26.150(e)(3) was to prevent situations where a guardian, who could benefit from the death of a ward, could decide whether or not the ward should die. It was thought that putting either a guardian or a ward in that position should be avoided. Unfortunately, there have been unforeseen consequences.

Life-saving procedures, once begun, cannot be stopped without a court order. Heroic treatment must always be applied, without regard to its ultimate usefulness. This results in prolonged useless medical treatment.

Let me offer you 2 examples: A 90 year old frail and deteriorating patient with a failing kidney. If the patient suffers acute renal failure, is hemodialysis appropriate? Probably not, unless you are a ward. If the patient goes into cardiac arrest, should defibrillation be administered? Probably not, unless you are a ward. In either case is there a realistic expectation of any positive or prolonged outcome? I would expect not.

Under current law there is no latitude in these cases. This is <u>not</u> the intent of the original law nor is it reasonable or humane treatment of individuals with proper concern for the dignity of the individual.

House Bill 485 offers a simple and realistic solution to this dilemma. It provides that a guardian can accept the advice of the medical community as it relates to the withholding of procedures when those procedures will only serve 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. The ward remains protected by the provisions of the guardianship law. The guardian retains the obligation to act on behalf of the ward and to protect the rights of the ward. This measure simply includes the option, not a mandate, to accept medical advice.

We do not believe that the guardian is placed in an impossible situation in this bill. A guardian retains the obligation to review the recommendations and if, in the guardian's opinion, the recommendation is not appropriate, to object. This bill simply says that the objection is not mandated in law. It restores judgement where it should have always been and restores rights to a ward which we believe were unintentionally taken away with the passage of Alaska's guardianship law.

Mr. Chairman, I would like to thank you for this opportunity to testify. I would be pleased to answer any questions.

(e) The temporary guardianship shall expire at the time of the appointment of a full or partial guardian or upon the dismissal of the petition for guardianship.

(f) If no guardianship petition is pending but the court is informed of a person who is apparently incapacitated and in need of emergency life-saving services, the court may authorize the services upon determining that delay until a guardianship hearing can be held would entail a life-threatening risk to the person. (§ 1 ch 73 SLA 1978; am § 11 ch 83 SLA 1981)

Effect of amendments. — The 1981 amendment rewrote this section.

Sec. 13.26.141. Emergency powers. Notwithstanding the limits of a temporary guardianship or guardianship order, a temporary guardian and guardian at all times have the right to authorize the provision of emergency life-saving services. This right includes the power to authorize hospitalization without advance court approval. (§ 12 ch 83 SLA 1981)

Sec. 13.26.145. Who may be guardian; priorities. (a) The court may appoint a competent person, the public guardian, or a private association or nonprofit corporation with a guardianship program for incapacitated persons, as guardian of an incapacitated person.

(b) The court may not appoint a person to be a guardian of an incapacitated person if the person

(1) provides, or is likely to provide during the guardianship period, substantial services to the incapacitated person in a professional or business capacity, other than in the capacity as guardian;

(2) is, or is likely to become during the guardianship period, a creditor of the incapacitated person, other than in the capacity as guardian;

(3) has, or is likely to have during the guardianship period, interests which may conflict with those of the incapacitated person; or

(4) is employed by a person who would be disqualified under (1) — (3) of this subsection.

(c) A person may be appointed as the guardian of an incapacitated person notwithstanding the provisions of (b) of this section if the person is the spouse, adult child, parent, or sibling of the incapacitated person and the court determines that the potential conflict of interest is insubstantial and that the appointment would clearly be in the best interests of the incapacitated person.

(d) Subject to (e) of this section, qualified persons have priority for appointment as guardian in the following order:

(1) a person, association, or private nonprofit corporation nominated by the incapacitated person, if at the time of the nomination the incapacitated person had the capacity to make a reasonably intelligent choice;

(2) the spouse of the incapacitated person;

(3) an adult child or parent of the incapacitated person;

(4) a relative of the incapacitated person with whom the incapacitated person has resided for more than six months during the year before the filing of the petition;

(5) a relative or friend who has demonstrated a sincere, longstanding interest in the welfare of the incapacitated person;

(6) a private association or nonprofit corporation with a guardianship program for incapacitated persons;

(7) the public guardian.

(e) The priorities established in (d) of this section are not binding, and the court shall select the person, association, or nonprofit corporation that is best qualified and willing to serve. The court shall also give consideration to a nomination by a person described in (d) of this section and to a nomination in the will of a deceased parent or spouse of the incapacitated person. (§ 1 ch 78 SLA 1972; am § 13 ch 83 SLA 1981)

Effect of amendments. — The 1981 amendment rewrote this section.

NOTES TO DECISIONS

Cited in In re O.S.D., Sup. Ct. Op. No. 2744 (File No. 7041), 672 P.2d 1304 (1983).

Sec. 13.26.150. General powers and duties of guardian. (a) A guardian shall diligently and in good faith carry out the specific duties and powers assigned by the court. In carrying out duties and powers, the guardian shall encourage the ward to participate to the maximum extent of the ward's capacity in all decisions which affect the ward, to act on the ward's own behalf in all matters in which the ward is able, and to develop or regain, to the maximum extent possible, the capacity to meet the essential requirements for physical health or safety, to protect the ward's rights, and to manage the ward's financial resources.

(b) A partial guardian of an incapacitated person has only the powers and duties respecting the ward enumerated in the court order.

(c) A full guardian of an incapacitated person has the same powers and duties respecting the ward that a parent has respecting an

unemancipated minor child except that the guardian is not liable for the care and maintenance of the ward and is not liable, solely by reason of the guardianship, to a person who is harmed by acts of the ward. Except as modified by order of the court, a full guardian's powers and duties include, but are not limited to, the following:

(1) the guardian is entitled to custody of the person of the ward and shall assure that the ward has a place of abode in the least restrictive setting consistent with the essential requirements for the ward's physical health and safety;

(2) the guardian shall assure the care, comfort, and maintenance of the ward;

(3) the guardian shall assure that the ward receives the services necessary to meet the essential requirements for the ward's physical health and safety and to develop or regain, to the maximum extent possible, the capacity to meet the ward's needs for physical health and safety;

(4) the guardian shall assure through the initiation of court action and other means that the ward enjoys all personal, civil, and human rights to which the ward is entitled;

(5) the guardian may give consents or approvals necessary to enable the ward to receive medical or other professional care, counsel, treatment, or services except as otherwise limited by (e) of this section;

(6) if a conservator for the estate of the ward has not been appointed, the guardian may receive money and property deliverable to the ward and apply the money and property for support, care, and education of the ward; however, the guardian may not apply the ward's money or property for the services as guardian or for room and board which the guardian, or the guardian's spouse, parent, or child has furnished the ward unless, before payment, the court finds that the ward is financially able to pay and that the charge is reasonable; notice of a request for payment approval shall be provided to at least one relative of the ward if possible; the guardian shall exercise care to conserve any excess money or property for the ward's needs;

(7) if a conservator of the estate of the ward has been appointed, the guardian shall pay all of the ward's estate received by the guardian in excess of the money expended to meet current expenses for support, care, and education of the ward, to the conservator for management as provided in AS 13.26.165 — 13.26.315, and the guardian shall account to the conservator for money expended.

(d) A guardian of a ward, for whom a conservator has also been appointed, shall have the custody and care of the ward and is entitled to receive reasonable sums for services and for room and board furnished to the ward as agreed upon between the guardian and the conservator. The guardian may request the conservator to expend the ward's estate for the ward's care and maintenance.

(e) A guardian may not

(1) place the ward in a facility or institution for the mentally ill other than through a formal commitment proceeding under AS 47.30 in which the ward has a separate guardian ad litem;

(2) consent on behalf of the ward to an abortion, sterilization, psychosurgery, or removal of bodily organs except when necessary to preserve the life or prevent serious impairment of the physical health of the ward;

(3) consent on behalf of the ward to the withholding of life-saving medical procedures;

(4) consent on behalf of the ward to the performance of an experimental medical procedure or to participation in a medical experiment not intended to preserve the life or prevent serious impairment of the physical health of the ward;

(5) consent on behalf of the ward to termination of the ward's parental rights;

(6) prohibit the ward from registering to vote or from casting a ballot at public election;

(7) prohibit the ward from applying for and obtaining a driver's license;

(8) prohibit the marriage or divorce of the ward. (§ 1 ch 78 SLA 1972; am § 28 ch 25 SLA 1973; am § 14 ch 83 SLA 1981)

Effect of amendments. — The 1981 amendment rewrote this section.

Legislative history reports. — For report on ch. 56, SLA 1973 (HCS SB 140), see 1973 Senate Journal Supplement No. 9; 1973 House Journal, p. 819.

NOTES TO DECISIONS

Sterilization of mental incompetents. — A superior court, as a court of general jurisdiction, does have, as part of its inherent parens patriae authority, the power to entertain and act upon a petition seeking an order authorizing the sterilization of a mental incompetent. K.C.M. v. State, Sup. Ct. Op. No. 2326 (File No. 4764), 627 P.2d 607 (1981).

Before sanctioning the sterilization of an incompetent, the court must take great care to ensure that the incompetent's rights are zealously guarded. K.C.M. v. State, Sup. Ct. Op. No. 2326 (File No. 4764), 627 P.2d 607 (1981).

The advocates of a proposed operation to sterilize an incompetent bear the heavy burden of proving by clear and convincing evidence that sterilization is in the best interests of the incompetent. K.C.M. v. State, Sup. Ct. Op. No. 2326 (File No. 4764), 627 P.2d 607 (1981).

The proponents of the sterilization of a mental incompetent must show that there is no less restrictive alternative to the proposed operation. K.C.M. v. State, Sup. Ct. Op. No. 2326 (File No. 4764), 627 P.2d 607 (1981).

Basic notions of procedural due process require that before an order for the sterilization of a mental incompetent is entered the incompetent be afforded a full judicial hearing at which medical testimony is presented and the incompetent, through a guardian ad litem, is allowed to present proof and cross-examine witnesses. K.C.M. v. State, Sup. Ct. Op. No. 2326 (File No. 4764), 627 P.2d 607 (1981).

Before an order for the sterilization of a mental incompetent is entered the court must assure itself that a comprehensive medical, psychological, and social evaluation is made of the incompetent. If it is

CS for HB485 (Judiciary)- An act relating to powers and duties of guardians
Overview prepared by Rep. John Sund's office

SECTIONAL ANALYSIS

Section 1, subsection (3) is amended to allow guardians to accept a medical decision to withhold medical procedures from their wards, when the procedures would only prolong the imminent death of a ward and provide no hope of relief or cure.

The guardian cannot be held civilly liable for adhering to the provisions of the statute.

BACKGROUND

Current law is interpreted as requiring that guardians insist on the continuation of medical procedures, once begun, regardless of a medical judgment that those procedures will not provide relief or cure for a guardian's ward.

The bill does not require the guardians to advocate for the withdrawal of any procedure nor to accept the medical judgment to discontinue a procedure. Rather, it gives them permission to accept or reject that judgment as they see fit, just as a family member who is not a guardian would be able to.

Guardians are appointed by the court with the "same powers and duties respecting the ward that a parent has respecting an unemancipated minor child". Guardians have a duty to assure the care and comfort of their wards.

The concept of the bill is supported by the Alaska Health Association, the Ketchikan General Hospital administrator, Wrangell General Hospital's administrator, Providence Hospital, PADD (Protection and Advocacy for the Developmentally Disabled), and the Older Alaskans Commission.

JOHN SUND, REPRESENTATIVE
2505 2nd Avenue
Ketchikan, Alaska 99901
(907) 225-5552

While in Juneau
P. O. Box V
Juneau, Alaska 99811
(907) 465-4919

March 25, 1986

TO: Senator Fahrenkamp's office

FROM: Kitty
Rep. John Sund's offcie

RE: HB485

Attached is information on HB485, relating to the powers and duties of guardians, which was recently assigned to the Senate HESS Committee.

Included is:
1. an overview, with sectional analysis and background information
2. a copy of the bill
3. written testimony from Sister Barbara Haase, Ketchikan General Hospital
4. a copy of the pertinent statutes
5. position paper and 0 fiscal note from Dept. of H&SS
6. position paper and 0 fiscal note from Office of Public Advocacy
7. position paper from the Alaska Health Association
8. a legal opinion from the office of William T. Council

Rep. Sund would like to testify on behalf of the bill as well as Dennis DeWitt, from the Alaska Health Association. (Rep. Sund will be out of town from April 4th-9th)

Please let me know what you can do about scheduling this bill. Thanks!

(7) the public guardian.

(e) The priorities established in (d) of this section are not binding, and the court shall select the person, association, or nonprofit corporation that is best qualified and willing to serve. The court shall also give consideration to a nomination by a person described in (d) of this section and to a nomination in the will of a deceased parent or spouse of the incapacitated person. (§ 1 ch 78 SLA 1972; am § 13 ch 83 SLA 1981)

Effect of amendments. — The 1981 amendment rewrote this section.

NOTES TO DECISIONS

Cited in In re O.S.D., Sup. Ct. Op. No. 2744 (File No. 7041), P.2d (1983).

Sec. 13.26.150. General powers and duties of guardian. (a) A guardian shall diligently and in good faith carry out the specific duties and powers assigned by the court. In carrying out his duties and powers, the guardian shall encourage the ward to participate to the maximum extent of his capacity in all decisions which affect him, to act on his own behalf in all matters in which he is able, and to develop or regain, to the maximum extent possible, his capacity to meet the essential requirements for his physical health or safety, to protect his rights, and to manage his financial resources.

(b) A partial guardian of an incapacitated person has only the powers and duties respecting his ward enumerated in the court order.

(c) A full guardian of an incapacitated person has the same powers and duties respecting his ward that a parent has respecting his unemancipated minor child except that the guardian is not liable for the care and maintenance of the ward and is not liable, solely by reason of the guardianship, to a person who is harmed by acts of the ward. Except as modified by order of the court, a full guardian's powers and duties include, but are not limited to, the following:

(1) he is entitled to custody of the person of his ward and shall assure that the ward has a place of abode in the least restrictive setting consistent with the essential requirements for the ward's physical health and safety;

(2) he shall assure the care, comfort, and maintenance of the ward;

(3) he shall assure that the ward receives the services necessary to meet the essential requirements for the ward's physical health and safety and to develop or regain, to the maximum extent possible, the capacity to meet his needs for physical health and safety;

(4) he shall assure through the initiation of court action and other means that the ward enjoys all personal, civil, and human rights to which the ward is entitled;

(5) he may give consents or approvals necessary to enable the ward to receive medical or other professional care, counsel, treatment, or services except as otherwise limited by (e) of this section;

(6) if a conservator for the estate of the ward has not been appointed, the guardian may receive money and property deliverable to the ward and apply the money and property for support, care, and education of the ward; however, the guardian may not apply the ward's money or property for his services as guardian or for room and board which he, his spouse, parent, or child have furnished the ward unless, before payment, the court finds that the ward is financially able to pay and that the charge is reasonable; notice of a request for payment approval shall be provided to at least one relative of the ward if possible; the guardian shall exercise care to conserve any excess money or property for the ward's needs;

(7) if a conservator of the estate of the ward has been appointed, the guardian shall pay all of the ward's estate received by the guardian in excess of the money expended to meet current expenses for support, care, and education of the ward, to the conservator for management as provided in AS 13.26.165 — 13.26.315, and the guardian shall account to the conservator for money expended.

(d) A guardian of a ward, for whom a conservator has also been appointed, shall have the custody and care of the ward and is entitled to receive reasonable sums for his services and for room and board furnished to the ward as agreed upon between the guardian and the conservator The guardian may request the conservator to expend the ward's estate for the ward's care and maintenance.

(e) A guardian may not

(1) place the ward in a facility or institution for the mentally ill other than through a formal commitment proceeding under AS 47.30.350 — 47.30.915 in which the ward has a separate guardian ad litem;

(2) consent on behalf of the ward to an abortion, sterilization, psychosurgery, or removal of bodily organs except when necessary to preserve the life or prevent serious impairment of the physical health of the ward;

(3) consent on behalf of the ward to the withholding of life-saving medical procedures;

(4) consent on behalf of the ward to the performance of an experimental medical procedure or to participation in a medical experiment not intended to preserve the life or prevent serious impairment of the physical health of the ward;

(5) consent on behalf of the ward to termination of the ward's parental rights;

(6) prohibit the ward from registering to vote or from casting a ballot at public election;

(7) prohibit the ward from applying for and obtaining a driver's license;

(8) prohibit the marriage or divorce of the ward. (§ 1 ch 78 SLA 1972; am § 28 ch 25 SLA 1973; am § 14 ch 83 SLA 1981)

Effect of amendments. — The 1973 amendment deleted "incompetent" following "next of kin of the" in paragraph (4)(B) of subsection (a).

The 1981 amendment rewrote this section.

Legislative history reports. — For report on ch. 56, SLA 1973 (HCS SB 140), see 1973 Senate Journal Supplement No. 9; 1973 House Journal, p. 819.

NOTES TO DECISIONS

Sterilization of mental incompetents. — A superior court, as a court of general jurisdiction, does have, as part of its inherent parens patriae authority, the power to entertain and act upon a petition seeking an order authorizing the sterilization of a mental incompetent. K.C.M. v. State, Sup. Ct. Op. No. 2326 (File No. 4764), 627 P.2d 607 (1981).

Before sanctioning the sterilization of an incompetent, the court must take great care to ensure that the incompetent's rights are zealously guarded. K.C.M. v. State, Sup. Ct. Op. No. 2326 (File No. 4764), 627 P.2d 607 (1981).

The advocates of a proposed operation to sterilize an incompetent bear the heavy burden of proving by clear and convincing evidence that sterilization is in the best interests of the incompetent. K.C.M. v. State, Sup. Ct. Op. No. 2326 (File No. 4764), 627 P.2d 607 (1981).

The proponents of the sterilization of a mental incompetent must show that there is no less restrictive alternative to the proposed operation. K.C.M. v. State, Sup. Ct. Op. No. 2326 (File No. 4764), 627 P.2d 607 (1981).

Basic notions of procedural due process require that before an order for the sterilization of a mental incompetent is entered the incompetent be afforded a full judicial hearing at which medical testimony is presented and the incompetent, through a guardian ad litem, is allowed to present proof and cross-examine witnesses. K.C.M. v. State, Sup. Ct. Op. No. 2326 (File No. 4764), 627 P.2d 607 (1981).

Before an order for the sterilization of a mental incompetent is entered the court must assure itself that a comprehensive medical, psychological, and social evaluation is made of the incompetent. If it is necessary in meeting this standard that independent advice be obtained then the court should, on its own motion, obtain such advice. K.C.M. v. State, Sup. Ct. Op. No. 2326 (File No. 4764), 627 P.2d 607 (1981).

Before an order for the sterilization of a mental incompetent is entered the court must first determine that the individual legally is incompetent to make her own decision whether or not to be sterilized and that this incapacity is in all likelihood permanent. It must then be established that the incompetent is capable of reproduction and that, as a result of her disability, she would be unable to adequately care and provide for her offspring. Next, it must be shown that sterilization is the only practicable means of contraception. To the extent possible, the court must also elicit testimony from the incompetent concerning her understanding and desire for the proposed operation and its consequences. Finally, the court must examine closely the motivation behind the petition. K.C.M. v. State, Sup. Ct. Op. No. 2326 (File No. 4764), 627 P.2d 607 (1981).

The guidelines set forth in this opinion for determining the procedure to be taken on a petition for an order to sterilize a mental incompetent are not intended to be an all-inclusive list of the various factors which the superior court should consider before ruling on a petition for sterilization. Rather, they set forth what are to be the minimum inquiries necessary to protect the constitutional rights of the incompetent. K.C.M. v. State, Sup. Ct. Op. No. 2326 (File No. 4764), 627 P.2d 607 (1981).

Although the individual's status as an "incapacitated person" prevents her expressed desires from being conclusive, this does not mean that her apparent preferences can be totally ignored. K.C.M. v. State, Sup. Ct. Op. No. 2326 (File No. 4764), 627 P.2d 607 (1981).

Upon the hearing of a petition for the sterilization of a mental incompetent, the

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WILLIAM T. COUNCIL
THOMAS E. WAGNER

(907) 586-1786

October 5, 1983

Mr. Dennis DeWitt, President
Alaska State Hospital Association
319 Seward Street
Juneau, Alaska 99801

Re: Effect of Appointment of a Guardian
Under AS 13.26.116 on "No Code" Status of
Incapacitated Patient in Health Care Facility.

Dear Dennis:

You have asked for our opinion on the question of what effect the appointment of a guardian for an incapacitated nursing home patient would have on an existing "No Code" order for that patient. The principal legal questions raised by your request are: (1) Whether a "No Code" order can be legally entered; (2) whether the guardian has the power or duty to seek withdrawal of the "No Code" order; and (3) whether the physician is required to comply with a guardian's request to withdraw a "No Code" order.

We are unable to give you definitive answers because the law in this area is not settled in Alaska. We will discuss the legal issues involved in this letter, and will suggest procedures for seeking some guidance for your members from the legislature or the courts.

I. Background - The Legality of "No Code" Orders.

Cardiopulmonary Resuscitation (CPR) is an emergency procedure for the restoration of respiration and pulse in a person whose heartbeat and breathing have ceased. "Code" is medical shorthand for the summoning of a resuscitation team by the announcement of "Code Blue" over a hospital's public address system. A "No Code" order is a treating physician's order to other physicians, nurses, and other health care professionals involved in a patient's care, that no cardiopulmonary resuscitation measures should be undertaken in the event of a cardiac or respiratory arrest.

The legal status of "No Code" orders has not been addressed by either the legislature or the courts in Alaska. Several other authorities have examined this and closely related issues, and their decisions give some indication of the results the Alaska courts might be expected to reach in cases where no guardian has been appointed. I conclude that it is possible that "No Code" orders will be upheld as legal in Alaska, at least in certain circumstances. In the next part (Part II), I will discuss the potential effect on such an order of the appointment of a guardian under AS 13.26.

Resuscitation after a cardiac arrest involves a series of steps directed toward sustaining adequate circulation of oxygenated blood to vital organs while heartbeat is restored.

> Efforts typically involve the use of cardiac massage or chest compression and the delivery of oxygen under compression through an endo-trachaeal tube into the lungs. An electrocardiogram is connected to guide the resuscitation team....Various plastic tubes are usually inserted intravenously to supply medications or stimulants directly to the heart. Such medications can also be supplied by direct injection into the heart.... A defibrillator may be used, applying electric shock to the heart to induce contractions. A pacemaker...may be fed through a large blood vessel directly to the heart's surface....These procedures to be effective, must be initiated with a minimum of delay....Many of the procedures are obviously highly intrusive, and some are violent in nature. The defibrillator, for example, causes violent (and painful) muscle contractions which...may cause fracture of vertebrae or other bones.

In Re Dinnerstein, 380 N.E.2d 134, 135-36 (Mass. App. 1978). Though initially developed for otherwise healthy persons whose heartbeat and breathing failed following surgery or near-drowning, resuscitation procedures are now used with virtually everyone who has a cardiac arrest in a hospital. The initial success rate for in-hospital resuscitation is about one in three for all victims and two in three for patients hospitalized with irregularities of heart rhythm. Among patients who are successfully resuscitated, about one in three recovers enough to be discharged from the hospital eventually. Especially when used on the general hospital population, long-term success is fairly

rare. In the past decade, health care providers have begun to express concern that resuscitation is being used too frequently and sometimes on patients it harms rather than benefits.

Certain professional organizations have recognized that non-resuscitation is appropriate when the patient's well-being would not be served by an attempt to reverse cardiac arrest. For example, the 1974 standards published by the American Heart Association and the American Academy of Sciences stated:

> The purpose of cardiopulmonary resuscitation is the prevention of sudden, unexpected death. Cardiopulmonary resuscitation is not indicated in certain situations, such as in cases of terminal irreversible illness where death is not unexpected or where prolonged cardiac arrest dictates the futility of resuscitation efforts. Resuscitation in these circumstances may represent a positive violation of an individual's right to die with dignity. When CPR is considered to be contra-indicated for hospital patients, it is appropriate to indicate this in the patient's progress notes. It also is appropriate to indicate this on the physician's order sheet for the benefit of nurses and other personnel who may be called upon to initiate or participate in cardiopulmonary resuscitation.

Standards and Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (E.C.C.), 227 J.A.M.A. 837, 864 (1980).

In general, policymakers have had to balance several sometimes competing values in this area. First is the individual patient's right of bodily self-determination as to medical treatment.

Sometimes this right has been cast in constitutional terms as a right to privacy. In Re Quinlan, 355 A.2d 674 (N.J. 1976); Superintendent of Belchertown v. Saikewicz, 370 N.E.2d 417 (Mass. 1977); Satz v. Perlmutter, 379 SO.2d 359 (Fla. 1980); In Re Colyer, 660 P.2d 738 (Wash. 1983). In other cases, courts have relied upon a common law right to refuse medical treatment. In Re Eichner, 423 N.Y.S.2d 580 (N.Y. Sup. Ct. 1979), modified sub nom. In Re Storar, 420 N.E.2d 64 (N.Y. 1979).

The second value is the well-being of the patient. For some patients, cardiopulmonary resuscitation may simply be an unnecessary prolongation of the dying process, and would probably not benefit the patient in any meaningful sense. For others, it may be of significant medical benefit. The treating physician's assessment of whether a patient stands to benefit from CPR sometimes points to a different result than consideration of self-determination alone. Other interests, such as State's the interests in the protection of innocent third parties (e.g., minor children), in the preservation of life and the prevention of suicide, and in upholding the integrity of the medical profession, may figure in the balance, but the patient's informed choice and the physician's assessment of the potential benefit of CPR are the primary factors to be balanced.

The analysis differs for patients with decisionmaking competence and those who are incompetent. For the purposes of this discussion, decisionmaking competence means that the individual must have sufficiently stable and developed personal values and goals, an ability to communicate and understand information adequately, and an ability to reason and deliberate sufficiently well to make an informed choice about a particular matter. Competence, in this sense, is a distinct concept from that of legal incapacity, which in Alaska refers to an individual's partial or total inability to care of himself or herself (AS 13.26.113).

A. Competent Patients

1. Where the patient opposes CPR

At least where the physician's assessment is that CPR will not benefit the patient's well-being in the case of cardiac arrest, and there are no minor children involved, a patient's informed refusal to submit to such treatment may possibly be upheld by the Alaska courts. The patient's death following cardiac arrest in such a case may not be considered a suicide because the death, whether or not desired by the patient, would result from natural causes, not from the patient's setting in motion a death

producing agent which causes his or her own death. See Saikewicz, supra, 370 N.E.2d at 426, n.11, citing Byrn, "Compulsory Life Saving Treatment for the Competent Adult," 44 Fordham L.Rev. 1 (1975).

It could also be maintained that the legal or ethical obligations of the physician would not be breached by entering a "No Code" order in such a case. A physician normally may not treat a person without first obtaining that person's informed consent to the treatment. Although an "implied consent" exception is usually made in emergency situations, such as when an unexpected cardiac arrest occurs, consent will not be implied even in an emergency if the patient has previously stated that he would not consent. In Re Storar, supra, 420 N.E.2d at 70.
According to case law in other jurisdictions, even when a physician believes that CPR will benefit the patient, he or she should usually honor the competent patient's informed refusal to consent to that treatment. Satz v. Perlmutter, supra, (73-year old terminally ill but competent patient had constitutional right to have a life-sustaining respirator removed); Lane v. Candura, 376 N.E.2d 232 (Mass. 1978) (77-year old widow had constitutional right to refuse amputation of gangrenous leg, a decision sure to result in death). There may be cases, however, in which the state interest in the preservation of life is so strong that it

could override the patient's expressed desires, as where CPR could potentially lead to the restoration of a full and vibrant life.

A conflict between the physician's assessment that CPR will benefit the patient's well-being and the patient's choice to forego such treatment calls for careful re-examination by both, further discussion, and perhaps consultation with experts. If neither the physician's assessment nor the patient's preference changes, however, then the competent patient's decision should be honored, according to the President's Commiss on for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, (hereafter "the President's Commiss on"), Deciding to Forego Life-Sustaining Treatment, 244-46 (1983). If a physician finds the course of action preferred by a competent patient to be medically or morally unacceptable and is unwilling to participate in carrying out the choice, he or she should help the patient find another physician. Id. There is, of course, no assurance that the Alaska courts would agree with the President's Commission but the Commission's report presents strong evidence of what is acceptable under current medical standards.

2. Where the Patient Expresses No Preference

a. Emergencies

The President's Commission recommends that if the competent

patient has not expressed a preference on the matter, the physician would ordinarily have "implied consent" to administer CPR in an emergency cardiac arrest situation, and should do so unless the physician's assessment is that CPR would not benefit the patient's well-being. Where the potential benefit of CPR is unclear, there should be a presumption in favor of resuscitation. Id. There is some question whether, in an emergency situation where no advance deliberation has led to a decision to withhold CPR, a physician or other health care provider can ever be justified in withholding CPR based on a spur-of-the-moment decision that CPR would not be in the patient's best interest. Alaska law is not settled in this situation. The most prudent legal course, where a "No Code" order has not been entered in advance, is for the medical providers to attempt CPR in all cases of cardiac arrest.

b. Where Cardiac Arrest is Foreseeable

There is also some controversy over whether, when cardiac arrest is foreseeable, a physician has a duty to ascertain the patient's preference, which involves informing the patient of the possible need for CPR and of the likely consequences (both beneficial and harmful) of either employing it or foregoing it if the need arises. The President's Commission has taken the position that

the physician has such a duty, and must secure the patient's consent to <u>any</u> course of treatment, whether involving omissions ("No Code"), or actions (CPR), unless the patient would experience needless harm in such a detailed discussion of resuscitation measures and procedures. The Commission cited a senior attorney at the National Institutes for Health for the countervailing proposition regarding "No Code," however:

> "Consent of the patient is irrelevant because we are dealing with a situation in which there is no course of treatment for which to secure consent. This is different from a case in which there is a medically accepted course of treatment, but the patient does not wish to be subjected to this care."

President's Commission, <u>Deciding to Forego Life-Sustaining Treatment</u>, <u>supra</u>, at 241 n.39.

Our opinion is that the most prudent legal course is to obtain the patient's informed consent to any proposed course of treatment, including "No Code," at least where such discussion is not likely to seriously harm the patient. Also, where cardiac arrest is foreseeable, the most prudent course is to develop and follow an established institutional procedure for making an advance decision regarding whether CPR will be appropriate and to review that decision frequently. Such a careful deliberate process, with written documentation of the factors upon which any decision is based, presents far less risk that the physician or

other health care provider will be charged with negligently making the wrong decision regarding CPR than does making a decision on the spur of the moment once cardiac arrest has occurred.

3. Where the Patient Favors CPR

If the physician's assessment is that CPR will benefit the patient's well-being, and the patient favors CPR, CPR should be performed. If the physician is doubtful about the potential benefit of CPR, the patient's wishes should control. Even where the physician is convinced that CPR would not benefit the patient, it is not clear that the treatment may be withheld when the patient desires it. Once a doctor has undertaken to treat a patient he cannot, without liability, abandon that patient. A few extra days, or even hours of life, even under the most excruciating conditions, may be of considerably different value to different people. Disagreements between doctor and patient regarding the value of CPR may be reason for re-examination by both doctor and patient, but unless the patient changes his or her mind, a physician who enters a "No Code" order for a competent patient who has expressed a preference for CPR treatment runs the risk of being charged with negligence or abandonment. In the future, case law may develop which, based on

the scarcity of medical resources, allows a physician to withhold CPR treatment if he or she believes it would not serve the patient's well-being, despite the patient's wishes to the contrary, but at this time it would be legally risky to deny such care.

B. Incompetent Patients

Decisionmaking regarding whether "Code" should be initiated is further complicated when the decisionmaking competence of the patient is impaired. Not only is there a problem as to what constitutes sufficient impairment such that ultimate decisionmaking authority should not be left with the patient, but there are also questions regarding who, if anyone, may legally act as a surrogate decisionmaker, and what standards should guide their decisions. Again, Alaskan law offers no clear resolution of these issues, but decisions from other authorities may offer some guidance.

1. When is a Patient Incompetent?

It is important to remember that, for the purposes of this analysis, the concept of decisionmaking incompetence is used to designate a person's inability to adequately comprehend his or

her situation, form and express a preference regarding CPR treatment, and communicate that preference. This concept is distinct from that of legal incapacity. Under the guardianship laws, a person may be declared partially or totally incapacitated legally if the person is unable to care for himself or herself, and the court may use guardianship or other means to provide for the person's needs. The guardianship statutes provide that:

> . . . An incapacitated person for whom a guardian has been appointed is not presumed to be incompetent and retains all legal and civil rights except those which have been expressly limited by court order or have been specifically granted to the guardian by the court.

AS 13.26.090.

Accordingly, the fact that a person is legally incapacitated, like the fact that the person makes a highly idiosyncratic decision, or the fact that the person has a medical or mental condition similar to others who have been unable to make decisions that advance their own well-being, may alert health care professionals to the possibility of decisionmaking incompetence, but does not conclusively resolve the matter.

The determination of decisional competence focuses on the patient's actual functioning in a particular decisionmaking situation rather than simply on a person's age, ability to care

for himself or herself, or diagnosis. What is relevant is whether a person is in fact capable of making the decision of whether to forego CPR treatment despite his or her youth, retardation, dementia, or other condition. Health care professionals should make a determination of incompetence only when people lack the ability to make decisions that promote their well-being in conformity with their own values and preferences, and should document the grounds for that determination. Even when a determination of incompetence is made, and the ultimate decisional authority is not left with the patient, reasonable efforts should be made to give the person relevant information about the situation and the available options and to solicit and accommodate his or her preferences. President's Commission, Deciding to Forego Life-Sustaining Treatment, at 121-124.

2. Who, if Anyone, May Act as a Surrogate Decisionmaker?

Courts in other jurisdictions have often relied on surrogate decisionmakers to make decisions for incompetent patients, under the doctrine of "substituted judgment," about whether to forego life-sustaining treatment. In the Quinlan case, the New Jersey court approved the appointment of the patient's father as guardian over the person of a patient in a vegetative comatose state. The father had favored discontinuance of a life-sustaining respirator, while the attending physician opposed it.

The court specifically authorized the father as guardian to select different attending physicians, and further authorized the attending physicians, if they concluded there was no reasonable possibility of the patient ever emerging from her comatose condition to a cognitive, sapient state, and upon concurrence of the guardian and the family and a hospital "Ethics Committee", to disconnect the life support system.

The Quinlan court thus required the consent of the guardian and the family as surrogates for the patient herself to the withdrawal of life-sustaining treatment, but left the actual decision to the attending physicians. The court stated that the decision to be made was particularly within the field of competence of the medical profession, and that absent a justiciable controversy, court oversight would be unnecessary. It stated that access to the courts would not be foreclosed in such cases, however, where a justiciable controversy existed.

In the Saikewicz case, the Massachusetts court accepted the principle of "substituted judgment," but held that once a justiciable controversy has been presented to the courts, the court itself should "don the mental mantle of the incompetent" (370 N.E.2d at 431) and act as the patient's surrogate decisionmaker regarding whether to forego potentially

life-prolonging treatment. 370 N.E.2d at 431. The lower courts were instructed to not attempt to shift the decision to any other person or group, such as the guardian, family, attending doctors and hospital "ethics committee" used in Quinlan for that purpose. The Saikewicz court articulated the standard to be used as follows:

> The decision should be that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decisionmaking process of the competent person." 370 N.E.2d at 431.

The court in In Re Dinnerstein, 380 N.E.2d 134 (Mass. App. 1978), distinguished a situation in which a "No Code" order was entered in the terminal stages of an unremitting, incurable mortal illness, Alzheimer's disease, a hopeless case in which death would come soon in any event, probably in the form of cardiac or respiratory failure, from the Saikewicz situation where chemotherapy for a 67-year old profoundly retarded leukemia victim was at issue. The Dinnerstein court held that when the Saikewicz court spoke of life-saving or life-prolonging treatments, it referred to "treatments administered, with some reasonable expectation of effecting a permanent or temporary cure of or relief from the illness or condition being treated," and that "'prolongation of life,' as used in the Saikewicz case, does not mean a mere suspension of the act of dying, but contemplates,

at the very least, a remission of symptoms enabling a return towards a normal, functioning, integrated existence." 390 N.E.2d at 137-8. The Appeals Court in Dinnerstein stated that "the question of what measures are appropriate to ease the imminent passing of an irreversibly, terminally ill patient in light of the patient's history and condition and the wishes of her family" was a "question peculiarly within the competence of the medical profession." 380 N.E.2d at 139. It entered a judgment declaring that a "No Code" order was not contrary to law and that the validity of such an order did not depend on prior judicial approval.

In In Re Spring, 405 N.E.2d 115, 120 (Mass. 1980), the Massachusetts Supreme Court noted in dictum "[w]ithout approving all that is said in the opinion of the Appeals Court [in Dinnerstein]," that the result reached in Dinnerstein was consistent with its Saikewicz holding. The Spring court went on to note that neither the case before it nor the Saikewicz case involved the legality of actions taken without judicial action, and held that its opinions should not be taken to establish any requirement of prior judicial approval that would not otherwise exist. Id. Accord, In Re Colyer, 660 P.2d 738, 746 (Wash. 1983).

In Custody of a Minor, 434 N.E.2d 601 (Mass. 1982), the

Massachusetts court upheld a "No Code" order entered by the Juvenile Court in the case of an abandoned infant with serious cardiac problems. The order was upheld over the opposition of the health care facility, which had originally sought the order, and the custodian of the child (the state Department of Social Services), a guardian ad litem, and the attorney for the child, each of whom had always opposed the order. All of the parties argued against the continuation of the "No Code" order, and argued that since they were in agreement, the issue was moot and the courts had no further role to play. The court disagreed. It distinguished the Dinnerstein holding, that the decision to enter a "No Code" order on the medical record of an irreversibly terminally ill patient, in consultation with the family or the patient's guardian, does not require prior judicial review, from the Saikewicz holding, that the court itself, once presented with the legal question whether treatment may be withheld, must decide the question and not delegate it to some private person or group. It pointed to the factors enumerated in In Re Spring as affecting when a court order is required:

> In Spring, we pointed out that various factors affect the question of when a court order is required. We stated that, among these factors, at least the following were material: [T]he extent of impairment of the patient's mental faculties, whether the patient is in the custody of a State institution, the prognosis without the proposed treatment, the prognosis with the proposed treatment, the complexity, risk and novelty of

> the proposed treatment, its possible side effects, the patient's level of understanding and probable reaction, the urgency of decision, the consent of the patient, spouse, or guardian, the good faith of those who participate in the decision, the clarity of professional opinion as to what is good medical practice, the interests of third persons, and the administrative requirements of any institution involved.

434 N.E.2d at 608. The court held that several of the Spring factors distinguished the case from Dinnerstein, and warranted a "No Code" order despite the position of the parties. It emphasized particularly that the child had no loving family members willing to be involved in the decision, and that the child was already a ward of the state. The court added that the child already was within the jurisdiction of the court before the question arose as to whether a "No Code" order should be issued and continued. It was thus appropriate for the court to decide, under the "substituted judgment" doctrine of Saikewicz, whether "Code" was appropriate. It ordered "No Code."

In Re Conroy, 457 A.2d 1232 (N.J. Super. Ct. 1983) held that if the patient is incompetent and had not earlier given a clear indication of her views, and the family is divided in its views, or the physicians are divided, juducial involvement is indicated.

The New York Court of Appeals appeared to reject the doctrine of "substituted judgment" altogether in the case of a profoundly retarded 52-year old victim of terminal cancer, who had always

been incapable of understanding or making a reasoned decision about medical treatment, holding that it would be unrealistic to attempt to determine whether he would want to continue potentially life-prolonging treatment if he were competent. In R Storar, 420 N.E.2d 64, 72 (N.Y.1981). The Storar court therefore assessed the patient's rights as it would those of an infant. Under New York law, the court held, a parent or guardian may not deprive a child of life-saving treatment, no matter how well intentioned. Therefore, blood transfusions to replace blood lost in bleeding from a cancerous bladder could not be terminated. It did not address, however, the Dinnerstein situation where life-saving life-prolonging treatment was not at issue but only "life-sustaining" treatment.

As you can see from the discussion of the above cases, there are complex medical, legal, social and moral issues involved in any attempt to determine who, if anyone, may act as a surrogate decisionmaker for an incompetent patient in deciding whether to forego life-sustaining, but not life-prolonging or life-saving treatment. In general, however, at least in cases where the patient had given no expression of his or her preference while previously competent, or had expressed a preference to forego life-sustaining treatment if his or her situation became terminal and irreversible, and where the patient's medical condition is

such that no "life-saving" or "life-prolonging" procedures are available which would have a reasonable expectation of effecting a temporary or permanent cure of or relief from the patient's condition, and where there is agreement among the treating physicians and the patient's family that it would be pointless and unnecessarily harmful to the patient to initiate CPR measures which would only prolong the act of dying, courts in other jurisdictions have indicated that family representatives may act as surrogate decisionmakers and consent on the patient's behalf to the withholding of life-sustaining treatment. No judicial involvement would be required. Rather, the physicians in those jurisdictions may simply enter a "No Code" order upon the family's informed consent on behalf of an incompetent patient. The law might be different, however, in situations where the surrogate decisionmaker is not adequately informed or does not give the matter adequate consideration. A "No Code" order was overturned on that basis in Hoyt v. St. Mary's Rehabilitation Center, No. 774555 (Dist. Ct., Hennepin County, Minn., Feb. 13, 1981).

In Alaska, however, the legal status of surrogate decisionmaking may be somewhat different. The Alaska guardianship statutes express a preference for family members over nonfamily members to be appointed as guardians. AS 13.26.145. As will be discussed

further below, even when a court makes a specific determination that a person is incapacitated, after an inquiry designed to reveal, among other things, the extent to which the person retains decisionmaking competence, and the court further determines that the person's needs cannot be met by any means short of guardianship, the court still may not confer on the guardian it appoints, even if that guardian is a family member, the power to "consent on behalf of the ward to the withholding of life-saving medical procedures." 13.26.150(e)(3). This suggests that unless the Alaskan courts are willing to distinguish, as the Dinnerstein court did, between "life-saving" medical procedures, as that term is used in AS 13.26.150(e)(3), and "life-sustaining" procedures which offer no reasonable probability of even temporary cure or remission, such as CPR in the case of an irreversibly terminally ill patient, no surrogate decisionmaker, not even a family member appointed as guardian, may give effective consent to a "No Code" order.

I can find no legislative history indicating that the legislature specifically focused on the words "life-saving medical treatment" in AS 13.26.150(e)(3), and meant to either include or distinguish "life-sustaining" procedures as I have defined them above. It is possible that the Alaska courts may make the distinction and follow Dinnerstein in holding that the decision to withhold CPR

is peculiarly within the competence of the medical profession, and that the attending physicians should take into account, but need not necessarily follow, the wishes of the patient's family when the death by cardiac arrest of an irreversibly, terminally ill patient is expected imminently. Or the Alaska courts might first make the life-saving/life-sustaining distinction and then hold that the patient's informed consent is required, and that a surrogate decisionmaker, whether a guardian or a non-guardian family member, may consent on behalf of the incompetent patient to the withholding of "life-sustaining," as opposed to "life-saving" medical treatment.

There is also the possibility, however, that the Alaska courts will refuse to make the distinction between "life-saving" and "life-sustaining" treatment, and hold that AS 13.26.150(e)(3) prohibits a guardian from consenting on behalf of the ward to the withholding of CPR treatment even in irreversible, terminal cases where death by cardiac arrest is expected imminently. They could further hold, by inference from that section, that no other surrogate decisionmaker may give effective consent for an incompetent patient, making the inference from the words of the statute that the legislature intended that nobody would have the right to withhold medical treatment from an incompetent dying patient. Conceivably, the courts could hold that a guardian has

a positive duty to not only refrain from consenting to a "No Code" order, but to seek reversal of any such order, even one entered before his or her appointment as guardian.

The uncertainty regarding the potential impact of AS 13.26.150(e)(3) can be reduced in one of two ways. First, your association could seek legislation, either a specific amendment to the guardianship statute clarifying that AS 13.25.150(e)(3) does not preclude a guardian's consent to "No Code" orders in an appropriate case, or more general "Natural Death Act" legislation, providing for advance directives, or "living wills," to be made by patients while still competent, stating their preferences regarding life-sustaining treatment in the event they become irreversibly, terminally ill, and providing for legal effect to be given such directives. Such legislation should also spell out who is to decide, and the standards for their decisionmaking, whether to withhold CPR treatment in the case of irreversibly and terminally ill incompetent patients who have made no advance directives regarding their preferences.

Second, interpretation could be sought in the courts. The medical provider or the guardian could, in a proper case, bring a declaratory judgment action seeking a declaration either that the guardian is not precluded from consenting to an appropriate "No

Code" order, or that such consent is unnecessary and the decision is to be left to the attending physicians guided by the wishes of the patient's family. Such a declaration is more likely to be granted if the health facility has clearly defined procedures and policies for determining when "No Code" is warranted, and can demonstrate to the court that adequate precautions have been taken to guard against inappropriate orders being entered. Several such health facility policies are included in Appendix I to the enclosed report of the President's Commission.

C. Principles of Liability

1. Potential liability for performing CPR

The potential for civil liability for entering or following a "No Code" order has not been addressed in Alaska. Virtually any type of medical treatment, including CPR, involves a touching of the patient's body. If performed without a valid, informed consent, it has been viewed as an intentional interference with the person--a battery. Note, Informed Consent and the Dying Patient, 83 Yale L.J. 1632 (1974). There is an "implied consent" exception in the case of emergencies, but consent will not be implied even in an emergency if the patient has previously stated that he would not consent. In Re Storar, 420 N.E.2d at 70. Accordingly, where a competent patient makes an informed decision

to exercise his or her constitutional or common law right to refuse treatment, the physician may be liable for an unpermitted touching of the patient if he applies CPR. The "No Code" order merely implements the patient's decision.

In other jurisdictions, as noted above, court approval of the withholding of treatment has often been framed as approval of a surrogate's exercise of the patient's right to refuse treatment. Since it is not clear in Alaska the extent to which, if any, either a guardian or a family member who has not been appointed as guardian may legally exercise an incompetent patient's right to refuse treatment, it is not clear whether a physician could be held liable for performing CPR when the surrogate has consented to "No Code," or has attempted to exercise the patient's right to refuse treatment.

It is at least possible, however, that an Alaska court would hold a physician liable for refusing to honor the refusal of a patient or a patient's surrogate to consent to CPR treatment, or for refusal to honor an advance directive of an incompetent patient, made while previously competent, and contained in a "living will" or other such document, directing that such treatment should not be administered should the patient's condition become hopeless. In addition to the possibility of liability for an unconsented

touching, the physician may be liable for negligence if he or she performs CPR, or allows it to be performed, on a patient for whom such treatment is futile, and is contra-indicated under current medical standards.

2. Potential Liability for Not Performing CPR

Just as a physician can be liable for negligently performing CPR, he or she can be liable for negligently failing to perform CPR. Whenever a physician in good faith decides that a particular treatment is not called for, there is a risk that in some subsequent litigation the omission will be found to be negligent. If, for example, a physician negligently misdiagnoses a patient's illness as terminal and irreversible, and enters a "No Code" order based on that misdiagnosis, the patient's death due to cardiac arrest might be actionable. A physician who has undertaken to render medical services violates his duty of care if he abandons his patient or fails to take the steps called for by good medical practice. W. Prosser, Torts, Sec. 56 (4th Ed. 1971).

Even where "No Code" is medically indicated, however, failure to obtain informed consent to that course of treatment may itself be negligence. The usual rule in treatment situations which involve

a touching of the patient is that failure to obtain informed consent may itself be negligence. Cobbs v. Grant, 502 P.2d 1, 8 (Cal. 1972); Poulin v. Zartman, 542 P.2d 251, 274 (Alaska 1974). There is some dispute within the medical community, as discussed above, whether it is necessary to obtain informed consent to a course of treatment involving omissions (of CPR attempts) rather than actions. Since at least some courts have held that the informed consent doctrine, which requires explanation of the treatment options and associated risks, is applicable even where the option eventually taken is no treatment, Truman v. Thomas, 611 P.2d 902 (Cal. 1980), and since the President's Commission has taken the position that the physician usually has a duty to obtain informed consent to a "No Code" order (at least where the discussion necessary to obtain such consent is not itself likely to unnecessarily harm the patient), the mere fact that "No Code" does not involve a touching may not automatically insulate a physician from liability for failure to obtain informed consent to that course of treatment. Even though it is perhaps possible that a court would find informed consent from the guardian or family to be inadequate, due to lack of authority to give such consent (effectively ruling that "No Code" orders for incompetent patients are impermissible and automatically constitute negligence), the risk of liability is considerably more substantial when no informed consent has been obtained from an incompetent patient's family or guardian.

To minimize the risk of liability for entering a "No Code" order, a physician would never even enter such an order for an incompetent patient. That course of action, however, risks liability for negligently applying "Code" treatment when such treatment was medically contra-indicated. To minimize the overall risk of liability, a "No Code" order should be entered for an incompetent patient if and only if the physician believes that "Code" is contra-indicated and the guardian or family of the patient, after having been informed of the available treatment alternatives, has consented to the "No Code" course of treatment. The standard for determining civil liability is not affected by whether prior court approval was sought.

> "In any subsequent litigation, the standard for determining whether the treatment was called for remains the same after the event as before. Negligence cannot be based solely on failure to obtain prior court approval, if the approval would have been given."

In Re Spring, 405 N.E.2d at 122.

3. Potential liability of health care institutions

If the physician is acting as a hospital or nursing home employee, the institution is liable under the doctrine of respondeat superior for the physician's negligent acts occurring within the scope of employment. Hoover v. University of Chicago

Hosps., 366 N.E.2d 925 (Ill. App. 1977). Where the physician is acting as an independent contractor, however, unless the patient is led to believe the physician is acting for the health facility, the facility will not usually be held vicariously liable for the physician's negligence. Haven v. Randolph, 342 F.Supp. 358 (D.D.C. 1972); Cooper v. Curry, 589 P.2d 201 (N.M. App. 1978).

Where an independent contractor attending physician gives direct and explicit orders to the health facility staff, the staff members, nurses and others involved in the patient's care are not authorized to determine for themselves what is a proper course of medical treatment. The facility would therefore not incur liability for its nurses carrying out the attending physician's negligent orders in a non-negligent manner.

The health facility may, however, have an independent duty to select, supervise, and review staff physicians, and to take action where an attending physician's order is not in accord with normal medical practice or otherwise inappropriate. Poor Sisters of St. Francis Seraph of the Perpetual Adoration, Inc. v. Catron, 435 N.E.2d 305 (Ind. App. 1982). This is another reason why each institution should have a well-developed pre-established procedure of consultation and review in "No Code" situations, so that all such orders are subject to peer approval and frequent review.

In most jurisdictions, the "borrowed servant rule" is an exception to the respondeat superior doctrine so that a health facility would not be liable for the negligent acts of a staff employee, e.g., a nurse, acting at the direction of an independent contractor or physician. Instead, the borrowing master (the physician) but not the lending master (the facility) would be liable for the negligent acts of the borrowed servant (the nurse). In Alaska, however, the "borrowed servant" rule has been abolished. Kastner v. Toombs, 611 P.2d 62 (Alaska 1980). Both the borrowing and the lending masters are initially liable under respondeat superior for the negligent acts of the borrowed employee, leaving it to principles of indemnity and contribution to allocate distribution of the loss. Thus, both the health facility and the physician may be held liable, at least initially, if a nurse or a staff physician, for instance, negligently applies CPR when a "No Code" order has been entered, or negligently fails to initiate resuscitation when no such order has been entered.

4. Potential Criminal Liability

There is little precedent regarding the possibility of criminal liability for implementing "No Code" orders, and what little there is suggests that the doctor will be protected if he acts on a good faith judgment that is not grievously unreasonable by

medical standards. In Re Spring, 405 N.E.2d at 121, citing Commonwealth v. Edelin, 359 N.E.2d at 4 (Mass. 1976). It is reported that apparently no prosecutor has proceeded to trial in a case where a physician chose to terminate life-preserving treatment or omit emergency treatment in a hopeless case. Id., citing Collester, Death, Dying and the Law: A Prosecutor's View of the Quinlan Case, 30 Rutgers L.Rev. 304, 310-311 (1977).

II. Effect of the Appointment of a Guardian Under AS 13.26.

Previously, the appointment of a guardian was discussed with regard to whether the guardian, or some other surrogate decisionmaker, could give effective consent to a "No Code" order on behalf of an incompetent patient. This section deals with the effect of a guardian under AS 13.26 upon the propriety of an existing "No Code" order.

It should be noted that the process by which a guardian is appointed affords an opportunity for judicial resolution of some important issues. First, if the court is satisfied that because of impaired ability to effectively receive and evaluate information regarding the proceedings or because of impaired ability to communicate regarding the proceedings, the ward or respondent cannot determine his own interests without assistance,

the court, upon request by the respondent or the respondent's attorney will appoint a guardian *ad litem* to assist the ward or respondent in determining his or her interests, or, if the person is entirely incapable of determining his interests, to make that determination and advise the court and counsel for all parties accordingly. AS 13.26.112.

The general procedure for the appointment of guardians for incapacitated persons is set forth in AS 13.26.090-.150. Those statutes provide that any person may petition the court for a finding of incapacity and the appointment of a guardian for himself or another person. The respondent, the person alleged to be incapacitated and for whom a guardian is sought, is entitled to be represented by counsel in the proceedings. The court appoints a trained visitor to investigate the respondent's situation and to make an evaluation report. A guardian *ad litem* may be appointed if the court is satisfied that the respondent, because of impaired ability to receive and evaluate information or to communicate decisions, cannot determine his own interests without assistance. A temporary guardian may be appointed if it appears that the respondent is in need of immediate services.

AS 13.26.150(e)(3) precludes a guardian, once appointed, from consenting on behalf of a ward to the withholding of life-saving

medical procedures. As discussed above, it is possible there should be a distinction drawn in accord with the Dinnerstein case between "life-saving" or "life-prolonging" procedures and "life-sustaining" procedures, and that AS 13.26.150(c)(3) does not preclude the guardian from consenting to the withholding of "life-sustaining" procedures in hopeless cases. Rather than even risking litigation over the proper scope of a guardian's duties after he or she has acted, it would be preferable to ask the court during the guardianship proceeding to appoint a guardian *ad litem* to determine whether the Dinnerstein distinction is relevant to the case at hand, and to advocate, if appropriate, giving the guardian the specific authority to consent, under appropriate circumstances, to the withholding of "life-sustaining" treatment if (a) no "life-saving" procedures are available; (b) the attending physician's assessment is that CPR will not benefit the patient's well-being; and (c) if the guardian determines that the patient, if competent, would wish to forego CPR. In that way, the risk to the guardian, and/or the physicians, of acting inappropriately with regard to the scope of the guardian's authority or the necessity of judicial approval of any subsequent "No Code" order can be minimized.

Second, the guardian *ad litem* could be charged with the "responsibility of presenting to the judge, after as thorough an

investigation as time will permit, all reasonable arguments in favor of administering treatment to prolong the life of the individual involved." In Re Saikewicz, 370 N.E.2d at 433. In that way, even if all concerned are in agreement that "No Code" is appropriate, the court will be presented with all reasonable contravailing arguments. These steps, taken during the pendency of the guardianship proceedings, could do much to clarify the duties of the various parties.

B. The Guardian's Powers and Duties

The court may appoint a guardian only if a determination of incapacity is made and the court finds that alternative forms of protection are not sufficient to meet the respondent's needs. The respondent has a jury trial right on the issue of incapacity. Even if guardianship is necessary, the law favors partial guardianship over full guardianship. Only if the court finds that the respondent is totally without capacity to care for himself, and that the combination of partial guardianship and alternatives to guardianship are not feasible or adequate to provide for the needs of the respondent, may a full guardian be appointed. It should be remembered, however, that legal incapacity is a distinct concept from decisionmaking incompetence, and that even an incapacitated ward for whom a full

guardian has been appointed retains decisionmaking autonomy regarding treatment alternatives unless he or she is also incompetent.

Notwithstanding the limits of a temporary guardianship or an order of appointment, any guardian at all times has the right to authorize the provision of emergency life-saving medical services. AS 13.26.141. A full guardian has the same powers respecting his ward that a parent has respecting his unemancipated minor child, except as modified by the order of appointment. AS 13.26.150(c). A parent could certainly object if he or she believed that his or her unemancipated minor child was the subject of an inappropriate "No Code" order. A guardian, therefore, probably has the power (or standing) to object to such an order. A guardian also has a duty to "assure the care, comfort, and maintenance of the ward." AS 13.26.150(2). This duty probably includes the duty to object to an inappropriately entered "No Code" order. Finally, no guardian may consent on behalf of his or her ward to the withholding of life-saving medical procedures. AS 13.26.150(e)(3). This also leads to the conclusion that the guardian has a duty to object when "No Code" is inappropriate, i.e., when "life-saving" measures, as opposed to "life-sustaining" measures, are available, because failure to object might be construed as "consenting" to the withholding of treatment.

In fact, if the Alaska courts refuse to make the Dinnerstein distinction, a guardian might have the duty to refrain from consenting to a "No Code" order under any circumstances. AS 13.26.150(e)(3) could be interpreted, when taken in conjunction with the duty to assure the care, comfort, and maintenance of the ward, to mean that a guardian has the duty to object to a "No Code" order, regardless of whether or not it was entered in accordance with accepted medical standards.

C. Judicial Clarification of Guardian's Authority.

If the health care provider determines that an incapacitated person for whom a guardian has been appointed is also incompetent with respect to decisionmaking regarding his or her own treatment, the provider should fully inform the guardian, to the same extent it would inform a competent patient, of the various treatment alternatives and the risks attendant to each. Failure to do so might result in liability for negligence, under the doctrine of Cobbs v. Grant, supra. It should also be noted that the hospital or nursing home, or any other person who "provides, or is likely to provide during the guardianship period, substantial services to the incapacitated person in a professional or business capacity," may not be appointed as the guardian for that person. AS 13.26.145.

The guardian must then decide whether to oppose the "No Code" order, either on the ground that the ward would, if competent, oppose the particular order, or on the ground that the guardianship statutes, as he or she interprets them, require the guardian to oppose any "No Code" order. If the guardian requests that the "No Code" order be withdrawn, or even refuses to consent to the order, the provider must decide whether to honor the guardian's request. If, upon review and reconsideration, the provider still believes CPR would be medically inappropriate, it should seek judicial resolution of the issue rather than risk negligence liability for proceeding with an unconsented course of treatment.

Even if the guardian "consents" to the "No Code" order, the provider risks negligence liability for an unconsented course of treatment in that a court might subsequently hold that the guardian cannot give effective consent under the terms of AS 13.2.150(e)(3). A cautious approach, which we recommend, would be to seek judicial approval of the "No Code" order, and of the guardian's power to consent to it, at that point. Other courts have held that practical limits on the capacity of the judiciary indicate that judicial involvement is not warranted where there is no disagreement among the family and physicians (and presumably the guardian) on the propriety of a "No Code"

order. In Re Dinnerstein, 380 N.E.2d at 137 n.5. Nevertheless, since Alaska courts have not ruled on that issue, and since any participant in the decision may petition the court for intervention, In Re Colyer, 660 P.2d at 750, it would not be inappropriate for a physician or health facility to seek judicial approval of a "No Code" order even though there is no disagreement as to its propriety, but only doubt as to the authority of a guardian, as a surrogate decisionmaker, to consent to such an order. Once Alaska law is established, it is not likely that decisions will normally require judicial resolution in cases where the physicians, the family, and the guardian all agree that "No Code" is appropriate.

III. Recommendations.

A. Natural Death Act Legislation Should Be Enacted.

To clarify the extent to which physicians are bound to follow the wishes of a competent patient, or an incompetent patient who while previously competent made his or her wishes known regarding continued treatment in the event the patient's condition should become terminal and irreversible, the Alaska State Hospital Assocation could seek enactment of Natural Death Act legislation, such as 1983 Alaska House Bill 107. Such legislation would

provide an avenue for a patient to clearly delineate his or her preference, and would provide that health care providers are not only immune from liability for following those wishes, but are bound to either follow those wishes or transfer the patient's care to a provider who will follow them.

1983 HB 107 should be amended, as indicated on the enclosed marked copy, to indicate the circumstances under which a "No Code" order may be entered for an incompetent patient in the absence of a written declaration as outlined in that proposed legislation.

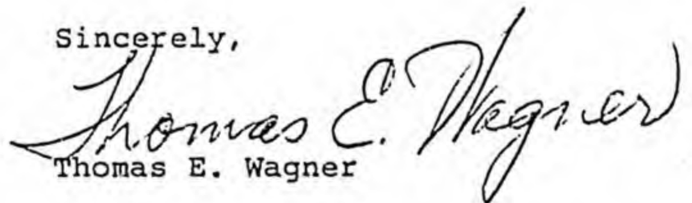
We also recommend that AS 13.26.150(e)(3) be amended by adding a clause similar to the following: "This section does not preclude the guardian from consenting in the case of an irreversible, terminal illness, to the withholding of medical procedures which, in the opinion of the attending physician(s), have no reasonable expectation of effecting a temporary or permanent cure of or relief from the illness or condition being treated, but which serve only to prolong the dying process."

III. Conclusion.

We hope you will find our discussion and recommendations helpful

in developing a policy for your members. We are enclosing a copy of the report by the President's Commission, which contains a more detailed discussion of some of the issues discussed herein, and which contains in the appendices (particularly Appendix I) several policy statements of professional societies, health care institutions, federal agencies and the State of California. Please call me if you have further questions regarding this matter.

Sincerely,



Thomas E. Wagner

STATE OF ALASKA

DEPARTMENT OF ADMINISTRATION

OLDER ALASKANS COMMISSION

BILL SHEFFIELD, GOVERNOR

POUCH C, M.S. 0209
JUNEAU, ALASKA 99811
PHONE: (907) 465-3250

June 4, 1985

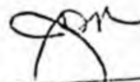
Dennis Dewitt
Alaska State Hospital Association
319 Seward Street
Juneau, Alaska 99801

Dear Dennis:

I want to express my appreciation to you and the Association for your participation at our "Aging Together in Alaska Conference". Your participation and that of other Association members was very beneficial to the success of our meeting.

Peggy Burgin and I have reviewed your draft amendment to the guardianship laws (AS 13.21.150(c)). We agree that it is important to clarify or limit the role of guardians in making a living will declaration on behalf of their client. Let me know if we can be of assistance.

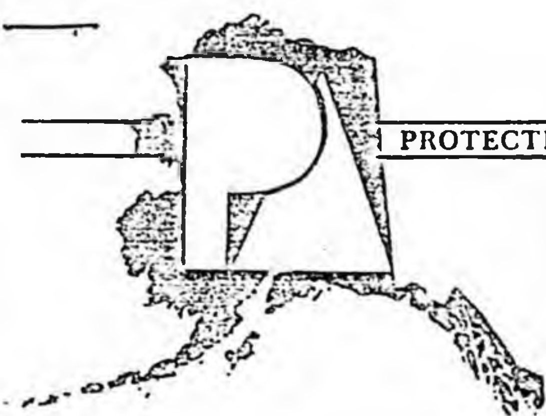
Sincerely,



Jon B. Wolfe
Executive Director

File with 1985 proposal state?

02-825LH



PROTECTION AND ADVOCACY FOR THE DEVELOPMENTALLY DISABLED

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Fairbanks, AK 99701
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December 23, 1985

Ms. Dot Truran
Governor's Council for the Handicapped & Gifted
600 University Ave., Suite C
Fairbanks, Alaska 99701

Re: No Code Bill

Dear Dot:

The legislative committee of the council has asked P.A.D.D. to address two proposed amendments to the guardianship statute. These proposed amendments concern AS 13.26.150(c)(5) which prohibits a guardian from consenting on behalf of the ward to the withholding of life-saving medical procedures. Copies of these proposed amendments are attached and marked Proposed Amendment A and Proposed Amendment B.

Proposed Amendment A continues the prohibition against consenting, but clarifies that a guardian need not oppose the cessation or withholding of life-saving medical procedures when they would only prolong dying and offer no reasonable expectation of cure or relief. Proposed Amendment B prohibits the withholding of comfort, care, or substantially beneficial medical treatment, but allows the guardian to consent to the withholding of medical procedures which offer no reasonable expectation of cure or relief.

The current law was fashioned to prevent situations where guardians, who may benefit from the death of a ward (i.e., as beneficiary of a will) are deciding whether or not the ward should die. The idea was to prevent the guardian from having such power. Unfortunately, there have been unforeseen consequences. Life-saving medical procedures, once begun, cannot be stopped without court order. This may result in prolonged useless medical treatment. It may also result in guardians not attempting life-saving medical treatments for the fear that once begun they cannot be discontinued.

The two proposed amendments take very different approaches to the same problem. Proposed Amendment A allows the guardian to defer to the physician's conclusions that life-saving procedures would be useless. It relieves the guardian of the obligation to interfere with and prevent a

doctor from acting pursuant to the doctor's reasonable medical judgment. Yet, if the guardian disagrees with the doctor, the guardian may still oppose and seek to prevent the doctor from carrying out the disputed cessation of treatment.

Proposed Amendment B would change the law in two ways. First, it changes "life-saving medical procedures" to "comfort, care, or ... substantially beneficial medical treatment." Second, it requires the guardian's consent before medical procedures can be terminated.

"Comfort" and "care" have been interpreted to include feeding and hydration and therefore go beyond "medical treatments" such as respirators.

Of the two amendments, Proposed Amendment A is preferable. The distinction between not having to oppose and having to consent is substantial. The former places the responsibility where it belongs, with the physician. While the guardian may interfere, he need not act if he does agree. Proposed Amendment B's obligation to consent is much different. This places responsibility on the guardian to approve a procedure he will likely know little about. The guardian may not merely defer to the physician. The guardian must make the decision himself. Under Proposed Amendment A the decision remains with the physician and the guardian need only act if he opposes that decision.

Change in the guardianship statute is a good idea which should be acted upon promptly. Proposed Amendment A is the preferable method and the Governor's Council should support it.

Thank you for this opportunity to comment. Please feel free to contact me if you have any questions or comments.

Sincerely,

Jonathon A. Katcher
Supervising Attorney

JAK:jim

cc: Cindy Farrens, Public Guardian, Office of Public Advocacy
Dennis L. Dewitt, President, Alaska State Hospital Association

Encl.

PROPOSED AMENDMENT A

IN THE HOUSE BY

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to powers and duties of guardians."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 13.26.150(e) is amended to read:

(e) A guardian may not

(1) place the ward in a facility or institution for the mentally ill other than through a formal commitment proceeding under AS 47.30.350 - 47.30.915 in which the ward has a separate guardian ad litem;

(2) consent on behalf of the ward to an abortion, sterilization, psychosurgery, or removal of bodily organs except when necessary to preserve the life or prevent serious impairment of the physical health of the ward;

(3) consent on behalf of the ward to the withholding of life-saving medical procedures; <u>however, the guardian is not required to oppose the cessation or withholding of life-saving 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</u>;

(4) consent on behalf of the ward to the performance of an experimental medical procedure or to participation in a medical experiment not intended to preserve the life or prevent serious impairment of the physical health of the ward;

(5) consent on behalf of the ward to termination of the

PROPOSED AMENDMENT B

POSSIBLE PROPOSAL FOR AN AMENDMENT

SENATE BILL NO. XXX

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "Protection of Persons Under Disability and Their Property."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 13.26.150(e)(3) is amended to read:

-- Sect. 13.26.150(e)(3). (e) A guardian may not

(3) consent on behalf of the ward to the withholding either of comfort care or of substantially beneficial medical treatment [OF LIFE-SAVING MEDICAL PROCEDURES], although consent may be granted to the withholding of medical procedures which offer no reasonable expectation of effecting a temporary or permanent cure of or relief from the illness or condition being treated.

* Section 2. This Act takes effect immediately in accordance with AS 01. 10.070(c).

Amendment VIII--Ethical Issues Forum
Cf. Rev. Ted Zembal, Providence Hospital
February 6, 1984

health
association
of alaska

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REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

HB 485

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Ketchikan

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Central Peninsula General Hospital
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Physician Member of the Board
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Anchorage

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Dennis DeWitt
Juneau

FORMERLY
alaska state hospital association

GUARDIANSHIP LAW: NO CODE ORDERS

POSITION:

Guardians should be permitted to consent to the withholding of medical procedures which offer no reasonable expectation of effecting a temporary or permanent cure of or relief from the illness or condition being treated. The current law, AS 13.26.150(e)(3) presently is being interpreted to require the continuation of "lifesaving medical procedures" no matter what value such procedures might offer the patient in terms of benefits received. The question which needs to be considered is whether the procedure offers relief or cure or rather is simply prolongation of the dying process by use of invasive and heroic means.

ACTION:

Amend AS 13.26.150(e)(3) to provide that 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.

December 6, 1985

set up file

FEB 10 1986

FEB [illegible] 1986

POSITION PAPER
Bill No. HB485

The Office of Public Advocacy in the Department of Administration performs the duties of the Public Guardian under A.S. 13.26.360-13.26.410. Guardians provide informed medical consents for incapacitated persons (wards) directly impacting the ward's health and safety according to A.S. 13.26.150(c)(5) except as limited by (e) of this section.

PRESENT STATUTE:

A.S. 13.25.150(e) "A guardian may not...(d) consent on behalf of the ward to the withholding of life-saving medical procedures."

PROPOSED AMENDMENT:

A.S. 13.25.150(e) "A guardian may not...(3) consent on behalf of the ward to the withholding of life-saving medical procedures; however, the guardian is not required to oppose the cessation or withholding of life-saving 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;"

RATIONALE:

The current law could be interpreted as requiring the guardian to insist upon the continuation of "life-saving medical procedures" regardless of the values such procedures might offer the patient in terms of benefits received. The question which needs to be considered is whether the procedure offers relief or cure, versus simply prolonging the dying process by the use of heroic means.

PROBLEM AREAS IN THE PRESENT STATUTE:

(1) A literal reading of the statute would mean that life-saving medical procedures cannot be stopped once they are started. Hence the possibility may arise that non-beneficial and even harmful procedures could not be withdrawn. A further possible effect might be that a different standard of care would be used for wards than for other patients. Also those with guardians might be either overtreated since the treatment could not be stopped or undertreated because the treatment was not begun lest it could not be withdrawn.

(2) the meaning of "life-saving medical procedures" is not clear nor is it defined. An attempt to define the phrase defies the enumeration process, as does a list of the exceptions. Moreover, such a task borders on the impossible because of the nature of the words. The phrase focuses on "procedures" instead of the "relationship" of the treatment to the ward in terms of the benefits received. E.G., chemotherapy or a respirator is life-saving if it is helpful in the restoration of health of the ward, but it would be counterindicated if it simply prolonged the dying process.

(3) An attempt to solve these problems by having the health care provider act independently of the guardian would defeat the purpose of guardianship. Further, such actions by the health care provider would be destructive of the informed consent process.

(4) The statute can create difficulties in the decision-making process for the guardian, ward, physician, health care institution and its personnel, and other health care providers. In addition, it would often conflict with the philosophy of medical ethics.

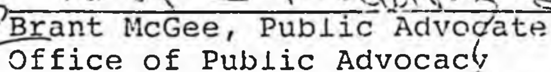
SUPPORT/HB485:

(1) The amendment more clearly delineates the different types of medical/nursing care involved, thus allowing the guardian to carry out more adequately his/her responsibilities toward the ward.

(2) The amendment allows the guardian to not oppose the cessation or withholding of life-saving medical procedures where they are clearly ineffective and not beneficial to the ward from the perspective of the ward.

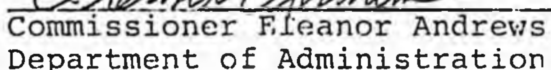
(3) The amendment facilitates and keeps open the communication process and dialogue among the guardian and health care providers at all times.

(4) There are no foreseen costs to the OPA with passage of HB485.



Brant McGee, Public Advocate
Office of Public Advocacy

2/3/86
Date



Commissioner Eleanor Andrews
Department of Administration

2/7/86
Date

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May, 1988

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Mary Van Nimwegen

HESS 4-1-86 1:35 pm