ALASKA LEGISLATURE COMMITTEE FILES 1985-1986 8672

3218 HHESS HB 474 - HB 485

STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: _____

REQUEST

Bill/Resolution No.: HB 474
Title: "An Act relating to volunteer guardians ad litem..."

Sponsor: Rep. Sund
Requestor: Finance
Date of Request: January 27, 1985

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-	83.6	88.6	93.9	99.5	105.4
TRAVEL		-0-	-0-	-0-	-0-	-0-
CONTRACTUAL		-0-	-0-	-0-	-0-	-0-
SUPPLIES		4.0	4.2	4.5	4.7	5.0
EQUIPMENT		14.3	-0-	-0-	-0-	-0-
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	101.9	92.8	98.4	104.2	110.4
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

GENERAL FUND	-0-	101.9	92.8	98.4	104.2	110.4
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	101.9	92.8	98.4	104.2	110.4

POSITIONS:

FULL-TIME	-0-	2.0	2.0	2.0	2.0	2.0
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary

Prepared by: for Phillip S McGee, Jr Brant McGee, Public Advocate Phone: 274-1684
Division: Office of Public Advocacy Date: 2/3/86

Approved by Commissioner: Eleanor Andrews 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)

10/25/85

CONTINUATION of FISCAL NOTE ANALYSIS

For Bill/Resolution No. HB 474

This bill relates to the establishment of a volunteer guardian ad litem program within the Office of Public Advocacy. This bill would substantially improve the ability of the Office of Public Advocacy to provide guardian ad litem representation to children in abuse and neglect cases as well as contested custody cases.

Since the Anchorage Office of Public Advocacy began accepting guardian ad litem cases in January 1985, approximately 658 cases have been opened from the period of January, 1985 through December, 1985. The Anchorage office presently has two attorneys and two associate attorney positions who handle guardian ad litem responsibilities.

It is anticipated that the Office of Public Advocacy would need a program coordinator position and a clerk typist III position in order to implement a volunteer guardian ad litem program.

BUDGET ANALYSIS

Personal Services		
Program Coordinator - Range 20	56.2	
Clerk Typist III - Range 08	27.4	
	83.6	83.6
Supplies		4.0
Equipment		
Program Coordinator	2.4	
Clerk Typist III	11.9	
	14.3	14.3
	TOTAL:	101.9

Position Title	No. of Positions	Range/Step	Barg. Unit	Geog.	Appear.	Disapp.
Program Coordinator	1	20/A	03			

Time Status	Staff Months	RP Number	Location	Election District
PFT	12		EBA	8

Type of Expenditure		Amount
1	2	3
Salary	42,769	
Benefits	13,466	
Premium Pay		
Other		
Total Personal Services		56,234
Travel		-0-
Contractual		-0-
Commodities		2,000
Equipment		2,429
Other		
Total Cost		60,663

Receipt Code	Funding Source		
	Federal Receipts	1002	
	G. F. Match	1003	
	General Funds	1004	60,663
	I-A Receipts	1005	
	Program Receipts	1028	
	CIP Receipts	1061	
	Other		

For B&M Use Only
Key Number _____

Justification

A program coordinator position is essential if the volunteer guardian ad litem program is to be implemented. It is not possible for present staff positions to carry a full guardian ad litem caseload and assume the duties of establishing and coordinating the volunteer program. It is anticipated that the program coordiantor will coordinate the solicitation, screening and training of volunteers in the Anchorage area. The program coordinator will also be responsible for establishing similar volunteer programs in Fairbanks and Juneau, and will study the feasibility of establishing such a program in the rural area of Alaska.

Request For New Position

Agency Department of Administration
BRU Office of Public Advocacy
Component Office of Public Advocacy

FY 87

Position Title	No. of Positions	Range/Step	Barg. Unit	Gov.	Approv.	Disapp
Clerk Typist III	1	08/A	G			

Time Status	Staff Months	RP Number	Location	Election District
PFT	12		EBA	8

Type of Expenditure		Amount
1	2	3
Salary	19,572	
Benefits	7,804	
Premium Pay		
Other		
Total Personal Services		27,376
Travel		-0-
Contractual		-0-
Commodities		2,000
Equipment		11,838
Other		
Total Cost		41,214

Receipt Code	Funding Source		
	Federal Receipts	1002	
	G. F. Match	1003	
	General Funds	1004	11,838
	I-A Receipts	1005	
	Program Receipts	1028	
	CIP Receipts	1061	
	Other		

For B&M Use Only
Key Number ___ - ___ - ___ - ___ - ___

Justification

A Clerk Typist III position will be necessary to provide clerical support to the volunteer guardian ad litem program coordinator. At present, Office of Public Advocacy has only 3 clerical positions who provide clerical support to a professional staff of 12 in the Anchorage office. It is not possible for the present secretarial positions to absorb the additional clerical support generated by the program coordinator and the volunteer program.

Request For New Position

Agency Department of Administration
BRU Office of Public Advocacy
Component Office of Public Advocacy

FY 87

POSITION PAPER
BILL # HB 474

An Act relating to volunteer Guardians ad Litem in the Office of Public Advocacy.

HISTORY AND DUTIES OF OPA:

The Office of Public Advocacy was created and placed within the Department of Administration in the Spring of 1984. The Office of Public advocacy is required by Statute (A.S. 44.21.410) to provide services in the following three areas.

(1) Guardian ad Litem representation to abused children in Child in Need of Aid proceedings, guardian ad litem representation of children in custody disputes, legal representation of parents in Child in Need of Aid proceedings where there is a conflict with the Public Defender's Office, guardian ad litem activities in contested adoptions, guardian ad litem activities in guardianships for minors, and a host of other civil functions, legal representation of parents involved in custody disputes where the other party is represented by a public agency i.e. Alaska Legal Services, as well as any other case involving a minor which may require the services of a guardian ad litem;

(2) Legal representation of indigent persons charged with crimes where the Alaska Public Defender Agency has a conflict of interest;

(3) Public Guardian services as well as payment to visitors, experts and attorneys for the respondent.

Prior to 1984, the Alaska Court System had provided these services primarily through a system of court appointed attorneys. The Public Guardian function was within the Alaska Court System.

In October or 1984, the Public Advocate and an administrative assistant were hired to create the OPA and initiate the transition to this new system of providing legal representation. In November of 1984, an Anchorage office was opened and began taking criminal cases. In January of 1985, OPA began taking civil cases in Anchorage. In February of 1985, a Fairbanks office was established and assumed responsibilities for both criminal and civil cases.

Until July 1, 1985, the Alaska Court System continued to appoint attorneys and other professionals to cases within the

OPA statutory mandate. In July of 1985, a contract structure covering the small population areas and second level conflict cases in Anchorage and Fairbanks went into effect.

RESPONSIBILITIES OF A GUARDIAN AD LITEM/CASA:

A guardian ad litem (GAL) is an individual who is a legal advocate for a child in court proceedings. A guardian ad litem's duty is to advocate to the court what he or she believes to be in the child's best interest. A guardian ad litem does not have the legal authority to make decisions effecting the child's person or property i.e., medical decisions or financial investments. A guardian ad litem's obligation is to objectively insure that the court receives all pertinent information necessary to make a decision which is in the child's best interest. A major difference between an attorney appointed to represent a child and a guardian ad litem for a child is that the guardian ad litem may disagree with the position of the child. A Guardian ad litem is appointed for every child the State of Alaska, Department of Health and Social Services petitions to be a child in need of aid due to abuse or neglect. A child may also have a GAL in contested divorce custody proceedings, contested adoptions, and guardianships.

HISTORY OF CASA

In 1976 King County, Seattle, Washington, Superior Court presiding Judge, David W. Soukop, began exploring ways to insure abused and neglected children's best interest were consistently presented to the court. Traditionally, the court appointed attorneys to serve as guardian ad litems (GAL's) for these children. However, due to the high number of cases involving children and the lack of adequate training by many attorneys, as well as cost considerations, Judge Soukop decided to recruit and train community volunteers who would be asked to make a long term commitment to each child for whom they serve as GAL. The term CASA, was coined by the National Council of Juvenile and Family Court Judges in 1982, at a meeting held in Reno, Nevada. A CASA has the same function as a volunteer GAL. The term CASA was developed by the National Council of Juvenile and Family Court Judges to better explain to the public the duties of the GAL. CASA is Spanish for home and it was felt that this was an appropriate and symbolic name for the efforts of the volunteers.

In May of 1985, the Office of Public Advocacy became a member of the National Court Appointed Special Advocate Association and began exploring the feasibility of a volunteer GAL/CASA program in the State of Alaska. The Office of Public

Advocacy began having round table meetings in Anchorage, Alaska with judges, family and children's court masters, the Division of Family and Youth Services, Alaska Youth Advocates, the District Attorney's Office, Attorney General's Office, Public Defender's Office, community mental health providers, and the Alaska Bar Association for their input and recommendations as to whether or not a volunteer guardian ad litem/CASA program would be acceptable in the Anchorage area. Due to the overwhelming support of the concept of a volunteer GAL/CASA program, the Office of Public Advocacy recruited and trained five volunteers in the summer of 1985. The five volunteers were screened by an advisory board. This advisory board continues to monitor the progress of the Office of Public Advocacy's five volunteer guardians ad litem on a continuing basis.

THE OFFICE OF PUBLIC ADVOCACY'S SUPPORT FOR HB 474:

The Office of Public Advocacy strongly supports passage of HB 474. The Office of Public Advocacy would request that the statute be amended to state volunteer guardian ad litem/CASA so as to be able to utilize the national efforts of the National Court Appointed Special Advocate Association. The passage of HB 474 would require that the Office of Public Advocacy recruit and develop a permanent volunteer guardian ad litem/CASA program. Passage of HB 474 would require creating the position of CASA coordinator and a clerical support person. It is believed that a non-attorney coordinator should be hired in order to implement the CASA/volunteer guardian ad litem program first in Anchorage, Fairbanks and Juneau and then study the feasibility to develop a plan to implement such a program in the rural areas of Alaska.

A national survey of all CASA/GAL programs in the nation was undertaken by the National Court Appointed Special Advocacy Program in July, 1985. Attached is a letter from Charles Miller, Ph.D., research director of the National Court Appointed Special Advocate Program. Dr. Miller states that the nationwide survey found that the average volunteer handled 2.56 cases. It is the belief of the Office of Public Advocacy that a CASA/GAL program in Anchorage would result in the recruitment of 50 volunteers in its first year. It is believed that a system could be developed to eventually have in excess of 150 volunteers in the Anchorage area providing advocacy for children. The existence of four OPA staff and a coordinator's position would provide adequate supervision for the volunteer guardian ad litem/CASA program.

Passage of HB 474 would substantially improve the ability of the Office of Public Advocacy to provide guardian ad litem representation to children. Since the Anchorage Office of Public Advocacy began accepting guardian ad litem cases in January of 1985 approximately 658 cases have been opened from the period of

January, 1985 through December, 1985 by the staff of the Anchorage Office of Public Advocacy. The Office of Public Advocacy currently has two attorneys and two associate attorney positions who handle guardian ad litem responsibilities. Under Alaska law a guardian ad litem does not need to be an attorney. The Office of Public Advocacy is attempting to use non-attorneys with training in the needs of children to provide the effective delivery of guardian ad litem services. It is essential that non-attorney guardian ad litem have the backup support of an attorney to ensure that the guardian ad litem's position and the best interest of the child are adequately litigated in contested court cases.

It is anticipated that the continued trend of dramatic increases in child abuse and neglect cases will continue. Additionally, the State of Alaska, Department of Health and Social Services' decision in October of 1985 to be in compliance with the Adoption Assistance and Child Welfare Act of 1980, Public Law 96-272, will result in the involvement of the guardian ad litem past the dispositional stage of a Child In Need of Aid proceeding. The effect of Public Law 92-272 will be higher caseloads for the Office of Public Advocacy due to the continued monitoring of cases by a guardian ad litem.

Philip Jay McCarthy, Jr.
Acting Public Advocate

2/6/86
Date

Commissioner Eleanor Andrews
Department of Administration

2/6/86
Date

Court Appointed Special Advocate Association
909 N.E. 43rd, Suite 202; Seattle, Washington 98105 (206)547-1059

January 22, 1986

Jay McCarthy
Project Director
Volunteer Guardian Ad Litem Program
Office of Public Advocacy
900 West 5th Avenue, Suite 525
Anchorage, Alaska 99501

FEB 3 1986

Dear Mr. McCarthy:

A national survey of all CASA/GAL programs in the nation was undertaken in July, 1985. Preliminary tabulations are now being made. A presentation of the results will be made at the National Conference in May, 1986 and a final report will be issued due June 30, 1986.

The preliminary calculations have been reported to the Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice. They may be of interest to you and others concerned with the CASA program in Alaska.

From the national survey we found that an average volunteer handles 2.56 cases. In turn each staff member supervises a number of volunteers. Nationally, there is a wide range in the ratio of volunteers to staff from a low of 0.6 volunteers per staff to a high of 210. The "mode", i.e., statistically the most frequent ratio, is 25 volunteers per staff. Some of the older programs have 50 to 70 volunteers per worker and a few have 75 to 110.

As I understand it, you will have two staff, a coordinator and clerical person in your program and recruit 50 volunteers. From the volunteer response in one program in the national survey, we found that an average of 52 hours of a volunteer's time was required for each case.

One method of assessing the cost effectiveness of your proposed program is the following. Using your 50 volunteers and the national ratio of 2.56 cases per volunteer your program can be expected to handle 128 cases in a year. This translates into a total of 6656 hours per year of volunteers' time. If attorneys were paid say $25 per hour, (an arbitrary estimate), then a projected total cost would be $166,400.

You should do this calculation using Alaska lawyer rates, but I think the conclusion will stand that a paid program coordinator with clerical assistance will provide more trained volunteer time for children than would a system of paying attorneys to do the same job.

Sincerely,

L. Charles Miller, Ph.D.
Research Director

LCM/CM

Court Appointed Special Advocate Association

909 N.E. 43rd, Suite 202; Seattle, Washington 98105 (206)547-1059

January 30, 1986

FEB 5 1986

Mr. Philip J. McCarthy, Jr.
Office of Public Advocacy
900 W. 5th Avenue, Ste. 525
Anchorage, AK 99501

Dear Jay,

Thank you for your memorandum and copy of the legislation which you introduced January 15, 1986. There is no problem at all with the National CASA Association's supporting this Bill.

I am wondering if there are particular items regarding your CASA Project or regarding your legislation which you would wish to address. Please let me know. There is no difficulty in simply stating that the legislation seems to be appropriate and helpful to the cause of Volunteer Guardians. As a matter of fact, I am a bit envious of your $44.21.450, that holds that the Volunteer Guardian may not be held civilly liable except in cases of gross negligence.

If you need more than the above statement please let me know.

Sincerely,

Marjorie MacAdams
President, National CASA Association
Executive Director, FOCAS

Alaska Court System

State of Alaska

303 "K" STREET
ANCHORAGE, ALASKA
99501

ARTHUR H. SNOWDEN II
ADMINISTRATIVE DIRECTOR

(907) 274-8611

January 29, 1986

Rep. Niilo Koponen
Rep. Max Gruenberg, Co-Chairman
House Health Education and
Social Services Committee
P. O. Box V
Juneau AK 99811

Dear Representatives Koponen and Gruenberg:

I am writing to express support by the Alaska Court System for those provisions of HB 474 which would permit the Office of Public Advocacy to develop and coordinate a volunteer guardian ad litem program.

Information from other states in which similar programs have been established indicates that programs of this nature improve the quality of guardian ad litem services and also help contain costs.

If you have any questions regarding the court's position, please contact either me or my staff counsel Karla Forsythe.

Sincerely,

Arthur H. Snowden, II
Administrative Director

KF/kl

cc: Karla Forsythe
Brant McGee
John Reese

Alaska Court System

State of Alaska

303 "K" STREET
ANCHORAGE, ALASKA
99501

ARTHUR H. SNOWDEN II
ADMINISTRATIVE DIRECTOR

(907) 274-8611

January 29, 1986

Rep. Niilo Koponen
Rep. Max Gruenberg, Co-Chairman
House Health Education and
Social Services Committee
P. O. Box V
Juneau AK 99811

Dear Representatives Koponen and Gruenberg:

I am writing to express support by the Alaska Court System for those provisions of HB 474 which would permit the Office of Public Advocacy to develop and coordinate a volunteer guardian ad litem program.

Information from other states in which similar programs have been established indicates that programs of this nature improve the quality of guardian ad litem services and also help contain costs.

If you have any questions regarding the court's position, please contact either me or my staff counsel Karla Forsythe.

Sincerely,

Arthur H. Snowden II

Arthur H. Snowden, II
Administrative Director

KF/kl

cc: Karla Forsythe
Brant McGee
John Reese

Alaska State Legislature

House of Representatives

REPRESENTATIVE
JOHN L. SUND

Box 6440
KETCHIKAN, ALASKA 99901
(907) 225-5552

WHILE IN JUNEAU
POUCH V
JUNEAU, ALASKA 99811
(907) 465-4919

CHAIR, HOUSE SPECIAL COMMITTEE ON LOANS
VICE-CHAIR, JUDICIARY COMMITTEE
MEMBER, SPECIAL COMMITTEE ON OIL AND GAS
MEMBER, RESOURCES COMMITTEE

January 21, 1986

TO: Lisa
Rep. Koponen's office

FROM: Kitty
Rep. John Sund's office

RE: HB474

Attached is background on HB474, related to a volunteer guardian program. The packet includes:

1. A copy of the bill

2. An overview, including sectional analysis and history

3. Letters of support

Still to come are a fiscal note and position paper from the Office of Public Advocacy. I have been assured that these will be available about February 1st.

Rep. Sund would like to schedule this bill as soon as possible, so perhaps we can set something up close to Feb, 1st.

Likely to testify are Corrine Radergraham and Judge Schulz, of Ketchikan, by teleconference, and Jay McCarthy of the Office of Public Advocacy in Anchorage (either in person or by teleconference). I can firm up arrangements for their testimony as we approach the hearing date.

Please let me know what committee time can be arranged.

Thanks.

HOUSE
COMMITTEE REPORT

2/7

JUDICIARY

Date referred: 1/15/86

FURTHER REFERRALS: FINANCE

DATE: 2/5/86

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee has considered HB 474

"An Act relating to volunteer guardians ad litem in the Office of Public Advocacy."

and recommends:

[ ] do pass

[ ] do not pass

[ ] do pass with attached amendment(s)

[ ] no recommendation

[X] replace with CS HB 474 (HESS) [ ] same title [X] new title

and recommends _____

[ ] further referral to the _____ Committee

and attaches: [ ] letter of intent
[✓] first fiscal note Sup #81
[ ] new fiscal note
[✓] zero fiscal note

SIGNING DO PASS:

SIGNING OTHER RECOMMENDATIONS:

Bryce Manley - No Rec

Vic Kohring co-chair
Chairman

co-chair

WHAT DOES GUARDIAN AD LITEM MEAN?

Guardian ad litem (GAL) is a legal term meaning guardian for a court case.

WHO CAN BE A GAL?

Anyone who cares about children and who can help the court make good decisions can be a GAL. Often lawyers are GAL's.The judge chooses the GAL.

WHAT IS A GAL SUPPOSED TO DO?

A GAL is supposed to represent the best interests of the child in court. That means making sure the judge is told:

- what has happened to the child,
- what the child needs to be happy and safe, and
- what decisions the judge can make to help the child.

WHY DOES A CHILD NEED A GAL?

Whenever a judge has to make decisions about what will happen to a child, the child may need a GAL.

For example, children whose parents are getting a divorce often have a GAL. And all children whose parents may have abused or neglected them should have a GAL.

A child might also need a GAL if someone other than the child's parents wants custody of the child, if a judge is asked to decide who the child's father is, or if the child might own property.

DOES EVERY CHILD HAVE A GAL?

NO. The court decides whether a child needs a GAL and appoints the GAL. Anyone can ask the judge to appoint a GAL for a child. The judge can be asked in court or by letter.

WHO PAYS FOR THE GAL?

The judge decides who will pay the GAL. Sometimes the child's parents pay, and sometimes the state pays.

DOES A GAL ALWAYS ASK THE JUDGE TO DO WHAT THE CHILD WANTS DONE?

NO. The GAL always listens to the child, but the GAL must decide whether what the child wants is really best.

Sometimes the GAL and the child do not agree. Then the GAL has to make up his or her own mind about what is best for the child. The GAL will tell the judge what the GAL thinks is really best for the child.

DOES THE GAL GET TO MAKE THE DECISIONS AT THE COURT HEARINGS?

NO. The judge makes the decisions after listening carefully to everyone who took part in the court hearing. Like the other people, the GAL is only allowed to make suggestions about what should happen.

HOW DOES A GAL DECIDE WHAT IS BEST FOR THE CHILD?

The GAL talks with everyone who knows a lot about the child. This includes the child, the child's parents, relatives, foster parents, teachers, social workers, psychologists, doctors, and others.

The GAL reads reports written about the child and the child's family. The GAL sometimes asks other professionals to help the GAL learn about the child.

The GAL visits where the child lives, and wherever the child might go live, or the GAL asks someone else to visit.

The GAL also learns about the services available where the child and family live.

WHAT IF THE GAL DOES NOT DO A GOOD JOB?

If you think the GAL is not doing a good job, you should first try to tell the GAL what you think should be done, and ask why the GAL is not doing that.

If this still does not help, you should tell either your social worker, if you have one, or the judge. Parents who are unhappy with their child's GAL should tell their lawyer, the social worker or the judge.

DOES THE GAL GO TO COURT?

Yes. The GAL goes to court. In some cases the GAL might be a witness who

answers questions asked by the lawyers for the other people in court, or the GAL may ask other witnesses questions.

DOES THE CHILD HAVE TO GO TO COURT TOO?

Sometimes the child has to be in the courtroom. Other times the child just comes to the court building, in case anyone wants to ask him or her some questions. Sometimes, the child does not need to be in court at all.

The GAL should find out how the child feels about being in court, and may tell the judge. If the child is going to be in court, or in the court building, the GAL may take the child for a visit first, so it is not so scary.

If the child is not present at court hearings, the GAL will tell the child what happened, as soon as possible after the court hearing, or arrange for someone else to tell the child.

WHAT CAN I DO TO HELP THE GAL?

A GAL needs lots of help to do a good job of representing a child's best interests.

The child can help the GAL most by trying to trust the GAL and by trying to tell the GAL everything he or she asks about. If the child forgets to tell the GAL something important, the child should call the GAL, or have someone else make the call. If anything changes, the child should let the GAL know about it.

Everyone else who is concerned about the child or who knows something important about the child can help by staying in touch with the GAL.

If the GAL has not called you, you should call the GAL.

HOW DO I FIND OUT IF THERE IS A GAL?

You can find out if there is a GAL by asking the judge, the child's social worker, if there is one, or the lawyers, who are already taking part in the court case.

HB474

WHAT IS A GUARDIAN AD LITEM?

An Informational Pamphlet for Children and Their Families

Written by the Committee on Guardian Ad Litem Representation in Alaska

Administrative Office
Alaska Court System
303 K Street
Anchorage, AK 99501

February 1983

PUB-3 STWD (4/83) GAL

RECORDS CERTIFICATION

I, the undersigned, an employee of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the original records of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original records after microfilm reproductions have been made.

James A. Smith
Signature of Camera Operator

7/25/89
Date


HB
480

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

HOUSE BILL NO. 480

For an Act entitled: "An Act relating to corporal punishment of students."

This bill would prevent a person employed by, or contracting with, a public or private school from inflicting or causing to be inflicted corporal punishment on a student. An employee or contractor is permitted to use reasonable and necessary physical restraint on a student for certain protections of the student and/or property.

The department supports this bill. As the state agency responsible for investigating child abuse reports and for providing protective services, the department would welcome a partnership with the schools to end the destructive cycle of child abuse. Considerable data exists to support the concern that physical violence cycles through generations of families and that the most effective way to end the pattern is to stop the use of physical force as a disciplinary measure. Public and private school employees are viewed by students and parents as role models of appropriate behavior. Teachers have been trained in other techniques for preventing and dealing with conflict including increasing students' self control and self concept. Teachers are therefore in a unique position to influence families to use positive approaches rather than physical force in dealing with children's problems.

RECOMMENDED: Michael L Price

Michael L. Price, Director
Division of Family
and Youth Services

DATE: March 18, 1986

APPROVED: Connie J Lisi, Deputy for

John R. Pugh, Commissioner
Department of Health
and Social Services

DATE: 3-20-86

STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date : _____

REQUEST

Bill/Resolution No. : HB 480
Title : An Act relating to corporal punishment of students.

Sponsor : _____
Requestor : _____
Date of Request : 3/17/86

FISCAL DETAIL

Agency Affected : Health & Social Services
BRU : _____

Components : _____

EXPENDITURES/REVENUES : (Thousands of Dollars)

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

FUNDING : (Thousands of Dollars)

GENERAL FUND		-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER						
TOTAL		-0-	-0-	-0-	-0-	-0-

POSITIONS :

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 : 3/17/86

Approved by Commissioner : John B. Pugh, Connie Taylor, Deputy for — Date : 3/20/86
Agency : Department of 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

Introduced: 1/16/86
Referred: Health, Education &
Social Services and State Affairs

IN THE HOUSE BY KOPONEN AND DAVIS

HOUSE BILL NO. 480

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to corporal punishment of students."

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

* Section 1. AS 14.30 is amended by adding a new section to read:

ARTICLE 8. CORPORAL PUNISHMENT.

Sec. 14.30.610. CORPORAL PUNISHMENT. (a) Except as provided in (b) of this section, a person employed by or contracting with a public or private school may not inflict or cause to be inflicted corporal punishment or bodily pain on a student.

(b) A person employed by or contracting with a public or private school may, within the scope of the person's employment, use reasonable and necessary physical restraint on a student to

(1) protect the person, a student, or others from physical injury;

(2) obtain possession of a weapon or other dangerous object from a student; or

(3) protect property from serious harm.

Official Business

COMMITTEE: House Hess

DATE: 3/5/86

SIGN-IN

Subject of meeting: HB: 688

NAME	ADDRESS	PHONE	REPRESENTING	DO YOU WANT TO TESTIFY?
Wendy Redman	1101 Breckenridge		UofA	

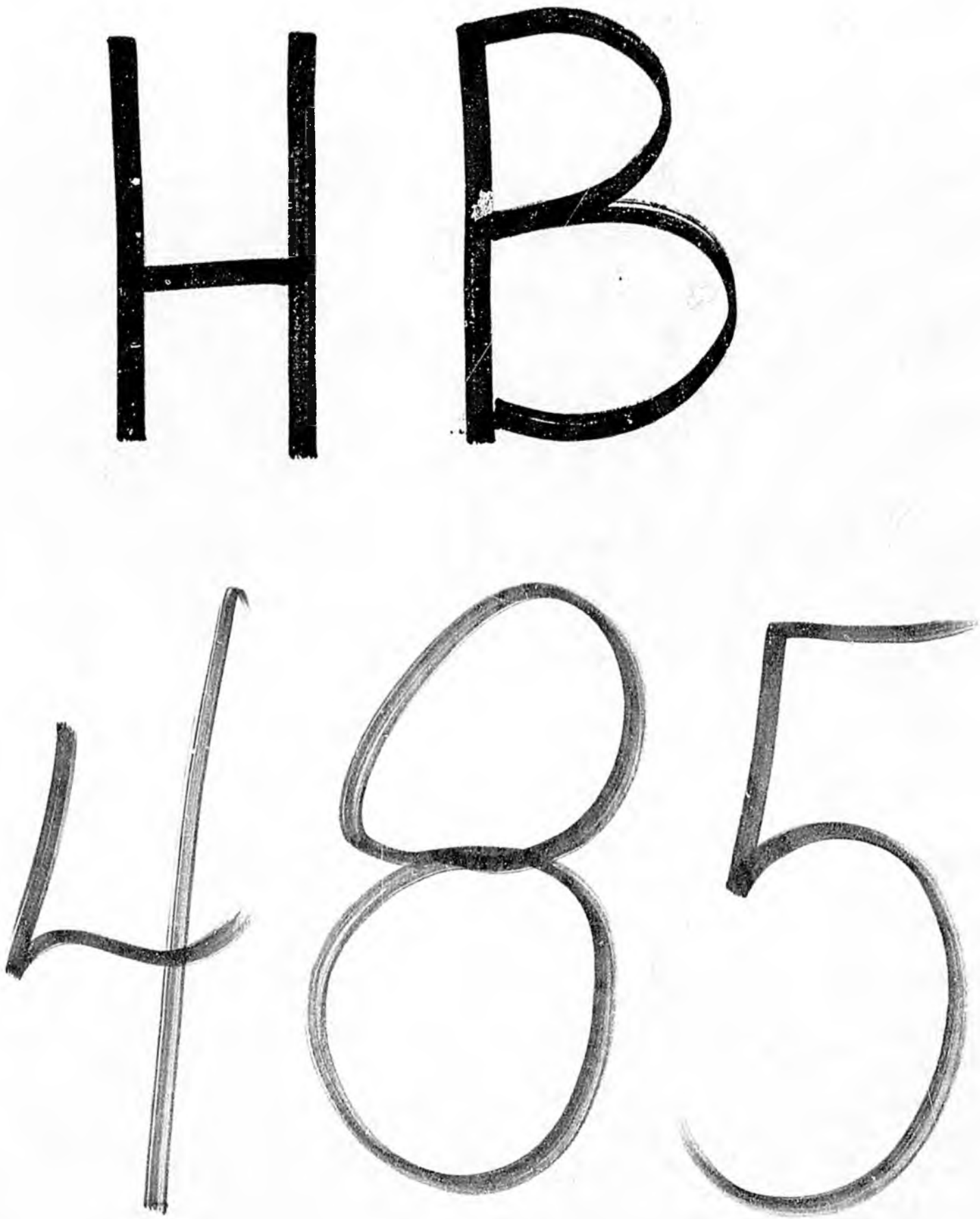
RECORDS CERTIFICATION

I, the undersigned, an employee of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the original records of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original records after microfilm reproductions have been made.

James O. Smith
Signature of Camera Operator

7/25/89
Date

02-519 (REV 8/78)


HB
4835

Introduced: 1/17/86
Referred: Health, Education &
Social Services and Judiciary

IN THE HOUSE BY SUND AND GRUENBERG

HOUSE BILL NO. 485

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - SECOND 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.[illegible](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 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; however, 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;

(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.

STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: _____

REQUEST

Bill/Resolution No.: HB 485
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)

GENERAL FUND	-0-	-0-				
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	-0-				

POSITIONS :

FULL-TIME	-0-	-0-				
PART-TIME						
TEMPORARY						

ANALYSIS : Attach a separate page if necessary

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

Approved by Commissioner: Eleanor Andrews — 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)

10/25/85

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)

GENERAL FUND		0	0	0	0	0
FEDERAL FUNDS						
OTHER						
TOTAL		0	0	0	0	0

POSITIONS :

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

Approved by Commissioner: John R. Pugh, Commissioner John R Pugh 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

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.

health
association
of alaska

319 Seward St., Juneau, Alaska 99801 • (907) 586-1790
REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

POSITION PAPER

GUARDIANSHIP LAW: NO CODE ORDERS

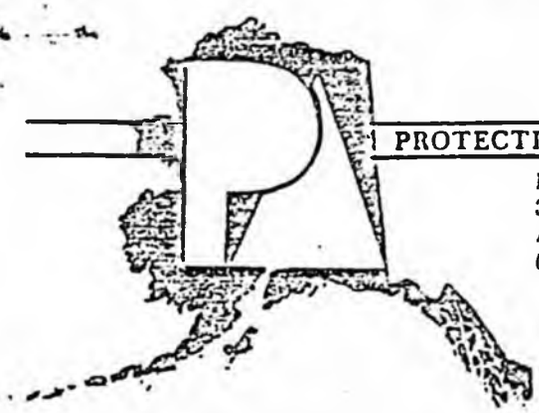
POSITION:

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



PROTECTION AND ADVOCACY FOR THE DEVELOPMENTALLY DISABLED

MAIN OFFICE
325 East 3rd, 2nd Floor
Anchorage, AK 99501
(907) 274-3658

SOUTHEAST
REGIONAL OFFICE
127 S. Franklin, Suite 2
Juneau, AK 99801
(907) 586-1627

NORTHERN
REGIONAL OFFICE
767 7th Ave.
Fairbanks, AK 99701
(907) 456-1070

Letters of support

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; 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;

(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 fro
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.

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

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF ADMINISTRATION

OLDER ALASKANS COMMISSION

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 13.21.159(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

02-825LH

File With Guardianship Legislation

PROVIDENCE HOSPITAL
3200 PROVIDENCE DRIVE—POUCH 6604
ANCHORAGE, ALASKA 99502-0604
PHONE: (907) 562-2211

SISTERS OF PROVIDENCE
SERVING IN THE WEST SINCE 1856

July 26, 1985

Joyce Munson
Director of Division of Pioneer Benefits
Pouch CL
Juneau, Alaska 99811

RE: Amendment to Guardianship Law

Dear Ms. Munson:

We were happy that you were able to attend our recent Bioethics Symposium on the Incompetent Patient. The problem with the present wording of the Guardianship Law arose several times during the day. After the final session you asked about the present status of the possible amendment.

Enclosed with this letter is a copy of a possible amendment. This possible amendment was itself amended because the public guardianship office felt an earlier version might offer too much latitude to the guardian. The present wording has the advantage of mentioning both the guardian and physician, thus implying a dialogue process of informed consent.

I am also enclosing a second possible amendment worked out by the Alaska State Hospital Association. This amendment also addresses the need for an amendment and proposes such an amendment. Those with whom I spoke found this amendment as very satisfactory but favored the first enclosed copy in its wording.

I do hope you will be able to further the passage of either of the proposed amendments or another which may better solve the uncomfortable problem created by the wording of the present law.

It was my pleasure to meet and speak to you. If I may of any assistance to you in the future, I would be happy if you called upon me.

Sincerely,

Ted Zembal S.J.
(Rev) Ted Zembal, S.J.
Coordinator, Human & Ethical Values

cc: Dennis DeWitt, ASHA
Brant McGee, Public Advocacy
Al M. Camosso, Providence Hospital
Tom Boling, OLCCC
Doug Smith, M.D.
Mark Agnew, M.D.
Donna Stephens, Pioneer Home
Enclosures (2)

July 26, 1985

A LETTER OF INTENT AND INTERPRETATION

Accompanying House Bill No.
Amending an Act entitled: "Protection of Persons Under Disability and Their Property."

PRESENT STATUTE:

AS 13.26.150(e)(3) presently reads: (e) A guardian may not...(3) consent on behalf of the ward to the withholding of life-saving medical procedures.

PROBLEM AREAS:

(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 result is that a different standard of care would be used for wards than for others. Those with guardians might be either overtreated since the treatment could not be stopped once started or undertreated because the treatment would not be begun lest it could not with withdrawn.

(2) The meaning of "life-saving medical procedures" is not clear nor is it defined. An attempt to define the phrase defies enumeration. Basically, this is so because the existing statute focuses on "procedures" etc., instead of the "relationship" of the procedure 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) To attempt to solve these problems by having the health care provider act independently of the guardian would defeat the purpose of guardianship. Also such activity on the part of the health care provider would undermine the informed consent process.

(4) In summary, this part of 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. Carrying out the existing law would sometimes lead to conflict with the practice of good medicine and ethics.

PROPOSED AMENDMENT:

AS 13.26.150(e) (3): (e) A guardian may not...(3) consent on behalf of the ward to the withholding either of comfort care of substantially beneficial medical treatment, although the guardian may consent to the physician's recommendation to withhold/withdraw medical procedures which offer no reasonable expectation of effecting a temporary or permanent cure of or relief from the illness or condition being treated.

POSSIBLE PROPOSAL FOR AN AMENDMENT

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH 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). (e) A guardian may not

(3) consent on behalf of the ward to the witholding either of comfort care or of substantially beneficial medical treatment [OF LIFE-SAVING MEDICAL PROCEDURES]; however, the guardian may consent to/concur with the physician's recommendation to withhold/withdraw 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).

GENERAL INTENT OF THE AMENDMENT:

(1) By clearer delineation of the different types of medical/nursing care involved, the amendment would allow the guardian more adequately to carry out his/her responsibilities toward the ward.

(2) By distinguishing among the three general categories, the amendment allows for one category where "life-saving medical procedures" may be withheld, viz., those which are clearly ineffective and not beneficial to the ward from the perspective of the ward.

(3) The amendment would facilitate and keep open communication, dialogue and the informed consent process among the guardian and health care providers at all times.

INTERPRETATION AND AMPLIFICATION ON THE MEANING OF THE TERMS USED IN THE AMENDMENT..

(1) "Comfort care" is meant to cover that type of supportive care that common decency grants to all people by virtue of their being human. It entails respect for all stages and conditions of human life. Comfort care has two basic aspects. (1) Basic "nursing-like" care aims at maintaining the ward physically comfortable and emotionally at ease. It includes such items as food, water, air, positioning, bathing, mouth care, suction, etc. in so far as these are consistent with supportive comfort care. (2) The second type of comfort care has a medical component but is not associated with aggressive medical treatment but rather aims at providing comfort or the easing of pain.

(2) "Substantially beneficial medical treatment" covers a broader range than "life-saving medical procedures", e.g., it would include the treatment and repair of a broken limb. The treatment decisions would be evaluated in relation to the benefits for the ward from the perspective of the ward, e.g., to restore the ward permanently or temporarily to a cognitive, sapient state would be considered "substantially beneficial medical treatment." Choices giving substantial benefits for the ward would of necessity be sought for by the guardian.

(3) The exception clause, "medical procedures which offer no reasonable expectation of effecting a temporary or permanent cure of or relief from the illness or condition being treated," is itself a definition of "ineffective, futile medical procedures which offer no benefit for the ward from his/her perspective." Rather than the vague phrase "ineffective futile medical procedure, the exception clause attempts to define its meaning.

(4) "Illness or condition being treated" is meant to prevent the holding back of medical treatment on the basis of another condition which is not treatable. For example, being mentally retarded is not a medically treatable condition and hence it cannot be used as a basis for withholding other medical procedures which are substantially beneficial for the ward.

(5) The terms "terminal", "dying", and the like were not used (1) because they defy definition and (2) because, although they may fit most situations, they do not fit all, e.g., is a person in a stable coma dying or not.

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:

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(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; 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;

(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

OUR LADY
OF COMPASSION
CARE CENTER

4805 CORDOVA STREET · POUCH 6611
ANCHORAGE, ALASKA 99502
PHONE: (907) 562-2281

SERVING IN THE WEST SINCE 1856

December 5, 1983

Kathleen Harrington, Atty.
Probate Master
303 K. Street
Anchorage, Alaska 99501

Dear Ms. Harrington:

I represent a local Long Term Care Facility, Our Lady of Compassion Care Center. Our Social Services staff have been very involved with your offices and the appointment of Guardians for our incompetant residents. An issue that is becoming more of a discussion point is that of the relationship of No Code orders and the Guardian.

It is my understanding that since your appointment as Probate Master you have been addressing the issue of No Code in the following manner. On a case by case basis you evaluate the need, and if appropriate, include in the language of the order acknowledgement that a Guardian can not withhold life saving actions. However, it is mentioned that other family members and the physician can make such a decision in regards to No Code. It has been explained to me that if it is not mentioned in the order, the above may not be assumed.

Our Facility Administrator has recently received a legal opinion through Dennis DeWitt, President of the Alaska State Hospital Association. I have enclosed a copy for your reference. It seems the conclusion is that a test case needs to be found to bring issue of No Code Orders and the Guardianship role to a conclusion.

Our facility staff are often involved with physicians and families in encouraging their participation in choosing their own plan of care. This includes decisions about life saving actions. Sometimes a decision has been made prior to Guardianship hearings, other times it has not. I feel clarification of the Guardians role is needed to provide structure to all parties in the midst of these decisions. Sometimes advocating for patients best care does not include advacating for a specific life saving action. This option is not always allowed under the present system.

OUR LADY
OF COMPASSION
CARE CENTER

4805 CORDOVA STREET · POUCH 6630
ANCHORAGE, ALASKA 99502
PHONE: (907) 522-2281

SISTERS OF
PROVIDENCE

SERVING IN THE WEST SINCE 1856

I am most interested in your input and reactions to the enclosed opinion. I am also looking at what possible steps we could take together to discuss this issue and find a reasonable solution. I realize the difficulty this issue raises for all parties and the complications legally and morally.

I look forward to hearing from you.

Sincerely,

OUR LADY OF COMPASSION CARE CENTER

Julia Thorsness, BSW
Director of Support Services

cc: John Nugent, Administrator
Dennis DeWitt, ASHA
D. Charlene Doris, Coroner

JT/jar 12/5/83

LAW OFFICE
WILLIAM T. COUNCIL
A PROFESSIONAL CORPORATION
424 NORTH FRANKLIN STREET
JUNEAU, ALASKA 99801

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, 854 (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 Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, (hereafter "the President's Commission"), 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 phycician'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 any 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, Deciding to Forego Life-Sustaining Treatment, supra, 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 Re 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." AS 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 di -ibution 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