

**Memorandum 96-39****Health Care Decisions: Selected Issues  
(Natural Death Act, Statutory Surrogacy, Execution Formalities)**

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This memorandum presents some preliminary material concerning health care decisions, discusses the scope of the study, and considers some technical issues with regard to execution formalities.

The right of a competent adult to direct or refuse medical treatment is a constitutionally protected right. This “fundamental liberty interest” is inherent in the common law and protected by federal and state constitutional privacy guarantees. See generally *Cruzan v. Commissioner, Missouri Dept. of Health*, 497 U.S. 261 (1990); *Cobbs v. Grant*, 8 Cal. 3d 229, 242, 501 P.2d 1, 104 Cal. Rptr. 505 (1972); *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1015, 195 Cal. Rptr. 484 (1983); *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 195, 209 Cal. Rptr. 220 (1984); *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1137, 225 Cal. Rptr. 297 (1986); *Conservatorship of Drabick*, 200 Cal. App. 3d 185, 206, 245 Cal. Rptr. 840 (1988); *People v. Adams*, 216 Cal. App. 3d 1431, 1437, 265 Cal. Rptr. 568 (1990); *Donaldson v. Van de Kamp*, 2 Cal. App. 4th 1614, 1619, 4 Cal. Rptr 2d 59 (1992); *Thor v. Superior Court*, 5 Cal. 4th, 725, 731, 855 P.2d 375, 21 Cal. Rptr. 2d 357 (1993); *Rains v. Belshé*, 32 Cal. App. 4th 157, 166, 38 Cal. Rptr. 2d 185 (1995). In the Natural Death Act, the Legislature made the explicit finding that “an adult person has the fundamental right to control the decisions relating to the rendering of his or her own medical care, including the decision to have life-sustaining treatment withheld or withdrawn in instances of a terminal condition or permanent unconscious condition.” Health & Safety Code § 7185.5(a). The right is not dependent on statutory recognition and continues to exist outside of statutory provisions.

This is the broad context in which this study takes place. Statutory schemes may implement this fundamental right and develop proximate solutions to the practical problems that arise, but statutes cannot constitutionally limit the fundamental liberty interest involved. Statutes can and do condition special outcomes on compliance with certain procedures and protections. Unfortunately,

statutes can also create confusion and erect unnecessary hurdles that discourage people from effectively exercising their rights or accomplishing their goals.

There are four main approaches to health care decision-making for patients lacking capacity that may be implemented by statute:

### **1. Court-Appointed Conservator or Other Judicial Intervention**

California law provides a highly developed guardianship-conservatorship law. Prob. Code § 1400 *et seq.* There is also a special procedure for court authorized medical treatment for adults without conservators. Prob. Code § 3200 *et seq.* The Lanterman-Petris-Short Act provides a special type of conservatorship for the gravely disabled. Welf. & Inst. § 5350 *et seq.*

— This body of law is **not** a subject of this study, although some conforming or technical revisions may be necessary.

### **2. Natural Death Act, Living Will**

California's Natural Death Act provides for a declaration concerning continuation of life sustaining treatment in the circumstances of a permanent unconscious condition. Under the original NDA, the patient executed a "directive to physicians." Under the new UHCDA, this type of writing is an "individual instruction" (although the instruction may also be given orally).

— The staff proposes detailed review of the NDA in light of the new UHCDA and recent statutes enacted in other states. Preliminary review also suggests that the NDA should be integrated with the UHCDA and consistently organized subject to general rules where possible.

### **3. Power of Attorney**

California has a detailed statute governing durable powers of attorney for health care and providing a special statutory form durable power of attorney for health care. Prob. Code § 4600 *et seq.* The DPAHC requires appointment of an attorney-in-fact ("agent" in the statutory form) to carry out the principal's wishes expressed in the power of attorney or otherwise made known to the attorney-in-fact, but the attorney-in-fact also has authority to act in the best interest of the principal where the principal's desires are unknown. See Prob. Code § 4720.

— As the Commission well knows, the general power of attorney statutes were recently reviewed and revised on Commission recommendation. See 1994 Cal. Stat. ch. 307; 1995 *Comprehensive Power of Attorney Law*, 24 Cal. L. Revision Comm'n Reports 323 (1994). In its report, the Commission noted that it had "not made a substantive review of the statutes concerning the durable power of

attorney for health care .... [I]t would have been premature to undertake a detailed review of the health care power statutes before the National Conference of Commissioners on Uniform State Laws completed its work on the Uniform Health-Care Decisions Act.” *Id.* at 335. As this study moves along, we think the consensus will be that quite a few changes need to be made in the DPAHC statute.

#### **4. Statutory Surrogacy**

California has not codified rules governing who may make health care decisions for an incompetent adult in the absence of an advance directive or court involvement. The new Uniform Health-Care Decisions Act provides for decisionmaking by family members and close friends of the patient.

— The staff will propose consideration of some form of statutory surrogacy. The starting point will be the UHCDA provision, but we will also want to consider what other states have done in this area.

In a 1991 article entitled *Time for a New Law on Health Care Advance Directives*, Professor George Alexander gives the following overview, which is fairly consistent with the staff’s suggested approach:

During the last decade, states have enacted three different kinds of documents to deal with health care of incompetent patients. The legislation’s main impetus and central focus have been to provide a procedure to approve life support termination in appropriate cases, although it also addresses other health care concerns. The earliest of the statutes was a natural death act, which authorizes a directive, popularly called a living will, to physicians. The second was a general durable power of attorney, sometimes in the form of a specially crafted health care durable power of attorney, which essentially empowers an appointed agent to make appropriate decisions for an incompetent patient. The agent is bound by directions contained in the appointing power. Finally, some states have enacted family consent laws empowering others, typically family, to decide health care matters absent a directive or power of attorney to guide them. At the end of 1990, Congress gave these laws new importance by mandating their observance.

The statutes differ; provisions of one form conflict with provisions of another form. Most contradictions raise problems, some nettlesome, others destructive of important interests. After more than a decade of experience with such forms, it is time to review the present state of the laws and to coordinate and debug them. In the author’s view, a single statute incorporating the best of each of the three types of law is now in order.

42 Hastings L.J. 755 (1991) (footnotes omitted).

The Prefatory Note to the Uniform Health-Care Decisions Act summarizes the Uniform Commissioners' viewpoint in this regard:

Since the Supreme Court's decision in *Cruzan v. Commissioner, Missouri Department of Health*, 497 U.S. 261 (1990), significant change has occurred in state legislation on health-care decision making. Every state now has legislation authorizing the use of some sort of advance health-care directive. All but a few states authorize what is typically known as a living will. Nearly all states have statutes authorizing the use of powers of attorney for health care. In addition, a majority of states have statutes allowing family members, and in some cases close friends, to make health-care decisions for adult individuals who lack capacity.

This state legislation, however, has developed in fits and starts, resulting in an often fragmented, incomplete, and sometimes inconsistent set of rules. Statutes enacted within a state often conflict and conflicts between statutes of different states are common. In an increasingly mobile society where an advance health-care directive given in one state must frequently be implemented in another, there is a need for greater uniformity.

The Health-Care Decisions Act was drafted with this confused situation in mind. The Act is built around the following concepts. *First*, the Act acknowledges the right of a competent individual to decide all aspects of his or her own health care in all circumstances, including the right to decline health care or to direct that health care be discontinued, even if death ensues....

*Second*, the Act is comprehensive and will enable an enacting jurisdiction to replace its existing legislation on the subject with a single statute. The Act authorizes health-care decisions to be made by an agent who is designated to decide when an individual cannot or does not wish to; by a designated surrogate, family member, or close friend when an individual is unable to act and no guardian or agent has been appointed or is reasonably available; or by a court having jurisdiction as decision maker of last resort.

*Third*, the Act is designed to simplify and facilitate the making of advance health-care directives....

*Fourth*, the Act seeks to ensure to the extent possible that decisions about an individual's health care will be governed by the individual's own desires concerning the issues to be resolved....

*Fifth*, the Act addresses compliance by health-care providers and institutions....

*Sixth*, the Act provides a procedure for the resolution of disputes....

## TERMINOLOGY

There are a number of California statutes and uniform acts that we will be referring to from time to time in this study. As we work on the materials, they will become more familiar and their acronyms will be readily recognizable.

<b>DPAHC</b>	<b>Durable power of attorney for health care</b> (Prob. Code § 4600 <i>et seq.</i> ) Health care powers of attorney under Part 4 of the comprehensive Power of Attorney Law; includes SF-DPAHC and RTFRM.
<b>DPAP</b>	<b>Durable power of attorney for property</b> (Prob. Code § 4000 <i>et seq.</i> ) Informal name for non-health care powers of attorney under the comprehensive Power of Attorney Law. (Also called DPAF — durable power of attorney for financial management — in CEB’s Durable Powers of Attorney.
<b>DPCDA</b>	<b>Due Process in Competence Determinations Act</b> (Prob. Code §§ 810-814, 1881, 3201, 3204, 3208, etc.) 1995 Cal. Stat. ch. 842. New statute setting standards for judicial determinations of competence.
<b>NDA</b>	<b>Natural Death Act</b> (Health & Safety Code §§ 7185-7194.5) The original NDA was enacted in 1976. It was replaced in 1991 with most of URTIA (1989), but the name was retained.
<b>PAL</b>	<b>Power of Attorney Law</b> (Prob. Code § 4000 <i>et seq.</i> ) The Commission’s comprehensive Power of Attorney Law, enacted in 1994.
<b>RTFRM</b>	<b>Request to forego resuscitative measures</b> (Prob. Code § 4753) 1994 Cal. Stat. ch. 966. Protects health care providers from liability for honoring a “do not resuscitate” (DNR) form, bracelet, or medallion. Located in the DPAHC statute, but not directly related.
<b>SF-DPAHC</b>	<b>Statutory form durable power of attorney for health care</b> (Prob. Code §§ 4770-4779) Part of DPAHC; also known as the “Keene Health Care Agent Act.”
<b>UAGA</b>	<b>Uniform Anatomical Gift Act (1987)</b> (Health & Safety Code § 7150 <i>et seq.</i> )
<b>UDPA</b>	<b>Uniform Durable Power of Attorney Act</b> (see Prob. Code § 4001) Part of the Uniform Probate Code or freestanding act dating back to 1969; incorporated into the comprehensive Power of Attorney Law.
<b>UHCDA</b>	<b>Uniform Health Care Decisions Act (1993)</b> Latest uniform act in this area. Supersedes URTIA (1985 & 1989) and the Model Health-Care Consent Act (1982).
<b>URTIA</b>	<b>Uniform Rights of the Terminally Ill Act (1985) (1989)</b> NDA is largely consistent with URTIA (1989).
<b>USFPA</b>	<b>Uniform Statutory Form Power of Attorney</b> (Prob. Code §§ 4400-4465) Part 3 of the comprehensive Power of Attorney Law.

We should attempt to be consistent in using terms like agent, attorney-in-fact, proxy, surrogate, directive, power, instruction, etc. Not all of these terms are used consistently among state statutes, uniform acts, and scholarly commentary. There may be some unavoidable overlap even within one statutory scheme — thus a power of attorney may appoint an “agent” or an “attorney-in-fact” to make health care decisions, and a patient may “designate” a “surrogate” in writing under the UHCDA. Some terms overlap because they approach a subject from a different perspective. Thus, under the UHCDA, an “advance health-care directive” includes powers of attorney and “individual instructions” which in turn include an “individual’s direction concerning a health-care decision for the individual” but the individual may also designate a surrogate by informing the supervising health-care provider. Unless the context forces another construction, however, we intend to restrict “surrogate” to mean a surrogate acting by statutory authority, not pursuant to a directive. We do not intend to use “proxy.” “Agent” and “attorney-in-fact” may be used interchangeably, but will always mean a person acting pursuant to a power of attorney, most likely a durable power of attorney for health care.

#### SCOPE OF STUDY — LOCATION OF NDA OR SUCCESSOR STATUTE

It is useful to consider some questions of location, although no final decision can be made. If it is possible to achieve the ideal of reorganizing the relevant statutes in one place, then some provisions must be relocated. The Probate Code and the Health and Safety Code are the obvious candidates. The catch-all Civil Code would have been a possible location, but the Commission has just consolidated the power of attorney statutes in the Probate Code and it makes no sense to move revised health care decision statutes back. If the study were limited to considering minor revisions of the NDA in light of the new UHCDA, then there might be insufficient reason to move the NDA out of the Health and Safety Code where it has been since 1976.

Leaving aside the inertia issues we commonly encounter, particularly at the initial stages of a statutory revision, it seems plain that the NDA should be moved. The statute is unfortunately located, being in the “Dead Bodies” division (Division 7 commencing with Section 7000) of the Health and Safety Code, which is otherwise concerned with determination of death (Uniform Determination of Death Act, etc.), interment, disposition and transportation of human remains, embalming, etc. This division also contains the Uniform Anatomical Gifts Act

(also mislocated) and provisions concerning organ transplants. The historical purpose of this division of the Health and Safety Code seems to have been related to sanitation issues centered on human remains.

The NDA and the UAGA provide for advance directives to be made by an individual, and thus enter the realm of individual planning — more an issue of private law than public health. The UAGA also relates to technical issues involving coroners and medical technicians, and it governs actions occurring only after death, and in this sense is more closely related to other provisions in this part of the Health and Safety Code. The origins and historical structure of the Health and Safety Code is apparent in the following outline, evidencing the original concern with public health administration and sanitation issues:

- Division 1. Administration of Public Health
- Division 2. Licensing Provisions
- Division 2.5. Emergency Medical Services
- Division 3. Pest Abatement
- Division 4. Communicable Disease Prevention and Control
- Division 5. Sanitation
- Division 6. Sanitary Districts
- Division 7. Dead Bodies**
  - Part 1. General Provisions
    - Chapter 1. Definitions (§§ 7000-7025)
    - Chapter 2. General Provisions (§§ 7050.5-7055)
    - Chapter 3. Custody, and Duty of Interment (§§ 7100-7117)
    - Chapter 3.5. Uniform Anatomical Gift Act (§§ 7150-7156.5)**
    - Chapter 3.6. Organ Transplants (§§ 7160)
    - Chapter 3.7. Death
      - Article 1. Uniform Determination of Death Act (§ 7180)
      - Article 2. Confirmation of Death (§§ 7181-7184)
    - Chapter 3.9. Natural Death Act (§§ 7185-7194.5)**
    - Chapter 4. Disposal of Unclaimed Dead (§§ 7200-7208)
    - Chapter 5. Embalming and Transportation
      - Article 1. Embalming (§§ 7300-7304)
      - Article 2. Transportation (§ 7355)
  - Part 2. Disinterment and Removal
- Division 8. Cemeteries
- Division 9. Vital Statistics

Over the past several decades, the Health and Safety Code has vastly increased in size and scope. Parts of the code are in the process of reorganization, with the newly structured provisions following Section 100000 in Division 101.

(See Health & Safety Code Section 100475 for the authorization to reorganize the code, particularly as relates to “public health laws.”) We are attempting to determine whether the reorganizers have plans for the Natural Death Act that should be coordinated with the Commission’s activity in this area. The new Division 106 on Personal Health Care or some other location might be intended to include the NDA, and by logical extension any successor act like the UHCDA.

The staff concludes that the NDA needs to be better coordinated with the DPAHC, regardless of the extent of any revisions drawn from UHCDA. Logically, we are led to the Probate Code. This is not to say that the Probate Code is necessarily the ideal location — just that it is the best of the practical choices. If the NDA is to be replaced in any significant respect with the new UHCDA, then the need for coordination and proximity with the DPAHC is clearer, since the UHCDA is broader in scope, pertains to powers of attorney, and envisions judicial oversight. The existing procedure for judicial review of actions of attorneys-in-fact in the PAL provides a useful model for any judicial review needed under the NDA or the UHCDA. The Probate Code also contains useful general provisions and provisions relating to uniform acts.

When we begin preparation of statute drafts for Commission consideration, the staff proposes to direct that effort toward the Probate Code and remove the NDA from the Health and Safety Code.

#### STATUTORY SUCROGACY

Earlier in this memorandum, we outlined three major approaches to private health care decisionmaking for incompetent adults: living wills, powers of attorney, and statutory surrogacy. California led the nation in developing the first two kinds of statutes, in the Natural Death Act of 1976 and the DPAHC of 1983. The third approach is not yet a part of California law — statutory surrogates (typically family members) authorized to make health care decisions for an incompetent adult who has not given an effective advance directive.

The surrogacy issue was probably before the Legislature in 1991 when the original NDA was revised to incorporate most of the URTIA. See 1991 Cal. Stat. ch. 895 (SB 980, Keene). Section 7 of the 1989 revision of URTIA provides that family members can give written consent to withholding or withdrawal of treatment, witnessed by two individuals. This authority is provided to family members in the following priority: (1) spouse, (2) adult child (or a majority of those reasonably available), (3) parents, (4) adult sibling (or a majority of those



reasonably available), or (5) nearest other adult relative by blood or adoption who is reasonably available for consultation.

This section was omitted when the NDA was revised in 1991 and cross-references to the surrogacy rules were omitted from other provisions that were enacted at that time. We have not yet determined whether this was done before the bill was introduced or happened as it moved through the legislative process.

The new UHCDA provides a more developed version of the surrogate rule. Note that this provision is not limited to “statutory surrogacy,” as we are using the term, but also includes surrogates designated by the patient. The section and the Uniform Commission comment are set out in full:

#### **SECTION 5. DECISIONS BY SURROGATE.**

(a) A surrogate may make a health-care decision for a patient who is an adult or emancipated minor if the patient has been determined by the primary physician to lack capacity and no agent or guardian has been appointed or the agent or guardian is not reasonably available.

(b) An adult or emancipated minor may designate any individual to act as surrogate by personally informing the supervising health-care provider. In the absence of a designation, or if the designee is not reasonably available, any member of the following classes of the patient’s family who is reasonably available, in descending order of priority, may act as surrogate:

- (1) the spouse, unless legally separated;
- (2) an adult child;
- (3) a parent; or
- (4) an adult brother or sister.

(c) If none of the individuals eligible to act as surrogate under subsection (b) is reasonably available, an adult who has exhibited special care and concern for the patient, who is familiar with the patient’s personal values, and who is reasonably available may act as surrogate.

(d) A surrogate shall communicate his or her assumption of authority as promptly as practicable to the members of the patient’s family specified in subsection (b) who can be readily contacted.

(e) If more than one member of a class assumes authority to act as surrogate, and they do not agree on a health-care decision and the

supervising health-care provider is so informed, the supervising health-care provider shall comply with the decision of a majority of the members of that class who have communicated their views to the provider. If the class is evenly divided concerning the health-care decision and the supervising health-care provider is so informed, that class and all individuals having lower priority are disqualified from making the decision.

(f) A surrogate shall make a health-care decision in accordance with the patient's individual instructions, if any, and other wishes to the extent known to the surrogate. Otherwise, the surrogate shall make the decision in accordance with the surrogate's determination of the patient's best interest. In determining the patient's best interest, the surrogate shall consider the patient's personal values to the extent known to the surrogate.

(g) A health-care decision made by a surrogate for a patient is effective without judicial approval.

(h) An individual at any time may disqualify another, including a member of the individual's family, from acting as the individual's surrogate by a signed writing or by personally informing the supervising health-care provider of the disqualification.

(i) Unless related to the patient by blood, marriage, or adoption, a surrogate may not be an owner, operator, or employee of [a residential long-term health-care institution] at which the patient is receiving care.

(j) A supervising health-care provider may require an individual claiming the right to act as surrogate for a patient to provide a written declaration under penalty of perjury stating facts and circumstances reasonably sufficient to establish the claimed authority.

#### **Comment**

Subsection (a) authorizes a surrogate to make a health-care decision for a patient who is an adult or emancipated minor if the patient lacks capacity to make health-care decisions and if no agent or guardian has been appointed or the agent or guardian is not reasonably available. Health-care decision making for unemancipated minors is not covered by this section. The subject of consent for treatment of minors is a complex one which in many states is covered by a variety of statutes and is therefore left to other state law.

While a designation of an agent in a written power of attorney for health care is preferred, situations may arise where an individual will not be in a position to execute a power of attorney for health care. In that event, subsection (b) affirms the principle of patient autonomy by allowing an

individual to designate a surrogate by personally informing the supervising health-care provider. The supervising health-care provider would then, in accordance with Section 7(b), be obligated to promptly record the designation in the individual's health-care record. An oral designation of a surrogate made by a patient directly to the supervising health-care provider revokes a previous designation of an agent. See Section 3(a).

If an individual does not designate a surrogate or if the designee is not reasonably available, subsection (b) applies a default rule for selecting a family member to act as surrogate. Like all default rules, it is not tailored to every situation, but incorporates the presumed desires of a majority of those who find themselves so situated. The relationships specified in subsection (b) include those of the half-blood and by adoption, in addition to those of the whole blood.

Subsection (c) permits a health-care decision to be made by a more distant relative or unrelated adult with whom the individual enjoys a close relationship but only if all family members specified in subsection (b) decline to act or are otherwise not reasonably available. Consequently, those in non-traditional relationships who want to make certain that health-care decisions are made by their companions should execute powers of attorney for health care designating them as agents or, if that has not been done, should designate them as surrogates.

Subsections (b) and (c) permit any member of a class authorized to serve as surrogate to assume authority to act even though there are other members in the class.

Subsection (d) requires a surrogate who assumes authority to act to immediately so notify the members of the patient's family who in given circumstances would be eligible to act as surrogate. Notice to the specified family members will enable them to follow health-care developments with respect to their now incapacitated relative. It will also alert them to take appropriate action, including the appointment of a guardian or the commencement of judicial proceedings under Section 14, should the need arise.

Subsection (e) addresses the situation where more than one member of the same class has assumed authority to act as surrogate and a disagreement over a health-care decision arises of which the supervising health-care provider is informed. Should that occur, the supervising health-care provider must comply with the decision of a majority of the members of that class who have communicated their views to the provider. If the members of the class who have communicated their views to the provider are evenly divided concerning the health-care decision, however, then the entire class is disqualified from making the decision and no individual having lower priority may act as surrogate. When such a deadlock arises, it may be necessary to seek court determination of the issue as authorized by Section 14.

Subsection (f) imposes on surrogates the same standard for health-care decision making as is prescribed for agents in Section 2(e). The surrogate must follow the patient's individual instructions and other expressed wishes to the extent known to the surrogate. To the extent such instructions or other wishes are unknown, the surrogate must act in the patient's best interest. In determining the patient's best interest, the surrogate is to consider the patient's personal values to the extent known to the surrogate.

Subsection (g) provides that a health-care decision made by a surrogate is effective without judicial approval. A similar provision applies to

health-care decisions made by agents (Section 2(f)) or guardians (Section 6(c)).

Subsection (h) permits an individual to disqualify any family member or other individual from acting as the individual's surrogate, including disqualification of a surrogate who was orally designated.

Subsection (i) disqualifies an owner, operator, or employee of a residential long-term health-care institution at which a patient is receiving care from acting as the patient's surrogate unless related to the patient by blood, marriage, or adoption. This disqualification is similar to that for appointed agents. See Section 2(b) and Comment.

Subsection (j) permits a supervising health-care provider to require an individual claiming the right to act as surrogate to provide a written declaration under penalty of perjury stating facts and circumstances reasonably sufficient to establish the claimed relationship. The authority to request a declaration is included to permit the provider to obtain evidence of claimed authority. A supervising health-care provider, however, does not have a duty to investigate the qualifications of an individual claiming authority to act as surrogate, and Section 9(a) protects a health-care provider or institution from liability for complying with the decision of such an individual, absent knowledge that the individual does not in fact have such authority.

At this stage, it is premature to get into a detailed analysis of this section and how it might fit with existing California law. But it is beneficial to review the section well enough to get an understanding of how it would work in practice.

The staff is interested in any comments Commissioners and other interested persons might have on the surrogacy alternative in general, as well as any technical problems or suggestions. The staff thinks this is an important issue and worth serious consideration in this study. Providing some guidance as to health care decisionmaking in the absence of an effective advance directive certainly seems useful in principle. We hope to obtain some input from the medical establishment and legal experts in this area of the law before getting too deeply into the technical drafting issues that will inevitably arise.

### 3. EXECUTION FORMALITIES

California law in this area has been fairly strict in its execution formalities and witnessing requirements, dating from the Natural Death Act in 1976 through the comprehensive Power of Attorney Act in 1994. Uniform acts have tended to take a more relaxed approach regarding witnessing and witness qualifications. See Uniform Durable Power of Attorney Act (1969) (no witness provisions); Uniform Rights of the Terminally Ill Acts (1985 & 1989) (two witnesses, but simple requirements); Uniform Health-Care Decisions Act (1993) (witnesses not required, though encouraged).

The Uniform Commissioners' comment to Section 2 of URTIA (1989) explains its witnessing rationale as follows:

The Act's provisions governing witnesses to a declaration are simplified. Section 2 provides only that the declaration be signed by the declarant in the presence of two witnesses. The Act does not require witnesses to meet any specific qualifications for two primary reasons. First, the interest in simplicity mandates as uncomplicated a procedure as possible. It is intended that the Act present a viable alternative for those persons interested in participating in their medical treatment decisions in the event of a terminal condition.

Second, the absence of more elaborate witness requirements relieves physicians of the inappropriate and perhaps impossible burden of determining whether the legalities of the witness requirements have been met. Many physicians understandably and rightly would be hesitant to make such decisions and, therefore, the effectiveness of the declaration might be jeopardized. It should be noted, as well, that protection against abuse in these situations is provided by the criminal penalties in Section 10. The attending physicians and other health-care professionals will be able, in most circumstances, to discuss the declaration with the patient and family and any suspicion of duress or wrongdoing can be discovered and handled by established hospital procedures.

The original California NDA in 1976 adopted the general rules applicable to executing and witnessing wills. Under former Health and Safety Code Section 7188, the Directive to Physicians had to be signed by the declarant

in the presence of two witnesses not related to the declarant by blood or marriage and who would not be entitled to any portion of the estate of the declarant upon his decease under any will of the declarant or codicil thereto then existing or, at the time of the directive, by operation of law then existing ... or any person who has a claim against any portion of the estate of the declarant upon his decease at the time of the execution of the directive.

In addition to these *financial* conflict of interest restrictions, the original NDA restricted witnesses based on possible *professional* conflicts of interest. Thus the witness could not be the "attending physician, an employee of the attending physician or a health facility in which the declarant is a patient." Finally, Section 7188.5 of the original NDA imposed special requirements on directives executed by patients in "skilled nursing facilities," requiring that one of the witnesses be a "patient advocate or ombudsman as may be designated by the State Department of Aging." The Legislature recognized that "some patients in skilled nursing

facilities may be so insulated from a voluntary decisionmaking role, by virtue of the custodial nature of their care, as to require special assurance that they are capable of willfully and voluntarily executing a directive.”

These principles were generally adopted in the Commission’s preparation of the original durable power of attorney for health care enacted in 1983. Although durable powers of attorney for other purposes did not have to be witnessed, former Civil Code Section 2432 more closely resembled the will execution rules by providing for the principal’s acknowledgment of his or her signature before the witnesses, to avoid the technical challenge that could arise if the witness had not actually seen the signing. The major change in this area, however, was the provision for acknowledgment before a notary public as an *alternative* to the witnessing rules. This rule was adopted to ameliorate the concern over the cumbersome and technical witnessing requirements drawn from the law of wills.

When the Commission undertook the comprehensive study of power of attorney law, the general rules on execution of powers of attorney were conformed in part to the more restrictive health care power rules. While no witnesses were required for a durable power of attorney under the former California version of the UDPA, the new durable power of attorney for property must be either acknowledged before a notary public or signed by two witnesses. However, the health care conflict of interest rules were not generalized to apply to DPAPs. Nor were the inconsistencies between the statutory forms and the general provisions smoothed out. The notarization requirement applicable to the statutory form durable power of attorney for property was retained without adding a witnessing option in the interest of sister state uniformity, since it implements the Uniform Statutory Form Power of Attorney Act (1988). See Prob. Code § 4400 *et seq.*

The new UHCDA adopts a more flexible approach, as explained in the Prefatory Note:

*Third*, the Act is designed to simplify and facilitate the making of advance health-care directives. An instruction may be either written or oral. A power of attorney for health care, while it must be in writing, need not be witnessed or acknowledged. In addition, an optional form for the making of a directive is provided.

Section 2 of the UHCDA, the substantive provision governing advance health-care directives applicable to both individual instructions and powers of attorney for health care, does not contain any witnessing or acknowledgment provision. Indeed, an “individual instruction” may be given orally. The comment to Section

2 notes that a power of attorney must be in writing and signed by the principal, but need not be witnessed or acknowledged. No other reference is made to notarization.

The instructions for completion of the optional form for an Advance Health-Care Directive in Section 4 of the UHCDA contain the following recommendation: “After completing this form, sign and date the form at the end. It is recommended but not required that you request two other individuals to sign as witnesses.” The optional form provides optional spaces for signatures by two witnesses.

The existing California law and selected uniform acts may be summarized as follows:

	Witnesses	Notary	Rules on Financial Conflicts	Rules on Professional Conflicts	Other
<i>California Law:</i>					
DPAP	2 optional	optional	—	—	—
DPAHC	2 optional	optional	1 witness	both witnesses & agent	ombudsman
NDA	2 required	—	1 witness	1 witness	ombudsman
RTFRM	—	—	—	—	—
SF-DPAHC	2 required	—	1 witness	both witnesses & agent	ombudsman
USFPA	—	required	—	—	—
<i>Uniform Acts:</i>					
UDPA	—	—	—	—	—
UHCDA	form option	—	—	as to agent or surrogate	—
URTIA	2 required	—	—	—	—

The Commission should consider making the various health care statutes (DPAHC, SF-DPAHC, NDA-UHCDA) subject to the same witnessing requirements, notary option, patient advocate or ombudsman requirements, and conflict of interest limitations. The staff contemplates that the detailed protections that have consistently been written into California law will continue to be required, but stating them once, or at least stating them consistently in related statutes, should help make the complexity understandable. In California, the law has a tendency to make informal approaches to dealing with problems

more formal and restricted. This may be a proper response to demonstrated abuses and weaknesses in the original procedures, but the judgment of the experts who drafted the UHCDA and other similar approaches is that less formal procedures are justified, even necessary, to deal with real problems that are not adequately covered by formal instruments like the California DPAHC. Hence, at the same time it aims for consistency, the Commission will need to make sure the statutes governing health care decisions do not become too complex and difficult to understand and apply. While it may be beneficial and generally preferable for a person to seek expert legal and medical advice before entering this thicket, we know from practical experience that many or most people will not fill out the forms or draft the necessary documents if it is too cumbersome, confusing, or expensive. California law recognizes the validity of durable powers of attorney for health care and similar instruments executed in other jurisdictions in compliance with local law and gives them the same effect as a valid California DPAHC. If the national trend is toward less formal advance directives, it seems anomalous that people able to take advantage of a sister state's law would be more likely to have their health care decisions honored here than California residents who have tried but failed to comply with our more technical and complicated statutes. Perhaps the problem can be sufficiently ameliorated by giving some effect to technically deficient DPAHCs under the "individual instruction" approach of the UHCDA.

In sum, there is a tension between the desire to make these procedures consistent so the statutes will be easier to understand and the need to provide sufficient flexibility to accomplish the intended purpose of effectuating the individual's important health care decisions. We will need to keep these conflicting goals in mind as the study proceeds.

Respectfully submitted,

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