

Memorandum 97-63

Health Care Decisions: Statutory Surrogacy

This memorandum considers alternative approaches to statutory designation of surrogate health care decisionmakers, meaning persons who would be authorized by statute to make health care decisions for an incompetent adult. It is fundamental that a statutory surrogacy scheme would apply only where the patient does not have an effective advance health care directive (power of attorney for health care or other written advance directive) and no conservator has been appointed with authority to make health care decisions.

At the June meeting, the Commission requested the staff to review the law of other states and consider alternatives to the priority list of statutory surrogates set forth in Section 5 of the Uniform Health-Care Decisions Act. This memorandum reviews California case law, considers a number of the major issues, and presents three main alternative approaches to statutory surrogacy and family consent. We anticipate that after the Commission resolves the major issues, we will be able to polish the drafting and insert the surrogacy chapter into the draft statute. (See draft statute attached to Memorandum 97-60, pp. 41-45, draft Section 4710 *et seq.*)

BACKGROUND

California statutes do not provide general surrogacy rules. Within the last five years, however, a detailed procedure has been developed for making “medical intervention” decisions for residents of skilled nursing facilities and intermediate care facilities if the person lacks capacity to make health care decisions and there is no person “with legal authority” to make such decisions. Health & Safety Code § 1418.8 (sometimes called the “Epple bill” after the author of the original legislation in 1992; copy attached as Exhibit). A “person with legal authority” is defined as a person designated under a durable power of attorney for health care, a guardian or conservator, or next of kin. We will consider this procedure in more detail later.

There is useful case law, but due to the nature of the cases, we do not have comprehensive guidance as to who can make health care decisions for incapacitated persons.

Cobbs v. Grant

In *Cobbs v. Grant*, 8 Cal. 3d 229, 501 P.2d 1, 104 Cal. Rptr. 505 (1972), a negligence case involving the issue of whether a competent patient had given informed consent, the Supreme Court wrote:

A patient should be denied the opportunity to weigh the risks only where it is evident he cannot evaluate the data, as for example, where there is an emergency or the patient is a child or incompetent. For this reason the law provides that in an emergency consent is implied ..., and if the patient is a minor or incompetent, the authority to consent is transferred to the patient's legal guardian or closest available relative In all cases other than the foregoing, the decision whether or not to undertake treatment is vested in the party most directly affected: the patient.

(*Id.* at 243-44, citations omitted.) The “closest available relative” statement cites three cases, none of which involve incapacitated adults. Consent on behalf of an incapacitated adult an issue in the case, as the patient did not lack capacity, but was claiming that he had not given informed consent. Still, *Cobbs* is cited frequently in later cases involving consent or withdrawal of consent to medical treatment.

Barber

Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983), is the leading case in this area. Two doctors were charged with murder for removing life support from the patient who had suffered severe brain damage, leaving him in a vegetative state likely to be permanent. The family was informed of the patient's condition and chances for recovery and they then drafted a request for removal of life support. When the patient continued to live after removal of the ventilator, the family requested removal of artificial nutrition and hydration and the patient died. The court recognized that “a murder prosecution is a poor way to design an ethical and moral code for doctors who are faced with decisions concerning the use of costly and extraordinary ‘life support’ equipment.” *Id.* at 1011. As in *Cobbs*, the court reaffirmed that a competent adult has the right to refuse medical treatment, and found that

intravenous administration of nutrition and hydration is, like the use of a respirator, a form of medical treatment. On the duty side of the ledger, the court found that a

physician has no duty to continue treatment, once it has proved to be ineffective. Although there may be a duty to provide life-sustaining machinery in the *immediate* aftermath of a cardio-respiratory arrest, there is no duty to continue its use once it has become futile in the opinion of qualified medical personnel.

Id. at 1017-18. In an effort to provide some guidelines in the absence of governing legislation, the court adopted a proportionate treatment standard (*id.* at 1019-20):

Under this approach, proportionate treatment is that which, in the view of the patient, has at least a reasonable chance of providing benefits to the patient, which benefits outweigh the burdens attendant to the treatment.” *Id.* at 1019. Thus, even if a proposed course of treatment might be extremely painful or intrusive, it would still be proportionate treatment if the prognosis was for complete cure or significant improvement in the patient’s condition. On the other hand, a treatment course which is only minimally painful or intrusive may nonetheless be considered disproportionate to the potential benefits if the prognosis is virtually hopeless for any significant improvement in condition....

Thus, the determination as to whether the burdens of treatment are worth enduring for any individual patient depends on facts unique to each case, namely, how long the treatment is likely to extend life and under what conditions. “[S]o long as a mere biological existence is not considered the *only* value, patients may want to take the nature of that additional life into account as well.” (President’s Commission, ch. 2, at p. 88.)

Of course the patient’s interests and desires are the key ingredients of the decision making process. When dealing with patients for whom the possibility of full recovery is virtually non-existent, and who are incapable of expressing their desires, there is also something of a consensus on the standard to be applied.

“[T]he focal point of decision should be the prognosis as to the reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of that biological vegetative existence” (*Matter of Quinlan*)

The next issue the court faced is who should make the decision on terminating treatment when the patient is incapacitated:

Given the general standards for determining when there is a duty to provide medical treatment of debatable value, the question still remains as to who should make these vital decisions. Clearly, the medical diagnoses and prognoses must be determined by the treating and consulting physicians under the generally accepted standards of medical practice in the community and, whenever possible, the patient himself should then be the ultimate decision-maker.

When the patient, however, is incapable of deciding for himself, because of his medical condition or for other reasons, there is no clear authority on the issue of who and under what procedure is to make the final decision.

It seems clear, in the instant case, that if the family had insisted on continued treatment, petitioners would have acceded to that request. The family's decision to the contrary was, as noted, ignored by the superior court as being a legal nullity.

In support of that conclusion the People argue that only duly appointed legal guardians have the authority to act on behalf of another. While guardianship proceedings might be used in this context, we are not aware of any authority *requiring* such procedure. In the case at bench, petitioners consulted with and relied on the decisions of the immediate family, which included the patient's wife and several of his children. No formal guardianship proceedings were instituted.

In the absence of legislation requiring such legal proceedings, we cannot say that failure to institute such proceedings made petitioners' conduct unlawful. Whether such proceedings are to be required in the future is again a question for the Legislature to decide.

The authorities are in agreement that any surrogate, court appointed or otherwise, ought to be guided in his or her decisions first by his knowledge of the patient's own desires and feelings, to the extent that they were expressed before the patient became incompetent. (President's Commission, ch. 4, p. 132; *Superintendent of Belchertown v. Saikewicz, supra*, 370 N.E.2d p. 431.)

If it is not possible to ascertain the choice the patient would have made, the surrogate ought to be guided in his decision by the patient's best interests. Under this standard, such factors as the relief of suffering, the preservation or restoration of functioning and the quality as well as the extent of life sustained may be considered. Finally, since most people are concerned about the well-being of their loved ones, the surrogate may take into account the impact of the decision on those people closest to the patient. (President's Commission, ch. 4, pp. 134-35.)

There was evidence that Mr. Herbert had, prior to his incapacitation, expressed to his wife his feeling that he would not want to be kept alive by machines or “become another Karen Ann Quinlan.” The family made its decision together (the directive to the hospital was signed by the wife and eight of his children) after consultation with the doctors.

[Footnote 2: The People urge that petitioners were obligated to consult Mr. Herbert’s sister-in-law rather than his wife and children for this most important decision. Despite the fact that Mr. Herbert apparently entered the name of his sister-in-law on a hospital form (the purpose of which was unclear from the evidence), his wife and children were the most obviously appropriate surrogates in this case. They were the people who would be most affected by the decision and were in the best position to know Mr. Herbert’s own feelings and desire. In addition, there was clear evidence that they were concerned for his comfort and welfare and some or all of them were present at the hospital nearly around the clock.]

Under the circumstances of this case, the wife was the proper person to act as a surrogate for the patient with the authority to decide issues regarding further treatment, and would have so qualified had judicial approval been sought. There is no evidence that there was any disagreement among the wife and children. Nor was there any evidence that they were motivated in their decision by anything other than love and concern for the dignity of their husband and father.

Furthermore, in the absence of legislative guidance, we find no legal requirement that prior judicial approval is necessary before any decision to withdraw treatment can be made.

Barber provides the most thorough discussion of the issues in California case law, but cannot provide full guidance, due to the way in which the issue arose — reliance on requests from the “family” of the patient as a defense to a charge of murder. Note also that the court is not in a position to determine issues such as who is included in the “family.” It is implicit that the wife, children, and sister-in-law are all family. However, the statement that the “wife was the proper person to act as a surrogate for the patient” based on the assumption she would have been qualified if judicial approval had been sought, is not completely consistent with other statements referring to the “family’s decision” and that the “wife and children were the most obviously appropriate surrogates,” and speculation on what would have happened if “the family had insisted on continued treatment.”

Nevertheless, *Barber* has been characterized as an “enormously important” decision: “Indeed, literature generated from within the medical community indicates that health care providers rely upon *Barber* — presumably every day —

in deciding together with families to forego [sic] treatment for persistently vegetative patients who have no reasonable hope of recovery.” Conservatorship of Drabick, 200 Cal. App. 3d 185, 198, 245 Cal. Rptr. 840 (1988).

Barber embodies several important principles: (1) a health care decision standard should focus on the desires of the patient, expressed or known to others; (2) a benefit versus burdens test may be appropriately applied where the patient’s desires are not known; (3) the “family” of an incapacitated patient are the proper surrogates; (4) selection of the best surrogate might be made by analogy to who would be an appropriate conservator; (5) judicial intervention or confirmation is not required.

Conservatorship of Drabick

Conservatorship of Drabick, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (1988), is the leading case on the authority of a conservator of the person to make health care determinations. The patient had been comatose in a persistent vegetative state for several years. His conservator, the patient’s brother, petitioned (or made the mistake of petitioning) for authority to remove a feeding tube keeping the patient alive and the trial court denied the petition. The Court of Appeal agreed with the petitioner that he had authority to terminate artificial life support based on medical advice and the conservatee’s best interests. The patient, William, had four brothers, no children, deceased parents, and a had lived with Jeannine for about 12 years. David, the conservator, had been given authority to make medical decisions under Probate Code Section 2355 on a finding that William lacked capacity to give informed consent. The court pointed out that this gave the conservator authority even over any objections the conservatee might make. The petition for authorization to withhold medical treatment was supported by all the brothers, was not otherwise opposed. In addition, the county public defender, appointed to represent William, concluded that the petition was in his best interests. Jeannine testified in some detail on William’s statements and beliefs about life-sustaining treatments and was convinced that he would not want to live in his condition.

The Court of Appeal stressed that nothing required judicial approval of the conservator’s decision to forgo further treatment. The court affirmed the reasoning in *Barber*:

We begin ... by reviewing the *Barber* decision, which states that families and physicians may decide to forego treatment for

persistently vegetative patients without judicial involvement. The *Barber* decision puts the conservatorship proceedings into a broader perspective. In light of *Barber*, it would be perverse to hold that an otherwise lawful course of action has been frustrated simply because the parties came to court in advance to obtain some certainty about their rights and obligations....

Even though the court of appeal in *Barber* wrote in the context of a criminal prosecution, much of the court's reasoning has broad applicability to cases involving decisions to forego life-sustaining measures....

The medical ethical principle on which *Barber* is based now has authoritative support in the medical community. In 1986 the American Medical Association's Council on Ethical and Judicial Affairs stated in a formal opinion that, "[e]ven if death is not imminent but a patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for the care of the patient, it is not unethical to discontinue all means of life-prolonging medical treatment."...

The evidence in the instant case appears to bring it squarely within the rationale of *Barber*, thus calling for approval of the conservator's decision.

Id. at 194-95 (footnotes omitted).

The court repeatedly returns to the point "courts are not the primary decisionmakers in the area of medical treatment," citing *Barber*, *Bartling*, and *Bouvia*:

Our citation of *Bartling* and *Bouvia*, which involved competent patients, is not intended to blur critical distinctions between competent and incompetent patients. Instead, we mean only to emphasize that courts do not have a general commission to supervise medical treatment decisions. Patients make their own treatment decisions with the advice of their physicians. Family members, and sometimes other persons, participate when the patients cannot. Courts, on the other hand, become involved only when no one is available to make decisions for a patient or when there are disagreements.

The *Barber* decision, which relies on these principles, has become enormously important in the five years since it appeared. Indeed, literature generated from within the medical community indicates that health care providers rely upon *Barber* — presumably everyday — in deciding together with families to forego treatment for persistently vegetative patients who have no reasonable hope of recovery.

For example, in 1985 a joint committee of the Los Angeles County medical and bar associations developed a set of “Principles and Guidelines Concerning the Foregoing of Life-Sustaining Treatment for Adult Patients”.... The Guidelines state that, “[b]ased upon two decisions by the California Court of Appeal [*Barber* and *Bartling*], physicians may forego (withhold or withdraw) life-sustaining treatment without prior court approval” in appropriate cases. One such case is that of “[a]n adult patient ‘who has been reliably diagnosed as in a comatose state from which any meaningful recovery of cognitive brain function is exceedingly unlikely,’ and whose surrogate decision-maker(s) concur(s) with the patient’s physician that continued treatment is not likely to significantly improve the patient’s prognosis for recovery and is, therefore, considered ‘disproportionate’ to any potential benefits from that treatment.”....

Id. at 198-99 (footnotes omitted). These cases agree with and affirm the custom and practice of the medical profession, and each case has built upon and affirmed its predecessors, even though the fact situations quite distinct. Based on *Barber*, the *Drabick* court summarizes:

faced with a persistently vegetative patient and a diagnosis establishing that further treatment offers no reasonable hope of returning the patient to cognitive life, the decision whether to continue noncurative treatment is an ethical one for the physicians and family members or other persons who are making health care decisions for the patient. Under *Barber*, physicians are not liable for actions taken in accordance with accepted medical standards. Moreover, when a conservator has authority under section 2355 for medical treatment decisions, there is no need for judicial approval absent a disagreement among the interested persons. When an interested person does seek the court’s approval, the court’s role is limited to determining whether the conservator has made a good faith decision based upon medical advice. (Prob. Code, § 2355, subd. (a).)

Id. at 204 (footnotes omitted).

In a discussion of the cornerstone New Jersey Supreme Court decision in *Quinlan*, the *Drabick* court suggests a different way to look at the patient’s rights:

In the years since the *Quinlan* decision, most courts have adopted the formula that a patient’s “right to choose” or “right to refuse” medical treatment survives incompetence. It would be more accurate to say that incompetent patients retain the right to have appropriate medical decisions made on their behalf. An

appropriate medical decision is one that is made in the patient's best interests, as opposed to the interests of the hospital, the physicians, the legal system, or someone else. Whatever term one uses to describe the right that an incompetent person retains, however, we are satisfied that the basic analysis is valid in California. To summarize, California law gives persons a right to determine the scope of their own medical treatment, this right survives incompetence in the sense that incompetent patients retain the right to have appropriate decisions made on their behalf, and Probate Code section 2355 delegates to conservators the right and duty to make such decisions. The state's interest in preserving life does not outweigh the patient's own rights.

The court recognizes that none of the three predecessor cases (*Barber*, *Bartling*, and *Bouvia*) had had occasion to decide the question of whether the fundamental right to determine medical treatment survived incapacity.

In William Drabick's case, we must frankly acknowledge that his noncognitive state prevents him from choosing anything. Thus, to claim that his "right to choose" survives incompetence is a legal fiction at best.... While William's condition may prevent conscious choice, however, it does not by any means follow that he has no protected, fundamental interest in the medical treatment decisions that affect him.

We are convinced that we deprive William of a fundamental right if we uphold the superior court's decision. At present, William's treatment is determined solely as a matter of medical technology; his life is prolonged because it is possible, not because anyone purporting to speak for him has decided that this is the best or the wisest course. Under California law, however, human beings are not the passive subjects of medical technology. The line of decisions beginning with *Cobbs v. Grant* and continuing with *Barber*, *Bartling*, and *Bouvia* compel this conclusion. These cases recognize that medical care decisions must be guided by the individual patient's interests and values.... Moreover, the respect due to persons as individuals does not diminish simply because they have become incapable of participating in treatment decisions. While William's coma precludes his participation, it is still possible for others to make a decision that reflects his interests more closely than would a purely technological decision to do whatever is possible. Lacking the ability to decide, he has a right to a decision that takes his interests into account.

Id. at 208.

In *Drabick*, the conservator had the *right* to decide. Even more, the conservator had a *duty* to exercise William’s rights. “Both the fundamental right to life — to continue receiving treatment — and the right to terminate unwanted treatment deserve consideration. Someone acting in William’s best interests can and must choose between them.” *Id.* at 210. In exercising this right and duty to make treatment decisions, a conservator “may consider the conservatee’s known preferences together with all other information bearing on the conservatee’s best interests.”

The conservator must make “a good faith decision consistent with the patient’s best interests.” *Id.* at 211.

Some courts have taken the position that an incompetent patient’s hypothetical desire to forego life-sustaining treatment must be proved by clear and convincing evidence or some other standard and, when so proved, is conclusive. This approach presents several serious problems. First, we have found no authority — other than cases on the subject of life-sustaining treatment — to support the idea that a person can exercise (or waive) a fundamental constitutional and common law right unintentionally through informal statements years in advance. It would be a dangerously unpredictable precedent. Second, if one bases the treatment of persistently vegetative patients not on the statutory delegation of rights to a conservator but on the theory that an evidentiary hearing can reveal the patient’s own hypothetical choice, one is left with no consistent basis for a decision when a patient has been silent on the matter. Third, the approach is contrary to the apparent intent of Probate Code section 2355, which is to give the conservator “exclusive” authority for medical treatment decisions. This authority is so absolute that section 2355 validates the conservator’s decisions “whether or not the conservatee objects.”

There is no need, however, to adopt such a rule. Stated precisely, the apparent role of the conservatee’s prior statements under existing law is this: the conservatee’s prior statements inform the decision of the conservator, who must vicariously exercise the conservatee’s rights. Such statements do not in themselves amount to the exercise of a right. The statute gives the conservator the exclusive authority to exercise the conservatee’s rights, and it is the conservator who must make the final treatment decision regardless of how much or how little information about the conservatee’s preferences is available. There is no necessity or authority for adopting a rule to the effect that the conservatee’s desire to have medical treatment withdrawn must be proved by clear and

convincing evidence or another standard. Acknowledging that the patient's expressed preferences are relevant, it is enough for the conservator, who must act in the conservatee's best interests, to consider them in good faith.

Id. at 211-212 (footnotes omitted).

Rains v. Belshé

Rains v. Belshé, 32 Cal. App. 4th 157, 166, 38 Cal. Rptr. 2d 185 (1995), upheld the constitutionality of the procedure in Health and Safety Code Section 1418.8 applicable to health care determinations made for patients in nursing homes who lack capacity to make health care decisions, "even though they do not have a next of kin, an appointed conservator, or another authorized decision maker to act as their surrogate." (The full text of Section 1418.8 is set out in the Exhibit attached to this memorandum.)

We conclude section 1418.8 is constitutional. As properly interpreted, the statute does not violate the constitutional privacy rights or due process rights of those nursing home patients who are determined by a physician to lack capacity to give informed consent to recommended medical intervention, and who do not have another person with legal authority to give that consent.

The Legislature was required to deal here with a very difficult and perplexing problem: how to provide nonemergency but necessary and appropriate medical treatment, frequently of an ongoing nature, to nursing home patients who lack capacity to consent thereto because of incompetence, and who have no surrogate or substitute decision maker with legal authority to consent for them. This was a legal conundrum of long standing; and although it has been held that the consent of the patient will be implied for emergency care, the question of the proper means of securing the consent of such incompetent patient for ongoing, medically necessary care, not rising to the level of an emergency, is one which is not fully addressed or satisfactorily answered by existing case law.... This problem required an effective legislative solution which would allow timely medical treatment of incompetent nursing home patients on an ongoing basis, without the delay of two to six months frequently necessary to secure a ruling on a petition authorizing treatment under Probate Code section 3201. It is highly significant that section 1418.8, subdivision (e) requires a patient representative to be a member of the interdisciplinary team overseeing the patient's care, to consider the need for medical intervention from the patient's point of view. While there may be exigent circumstances in which the

participation of such a representative is not practicable, due to temporary unavailability, illness, or similar causes, the Legislature clearly required the routine and ongoing participation of a patient representative in such medical care decisions to ensure that nothing is overlooked from the patient's perspective.

Id. at 166-67 (footnotes omitted).

As in *Drabick*, the court recognizes that incapacitated persons have an interest in others making decisions on their behalf:

Neither the development of the common law, nor the statutory enactment in issue here, nor the ballot arguments in support of the adoption of the privacy right, purport to prevent medical professionals from administering necessary treatment in these circumstances. Thus, while the patients in issue here have a legally protected privacy interest, this interest is considerably attenuated by the fact they are determined by their physicians to be in need of medical care, yet incompetent to provide the necessary consent for that care. Under these circumstances, patients may also have an important interest in securing treatment, even though unable to provide consent, so as to avoid constant pain, injury, malnutrition, or physical decline. In sum, while there is certainly a legally protected privacy interest here, it is not an "unbridled right" which may be applied in isolation, regardless of the specific circumstances and pressing medical needs of these patients.

Id. at 172.

As in earlier cases, the court was not receptive to the argument that the courts should be making health care decisions in these cases:

[I]t is suggested that the procedure specified by Probate Code section 3201, which allows a judge to make a medical treatment decision (after the resulting delay of uncertain and varying length to secure a hearing and decision), could exclusively continue to govern these cases.

While we agree that the interposition of another layer of bureaucracy between medical professionals and their patients might have some potential value insofar as it would discourage unnecessary medical treatment, it is far from clear that this would result in better and more timely medical care to nursing home patients as a whole, especially those who suffer more from neglect than from overattention by the medical community. Further, it is not clear that this alternative would be any more sensitive to privacy rights; it would seem to involve a greater number of persons in the decisionmaking process, without necessarily

improving it from a privacy standpoint, and without necessarily resulting in a greater likelihood of appropriate treatment.... As the federal Supreme Court has held, in rejecting a similar constitutional challenge to the treating of mentally ill inmates without a court order: “Notwithstanding the risks that are involved, we conclude that an inmate’s interests are adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge.... We cannot make the facile assumption that the patient’s intentions, or a substituted judgment approximating those intentions, can be determined in a single judicial hearing apart from the realities of frequent and ongoing clinical observation by medical professionals.” (Washington, *supra*, 494 U.S. at pp. 231-232,)

Id. at 176-77.

The court in *Rains* repeatedly recognizes the role of physicians in the decisionmaking process. For example:

We must stress in this context that we deal here with the privacy rights of persons who are initially determined by their physicians to be incompetent to make medical decisions or provide effective informed consent, and who are in need of medical intervention, according to the medical judgment of their treating physicians, yet have no surrogate who can provide a proxy for consent.

Id. at 172.

These decisions are medical decisions. “[W]e agree with those [courts] which have held that requiring judicial intervention in all cases [alleged failure of medical providers to continue treatment of a terminally ill patient] is unnecessary and may be unwise....” (*Barber v. Superior Court* (1983)....)

“We consider that a practice of applying to a court to confirm such decisions [to give or withhold medical treatment to a comatose patient] would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession’s field of competence, but because it would be *impossibly cumbersome*....” (*Matter of Quinlan* (1976) 70 N.J. 10, 355 A.2d 647, 669, italics added; cf. *Youngberg v. Romeo* (1982) 457 U.S. 307, 322-323, ... [There is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions.]

....

It is common knowledge that the determinate evidentiary factor in court hearings, both civil and criminal, by which the mental capacity of human beings is decided, is the expressed expert views

of the medical profession. Petitioner simply argues that a hypothetical possibility exists, which this record does not support, that a physician may misrepresent the mental capacity of a nursing home patient to consent to medical intervention in order to impose that treatment for the financial gain of the physician or an associated institution.

Petitioner then urges that due process, allegedly lacking under her hypothetical proposition, requires that adversarial hearings must always be held after a physician concludes, following the protocol the Legislature has painfully and carefully constructed, that a patient with no surrogate lacks capacity to consent to medical intervention.

Capacity determination, which must be decided under section 1418.8 *before* required medical intervention is activated thereunder on potentially thousands of elderly nursing home patients in this state, would thereby be delayed, as would such treatment. No case cited to us, or disclosed by our independent research, has suggested that procedural due process requires postponement of medical intervention for a nursing home patient who is found by a physician to lack capacity to consent thereto until, in each case, the medical capacity issue is separately decided in some adversarial hearing.

To so rule would not only be cumbersome to thousands of these patients and to the courts, it would presume the bias if not dishonesty of physicians opining as to the patient's capacity. We emphatically decline to adopt that presumption. Prompt and effective medical treatment of these unfortunate citizens would be seriously jeopardized.

.... To do otherwise would negate the Legislature's reforming work on a speculative basis, one absolutely contrary to the ethical standards of the medical profession. Nursing home patients are not denied due process because their incapacity to give consent to medical intervention is initially determined by a physician and surgeon, rather than by a judicial or quasi-judicial hearing.

Id. at 180-82.

All this (and more) having been said, the court emphasized a significant limitation on the procedure in Section 1418.8:

In addition, section 1418.8 by its own terms applies only to the relatively nonintrusive and routine, ongoing medical intervention, which may be afforded by physicians in nursing homes; it does not purport to grant blanket authority for more severe medical interventions such as medically necessary, one-time procedures which would be carried out at a hospital or other acute care facility,

as to which compliance with Probate Code section 3200 et seq. would still be required, except in emergency situations.

Id. at 186.

Wendland

Wendland v. Superior Court, 49 Cal. App. 4th 44, 56 Cal. Rptr. 2d 595 (1996), involves a technical issue of whether independent counsel should be appointed in conservatorship proceedings for a comatose 43-year old man. Based on the claim that Robert had told his wife Rose and other family members that he “would never want to live in a state of total dependence,” Rose decided to withhold nutrition and hydration. This decision was supported by Robert’s doctors and by the hospital ethics committee. Notified of these plans by an anonymous telephone call, Robert’s mother and sister obtained a temporary restraining order and Rose petitioned for appointment as conservator, including specific authority to withdraw life-sustaining treatment. The court ordered appointment of independent counsel for Robert, but no more, declining to “render an advisory opinion on the merits of the dispute.” *Id.* at 598, n.3. The court distinguished the facts of this case from *Drabick*:

Rose has sought court approval before withdrawing life-sustaining treatment. We have no need in this proceeding to decide whether court approval is required. *Conservatorship of Drabick* ... indicated a conservator has authority under Probate Code section 2355 to withdraw treatment without court approval if the patient is in a persistent vegetative state and the interested parties all agree on the course of action (though the conservator has the right to petition for court approval before taking action)... Here, the patient is not in a persistent vegetative state, and the interested parties disagree.

Id. at 599, n.6. We understand that the county public defender has been appointed as independent counsel for Robert and the case is set for trial in late October, more than four years after Robert’s accident and more than two years after conservatorship proceedings were initiated.

Obviously, this sort of case, where family members and others disagree, will continue to arise and courts will be involved. It is useful to remember the facts of this case as the Commission considers surrogacy priorities or other schemes. Typically statutes give priority to a spouse and then to parents. The result under that type of statute would appear to be the same as in the *Wendland* case. The

doctors would have relied on Rose’s decision, but if a person in a lower priority classes of surrogates disagreed, court proceedings would be the likely result.

Other Cases — Bartling, Bouvia, and Thor

Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984), involved refusal of a hospital to remove a ventilator from a competent 70-year old man with serious illnesses. Bartling executed a “living will,” a declaration, and a durable power of attorney for health care appointing his wife as attorney-in-fact. Bartling and his wife and daughter executed releases of liability for the hospital and doctors. The court reaffirmed the policies of *Cobbs* and *Barber* concerning a person’s right to consent to or refuse medical treatment. This case does not bear directly on the right of others to act as surrogates, since Bartling was not incompetent, and had executed a durable power. It does illustrate the difficulty of getting recalcitrant medical institutions to implement the patient’s treatment decisions, regardless of how many documents were executed.

Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1137, 225 Cal. Rptr. 297 (1986), involved a competent (“very competent”) non-terminally ill 28-year old quadriplegic patient who, as in *Bartling*, desired to terminate forced feeding. The court recognized her absolute right to refuse medical treatment, reaffirming the line of cases from *Cobbs* to *Bartling*.

Thor v. Superior Court, 5 Cal. 4th, 725, 731, 855 P.2d 375, 21 Cal. Rptr. 2d 357 (1993), determined that a prisoner serving a life sentence has, as “a competent, informed adult ... a fundamental right of self-determination to refuse or demand the withdrawal of medical treatment of any form irrespective of the personal consequences.” *Id.* at 360. In this case, the prison doctor wanted to perform an operation to preserve his life, notwithstanding the patient’s refusal to consent. Of particular interest for our purposes is the Supreme Court’s statement concerning judicial intervention, citing *Barber*:

[A]s a general proposition, judicial intervention of the type proposed tends to denigrate the principle of personal autonomy, substituting a species of legal paternalism for the medical paternalism the concept of informed consent seeks to eschew. “Rationality” is for the patient to determine. Judicial scrutiny therefore should be considered as a course of last resort.

Id. at 371. The court also cites *Cobbs*, *Bartling*, and *Bouvia* with approval.

LACMA-LACBA Pamphlet

In the mid-1980s, the Joint Committee on Biomedical Ethics of the Los Angeles County Medical Association (LACMA) and Los Angeles County Bar Association (LACBA) issued and has since updated a pamphlet entitled “Guidelines: Forgoing Life-Sustaining Treatment for Adult Patients.” We surmise that the *Guidelines* are widely relied on by medical professionals and are probably the foremost statement of custom and practice in California. The *Guidelines* were cited in *Bouvia* and *Drabick*. A 1993 addendum to the *Guidelines*, pertaining to decisionmaking for incapacitated patients without surrogates, provides a concise statement of the “Relevant Legal and Ethical Principles”:

The process suggested in these Guidelines has been developed in light of the following principles established by the California courts and drawn from the Joint Committee’s Guidelines for Forgoing Life-Sustaining Treatment for Adult Patients:

(a) Competent adult patients have the right to refuse treatment, including life-sustaining treatment, whether or not they are terminally ill.

(b) Patients who lack capacity to make healthcare decisions retain the right to have appropriate medical decisions made on their behalf, including decisions regarding life-sustaining treatment. An appropriate medical decision is one that is made in the best interests of the patient, not the hospital, the physician, the legal system, or someone else.

(c) A surrogate decision-maker is to make decisions for the patient who lacks capacity to decide based on the expressed wishes of the patient, if known, or based on the best interests of the patient, if the patient’s wishes are not known.

(d) A surrogate decision-maker may refuse life support on behalf of a patient who lacks capacity to decide where the burdens of continued treatment are disproportionate to the benefits. Even a treatment course which is only minimally painful or intrusive may be disproportionate to the potential benefits if the prognosis is virtually hopeless for any significant improvement in the patient’s condition.

(e) The best interests of the patient do not require that life support be continued in all circumstances, such as when the patient is terminally ill and suffering, or where there is no hope of recovery of cognitive functions.

(f) Physicians are not required to provide treatment that has been proven to be ineffective or will not provide a benefit.

(g) Healthcare providers are not required to continue life support simply because it has been initiated.

Patient Information Pamphlet

A patient information pamphlet (“Your Right To Make Decisions About Medical Treatment”) has been prepared by the California Consortium on Patient Self-Determination and adopted by the Department of Health Services for distribution to patients at the time of admission. The federal Patient Self-Determination Act in 1990 mandated preparation of such pamphlets and, among other things, requires them to include a summary of the state’s law on patients’ rights to make medical treatment decisions and to make advance directives. The California pamphlet contains the following statement:

What if I’m too sick to decide?

If you can’t make treatment decisions, your doctor will ask your closest available relative or friend to help decide what is best for you. Most of the time, that works. But sometimes everyone doesn’t agree about what to do. That’s why it is helpful if you say in advance what you want to happen if you can’t speak for yourself. There are several kinds of “advance directives” that you can use to say *what* you want and *who* you want to speak for you.

We are not confident that California law says that the *closest* available relative or *friend* can make health care decisions. It may be true in practice that these are the persons doctors will ask. See, e.g., AMA Code of Medical Ethics § 2.20, at 36 (1994) (“[W]hen there is no person closely associated with the patient, but there are persons who both care about the patient and have sufficient relevant knowledge of the patient, such persons may be appropriate surrogates.”); President’s Comm’n etc., *Deciding To Forego Life-Sustaining Treatment* 126-27 (1983) (“When a patient lacks the capacity to make a decision, a surrogate decisionmaker should be designated. Ordinarily this will be the patient’s next of kin, although it may be a close friend or another relative if the responsible health care professional judges that this other person is in fact the best advocate for the patient’s interests.”) Most of the time that may work, but wouldn’t be better if the law were clear on the issue?

STATUTORY SUROGACY ISSUES

Should the Law Include a Statutory Surrogacy Scheme?

The Commission has implicitly approved including a statutory surrogacy scheme in the revision of the power of attorney for health care and other health care decisionmaking rules. Adoption of a statute based on the Uniform Health-

Care Decisions Act would include surrogate provisions. As the Commission considers the various options, however, it should also be considered whether and to what extent statutory surrogacy provisions would be an improvement over reliance on the general case law as outlined above and reflected in the Patient Information Pamphlet.

The trend in other states is decidedly in favor of providing statutory guidance, generally through a priority scheme. The collective judgment of the states would seem to be that, since most people will not execute any form of advance directive, the problem needs to be addressed with some sort of default rules, perhaps based on an intestate succession analogy.

As described by Professor Meisel:

The primary purpose of these statutes is to make clear what is at least implicit in the case law: that the customary medical professional practice of using family members to make decisions for patients who lack decisionmaking capacity and who lack an advance directive is legally valid, and that ordinarily judicial proceedings need not be initiated for the appointment of a guardian. Another purpose of these statutes is to provide a means, short of cumbersome and possibly expensive guardianship proceedings, for designating a surrogate decisionmaker when the patient has no close family members to act as surrogate.

2 A. Meisel, *The Right to Die* § 14.1 at 249-50 (2d ed. 1995).

The focus of statutory surrogacy rules should be to provide some needed clarity without creating technical rules that would make compliance confusing or risky, thereby bogging the process down or paralyzing medical decisionmaking. A statute should not introduce roadblocks or doubt into this complicated area. Just as the courts have consistently been reluctant to favor judicial involvement except as a last resort, the statute should assist, rather than disrupt, existing practice.

Who Should Have Decisionmaking Authority?

The general understanding is that “family” and maybe close friends should make health care decisions in consultation with medical professionals. Wives, brothers, mothers, sisters-in-law, and domestic partners have been involved implicitly as “family” surrogate decisionmakers in reported California cases, although no case is exactly on point. But clearly, the courts and legislatures nationwide naturally rely on a family or next of kin approach because these are

the people who are presumed to best know the desires of the patient and to determine the patient's best interests.

Priority schemes among relatives and friends seem natural. Lawyers drafting statutes will gravitate toward an intestate succession analogy as a natural and convenient pattern — thus, spouse, children, parents, siblings, and so forth, as provided in Probate Code Section 6400 *et seq.*. The same order is established in the preference for appointment as conservator by Probate Code Section 1812. But the analogy between health care, life-sustaining treatment, and personal autonomy on one hand and succession to property on the other is weak. A health care decision cannot be parceled out like property in an intestate's estate. The consequences of a serious health care decision are different in kind from decisions on how to distribute property.

Professor Meisel describes this fundamental problem with priority classes as follows:

Although the intent of such priority lists is a good one — to eliminate possible confusion about who has the legal authority to make decisions for incompetent patients — the result of surrogate-designation pursuant to statute is not only mechanical but can be contrary or even inimical to the patient's wishes or best interests. This would occur, for example, if the patient were estranged from his spouse or parents. However, it is not clear that the result would be much different in the absence of a statute because the ordinary custom of physicians sanctioned by judicial decision, is to look to incompetent patients' close family members to make decisions for them. In the absence of a statute, the physician might ignore a spouse known to be estranged from the patient in favor of another close family member as surrogate, but because there is nothing in most statutes to permit a physician to ignore the statutory order of priority, the result could be worse under a statute than in its absence.

(Meisel, *supra*, § 14.4, at 255, footnotes omitted.)

Examples

Before considering the major options for a statutory surrogate scheme, it is important to have in mind the range of fact common situations that the statute will govern. The following examples are from Quinn, *Who Should Make Medical Decisions for Incompetent Adults?*, 20 Seattle Univ. L. Rev. 573, 586-88 (1997). They are framed in terms of the Washington statute which provides classes of

decisionmakers in this order: spouse, adult children, parents, and adult siblings. No other classes are authorized under that statute, and classes have to act unanimously and lower classes cannot make a decision if a person in a higher class can be located.

Illustration 1

Derrick is twenty-nine years old and is incompetent due to a rare genetic disorder. His parents were divorced when he was three. Derrick's mother was his primary caretaker and has cared for Derrick as his condition has deteriorated over the last three years. Derrick's father rarely paid the required child support as Derrick was growing up and only saw Derrick about once every year or two. Derrick's doctors believe that Derrick is a good candidate for an experimental treatment, which, if successful, may enable Derrick to lead a fairly normal life, but if unsuccessful will likely result in Derrick's death. Derrick had often indicated to his mother that he would take any risk if by doing so he might be cured. The doctors are obligated to obtain permission from both parents under the statute. Derrick's father refuses to consent to the treatment.

Illustration 2

Jasmine and Charlie have lived together as significant others for six years. Both of Charlie's parents are deceased, though he has a younger brother to whom he has never been particularly close. When Charlie is critically injured in a car accident, the hospital seeks consent for certain surgical procedures from his brother, rather than Jasmine, because an unmarried partner cannot give consent for treatment under the current version of the statute.

[This could have been the *Drabick* situation, except that the brothers, including the conservator, appeared to have been in agreement with the 12-year domestic partner.]

Illustration 3

Monique is twenty-one years old. She has lived with her grandmother who has raised her since Monique was three years old. Monique's mother is a substance abuser and has been in and out of Monique's life depending on whether she is clean and sober or on a substance binge. Monique is shot at a party after a fight breaks out between two individuals standing near Monique. Because grandparents are excluded from the statute's hierarchy, the hospital is legally obligated to consult with Monique's mother to gain consent for Monique's treatment.

Illustration 4

Richard and Doug, who consider themselves to be life partners, have been together for twelve years. Doug, dying from complications due to AIDS, has had infrequent contact with his family over the past fifteen years. He has never come out to his family because he believes they would condemn him because of his homosexuality. Doug has not written out a medical durable power of attorney. He has, however, told Richard, emphatically, that he does not want to be maintained on a respirator or other life support systems. When Doug becomes incompetent, the hospital contacts his parents in Ohio, because Richard may not legally give consent to Doug's treatment. Doug's parents are shocked and outraged when they find out that Doug is gay and is dying from complications due to AIDS. Over Richard's objections, Doug's parents order the hospital to maintain Doug on a respirator.

Illustration 5

Kathryn lives in a wealthy suburb of Seattle with her four children, ages twelve to five. She and her husband have been separated, though not legally, for nearly a year. Kathryn's parents, who live in the same city, have been tremendously supportive of her in her struggle to put her life back together. When Kathryn is rendered incompetent due to a car accident, the statute requires that the hospital first seek consent from her husband for nonemergency surgery. Kathryn's parents are excluded from decision-making because if there is someone available from a higher priority class, here a spouse, the lower priority class may not be consulted.

Illustration 6

Diane, aged thirty-three, is an only child. Her father passed away when she was six and her mother passed away just last year. Diane and her cousin Sharon have been like sisters their whole lives. After feeling ill for over a month, Diane is diagnosed with leukemia and her condition degenerates very quickly. Within six weeks she is incompetent. Sharon has been at her side continuously. Diane, refusing to believe that she was dying, would not fill out a medical durable power of attorney. After Diane becomes incompetent, Diane's doctors may not turn to Sharon to make decisions, because cousins (or friends) are not listed in the statute.

Illustration 7

Eileen McCafferty has lived in the same eastern Washington community for all of her seventy-two years. She has one child,

Mike, who she sees about once a year. She speaks to him on the phone about once every two or three months. Mrs. McCafferty and Etta Jones have been each other's closest friend since the two women graduated from high school together in 1936. Each morning Eileen and Etta walk the one mile trail around the lake and then have coffee at Etta's house. One morning Eileen collapses and never regains consciousness. Although Etta knows Eileen better than anyone, the hospital must seek consent from Eileen's son, Mike, for Eileen's medical treatment.

Priority Scheme Option

At the June meeting, the Commission considered the surrogacy priority scheme drawn from the Uniform Health-Care Decisions Act. (This basic scheme is set out in our drafting style in Sections 4710-4718 in the second staff draft attached to Memorandum 97-60, pp. 41-45.) The UHCDA provides:

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.

The UHCDA scheme lists the usual top four classes of surrogates (spouse, children, parents, siblings), but is less restrictive than many state statutes in several respects:

(1) Class members *may* act as surrogate and need to *assume authority* to do so. It is not clear whether a class member must affirmatively decline to act or may be disregarded if he or she fails to assume authority, but unlike some state statutes, an abstaining class member does not prevent action.

(2) Determinations within classes can be made by majority vote, as provided in subdivision (e). It is recognized that this is not likely to be a common approach to making decisions where there are disagreements, but it would be a useful rule enabling decisionmaking where there are minority class members whose views are unknown or in doubt.

(3) Professor English points out that the provision in subdivision (b) for an orally designated surrogate, who appears first on the priority list, is an attempt to

deal with the fact that a strict statutory priority list does not necessarily reflect reality. At the same time, he notes that the “orally designated surrogate was added to the Act not because its use is recommended but because it is how decision makers are often designated in clinical practice.”

(4) The authorization for adults who have “exhibited special care and concern” in subdivision (c) is relatively new. In California, no cases suggest that friends would have health care decisionmaking authority. Under the common law generally, the status of friends as surrogates is, in Professor Meisel’s words, “highly uncertain.” Meisel, *supra*, § 14.4, at 51 (Supp. #1, 1997). Health and Safety Code Section 1418.8 requires consultation with friends of nursing home patients and authorizes a friend to be appointed as the patient’s representative. These features are noted with approval in *Rains v. Belshé.*, but the authority is strictly statutory and quite limited.

Of course, after the most common four classes of surrogates, state statutes include a variety of other classes, such as grandparents, adult grandchildren, nieces and nephews, aunts and uncles, and nearest living relative. We do not think any of these more remote classes need to be added to the specific description of classes, if the Commission decides to recommend a priority scheme based on the uniform act, since the “caring adult” standard would any of the remoter relatives that you would want.

Oral surrogacy. At the June meeting, the Commission was concerned that oral surrogacy designations could become stale and that some limitation should be added to the uniform act scheme, such as relating the oral designation to the current illness or hospital admission. This limitation could be implemented as follows (in the language of staff draft Section 4711(a):

An adult may designate any [individual] to act as surrogate to make health care decisions by personally informing the supervising health care provider. An oral designation of a surrogate is effective only during the course of treatment or illness or during a hospital stay during which the designation is made.

This would probably not have much practical effect since the clinical practice referred to by Professor English is probably within the bounds of the suggested limitation. It is conceivable that there would be a case where the oral designation was made at an earlier time and there are no statutory surrogate classes available, in which case we might want the technically stale oral designation to

be effective. We could anticipate this problem by rephrasing the limitation: “An oral designation of a surrogate is ~~effective~~ has priority over persons listed in subdivision (b) only during the course of treatment or illness or during a hospital stay during which the designation is made.

The Uniform Health-Care Decisions Act has been enacted in three states with several variations. Delaware enacted the oral surrogacy provision in the following form:

2507(b)(1). A mentally competent patient may designate any individual to act as a surrogate by personally informing the supervising health-care provider in the presence of a witness. The designated surrogate may not act as a witness. The designation of the surrogate shall be confirmed in writing in the patient’s medical record by the supervising health-care provider and signed by the witness.

Maine does not appear to have enacted the oral designation provision. New Mexico enacted the UHCDA version.

Domestic partners. New Mexico has also confronted the domestic partner issue head-on — the first two surrogate classes in Section 24-7A-5 are:

(1) the spouse, unless legally separated or unless there is a pending petition for annulment, divorce, dissolution of marriage or legal separation;

(2) an individual in a long-term relationship of indefinite duration with the patient in which the individual has demonstrated an actual commitment to the patient similar to the commitment of a spouse and in which the individual and the patient consider themselves to be responsible for each other’s well-being;...

The staff suggests serious consideration of this type of rule if the Commission wants to adopt a priority scheme. The UHCDA provision for oral surrogacy (positioned before relatives) and for friends (positioned after relatives) does not respond directly to common situations in California.

Friends. It appears that six states have enacted statutes authorizing friends to act as surrogates. Professor Meisel summarizes these statutes as follows:

The friend

1. must be 18 years or older ... or an “adult” ...;
2. must have exhibited special care and concern ... (Arizona, Florida, Illinois, West Virginia);

3. must be willing to make health care decisions ... to the satisfaction of the attending physician;
4. has presented an affidavit to the treating physician stating that he or she is a friend of the principal (Florida, Illinois, Maryland, New York), which must state facts and circumstances demonstrating the familiarity (Illinois, New York);
5. is familiar with principal's health care concerns (Arizona); and
6. has maintained regular contact with the principal so that he or she would be familiar with the principal's activities, health, and religious or moral beliefs (Florida, Illinois, Maryland, New York, West Virginia).

Meisel, *supra*, at 51-52. This summary demonstrates that there are a variety of approaches. **The staff recommends consideration of the UHCDA approach applicable to adults who have exhibited special care and concern**, in line with the Commission's general presumption in favor of the uniform act. (See Minutes, January 1997 Meeting, p. 9.) However, the Commission is certainly free to consider additional qualifications if the uniform act standard is thought to need clarification. The most important advance represented by the UHCDA is that some practical recognition of friends as surrogates should be included in the statute to resolve a highly doubtful point.

Disputes among surrogates. As noted, the UHCDA provides for majority vote in a class, but a tie would lock up the process since lower classes cannot act if higher classes are available and can't act. Two revisions that would facilitate decisionmaking are to enable any qualified member of a class to act as surrogate and to provide some flexibility within the presumptive order of classes. Consider, for example, the West Virginia priority scheme (emphasis added):

§ 16-30B7. (a) When a person is incapacitated, the health care provider must make reasonable inquiry as to the availability and authority of a medical power of attorney representative When no representative is authorized or available, and willing to serve, the health care provider must make a reasonable inquiry as to the availability of possible surrogates listed in items (1) through (8) of this subsection:

- (1) The person's guardian of the person or committee;
- (2) The person's spouse;
- (3) Any adult child of the person;
- (4) Either parent of the person;

- (5) Any adult sibling of the person;
- (6) Any adult grandchild of the person;
- (7) A close friend of the person;
- (8) Such other persons or classes of persons including, but not limited to, such public agencies, public guardians, other public officials, public and private corporations, and other representatives as the department of health and human resources may from time to time designate in rules and regulations

(b) After such inquiry, the health care provider shall rely on surrogates in the order of priority set forth above, provided:

(1) Where there are multiple possible surrogate decision-makers at the same priority level, the health care provider shall, after reasonable inquiry, choose as the surrogate the one who reasonably appears to be best qualified. In determining who appears to be best qualified, the health care provider shall give special consideration to whether the proposed surrogate reasonably appears to be better able to make decisions either in accordance with the known wishes of the person or in accordance with the person's best interests. The health care provider shall consider in this determination the proposed surrogate's regular contact with the person prior to and during the incapacitating illness, his or her demonstrated care and concern, and his or her availability to visit the person during the illness and to engage in face-to-face contact with the provider for the purposes of fully participating in the decision-making process;

or

(2) The health care provider may rely instead on a proposed surrogate lower in the priority if, in the provider's judgment, such individual is best qualified, as described in subsection (b) of this section, to serve as the person's surrogate. The health care provider shall document in the medical record his or her reasons for selecting a surrogate in exception to the priority order in subsection (a) of this section.

The West Virginia approach appears to be a creative way to resolve the tension between the statutory priority lists, favored in most jurisdictions and in the UHCDA, and the practical necessities of the medical establishment. We understand that the California Medical Association has been opposed to (or reluctant to support) statutory surrogacy schemes because of the complications they introduce in the clinical environment and the sense that they increase the opportunity for statutory violations with attendant risks of liability. By attempting to balance medical discretion with surrogate priority classes, **the West Virginia statute looks to the staff like a preferable alternative to the**

UHCDA scheme, and we recommend its serious consideration by the Commission.

An important element exhibited in the West Virginia statute is the application of substantive standards to the qualification of a surrogate in any class. Professor Meisel emphasizes this concern as one way of sorting through disagreement among possible surrogates:

[T]he statutory provisions addressing disagreements between potential surrogates seem to have been drafted without any awareness that the proper role of the surrogate is not to make a decision *per se* but to make a decision on the basis of a particular substantive standard, and that the standard dictates the kind of evidence that is to be taken into account. The statutory provisions that do address the resolution of conflicts among members of a class of surrogates are unduly concerned with procedure at the expense of substance. The role of surrogates — or of all members of a class of surrogates if there is more than one — should be to discern and articulate the wishes of the *patient*, not their own wishes; and if the patient's actual or probably wishes are unknown, in some jurisdictions it is their role to determine the *interests* of the patient, not their own wishes or interests. Any decision made by a surrogate that is not based on some conception of the *patient's* wishes or interests is almost certain to be an illegitimate decision.

If the focus is on the patient's actual or probable treatment preferences — or if unknown, the patient's interests — it might be less likely for there to be conflicts between members of a class of surrogates than if the focus is, wrongly, on the wishes or interests of the surrogates. If members of the health care team can get the disputants to focus on the patient's wishes and interests rather than on the disputants' own wishes and interests, it might prove easier to avoid or resolve disputes while remaining faithful to the statutory and common-law standards for decisionmaking by surrogates. This is an extremely important point, not only as a matter of law but also as a matter of clinical practice. When members of a class of surrogates are warring with each other over what decision is to be made about a relative's medical treatment, it may prove helpful for physicians (and lawyers, if they are involved at this stage) to remind the warring parties of their property role.

None of the surrogate decisionmaking statutes have such a focus....

Meisel, *supra*, § 14.6, at 258.

Consensus or Group Option

Three states with statutory surrogacy rules have taken a different approach, one that does not rely on statutory priorities, but encourages family and friends to work at developing a general consensus and designating one of their number as the surrogate with health care decisionmaking authority. This type of procedure avoids the pitfalls and stereotyping inherent in a priority scheme, but may create new problems in administration. As a third option, **the staff recommends serious consideration of a consensus approach.**

The Colorado statute provides as follows (emphasis added):

§ 15-18.5-103 (1997). (1) A health care provider or health care facility may rely, in good faith, upon the medical treatment decision of a proxy decision-maker selected in accordance with subsection (4) of this section if an adult patient's attending physician determines that such patient lacks the decisional capacity to provide informed consent to or refusal of medical treatment and no guardian with medical decision-making authority, agent appointed in a medical durable power of attorney, or other known person has the legal authority to provide such consent or refusal on the patient's behalf.

(2) The determination that an adult patient lacks decisional capacity to provide informed consent to or refusal of medical treatment may be made by a court or the attending physician, and such determination shall be documented in such patient's medical record. The attending physician shall make specific findings regarding the cause, nature, and projected duration of the patient's lack of decisional capacity, which findings shall be included in the patient's medical record.

(3) Upon a determination that an adult patient lacks decisional capacity to provide informed consent to or refusal of medical treatment, the attending physician, or such physician's designee, shall make reasonable efforts to notify the patient of the patient's lack of decisional capacity. In addition, the attending physician, or such physician's designee, shall make reasonable efforts to locate as many interested persons as defined in this subsection (3) as practicable and the attending physician may rely on such individuals to notify other family members or interested persons. For the purposes of this section, "interested persons" means the patient's spouse, either parent of the patient, any adult child, sibling, or grandchild of the patient, or any close friend of the patient. Upon locating an interested person, the attending physician, or such physician's designee, shall inform such person of

the patient's lack of decisional capacity and that a proxy decision-maker should be selected for the patient.

(4)(a) It shall be the responsibility of the interested persons specified in subsection (3) of this section to make reasonable efforts to reach a consensus as to whom among them shall make medical treatment decisions on behalf of the patient. The person selected to act as the patient's proxy decision-maker should be the person who has a close relationship with the patient and who is most likely to be currently informed of the patient's wishes regarding medical treatment decisions. If any of the interested persons specified in subsection (3) of this section disagrees with the selection or the decision of the proxy decision-maker or, if, after reasonable efforts, the interested persons specified in subsection (3) of this section are unable to reach a consensus as to who should act as the proxy decision-maker, then any of the interested persons specified in subsection (3) of this section may seek guardianship of the patient ... Only said persons may initiate such proceedings with regard to the patient.

(b) Nothing in this section shall be construed to preclude any interested person described in subsection (3) of this section from initiating a guardianship proceeding pursuant to part 3 of article 14 of this title for any reason any time after said persons have conformed with paragraph (a) of this subsection (4).

...

(6) Artificial nourishment and hydration may be withheld or withdrawn from a patient upon a decision of a proxy only when the attending physician and a second independent physician trained in neurology or neurosurgery certify in the patient's medical record that the provision or continuation of artificial nourishment or hydration is merely prolonging the act of dying and is unlikely to result in the restoration of the patient to independent neurological functioning.

(6.5) The assistance of a health care facility's medical ethics committee shall be provided upon the request of a proxy decision-maker or any other interested person specified in subsection (3) of this section whenever the proxy decision-maker is considering or has made a decision to withhold or withdraw medical treatment. If there is no medical ethics committee for a health care facility, such facility may provide an outside referral for such assistance or consultation.

...

(8) Except for a court acting on its own motion, no governmental entity, including the state department of human services and the county departments of social services, may petition the court as an interested person....

The core of this procedure is in subsections (3) and (4). This approach is based on the assumption that interested persons will become involved and should be able to work together. It recognizes the family and close friends as a social system and relies on them to make the right decisions, rather than attempting to prescriptively determine who in the family should make decisions.

Clearly a family and friend consensus approach cannot solve intractable problems arising where there is significant disagreement among the interested persons. In these cases, court proceedings will be likely no matter what the statutory scheme. The question that we need to consider, however, is whether there would be any greater need for court involvement under this type of procedure than under existing law or a priority approach based on the UHCDA or the West Virginia statute. If a patient's parent disagrees strongly enough with the spouse under existing law or a priority scheme, or if the children can't agree among themselves, the informal procedures are likely to be stymied and the dispute may end up in court. The same thing will happen under the consensus approach. A priority scheme is not likely to work where there are significant disagreements, even though such a scheme on its face permits the first priority spouse to determine the outcome notwithstanding disagreements from the second priority children or third priority parents. It is difficult to know whether a priority scheme might actually be implemented as designed.

Illinois and Louisiana also provide consensus standards, although not to the broad extent provided in Colorado.

What If No Surrogate Is Available?

At the June meeting, a question was raised as to the authority to make health care decisions for incapacitated adults who do not have any advance directive and where none of the statutory surrogacy rules (whatever they may be) result in an authorized surrogate. In existing law, as indicated above in the discussion of *Rains v. Belshé*, this problem in the nursing home context has been dealt with in Health and Safety Code Section 1418.8 (copy attached as Exhibit). But there is no general surrogacy rule applicable in these circumstances, and the UHCDA would not solve the problem.

Under existing law, it appears that a conservator would have to be appointed. In most such cases, it will be the Public Guardian (which may be a non-solution if the Public Guardian's policy is not to exercise the duty to decide as set down in *Drabick*). While it is possible to seek court approval for medical "treatment"

under Probate Code Section 3200 *et seq.* (authorization of medical treatment for adult without conservator), it is not clear that this procedure authorizes orders for *withdrawal* of treatment or *refusal* of consent — Section 3208 refers to “authorizing the recommended course of medical treatment of the patient” and “the existing or continuing medical condition.” **At a minimum, this procedure should be amended to make the scope possible health care decision orders under it commensurate with the authority of a conservator.**

One general approach to the issue would be to adopt a statute based on Section 1418.8. There may be some hurdles, however. Remember that the court in *Rains v. Belshé* intimated that the procedure could not be used for life-sustaining measures: Section 1418.8 “does not purport to grant blanket authority for more severe medical interventions such as medically necessary, one-time procedures which would be carried out at a hospital or other acute care facility.” The staff has not pursued this issue in any detail. But after the discussion at the June meeting, it appeared that there was interest in attempting to provide some way to deal with the general problem of incapacitated persons with no known relatives or friends. For a future memorandum, unless otherwise instructed, **the staff will try to develop a draft procedure adapting the ethics committee and patient representative approach of Section 1418.8 for general use.**

Conclusion

The staff is suggesting consideration of three main alternatives, although some elements from each could be combined. We have focused on (1) the UHCDA scheme with oral surrogacy, a short priority list, and concerned adult class, (2) the West Virginia “soft priority” approach, and (3) the Colorado consensus approach. There does not appear to be one overwhelmingly best approach, although we are now leaning toward the West Virginia soft priority approach, with the Colorado consensus model a near second. The UHCDA scheme should only be adopted if, at a minimum, it is modified along the lines of New Mexico to deal more directly with domestic partners.

Respectfully submitted,

Stan Ulrich
Assistant Executive Secretary

Exhibit

Health & Safety Code § 1418.8 — The “Epple Bill”

§ 1418.8. Consent for incapacitated patient in skilled nursing facility or intermediate care facility

1418.8. (a) If the attending physician and surgeon of a resident in a skilled nursing facility or intermediate care facility prescribes or orders a medical intervention that requires informed consent be obtained prior to administration of the medical intervention, but is unable to obtain informed consent because the physician and surgeon determines that the resident lacks capacity to make decisions concerning his or her health care and that there is no person with legal authority to make those decisions on behalf of the resident, the physician and surgeon shall inform the skilled nursing facility or intermediate care facility.

(b) For purposes of subdivision (a), a resident lacks capacity to make a decision regarding his or her health care if the resident is unable to understand the nature and consequences of the proposed medical intervention, including its risks and benefits, or is unable to express a preference regarding the intervention. To make the determination regarding capacity, the physician shall interview the patient, review the patient’s medical records, and consult with skilled nursing or intermediate care facility staff, as appropriate, and family members and friends of the resident, if any have been identified.

(c) For purposes of subdivision (a), a person with legal authority to make medical treatment decisions on behalf of a patient is a person designated under a valid Durable Power of Attorney for Health Care, a guardian, a conservator, or next of kin. To determine the existence of a person with legal authority, the physician shall interview the patient, review the medical records of the patient and consult with skilled nursing or intermediate care facility staff, as appropriate, and family members and friends of the resident, if any have been identified.

(d) The attending physician and the skilled nursing facility or intermediate care facility may initiate a medical intervention that requires informed consent pursuant to subdivision (e) in accordance with acceptable standards of practice.

(e) Where a resident of a skilled nursing facility or intermediate care facility has been prescribed a medical intervention by a physician and surgeon that requires informed consent and the physician has determined that the resident lacks capacity to make health care decisions and there is no person with legal authority to make those decisions on behalf of the resident, the facility shall, except as provided in

subdivision (h), conduct an interdisciplinary team review of the prescribed medical intervention prior to the administration of the medical intervention. The interdisciplinary team shall oversee the care of the resident utilizing a team approach to assessment and care planning and shall include the resident's attending physician, a registered professional nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident's needs, and, where practicable, a patient representative, in accordance with applicable federal and state requirements. The review shall include all of the following:

- (1) A review of the physician's assessment of the resident's condition.
 - (2) The reason for the proposed use of the medical intervention.
 - (3) A discussion of the desires of the patient, where known. To determine the desires of the resident, the interdisciplinary team shall interview the patient, review the patient's medical records and consult with family members or friends, if any have been identified.
 - (4) The type of medical intervention to be used in the resident's care, including its probable frequency and duration.
 - (5) The probable impact on the resident's condition, with and without the use of the medical intervention.
 - (6) Reasonable alternative medical interventions considered or utilized and reasons for their discontinuance or inappropriateness.
- (f) A patient representative may include a family member or friend of the resident who is unable to take full responsibility for the health care decisions of the resident, but has agreed to serve on the interdisciplinary team, or other person authorized by state or federal law.
- (g) The interdisciplinary team shall periodically evaluate the use of the prescribed medical intervention at least quarterly or upon a significant change in the resident's medical condition.
- (h) In case of an emergency, after obtaining a physician and surgeon's order as necessary, a skilled nursing or intermediate care facility may administer a medical intervention which requires informed consent prior to the facility convening an interdisciplinary team review. If the emergency results in the application of physical or chemical restraints, the interdisciplinary team shall meet within one week of the emergency for an evaluation of the medical intervention.
- (i) Physician and surgeons and skilled nursing facilities and intermediate care facilities shall not be required to obtain a court order pursuant to Section 3201 of the Probate Code prior to administering a medical intervention which requires informed consent if the requirements of this section are met.
- (j) Nothing in this section shall in any way affect the right of a resident of a skilled nursing facility or intermediate care facility for whom medical intervention has been prescribed, ordered, or administered pursuant to this section to seek appropriate judicial relief to review the decision to provide the medical intervention.

(k) No physician or other health care provider, whose action under this section is in accordance with reasonable medical standards, is subject to administrative sanction if the physician or health care provider believes in good faith that the action is consistent with this section and the desires of the resident, or if unknown, the best interests of the resident.

(l) The determinations required to be made pursuant to subdivisions (a), (e), and (g), and the basis for those determinations shall be documented in the patient's medical record and shall be made available to the patient's representative for review.

Added Stats 1992 ch 1303 §1 (AB 3209), operative until January 1, 1995. Amended Stats 1994 ch 146 §100 (AB 3601), operative until January 1, 1995 (ch 791 prevails), ch 791 §1 (AB 1139), operative until January 1, 1997; Stats 1996 ch 126 §1 (SB 1848).

Note— Stats 1992 ch 1303 provides:

SECTION 1. The Legislature finds and declares as follows:

(a) When a skilled nursing facility or intermediate care facility resident loses capacity to make health care decisions, there is a need to identify a surrogate decisionmaker to make health care treatment decisions on his or her behalf. However, in many cases, the skilled nursing facility or intermediate care facility resident may have no family member who is available and willing to make health care decisions, no conservator of the person, and no other health care agent, such as an agent appointed pursuant to a valid Durable Power of Attorney for Health Care. In California, this has been identified by health care providers and others as a significant dilemma.

(b) The current system is not adequate to deal with the legal, ethical, and practical issues that are involved in making health care decisions for incapacitated skilled nursing facility or intermediate care facility residents who lack surrogate decisionmakers. Existing Probate Code procedures, including public conservatorship, are inconsistently interpreted and applied, cumbersome, and sometimes unavailable for use in situations in which day-to-day medical treatment decisions must be made on an on-going basis.

(c) Therefore, it is the intent of the Legislature to identify a procedure to secure, to the greatest extent possible, health care decisionmakers for skilled nursing facility or intermediate care facility residents who lack the capacity to make these decisions and who also lack a surrogate health care decisionmaker. It is also the intent of the Legislature to ensure that the medical needs of nursing facility residents are met even in the absence of a surrogate health care decisionmaker and to ensure that health care providers are not subject to inappropriate civil, criminal, or administrative liability when delivering appropriate medical care to these residents.