Study L-4004 January 30, 2001

Memorandum 2001-15

Health Care Decisions Law: Technical Revisions (Comments on Tentative Recommendation)

This memorandum considers comments we have received on the tentative recommendation on *Health Care Decisions Law: Technical Revisions*. A staff draft of a final recommendation is attached, making a number of editorial revisions and including other revisions in response to the commentary. (In light of the important issues raised, however, the recommendation may need further substantive revision before the Commission wishes to approve it.)

A bill has been drafted based on the tentative recommendation, to meet legislative bill-drafting deadlines. If the Commission approves a final recommendation for introduction, the staff will have the bill revised and seek an author.

The following letters are also attached in the Exhibit:

General Reactions

Comments on the tentative recommendation were generally favorable, with the major exception of the proposed clarification on the duration of a surrogate designation under Probate Code Section 4711. The State Bar Estate Planning, Trust and Probate Law Section Executive Committee has "no objections" to the recommendation, other than the surrogate duration issues in Section 4711, discussed below. See Exhibit p. 15.

A number of commentators objected to the title of the recommendation on the grounds that the revision concerning surrogate designations are not "technical." See Exhibit pp. 2, 10, 12. To avoid nonproductive arguments over titles, the staff proposes changing "technical" to "miscellaneous."

Agent's Liability for Disposition of Remains — Health & Safety Code § 7100
Staff Draft Recommendation, pp. 9-12 (text), 15-18 (statute)

Alan F. Carpenter, MD, reads Section 7100(a)(1) to require the agent to "specifically exclude himself" from authority to direct disposition of remains in order to avoid liability. See Exhibit p. 1. That is not the intent of the amendments. The second sentence begins "unless the agent specifically agrees …," meaning that the agent is not bound unless he or she agrees to be bound. This is the converse of the interpretation Dr. Carpenter gives it. The next sentence covers the case where the agent assumes the duty to determine disposition of remains, thereby implicitly agreeing to be bound.

Elizabethanne Miller Angevine "strongly" agrees with the proposed amendment, as does Sister Marilee Howard. See Exhibit pp. 8, 9, respectively.

Capacity Definition — Prob. Code § 4609
Staff Draft Recommendation, pp. 5-7 (text), 19-20 (statute)

Most writers approved of or had no objection to the clarification of the "capacity" definition in Section 4609. See Exhibit pp. 9, 15.

Elizabethanne Miller Angevine thinks distinguishing between capacity to make health care decisions and to appoint agents is "not needed and will create more problems than it solves." Exhibit p. 7. She writes:

> The premise for the need of this change is that at the time a person is filing this out they are not contemplating proposed health care is not true. Anyone filing out the form is dealing with future life support, "proposed health care" which is actual possible care. Most people also fill the PAHC out before surgery at hospitals or out patients clinics and they actually are contemplating proposed care.

She adds, "two prong tests are legal concepts and are very confusing to the public and to doctors." *Id.*

The staff does not think the two-prong test is confusing, but confusion could arise if a doctor was in the position of deciding whether a patient has capacity to make an effective revocation of an agent's authority. How could the "proposed health care" element of subdivision (a) be satisfied? If there is any pending proposed health care, it is not an issue in whether the patient has capacity to revoke the designation of the agent. If there is no proposed health care, regardless of any possible relevance, it would not be possible to make a judgment on the "patient's ability to understand the nature and consequences of proposed health care, including its significant benefits, risks, and alternatives." Mixing the ability to understand significant benefits, risks, and alternatives of health care into the question of who should be an agent or whether the agency should be revoked is counter to the refinements in the law governing how capacity is determined that have been enacted over the last 30 years in the Guardianship and Conservatorship Law and the Due Process in Competency Determinations Act. Simply put, capacity is to be determined based on the task at hand.

The staff would prefer that we could have one simple capacity standard, but there have been objections to Section 4609 as enacted in 1999, and on closer examination, it is clear that the standard cannot be satisfied, technically and literally, where there is no proposed health care. We have not been able to craft a single standard that takes care of both types of situations, and no one has suggested language that would work. It would be possible to put "if any" following "proposed health care," but that would be more confusing than the proposed language. Nor would it solve the problem of confusing capacity to select or reject agents with the capacity to make health care decisions.

Stuart D. Zimring also objects to the bifurcated definition. Exhibit p. 12. He finds that applying a contract standard of capacity to the execution of a power of attorney for health care "increases the quagmire rather than lessening it." He believes two separate definitions of capacity raise a potential for conflict and ambiguity, and wonders whether a patient could have capacity to execute a power of attorney for health care but lack capacity to make health care decisions and vice versa. (Normally, the contract standard is a lower standard; there is no need to understand significant benefits, risks, and alternatives to proposed treatment. Thus, in theory, a person could have capacity to execute a power of

attorney for health care while failing to have sufficient capacity to make a health care decision. In practice, however, the staff doubts that many of the capacity distinctions make a real difference.)

The staff is sympathetic to Mr. Zimring's concern, but we don't see how to avoid the technical objection that the amendment addresses: how can the patient's ability to understand the nature and consequences of proposed health care be assessed if there is no proposed health care, which we believe is the usual situation when a power of attorney for health care is executed.

Further review of this language suggests that **the execution standard in subdivision (b) needs to include the "make and communicate" concept** that is in subdivision (a). This will make the two subdivisions more parallel:

> 4609. ~~"Capacity"~~ (a) With respect to making health care decisions, "capacity" means a patient's ability to understand the nature and consequences of proposed health care, including its significant benefits, risks, and alternatives, and to make and communicate a health care decision.
>
> (b) With respect to giving or revoking an advance health care directive or selecting or disqualifying a surrogate, "capacity" means the patient's ability to understand the nature and consequences of the action and to make and communicate a decision.

Supervising Health Care Provider as Agent — Prob. Code § 4659
Staff Draft Recommendation, pp. 13-14 (text), 20-21 (statute)

Dr. Alan F. Carpenter applauds the addition of domestic partners to the class of relationships excepted from the ban on supervising health care providers serving as agents. See Exhibit p. 1; draft Recommendation, pp. 6 (text), 10-11 (statute). Elizabethanne Miller Angevine "generally" agrees with this change. See Exhibit p. 8.

Duration of Surrogate Designation — Prob. Code § 4711
Staff Draft Recommendation, pp. 7-9 (text), 21-23 (statute)

Effect of Surrogate Designation on Agency

Writers expressing an opinion on the point support the proposed amendment in Section 4711(c) making clear that naming a surrogate does not revoke the appointment of an agent under a power of attorney for health care, unless the patient expresses the intention to revoke. See, e.g., Exhibits p. 5, 7.

Duration of Surrogate Designation

Six writers disagree with the resolution of the problems concerning duration of surrogate designations. See Exhibit pp. 2-4 (Carlson), 5-6 (McGinnis), 7 (Angevine), 10 (Powers), 11 (Szego), 15 (Stern). Another writer is opposed to oral surrogacies generally and does not believe that surrogate designations can "coexist" with advance directives. See Exhibit p. 13 (Zimring). The staff also heard concerns expressed orally at a meeting on January 26 of the Advance Care Planning Group of the California Coalition for Compassionate Care.

One writer supports the proposed revision, noting that the "patient's stated choice is the governing factor." See Exhibit p. 9 (Howard). Another writer finds the surrogate provisions useful and that giving surrogate designations legal standing is important. See Exhibit p. 14 (Menkin).

The proposed revisions of Section 4711 in the tentative recommendation focused on two policy goals: resolving the potential conflict between prior agency designations and later surrogate designations, and effectuating patient intent. The concern in Section 4711 as enacted relating to "stale" surrogate designations, which was expressed in the general limitation on oral surrogacies to the duration of the treatment, illness, or hospitalization, was rethought. The distinction between designating surrogates by oral communication or written communication was eliminated. Some commentators still refer to oral surrogacies, but we do not detect any objection to eliminating the separate, and confusing, treatment of oral and written surrogate designations. We also suspect that some commentators have not adequately focused on the limitation that a patient can make a surrogate designation only by communicating directly to the supervising health care provider, i.e., usually the primary physician. The statute does not authorize just anyone to receive the communication.

Some writers express concerns about the problem of recordkeeping. Ms. Angevine, for example, states that "in practice hospitals do not keep those kind of records from one visit to another." Exhibit p. 7. The easy answer in this case, for those who are concerned about "stale" surrogacies, is that if there is no record, there will be no known surrogate, and hence, no "stale" surrogate. On the other hand, the staff is informed that the statutory rules are likely to lead to Department of Health Services regulations requiring improved recordkeeping.

Eric Carlson suggests that reliance on medical records is undesirable for a number of reasons:

> It is inappropriate and dangerous for an individual's health care decision-maker to be determined **forever** by a physician's note in medical records. Access to, and retrieval of, medical records can be very difficult, particularly if the records are years or decades old. In addition, a physician's note might or might not be accurate, and an individual would not be aware that a conversation with a physician could appoint a health care surrogate for life. Also, medical records are more easily manipulated or fabricated than are powers of attorney for health care ….

Exhibit p. 3 (emphasis in original). And others point out the desirability of using powers of attorney for health care and fear that the recognition of surrogate designations is a threat to using advance directives. Patricia McGinnis writes:

> It is poor public policy to permit the one-time oral designation of a surrogate to remain indefinitely. We have a carefully crafted system under current law that encourages citizens to execute health care decisions and appoint agents. Allowing a simple oral designation of a surrogate to remain indefinitely in a patient's record would undermine this system.

Exhibit p. 6. See also Exhibit pp. 7, 10, 11, 15.

The objecting writers generally propose the same solution: apply the limitations regardless of whether the patient has previously executed a power of attorney for health care. In other words, the 30-day limitation would apply in long-term care facilities and the "treatment, illness, or stay" limitation would apply to acute care facilities. See Exhibit pp. 4, 5-6, 7 (probably), 10, 11, 15. **The staff has implemented this approach in the attached draft recommendation.**

There are several problems with this approach:

(1) *Why 30 days?* This time period was suggested in the discussion at the October 2000 meeting. But it is completely arbitrary. It is a baby-bear time period — not too long, not too short — although it may not be "just right." Whether it is a usable time period, depends on how one lines up one's bears. This writer believes it is far too short as a general limitation. Some speak of the danger of oral surrogacies that are years or decades old. (Of course, if the surrogacy expresses the patient's intent, what is the difference between a two-year old surrogate designation and a two-year old agency? And if the age of the patient's expression is an issue, what are we to think of a 20-year old power of attorney for health care?) Consider what happens if the patient's designation must expire after 30 days (or any rigid period): patient makes the designation three weeks

before surgery; things don't go well, and the patient becomes comatose within a week following surgery. It is now the 29th day. What happens? Can the surrogate only make decisions for two more days? Does the patient's autonomy and right to self-determination, as expressed in selecting the surrogate, expire at the end of the 30th day? Are health care providers precluded from acting based on the designated surrogate's opinions? On what principle do we invalidate the expression of the patient's intentions on Day 31 that was valid on Day 30? And after that, who decides? In the nursing home, instead of the person desired by the patient, we now may substitute decisionmaking by the "interdisciplinary team" under Health and Safety Code Section 1418.8. The staff finds it incongruous that advocates for nursing home patients would prefer this result.

(2) *Can we effectively distinguish between acute and long-term care?* The version in the tentative recommendation ameliorated the distinction since the limitation only applied where there was a power of attorney for health care. If that limitation is removed, the 30-day rule would apply in custodial care situations (assuming that is a clear category) and the treatment-illness-stay limitation in all others. Dr. Menkin reports, however, that nursing homes are being used as acute care hospitals for therapy and rehabilitation. See Exhibit p. 14. Is the reference to "custodial" care sufficient to draw a clear line?

(3) *How long is a treatment or an illness?* The objection was made to the "stay" in the health care institution standard that it was open-ended and was no limitation at all in the nursing home setting. What then of "illness"? If a patient is suffering from cancer or diabetes or Alzheimers, what kind of limitation is a reference to the "illness"? The "treatment" limitation has similar problems, although the difficulties are not as dramatic. The existing limitation is phrased in the disjunctive: "during the course of treatment or illness or during the stay in the health care institution when the designation is made." It is not clear whether the shorter or longer period would apply. The staff assumes the longer period would apply.

(4) *Can we provide limits without doing harm?* The staff has been seeking a way to satisfy the concern for limitations on the surrogate designation while not negatively affecting surrogate decisionmaking customs and practices that are commonly accepted, alluded to in case law, and in guidelines such as the Patient Information Pamphlet and ethical statements. If health care providers are willing to make ethical decisions based on custom and practice that include the

"surrogate," then the law should not interfere — at least until the law has a better resolution of all of the important issues. The staff does not believe that applying the 30-day limit or the treatment-illness-stay limit meets this test. The challenge is to find either a more flexible, practical standard in place of those we've discussed so far or to make clear that the statute is intended as an authorization not a prohibition.

(5) *Should surrogate designations be kept in force while patients lack capacity?* In order to avoid overriding the incpacitated patient's expressed intentions, at a time when the patient is incapable of renewing the intention or executing an advance directive, the statute could provide that the surrogate designation does not expire under the normal rules when the patient is incapacitated. This strikes a compromise between the interest in promoting formal advance directives against informal substitutes and the interest in validating patient autonomy and using the best available evidence of patient intent.

Another alternative would be to leave the duration issue alone, and deal only with the revocation issue by making clear that designating a surrogate is not presumed to revoke an agency. If the Commission can't settle on an appropriate rule for modifying Section 4711 as it currently exists to deal with the issues raised about nursing home situations, then it is better to leave the law alone for now.

Limitations on Disqualification

Should the disqualification under Section 4715 be limited to the same extent as designation of a surrogate? This section reads:

> 4715. A patient having capacity at any time may disqualify another person, including a member of the patient's family, from acting as the patient's surrogate by a signed writing or by personally informing the supervising health care provider of the disqualification.

If designations are suspect after a certain time, does that logic apply to disqualifications?

Scope of Petition — Prob. Code § 4766
Staff Draft Recommendation, pp. 12-13 (text), 24-25 (statute)

Elizabethanne Miller Angevine "strongly" agrees with the proposal to add petitions to compel third persons to honor individual health care instructions or the authority of agents and surrogates to the grounds for petitions under Section 4766. See Exhibit p. 8.

Sister Marilee Howard is concerned that the authorization of a petition to compel a third person to honor health care instructions or the authority of an agent or surrogate might be viewed as overriding other limitations. See Exhibit p. 9. She notes the cross-references to other provisions in the Comment, but would like to see a reference in the statute. The staff does not think it is a good idea to attempt to list all limitations in the section. As it is worded, subdivisison (e) is consistent with the parallel provision applicable to powers of attorney for property (Section 4541(f)), although there are more exceptions to the duty to comply with health care instructions, such as the conscience rule in Section 4734. But most importantly, Section 4766 is a procedural section providing grounds for a petition under the Health Care Decisions Law. Section 4734 does not create any duties. It only provides a means to compel compliance with the statute. We could revise subdivision (e) to read something like "compelling a third person to perform duties under this division," but that isn't very concrete and would not be consistent with Section 4541.

Respectfully submitted,

Stan Ulrich
Assistant Executive Secretary

California Law Review Commission
Attention: Stan Ulrich, secretary
4000 Middlefield Rd, Room D-1
Palo Alto, CA 94303 - 4739

Jan. 7, 2001

Subject: public commentary on the Commission's "Tentative Recommendations" to the Health Care Decisions Law.

Dear Mr. Ulrich:

I have reviewed the "tentative recommendations" and the News Release of December 26, 2000 in RE AB 891.

I wish to applaud the commission for making the critically needed recommendations regarding, in particular, 1) the relief of the Agent under the DPAHC from any monetary liability attending his activities to direct the disposition of the remains of the principal; and 2) the inclusion of registered domestic partners along with the previously identified "related by blood, marriage, or adoption".

In regard to the first (the relief from monetary liability of the agent directing disposition of the remains of the principal), my reading of the proposed legislation, section 7100 (a),(1) implies that the agent will need to specifically exclude himself from directing the disposition of the remains of the principal. Otherwise he will continue to be liable for expenses "to the extent that the decedent's estate or other appropriate fund is insufficient". Is this what you want for the agent?

If the agent chooses a medical care program that is more expensive than can be covered by the patient's health care insurance and, in the end, is more expensive than can be paid for by the residue of the principal's estate, is the agent similarly liable for the costs of this care "to the extent that the decedent's estate or other fund is insufficient?" If the agent is not liable for these costs, he should not be liable for the costs relating to the disposition of the remains of the principal either.

Sincerely yours,

Alan F. Carpenter MD.
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January 12, 2001

Law Revision Commission
RECEIVED
JAN 16 2001
File:

David Huebner, Chairperson
California Law Revision Commission
4000 Middlefield Road, Room D-1
Palo Alto, California 94303-4739

Re: Tentative Recommendation #L-4004;
"Technical Revisions" to Health Care Decisions Law

Dear Chairperson Huebner, and Members of the Law Revision Commission:

We write in opposition to one provision of Recommendation #L-4004. Although the recommendations are labeled "technical" by the Commission, one recommendation (the revision of Probate Code section 4711) is drastic in its effect.

Under the Commission's tentative recommendation, a designation of a surrogate (potentially nothing more than an oral statement to one physician) is effectively indefinitely, if the individual has not designated an agent in a power of attorney for health care. The tentative recommendation, if enacted into law, would create great confusion, because health care providers would be legally obligated to follow oral statements made to other health care providers years or possibly decades earlier. The tentative recommendation would reduce the use and effectiveness of written powers of attorney for health care, which reasonably require witnessing or notarization.

Current Law

Under current law, an individual can appoint an health care "agent" by naming that person in a power of attorney for health care. The power of attorney must be witnessed by two adults and/or notarized. For nursing facility residents, the power of attorney also must be witnessed by a representative of the state's Long-Term Care Ombudsman Program. The agent has authority to make the individual's health care decision's indefinitely, once the individual is no longer able to make his or her own decisions.

BET TZEDEK, The House of Justice, is a non-profit organization funded in part by the Jewish Federation Council of Los Angeles, United Way, the State Bar of California, the City of West Hollywood, and the City of Los Angeles.

An individual can appoint a health care "surrogate" simply by telling the individual's physician (orally or in writing) that the individual wants to have the surrogate make the individual's health care decisions, if and when the individual can no longer make his or her own decisions. The surrogate's authority lasts only while the individual is under treatment for the same illness, or resides in the same health care facility.

Under current law, appointment of an agent is the formal way of selecting a health care decision-maker for the future, while designation of a surrogate is a relatively informal way of appointing a decision-maker in an emergency, when there is not enough time to appoint an agent.

Proposed Change Under the Tentative Recommendation

The Commission proposes to alter the duration of the effectiveness of a surrogate designation. The Commission describes this alteration as a limitation, because the authority of a surrogate would be capped at 30 days for individuals residing in a nursing facility, if the individual previously had appointed an agent. But, in making this change, the Commission is eliminating the time restrictions for individuals who have not previously appointed an agent. In the Tentative Recommendation, the time restrictions in subsection (b) of Probate Code section 4711 apply only "[i]f the patient has designated an agent in a power of attorney for health care and the existence of the power of attorney for health care is recorded in the patient's health care record or otherwise known to the supervising health care provider." The comment to section 4711, on line 9 of page 12 of the Commission's recommendation, states that "[i]f there is no agent, the time limitations are not applicable."

Inappropriateness of Commission's Proposed Change

It is inappropriate and dangerous for an individual's health care decision-maker to be determined forever by a physician's note in medical records. Access to, and retrieval of, medical records can be very difficult, particularly if the records are years or decades old. In addition, a physician's note might or might not be accurate, and an individual would not be aware that a conversation with a physician could appoint a health care surrogate for life. Also, medical records are more easily manipulated or fabricated than are powers of attorney for health care, which are witnessed or notarized, and are generally circulated to the agent, family members, health care providers, and other interested parties.

Appointment of a health care decision-maker for the indefinite future should continue to be made through a power of attorney, so that the individual can consider his or her options and understand the impact of his or her decisions, and so the decisions can be witnessed and/or notarized. The procedures for execution of a power of attorney for health care properly balance the need for convenience with the need for a trustworthy document. A fill-in-the-blanks power of attorney for health care can be completed, executed and witnessed in no more than five or ten minutes.

Requested Change to Commission's Proposed Change

We request that the Tentative Recommendation be revised so that the durational limits to a surrogate's authority apply whether or not the individual has appointed an agent under a power of attorney for health care. Current law properly provides a surrogate with time-limited authority. This concept should not be altered during the making of technical amendments.

Thank you for your diligent work with these important issues.

Sincerely,

Eric M. Carlson
Attorney at Law

California Advocates for Nursing Home Reform

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January 22, 2001

David Huebner, Chairperson
California Law Revision Commission
4000 Middlefield Road, Room D-1
Palo Alto, CA 94303-4739
By mail and fax: (650) 494-1827

Re: Tentative Recommendation #L-4004/Technical Revisions to Health Care Decisions Law

Dear Mr. Huebner:

On behalf of California Advocates for Nursing Home Reform, I would like to submit the following comments regarding the above-referenced tentative recommendations.

1. We support the proposed language in § 4711(c) clarifying that the oral designation of a surrogate does not automatically revoke the designation of an agent appointed under a Health Care Directive.

2. We greatly appreciate the Commission's response to our concerns regarding the oral designation of surrogates when the patient is a resident in a nursing home. We support the provision limiting the oral designation of surrogates by nursing home residents to 30 days. However, we strongly believe that this 30-day limitation should apply whether or not the resident has named a health care agent.

3. In other cases, the current language limiting oral designation of surrogates to the "period of treatment or illness" should remain, whether or not the patient has named an agent.

It is poor public policy to permit the one-time oral designation of a surrogate to remain indefinitely. We have a carefully crafted system under current law that encourages citizens to execute health care decisions and appoint agents. Allowing a simple oral designation of a surrogate to remain indefinitely in a patient's record would undermine this system.

The very nature of an oral designation of a surrogate lends itself to emergency situations and to other, time-limited, health care situations.

We hope the Commission will consider our concerns.

Sincerely,

Patricia L. McGinnis
Executive Director

Date: Tue, 23 Jan 2001 08:53:37 -0800
From: Betsy Angevine <angevine@earthlink.net>
Organization: The Law Offices of Miller & Angevine
To: comment@clrc.ca.gov
Subject: health care decision law

Dear Law Revision Commission:

I am Elizabethanne Miller Angevine and practice in probate and estate planning. I have also been a member of the National Academy of Elder Law Attorneys since 1989 and am their current co-chair of their health care decision making Special interest group. This is my third year to serve in that capacity.

I have read the proposed changes to the the recent law change. Following are my comments:

1. Definition of Capacity

One of that stated purposes of the recent change in the law was to make the law less intimidating to both the public and the doctors and to make it more "user friendly". This proposed change will make this law more confusing to the non lawyers who still do the preponderance of helping people fill out the document (chaplains, nurses, senior center volunteers). The premise for the need of this change is that at the time a person is filing this out they are not contemplating proposed health care is not true. Anyone filing out the form is dealing with future life support, "proposed health care" which is actual possible care. Most people also fill the PAHC out before surgery at hospitals or out patients clinics and they actually are contemplating proposed care. But my best argument is that two prong tests are legal concepts and are very confusing to the public and to doctors. This makes the document harder to use and will discourage its use. This change is just plain not needed and will create more problems than it solves.

2. Designation of Surrogate

I strongly agree that the code needs to be clear that there is a presumption that a surrogate designation does not revoke the properly nominated agent under a PAHC.

3. Duration of Surrogate

I also agree that a SNF designation should only last for 30 days or when the agent is able to act.

But I strongly disagree that an orally created surrogate at a hospital should continue form one hospitalization to another. In practice hospitals do not keep those kind of records from one visit to another. The don't even keep a copy of a power of attorney from my experience. This provision could discourage the hospital from getting the patient to do a proper document completed and to discuss the issues involved with the person is supposed to be able to know what they want. The hospitals have had pressure on them to have someone who can give informed consent and therefore they have funded a chaplain program to go over these documents with patients. Your propose change may make them believe that their record keeping is better than it is and may encourage them to end the chaplain as educator program. Finally this change is not really a problem because if the person is unable to orally nominate someone on a second visit and did no document, I believe the hospital would say that the new hospitalization is just continuing treatment for the old problem and would try to figure out who was orally nominated last time and use that person. That is what has been happening for years as the hospitals made up their own informal surrogate rules.

4. I strongly agree with the changes to limit the agents liability for the principals remains.

5. I strongly agree with the changes of judicial review.

6. I generally agree with this change.

Thank you for considering my opinions.

Elizabethanne Miller Angevine
13215 Penn St., Ste 205
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Bar #126541

From: "Howard, Sister Marilee" <MHoward@chw.edu>
To: "'sulrich@clrc.ca.gov'" <sulrich@clrc.ca.gov>
Subject: Proposed Technical Revisions: Health Care Decisions Law
Date: Tue, 23 Jan 2001 13:31:08 -0800

California Law Revision Commission
4000 Middlefield Road, Room D.1
Palo Alto, CA 94303
Submitted by E-mail
January 23, 2001
To the Members of the Commission

I have consulted with our legal Department at Mercy Healthcare Sacramento and want to offer the following comments on the proposed Technical Revisions to the Health Care Decisions Law

These revisions will help to fulfill the intent of the law to make it easier for individuals to designate a decision-maker and have their statement of treatment preferences honored. References to item numbers below refer to the summary list provided with the proposed revisions.

The revision regarding the health care agent's liability for disposition of remains (item 4) is an important amendment and I strongly support it. Any unintended liability of the agent can only make it more difficult for patients seeking agents willing to act on their behalf.

The clarifications of the duration of a surrogate's authority and of the relationship of surrogate and agent when both exist (items 2 and 3) are helpful. They should assist care givers in identifying the appropriate decision-maker in circumstances that might otherwise have become confusing. The phrase "except as the patient otherwise informs the supervising health care provider" in SEC. 5. Section 4711 (b) on page 11 is especially helpful in that the patient's stated choice is the governing factor

Distinguishing two definitions of capacity (item 1) will help to facilitate the ability of persons to make advance directives by applying an appropriate standard to this process.

In regard to item 5, we have some concern that, as stated, this provision might be interpreted as conflicting with or overriding limitations elsewhere in the statute.. Your comments include a clarification: "The extent to which a third person may be compelled to comply with decisions of an agent or surrogate is subject to other limitations in this division" Some reference in the statute text that makes this clear would be helpful.

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Sister Marilee Howard

CONGRESS OF CALIFORNIA SENIORS

CALIFORNIA'S VOICE FOR THE NATIONAL COUNCIL OF SENIOR CITIZENS

January 22, 2001

David Huebner, Chairperson
California Law Revision Commission
4000 Middlefield Road, Room D-1
Palo Alto, CA 94303-4739

Re: Tentative Recommendation #L-4004;
"Technical Revisions" to Health Care Decisions Law – Opposed

Dear Chairperson Huebner, and Members of the law Revision Commission:

I am writing on behalf of the Congress of California Seniors to oppose one provision of the cited proposed recommendation. We believe that the proposed revision is significant rather than just "technical" as described in the proposal.

The proposed revision would cap the effective time for the designation of a surrogate if the individual previously had appointed an agent. At the same time, the proposal would eliminate the time restriction for individuals who have not previously appointed an agent. It is this that we oppose.

We believe that it is inappropriate for indefinite terms for a surrogate to be based oral or written instruction to a doctor, which may or may not be witnessed. Long-term appointments of decision-makers should only be done through a power of attorney so that the decisions are witnessed and notarized. Anything less would be problematic for the individual/patient.

We urge that the Tentative Recommendation be changed so that the time limits for surrogates be applied to both cases cited above.

Sincerely,

William Powers

William Powers
Legislative Director

WP:ef

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January 24, 2001

File:_____

Mr. David Huebner, Chairperson
California Law Revision Commission
4000 Middlefield Road, Room D-1
Palo Alto, CA 94303-4739

Re: Tentative Recommendation #L-4004
Technical Revisions to Health Care Decision Law

Dear Chairperson Huebner and Members of the Law Revision Commission:

We are writing to express our concern with the provisions set forth in Recommendation #L-4004. It is our understanding that this tentative recommendation would allow for the informal designation of a surrogate to be effective indefinitely, if the individual has not designated an agent in a Power of Attorney for Health Care.

We are supportive of family members and loved ones being able to act as surrogate decision makers and the right of the individual to informally appoint a health care "surrogate". However, the indefinite time frame included in this recommendation lacks the safeguards available in the Power of Attorney for Health Care. In addition, the indefinite "surrogate" time frame underminds the safeguards afforded by the Power of Attorney for Health Care. Individuals under long term treatment will no longer appreciate the need to execute a formal document.

We urge the Commission to revise the recommendation and consider the addition of safeguards that would protect the individual who has designated a "surrogate" for an unlimited time frame, as well as support the need for the formal execution of a Power of Attorney for Health Care.

Thank you for your consideration of our concern.

Sincerely,

Peter A. Szego

Peter Szego, Chair
California State Legislative Committee

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January 24, 2001

Via Fax & First Class Mail

Mr. Stan Ulrich
Assistant Executive Secretary
California Law Revision Commission
4000 Middlefield Road, Room D-1
Palo Alto, California 94303-4739

Re: Health Care Decision Law - Technical Revisions

Dear Mr. Ulrich:

I have reviewed the proposed tentative recommendation issued in December 2000 regarding the technical revisions to the Health Care Decisions Law and have the following comments:

1. First, I believe these proposed changes are in certain ways major changes, not "minor substantive and technical" and bear careful scrutiny and thought.

2. The recommendation states that "capacity is a fluid concept." This is certainly true as illustrated by the adoption of DPCDA. However, the tentative proposal to split the definition of capacity (or in actuality, have two more definitions of capacity) applicable to the same situation, (i.e., health care decision making) overly complicates the situation. To apply a contract standard to the execution of the document and another standard to decisions under the document or in other medical context I believe merely increases the quagmire rather then lessening it. If the goal is to apply one standard of capacity to the execution of Powers of Attorney and another to health care decision making, I think the commission can find a simpler way to do that then the one proposed. Further, if we have two separate definitions of capacity, there is a potential for conflict and ambiguity. Can one have contractual capacity to execute a Power of Attorney for Health Care but lack the capacity to make medical decisions at the same time? What about the reverse?

3. A more serious issue arises over the issue of health care surrogate. I do not think it is possible for a surrogate designation to coexist with an advance directive. If someone wishes to appoint a surrogate where there is an existing advance directive, then there should be a clear revocation of the advance directive without having to rely on presumptions running in either direction and then a separate, written appointment of a surrogate. At a more basic level, I am unalterably opposed (as I have indicated in the past) to oral designation of surrogates.

I thank the Commission for its time and effort and appreciate this opportunity to share my thoughts.

Sincerely,

Stuart D. Zimring

SDZ:tmb

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0101240225

Date: 29 Jan 2001 07:10:59 -0800
From: Elizabeth Menkin <Elizabeth.Menkin@kp.org>
To: sulrich <sulrich@clrc.ca.gov>
Subject: oral (verbal) advance directives

Dear Stan

I heard from Theresa Drought's presentation to the board of the CCCC that there was discussion about revising the statute regarding oral advance directives to have them apply only in the acute hospital setting, not in Skilled Nursing facilities.

I hope to persuade you not to be that restrictive. In many ways, some of the "nursing homes" are being used as acute care hospitals. Many people now getting placed in SNFs are the same patients who 10 years ago would have stayed in hospital. Some patients are being placed directly from emergency room to SNF for intravenous therapy and rehabilitation. Many arrive with acute illness still being treated, and although they might have been stable for 24-48 hrs in the acute hospital, some of them do destabilize in the next 1-2 weeks.

I feel it has been a very useful device that I can document what a patient tells me about his preferences for treatment or for withholding treatment, or regarding his/her preferences for who should make decisions on his/her behalf if that should be needed, and feel that such can have legal standing should the need arise. What is the pressure or motivation to drop this provision?

Elizabeth S. Menkin, M.D.
Hospice Medical Director
Dept of Continuing Care
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January 24, 2001

Law Revision Commission
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File:_____

David Huebner, Chairperson
California Law Revision Commission
4000 Middlefield Road, Room D-1
Palo Alto, California 94303

Re: Tentative Recommendation L-4004; "Technical Revisions" to Health Care Decisions Law

Dear Mr. Huebner and Members of the Law Revision Commission:

I am writing on behalf of the Executive Committee of the Estate Planning, Trust, and Probate Law Section of the State Bar of California. Donald Travers and I, who sit on the Executive Committee, have reviewed the technical revisions you have under consideration to the Health Care Decisions Law, and Mr. Travers has asked me to forward our observations.

The summary of the revisions has six subparts. We have reviewed each of them, and we have no objections to raise or clarifications to request with regard five of them. We are concerned, however, with those provisions in the tentative recommendation that relate to the duration of a surrogate designation. The present text of section 4711 of the Probate Code permits a patient to designate a surrogate to make health care decisions by oral statement to the supervising health care provider. We think that the proposed change, in that it makes clear that an oral surrogacy designation does not revoke a power of attorney for health care, is a good one, but we are concerned that the time limitations created by proposed subsection (b) apply only in cases where there is a power of attorney for health care on record.

We would oppose the proposed language in subsections (b)(1) and b(2) insofar as that language does not limit the appointment of an oral surrogate. We believe that it would be appropriate to remove the first clause of subsection (b), so that the duration of the surrogate designation would be subject to the limitations in subsection (b)(1) and subsection (b)(2) in all cases, whether or not the patient has designated an agent in a power of attorney for health care.

Very truly yours,

Peter S. Stern

STATE OF CALIFORNIA

CALIFORNIA LAW REVISION COMMISSION

STAFF DRAFT RECOMMENDATION

Health Care Decisions Law: Miscellaneous Revisions

February 2001

California Law Revision Commission
4000 Middlefield Road, Room D-1
Palo Alto, CA 94303-4739

NOTE

This report includes an explanatory Comment to each section of the recommended legislation. The Comments are written as if the legislation were already operative, since their primary purpose is to explain the law as it will exist to those who will have occasion to use it after it is operative.

Cite this report as *Health Care Decisions Law: Miscellaneous Revisions*, 30 Cal. L. Revision Comm'n Reports ____ (2000). This is part of publication #209.

STATE OF CALIFORNIA

CALIFORNIA LAW REVISION COMMISSION
4000 Middlefield Road, Room D-1
Palo Alto, CA 94303-4739
650-494-1335

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JOYCE G. COOK, Vice Chairperson
BION M. GREGORY
SENATOR BILL MORROW
SANFORD M. SKAGGS
ASSEMBLY MEMBER HOWARD WAYNE

[February 1, 2001]

STAFF DRAFT

To: The Honorable Gray Davis
Governor of California, and
The Legislature of California

This recommendation proposes a number of minor substantive and technical revisions as a follow-up to the Health Care Decisions Law enacted in 1999 on recommendation of the Law Revision Commission:

(1) The definition of "capacity" would be amended to apply a contract standard to situations involving execution of advance directives.
(2) The patient's designation of a surrogate health care decisionmaker would not revoke a prior designation of an agent in a power of attorney for health care unless the patient expresses the intention to remove the agent.
(3) The duration of a surrogate designation by a patient in a nursing home would generally be limited to 30 days.
(4) The health care agent would not be automatically liable for the costs of disposition of the principal's remains.
(5) The grounds for petitioning the court would be amended to include a petition to compel a third person to honor the authority of a health care agent or surrogate.
(6) The rules limiting who can act as agent would be amended to make clear that a supervising health care provider can never act as agent for his or her patient, even if related to the patient by blood, marriage, adop-

tion, or registered domestic partnership, or where they are coworkers.

This recommendation is submitted pursuant to Resolution Chapter 81 of the Statutes of 1999.

Respectfully submitted,

David Huebner
Chairperson

STAFF DRAFT

HEALTH CARE DECISIONS LAW: MISCELLANEOUS REVISIONS

The Health Care Decisions Law was enacted in 1999 on recommendation of the Law Revision Commission.[1] As health care institutions and professional groups have begun to study and implement the new law, the Commission has learned of several problems that need further attention. This recommendation proposes a number of minor substantive and technical revisions as a follow-up to the 1999 legislation.

Definition of Capacity

Capacity is a fluid concept. Its meaning varies depending on the circumstances and the nature of the action an individual wishes to take. In the Power of Attorney Law, which included the durable power of attorney for health care,[2] the Commission did not attempt to flesh out the meaning of capacity, but adopted the general rule that a "natural person having the capacity to contract may execute a power of attorney."[3]

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1. 1999 Cal. Stat. ch. 658 (AB 891, Alquist) (operative July 1, 2000). For the Commission's original recommendation, see *Health Care Decisions for Adults Without Decisionmaking Capacity*, 29 Cal. L. Revision Comm'n Reports 1 (1999). The law as enacted, with revised Comments, is included in *2000 Health Care Decisions Law and Revised Power of Attorney Law*, 30 Cal. L. Revision Comm'n Reports 1 (2000).

2. Durable powers of attorney for health care were formerly governed by the Power of Attorney Law. See former Prob. Code §§ 4600-4806. These sections were repealed in connection with enactment of the Health Care Decisions Law. See 1999 Cal. Stat. ch. 819, § ___.

3. Prob. Code § 4120 & Comment. This is consistent with the general agency rule in Civil Code Section 2296. See also Civ. Code § 1556 ("All persons are capable of contracting, except minors, persons of unsound mind, and persons deprived of civil rights.").

All further statutory references are to the Probate Code, unless otherwise indicated.

In the new Health Care Decisions Law, the Commission included a definition of capacity based on Health and Safety Code Section 1418.8(b) and the Uniform Health-Care Decisions Act of 1993.[4] The new definition is specifically crafted to apply in the health care decisionmaking context: "'Capacity' means a patient's ability to understand the nature and consequences of proposed health care, including its significant benefits, risks, and alternatives, and to make and communicate a health care decision."[5]

A technical problem has been noted in the application of this definition where there is no "proposed health care" at the time the individual's capacity is relevant. This would commonly be the situation where a person is filling out an advance health care directive to appoint a health care agent or to give future health care instructions.[6] The "capacity" definition can still work in these cases, because the other prong of the test would apply — the "ability to make and communicate a health care decision."[7] It would be better, of course, if the statute were not phrased in a way that might cause confusion or mislead.

Accordingly, the Commission recommends splitting the definition of capacity into two parts, one applicable to the capacity to make health care decisions and the other applicable to execution of advance directives. The existing definition should continue to apply to making health care decisions. A general contract standard should apply to execution of advance directives, based on the individual's ability to

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4. UHCDA § 1(3).

5. Section 4609.

6. See Sections 4605 ("advance health care directive" defined), 4607 ("agent" defined), 4623 ("individual health care instruction" defined), 4629 ("power of attorney for health care" defined), 4670 *et seq.* (provisions governing advance health care directives).

7. Definitions in the Health Care Decisions Law govern its construction "unless the … context otherwise requires." See Section 4603.

understand the nature and consequences of the action.[8] In effect, this would return the law concerning capacity to execute a power of attorney for health care to the rule operative under the Power of Attorney Law. In addition, the contract standard would be applied to selecting or disqualifying a surrogate.[9]

Patient's Designation of Surrogate

The Health Care Decisions Law includes provisions recognizing the patient's right to designate a "surrogate" by personally informing the supervising health care provider, orally or in writing.[10] While designation of an agent under a power of attorney for health care is preferred, recognition of the clinical reality of surrogate designations affirms the fundamental principle of patient autonomy. Due to concerns about the possibility of giving effect to obsolete oral statements in the patient's record, the effectiveness of oral surrogate designations under Section 4711 is limited to the "course of treatment or illness or during the stay in the health care institution when the designation is made."[11] A surrogate designation communicated to the supervising health care provider in writing is not subject to this limitation.

Two concerns have arisen in applying Section 4711: (1) The default rule that a surrogate designation, whether oral or writ-

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8. See proposed amendment to Section 4609 *infra*. See, e.g., Hellman Commercial Trust & Sav. Bank v. Alden, 206 Cal. 592, 603, 275 P. 974 (1929) (discussing "nature, purpose, and effect" of the action); Burgess v. Security-First Nat'l Bank, 44 Cal. App. 2d 808, 816-18, 113 P.2d 298 (1941). The specialized rules for determining capacity under the Due Process in Competence Determinations Act (Sections 810-813) are applicable in judicial determinations. See Sections 811(e), 813.

9. See Section 4711. A "surrogate" is an adult, other than an agent or conservator, authorized to make health care decisions for the patient. See Section 4643.

10. Sections 4711-4715 & Comments.

11. See second sentence of Section 4711 & Comment.

ten, would act as a revocation of the appointment of an agent under a power of attorney for health care[12] is too harsh and may actually defeat the patient's intent. (2) In the nursing home setting, the restriction on the duration of oral surrogate designations to the "stay in the health care institution" is not a meaningful limitation.

The Commission recommends amending Section 4711 to address these problems and provide additional statutory guidance on surrogate designations:[13]

(1) Relation of Surrogate Designation to Health Care Agent

The presumption that a surrogate designation revokes the appointment of a health care agent should be reversed. A surrogate designation should act as a revocation of the agency only if the patient expresses that intention in compliance with the general rule governing powers of attorney for health care.[14] A patient may want the surrogate to act in place of an agent named in a power of attorney for any number of reasons, without intending to permanently replace the agent. The agent may be unavailable because he or she is on vacation or otherwise unavailable when the patient is hospitalized. Or the named agent may be experiencing health or personal problems that impel the patient to seek someone else as a temporary surrogate.

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12. The statute does not provide explicitly that the surrogate designation revokes the agent's authority, but a Uniform Health-Care Decisions Act comment incorporated as background in the Commission's Comment to Section 4711 states that an "oral designation of a surrogate made by a patient directly to the supervising health-care provider revokes a previous designation of an agent." The uniform act comment does not suggest the effect of a written surrogate designation, but there is no reason to think it would have a less significant effect than an oral communication to the supervising health care provider. See also Section 2(b) (provisions drawn from uniform acts to be construed to make law uniform in enacting states).

13. See proposed amendment to Section 4711 *infra*.

14. See Section 4695(a).

(2) Duration of Surrogate Designation in Nursing Home Setting

In the long-term custodial care setting, a surrogate designation should be effective for no more than 30 days. An arbitrary time period is needed to avoid over-dependence on surrogate designations entered in patients' medical records.

(3) Duration of Surrogate Designation in Hospital Setting

The existing general limitation on the duration of oral surrogacies should apply in the acute care setting, so that the surrogate designation would be effective "during the course of treatment or illness or during the stay in the health care institution."

(4) Patient Control

The statutory rules concerning the relation of surrogate designations to agent designations, and the duration and conditions governing surrogates, should be subject to control by the patient. If the patient wants the surrogate designation to last longer than the statutory default period, the patient's intention, expressed to the supervising health care provider and recorded in the patient's record, should govern.

Agent's Liability for Disposition of Remains

The Health and Safety Code sets up a detailed scheme defining rights, duties, and liabilities of surviving family members and other persons, including agents and public guardians, pertaining to disposition of remains.[15] An agent under a power of attorney for health care has priority over all others to control the disposition of a decedent's remains.[16]

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15. See generally Health & Safety Code §§ 7100-7117.

16. Health & Safety Code § 7100(a). This section was amended in 1998 to provide that an attorney-in-fact under a durable power of attorney for health care has the top priority to control disposition of remains. See 1998 Cal. Stat. ch. 253, § 1 (SB 1360). The liability and duty provisions were already in place. In 1999, this section was amended to conform to the terminology of the Health Care Decisions Law. See 1999 Cal. Stat. ch. 658, § 5.5 (AB 891). The latter amendment was made on Commission recommendation as a conforming

The statutory scheme also includes provisions making it a misdemeanor to fail to perform the statutory duty and providing liability for treble damages.[17]

The top priority for health care agents was added to the law by an amendment of Health and Safety Code Section 7100 in 1998.[18] The 1998 legislation focused on the problem of a person charged with the decedent's murder having priority in disposition of the remains.[19] The legislative committee analyses do not discuss or recognize the potential effect of the amendment on the liability of attorneys-in-fact, nor is the purpose of adding attorneys-in-fact explained.

The Commission has received reports that some potential agents, when informed of the apparent liability under the Health and Safety Code, are reluctant to agree to act as agents, and persons preparing powers of attorney for health care are worried about imposing such a liability on their relatives or friends whom they want to name as agents.[20] Clarifying the relation between the Health and Safety Code provisions and the Probate Code, and resolving internal inconsistencies in the Health and Safety Code provisions, are

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revision, but the Commission did not reexamine the language or underlying policy of Section 7100 at that time.

17. Health & Safety Code § 7103. In addition, Health and Safety Code Section 7105(a) provides that a cemetery authority or any relative of the decedent may seek a court order directing the person with a duty of interment to make the disposition.

18. See *supra* note 15.

19. See, e.g., Senate Committee on Business and Professions, Analysis of SB 1360, as amended April 1, 1998 (hearing date April 13, 1998); Assembly Committee on Consumer Protection, Governmental Efficiency, and Economic Development, Analysis of SB 1360, as amended June 10 1998 (hearing date June 23, 1998); Senate Rules Committee, Floor Analysis of SB 1360, as amended July 2, 1998.

20. See, e.g., Letter from Theresa Drought, Ph.D., R.N., Ethics Committee Chair, Kaiser Oakland Medical Center, to Stan Ulrich (Oct. 5, 2000) (attached to Third Supplement to Commission Staff Memorandum 2000-62, Oct. 5, 2000).

outside the scope of this recommendation.[21] But it is important to insulate agents under powers of attorney for health care from this apparently unintended imposition of liability, which can act to defeat the fundamental purpose of the Health Care Decisions Law of effectuating patient autonomy through the use of advance health care directives.

Accordingly, the Commission recommends that Health and Safety Code Section 7100 be amended to make clear that, unless they agree otherwise, agents do not have an enforceable duty to direct the disposition of the principal's remains and are not liable under that section for failure or refusal to act. Furthermore, in a case where an agent does exercise the authority to direct disposition of remains, the agent should be liable only for reasonable costs that cannot be satisfied out of

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21. Some of these provisions, particularly Section 7100, may be misleading when read in isolation. For example, in addition to the statutory order of liability for disposition costs specified in subdivision (a) of Section 7100, subdivision (d) provides that liability for the reasonable cost of final disposition "devolves jointly and severally upon all kin of the decedent in the same degree of kindred and upon the estate of the decedent." Moreover, Section 7101 provides that the decedent's estate shall be charged with the reasonable cost of interment. If the decedent has given written instructions for disposition, the cost is payable from designated funds or the decedent's estate as provided in Section 7100.1. See also Prob. Code §§ 11421(a) (funeral expenses as priority claim on decedent's estate), 11446 (funeral expenses charged against estate, not community share of surviving spouse, notwithstanding any other statute or whether spouse or "any other person is also liable for the expenses"). This confusion regarding liability for the cost of interment is noted in Sher, *Funeral Prearrangement: Mitigating the Undertaker's Bargaining Advantage*, 15 Stan. L. Rev. 415, 430 n.39 (1963).

The courts, in attempting to reconcile the various statutes, have declined to apply the literal statutory rule of Section 7100(a) and have generally held that a solvent estate is primarily liable and the liability provided in Section 7100(a) is secondary if the estate is insufficient. See Estate of Kemmerrer, 114 Cal. App. 2d 810, 251 P.2d 345 (1952); Benbough Mortuary v. Barney, 196 Cal. App. 2d Supp. 861, 16 Cal. Rptr. 811 (1961); Estate of Dennis, 110 Cal. App. 2d 667, 243 P.2d 579 (1952). *Cf.* Sinai Temple v. Kaplan, 54 Cal. App. 3d 1103, 1108, 127 Cal. Rptr. 80 (1976) (volunteer who has assumed duty of paying for funeral services is primarily liable, but if debt remains unsatisfied, estate is secondarily and absolutely liable, with recourse to surviving kin only where an estate is insufficient to pay expenses).

the principal's estate or other appropriate fund. The proposed liability limitation would apply only to the person when acting as agent and not in situations where the statute imposes liability based on some other relationship, such as a spouse, child, or parent.

Scope of Petition

The Health Care Decisions Law, like its predecessor, provides an expeditious procedure for obtaining judicial review in appropriate situations.[22] The grounds for a petition are broad, but not unlimited, and include determining (1) whether the patient has capacity to make health care decisions, (2) whether an advance health care directive is in effect, and (3) whether the acts or proposed acts of an agent or surrogate are consistent with the patient's desires as expressed in an advance health care directive or otherwise made known to the court or, where the patient's desires are unknown or unclear, whether the acts or proposed acts of the agent or surrogate are in the patient's best interest.[23]

For the purpose of getting comments from interested persons, the Commission tentatively proposes to permit a petition requiring third persons to honor the agent's authority under the power of attorney for health care.[24] This would include health care decisions,[25] as well as decisions concerning disposition under the Uniform Anatomical Gift Act, authorizing an autopsy, and directing disposition of remains,[26]

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22. Sections 4765-4771.

23. Section 4766.

24. See proposed amendment to Section 4766 *infra*.

25. See Sections 4615 ("health care" defined), 4617 ("health care decision" defined)..

26. See Section 4683 (scope of agent's authority). See also Sections 4678 (right to health care information), 4690 (agent's right of consultation and to receive information).

or making personal care decisions.[27] The petition should also be available to compel a third person to honor the authority of a surrogate, i.e., a person (other than an agent or conservator) with the authority to make health care decisions for an adult under the Health Care Decisions Law or other governing principles.

Supervising Health Care Provider as Agent

The Health Care Decisions Law carried forward the limitations on who can be designated as a health care agent and the exceptions to the limitations, which were enacted in the 1980s.[28] Section 4659 now provides that the patient's supervising health care provider or an employee of the health care institution cannot act as an agent or surrogate health care decisionmaker. However, subdivision (b) of Section 4659 provides an exception to this limitation, which permits employees who are related to the patient by blood, marriage, or adoption, or who are employed by the same health care institution, to act as the relative's or coworker's health care agent. Thus, if a patient is employed by the same institution as his or her doctor, or is related to the doctor and the doctor is an employee, the exception to the statutory prohibition would literally seem to apply.

It does not appear that this statute ever intended to permit the treating physician (included within the term "supervising health care provider")[29] to serve as the patient's health care agent, but this construction is possible under a literal reading of the statute in circumstances where the physician falls into the class of employees and the patient is a relative or coworker.

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27. See Section 4671(b).

28. Section 4659 restates former Section 4702 (enacted as part of the Power of Attorney Law, 1994 Cal. Stat. ch. 307, § 16), which continued former Civil Code Section 2432.5 (enacted by 1984 Cal. Stat. ch. 312, § 4).

29. Section 4641.

The proposed amendment makes clear that a supervising health care provider cannot make decisions as a health care agent for his or her patient in any circumstances.[30] Under this rule, if a doctor wants to act as the agent for his or her spouse, for example, the doctor would need to decline to act as the supervising health care provider.

The statute should also be amended to add registered domestic partners[31] to the list of excepted classes in existing law, which currently includes persons related to the patient by blood, marriage, or adoption.

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30. See proposed amendment to Section 4659 *infra*.

31. For provisions governing domestic partner registration, see Fam. Code § 297 *et seq.*

STAFF DRAFT

Health & Safety Code § 7100 (amended). Right to control disposition of remains

SECTION 1. Section 7100 of the Health and Safety Code is amended to read:

7100. (a) The right to control the disposition of the remains of a deceased person, the location and conditions of interment, and arrangements for funeral goods and services to be provided, unless other directions have been given by the decedent pursuant to Section 7100.1, vests in, and the duty of disposition and the liability for the reasonable cost of disposition of the remains devolves upon, the following in the order named:

(1) An agent under a power of attorney for health care governed by Division 4.7 (commencing with Section 4600) of the Probate Code. *Unless the agent specifically agrees, the agent does not have a duty or liability under this section. If the agent assumes the duty under this section, the agent is liable only for the reasonable costs incurred as a result of the agent's decisions, to the extent that the decedent's estate or other appropriate fund is insufficient.*

(2) The competent surviving spouse.

(3) The sole surviving competent adult child of the decedent, or if there is more than one competent adult child of the decedent, the majority of the surviving competent adult children. However, less than one-half of the surviving adult children shall be vested with the rights and duties of this section if they have used reasonable efforts to notify all other surviving competent adult children of their instructions and are not aware of any opposition to those instructions on the part of more than one-half of all surviving competent adult children.

(4) The surviving competent parent or parents of the decedent. If one of the surviving competent parents is absent, the remaining competent parent shall be vested with the rights and duties of this section after reasonable efforts have been unsuccessful in locating the absent surviving competent parent.

(5) The surviving competent adult person or persons respectively in the next degrees of kindred. If there is more than one surviving competent adult person of the same degree of kindred, the majority of those persons. Less than the majority of surviving competent adult persons of the same degree of kindred shall be vested with the rights and duties of this section if those persons have used reasonable efforts to notify all other surviving competent adult persons of the same degree of kindred of their instructions and are not aware of any opposition to those instructions on the part of one-half or more of all surviving competent adult persons of the same degree of kindred.

(6) The public administrator when the deceased has sufficient assets.

(b)(1) If any person to whom the right of control has vested pursuant to subdivision (a) has been charged with first or second degree murder or voluntary manslaughter in connection with the decedent's death and those charges are known to the funeral director or cemetery authority, the right of control is relinquished and passed on to the next of kin in accordance with subdivision (a).

(2) If the charges against the person are dropped, or if the person is acquitted of the charges, the right of control is returned to the person.

(3) Notwithstanding this subdivision, no person who has been charged with first or second degree murder or voluntary manslaughter in connection with the decedent's death to whom the right of control has not been returned pursuant to

paragraph (2) shall have any right to control disposition pursuant to subdivision (a) which shall be applied, to the extent the funeral director or cemetery authority know about the charges, as if that person did not exist.

(c) A funeral director or cemetery authority shall have complete authority to control the disposition of the remains, and to proceed under this chapter to recover usual and customary charges for the disposition, when both of the following apply:

(1) Either of the following applies:

(A) The funeral director or cemetery authority has knowledge that none of the persons described in paragraphs (1) to (5), inclusive, of subdivision (a) exists.

(B) None of the persons described in paragraphs (1) to (5), inclusive, of subdivision (a) can be found after reasonable inquiry, or contacted by reasonable means.

(2) The public administrator fails to assume responsibility for disposition of the remains within seven days after having been given written notice of the facts. Written notice may be delivered by hand, U.S. mail, facsimile transmission, or telegraph.

(d) The liability for the reasonable cost of final disposition devolves jointly and severally upon all kin of the decedent in the same degree of kindred and upon the estate of the decedent. However, if a person accepts the gift of an entire body under subdivision (a) of Section 7155.5, that person, subject to the terms of the gift, shall be liable for the reasonable cost of final disposition of the decedent.

(e) This section shall be administered and construed to the end that the expressed instructions of the decedent or the person entitled to control the disposition shall be faithfully and promptly performed.

(f) A funeral director or cemetery authority shall not be liable to any person or persons for carrying out the

instructions of the decedent or the person entitled to control the disposition.

(g) For purposes of this section, "adult" means an individual who has attained 18 years of age, "child" means a natural or adopted child of the decedent, and "competent" means an individual who has not been declared incompetent by a court of law or who has been declared competent by a court of law following a declaration of incompetence.

Comment. Subdivision (a)(1) of Section 7100 is amended to make clear that an agent under a power of attorney for health care is not automatically liable for the costs of disposition of remains. Nor does the agent have a duty greater than that agreed to under the Health Care Decisions Law, Probate Code Section 4600 *et seq*. Even if the agent assumes the duty to make decisions under this section, the agent is not liable unless the estate or other fund is insufficient. See Section 7101; see also Prob. Code §§ 11421 (payment of funeral expenses from estate), 11446 (funeral expenses from estate, not community property). The limitation on liability in subdivision (a)(1) applies only to the person when acting as agent and not where the statute imposes liability based on some other relationship, such as a spouse under subdivision (a)(2) or child under subdivision (a)(3).

Prob. Code § 4123 (technical amendment). Permissible purposes of general power of attorney

SEC. 2. Section 4123 of the Probate Code is amended to read:

4123. (a) In a power of attorney *under this division*, a principal may grant authority to an attorney-in-fact to act on the principal's behalf with respect to all lawful subjects and purposes or with respect to one or more express subjects or purposes. The attorney-in-fact may be granted authority with regard to the principal's property, personal care, ~~health care~~, or any other matter.

(b) With regard to property matters, a power of attorney may grant authority to make decisions concerning all or part of the principal's real and personal property, whether owned by the principal at the time of the execution of the power of

attorney or thereafter acquired or whether located in this state or elsewhere, without the need for a description of each item or parcel of property.

(c) With regard to personal care, a power of attorney may grant authority to make decisions relating to the personal care of the principal, including, but not limited to, determining where the principal will live, providing meals, hiring household employees, providing transportation, handling mail, and arranging recreation and entertainment.

Comment. Subdivision (a) of Section 4123 is amended to recognize the limitations on the scope of this division. Powers of attorney for health care are governed by the Health Care Decisions Law, Division 4.7 (commencing with Section 4600). This division — the Power of Attorney Law, Division 4.5 (commencing with Section 4000) — does not apply to power of attorney for health care. See Section 4050 (types of powers of attorney governed by this division).

Prob. Code § 4609 (amended). "Capacity"

SEC. 3. Section 4609 of the Probate Code is amended to read:

4609. ~~"Capacity"~~ *(a) With respect to making health care decisions,* "*capacity*" means a patient's ability to understand the nature and consequences of proposed health care, including its significant benefits, risks, and alternatives, and to make and communicate a health care decision.

(b) With respect to giving or revoking an advance health care directive or selecting or disqualifying a surrogate, "capacity" means the patient's ability to understand the nature and consequences of the action and to make and communicate a decision.

Comment. Subdivision (b) is added to Section 4609 to recognize a contract standard of capacity as applied to actions involving advance health care directives. Subdivision (b) is consistent with the rule formerly applicable to durable powers of attorney for health care under Section 4120 in the Power of Attorney Law.

For provisions relating to the capacity definition in subdivision (a), see Sections 4651 (authority of person having capacity not affected), 4658

(determination of capacity and other medical conditions), 4682 (when agent's authority effective), 4683 (scope of agent's authority).

For provisions relating to the capacity definition in subdivision (b), see, e.g., Sections 4670 (authority to give individual health care instruction), 4671 (authority to execute power of attorney for health care), 4695 (revocation of power of attorney for health care), 4715 (disqualification of surrogate).

See also Sections 4657 (presumption of capacity), 4732 (duty of primary physician to record relevant information), 4733 (obligations of health care provider), 4766 (petition as to durable power of attorney for health care).

Prob. Code § 4659 (technical amendment). Limitations on who may act as agent or surrogate

SEC. 4. Section 4659 of the Probate Code is amended to read:

4659. (a) Except as provided in subdivision (b), none of the following persons may make health care decisions as an agent under a power of attorney for health care or a surrogate under this division:

(1) The supervising health care provider or an employee of the health care institution where the patient is receiving care.

(2) An operator or employee of a community care facility or residential care facility where the patient is receiving care.

(b) The prohibition in subdivision (a) does not apply to the following persons:

(1) An employee *(other than the supervising health care provider)* who is related to the patient by blood, marriage, or adoption*, or is a registered domestic partner of the patient.*

(2) An employee *(other than the supervising health care provider)* who is employed by the same health care institution, community care facility, or residential care facility for the elderly as the patient.

(c) A conservator under the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code) may not be designated as an

agent or surrogate to make health care decisions by the conservatee, unless all of the following are satisfied:

(1) The advance health care directive is otherwise valid.

(2) The conservatee is represented by legal counsel.

(3) The lawyer representing the conservatee signs a certificate stating in substance:

> "I am a lawyer authorized to practice law in the state where this advance health care directive was executed, and the principal or patient was my client at the time this advance directive was executed. I have advised my client concerning his or her rights in connection with this advance directive and the applicable law and the consequences of signing or not signing this advance directive, and my client, after being so advised, has executed this advance directive."

Comment. Section 4659 is amended to clarify an ambiguity that existed in prior law. See former Section 4702. As amended, the exception in subdivision (b) does not apply to supervising health care providers. Consequently, the bar on supervising health care providers acting as agents or surrogates for their patients, as provided in subdivision (a), is absolute. If a supervising health care provider is the spouse of a patient, he or she would need to cease acting as the patient's primary physician or other supervising health care provider in order to undertake responsibilities as an agent under a power of attorney for health care or as a surrogate health care decisionmaker. The extension of the relationship exception in subdivision (b)(1) to include registered domestic partners is new. See Fam. Code § 297 *et seq.* (domestic partner registration).

Prob. Code § 4711 (amended). Patient's designation of surrogate

SEC. 5. Section 4711 of the Probate Code is amended to read:

4711. *(a)* A patient may designate an adult as a surrogate to make health care decisions by personally informing the supervising health care provider. ~~An oral~~ *The* designation of a surrogate shall be promptly recorded in the patient's health care record ~~and is effective only~~.

(b) The duration of a surrogate designation under this section is subject to the following limitations, except as the patient otherwise informs the supervising health care provider:

(1) In the case of a patient in custodial or long-term care in a skilled nursing facility or other health care institution, the surrogate designation is effective for 30 days.

(2) In other cases, the surrogate designation is effective during the course of treatment or illness or during the stay in the health care institution when the *surrogate* designation is made.

(c) Designation of a surrogate under subdivision (a) temporarily replaces but does not revoke the designation of an agent under a power of attorney for health care, unless the patient communicates the intention to revoke in compliance with subdivision (a) of Section 4695.

Comment. Section 4711 is amended to clarify the duration of surrogate designations and the relation between a surrogate designation under this section and a formal agent designation in a power of attorney for health care under Section 4671 and related provisions. Both the patient and the surrogate must be adults. See Sections 4625 ("patient" defined), 4643 ("surrogate" defined). "Adult" includes an emancipated minor. See Fam. Code § 7002 (emancipation). "Personally informing," as used in this section, includes both oral and written communications.

Consistent with the statutory purpose of effectuating patient intent, subdivision (a) recognizes the patient's ability to name a person to act as surrogate health care decisionmaker. As amended, this section no longer distinguishes between surrogates named orally and surrogates named in a written communication to the supervising health care provider. Whether it is communicated to the supervising health care provider orally or in writing, the surrogate designation must be promptly recorded in the patient's health care record. See also Section 4731 (supervising health care provider's duty to record relevant information).

Subdivision (b) provides special limitations on the duration of surrogate designations. Subdivision (b)(1) provides a new rule concerning the duration of a surrogate designation in situations involving custodial or long-term care. In acute care settings, the duration of the surrogate designation depends on the length of the patient's stay in the hospital or the patient's illness or course of treatment, as provided in

subdivision (b)(2). The default limitations on surrogate designations are subject to the patient's expression of a different limitation, as recognized in the introductory paragraph of subdivision (b). Thus, for example, a patient in either a long-term or acute care setting may designate a surrogate to make decisions until an agent under a power of attorney for health care returns from an overseas trip or some other period dependent on events. The arbitrary 30-day period in subdivision (b)(1) and the limitations in subdivision (b)(2) are provided as guidelines subject to the patient's control. If the patient names an agent in a power of attorney for health care executed after making a surrogate designation, the agent would have priority over the surrogate as provided in Section 4685 (agent's priority).

Subdivision (c) makes clear that the appointment of an agent under a power of attorney for health care is not revoked simply by the act of naming a surrogate under this section. A surrogate designation is only a temporary suspension of the agent's authority, unless the patient expresses the intent to revoke the agent's appointment, under the terms of the general rule in Section 4695(a). Subdivision (c) reverses the former presumption that a surrogate designation under this section revoked a previous designation of an agent. See Background from Uniform Act in Comment to Section 4711 as enacted, 1999 Cal. Stat. ch. 658, § 39 (operative July 1, 2000).

See also Sections 4617 ("health care decision" defined), 4619 ("health care institution" defined), 4635 ("reasonably available" defined), 4639 ("skilled nursing facility" defined), 4641 ("supervising health care provider" defined).

Heading of Chapter 3 (commencing with Section 4765) (technical amendment)

SEC. 6. The heading of Chapter 3 (commencing with Section 4765) of Part 3 of Division 4.7 of the Probate Code is amended to read:

CHAPTER 3. PETITIONS, *AND* ORDERS, ~~APPEALS~~

Comment. The chapter heading is amended to accurately reflect the contents of the chapter. Appeals under the Probate Code are governed generally by Part 3 (commencing with Section 1300) of Division 3. See Section 1302.5 (grounds for appeal under Health Care Decisions Law).

Prob. Code § 4766 (amended). Purposes of petition

SEC. 7. Section 4766 of the Probate Code is amended to read:

4766. A petition may be filed under this part for any one or more of the following purposes:

(a) Determining whether or not the patient has capacity to make health care decisions.

(b) Determining whether an advance health care directive is in effect or has terminated.

(c) Determining whether the acts or proposed acts of an agent or surrogate are consistent with the patient's desires as expressed in an advance health care directive or otherwise made known to the court or, where the patient's desires are unknown or unclear, whether the acts or proposed acts of the agent or surrogate are in the patient's best interest.

(d) Declaring that the authority of an agent or surrogate is terminated, upon a determination by the court that the agent or surrogate has made a health care decision for the patient that authorized anything illegal or upon a determination by the court of both of the following:

(1) The agent or surrogate has violated, has failed to perform, or is unfit to perform, the duty under an advance health care directive to act consistent with the patient's desires or, where the patient's desires are unknown or unclear, is acting (by action or inaction) in a manner that is clearly contrary to the patient's best interest.

(2) At the time of the determination by the court, the patient lacks the capacity to execute or to revoke an advance health care directive or disqualify a surrogate.

(e) Compelling a third person to honor individual health care instructions or the authority of an agent or surrogate.

Comment. Section 4766 is amended to add the grounds for a petition specified in subdivision (e). This subdivision is consistent with the provision applicable to compel compliance with powers of attorney for property matters in Section 4541(f). The remedy provided by this

subdivision would be appropriate where the third person has a duty to honor the authority of an agent or surrogate. See, e.g., Sections 4685 (agent's priority), 4733 (duty of health care provider or institution to comply with health care instructions and decisions).

The extent to which a third person may be compelled to comply with decisions of an agent or surrogate is subject to other limitations in this division. See, e.g., Sections 4652 (excluded acts), 4653 (mercy killing, assisted suicide, euthanasia not approved), 4654 (compliance with generally accepted health care standards), 4734 (right to decline for reasons of conscience or institutional policy), 4735 (right to decline to provide medically ineffective care).

An advance health care directive may limit the authority to petition under this part. See Sections 4752 (effect of provision in advance directive attempting to limit right to petition), 4753 (limitations on right to petition).

See also Sections 4605 ("advance health care directive" defined), 4607 ("agent" defined), 4609 ("capacity" defined), 4613 ("conservator" defined), 4623 ("individual health care instruction" defined), 4629 ("power of attorney for health care" defined), 4633 ("principal" defined), 4643 ("surrogate" defined).

Prob. Code § 4769 (amended). Notice of hearing

SEC. 8. Section 4769 of the Probate Code is amended to read:

4769. (a) Subject to subdivision (b), at least 15 days before the time set for hearing, the petitioner shall serve notice of the time and place of the hearing, together with a copy of the petition, on the following:

(1) The agent or surrogate, if not the petitioner.

(2) The patient, if not the petitioner.

(b) In the case of a petition to compel a third person to honor *individual health care instructions or* the authority of an agent or surrogate, notice of the time and place of the hearing, together with a copy of the petition, shall be served on the third person in the manner provided in Chapter 4 (commencing with Section 413.10) of Title 5 of Part 2 of the Code of Civil Procedure.

Comment. Subdivision (b) of Section 4769 is amended for consistency with Section 4766(e) (petition to compel third person to honor health care instructions or authority of agent or surrogate).

See also Sections 4607 ("agent" defined), 4623 ("individual health care instruction" defined), 4625 ("patient" defined), 4633 ("principal" defined), 4643 ("surrogate" defined).