Study L-4000 June 17, 1999

Memorandum 99-38

1999 Legislative Program: AB 891 — Health Care Decisions

Assembly Bill 891, the Commission's Health Care Decisions Law, has passed the Assembly in amended form, and has been referred to the Senate Judiciary Committee. We expect it to be heard on July 13th. This memorandum reports on amendments to the bill, which need to be reviewed by the Commission, and on current efforts to resolve issues raised in the Assembly Judiciary Committee.

AMENDMENTS MADE TO AB 891 IN ASSEMBLY

Surrogate Committee

At the last meeting, the staff reported to the Commission that Assembly Member Sheila Kuehl, Chair of the Assembly Judiciary Committee, and the Committee consultant reviewing AB 891, had suggested that the Commission agree to remove the surrogate committee provisions applicable to health care decisionmaking for "friendless" patients. The Commission approved removing this material from the bill, with a view toward giving it further consideration and perhaps submitting recommended legislation next year. (This issue is discussed in more detail later near the end of this memorandum.)

Family Consent

Some additional issues were raised by the Assembly Judiciary Committee consultant, mainly concerning the rule recognizing that primary physicians determine capacity and the flexible family consent rules (see proposed Prob. Code §§ 4710-4716, Exhibit pp. 3-6). Before the hearing, Chairperson Kuehl, Assembly Member Elaine Alquist (who is carrying the bill for the Commission), and staff had a brief meeting, at which it was strongly suggested that the bill would be best served if the family consent provisions were removed and given further study. Unlike the surrogate committee provisions, however, the agreement was that the family consent provisions should be amended back into the bill in revised form on the Senate side. The bill would then return to the Assembly for concurrence. For obscure reasons, AB 891 is a fiscal bill, so it has to meet the deadlines and pass through two committees. The looming deadlines

and work burdens on the Assembly Judiciary Committee staff made it impossible to work out their concerns before the hearing.

Consequently, the staff agreed to remove the family consent sections from the bill. The consultant's analysis for the April 26 hearing in the Assembly Judiciary Committee reported as follows:

> Committee staff raised concerns regarding these provisions with the author and the sponsor, they concurred the best approach is to limit the bill at this time to the noncontroversial provisions described above and to work with Committee staff and other interested parties as the bill progresses in an attempt to achieve consensus on these issues. The recent amendments to the bill deleted these controversial provisions.

Consistent with the commitment of the Assembly Judiciary Committee Chair and staff, we have made it clear in the bill summary communicated to members of the Legislature that the author and sponsor intend to restore family consent provisions to the bill in the Senate. (See the Summary of AB 891, Exhibit p. 1.)

Oral Revocation

The Committee consultant was also concerned that the explicit rule in Probate Code Section 4724, to the effect that an agent could not give consent if the principal objects, had been superseded by more general rules concerning revocation of the agent's authority based on the uniform act. The staff agreed to restore this provision of existing law:

> 4689. Nothing in this division authorizes an agent under a power of attorney for health care to make a health care decision if the principal objects to the decision. If the principal objects to the health care decision of the agent under a power of attorney, the matter shall be governed by the law that would apply if there were no power of attorney for health care.
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> **Comment.** Section 4689 continues former Section 4724 without substantive change. Terminology has been revised for consistency with the language of the Health Care Decisions Law. See Sections 4607 ("agent" defined), 4629 ("power of attorney for health care" defined), 4617 ("health care decision" defined), 4633 ("principal" defined). As under the former section, this section does not limit any right the agent may have apart from the authority under the power of attorney for health care. See Section 4687.

Advance Directive Execution Requirements

Although the Committee consultant did not object to the elimination of general witnessing and dating requirements for advance directives (existing requirements for patients in long-term care settings had been preserved in the Commission's recommendation), these issues were raised in the analysis, and members raised the issues orally in both the Judiciary Committee and the Appropriations Committee. Assembly Member Alquist decided that she would like to restore the existing provisions for two witnesses (or alternately, notarization) and for dating the document. The staff prepared the necessary amendments, and the bill was amended on the Assembly floor. (For the text of the main revisions, see Exhibit pp. 7-20.)

Our assessment of the witnessing issue is that it is a close call. The Commission adopted the Uniform Health-Care Decisions Act approach of encouraging the use of witnesses, but not requiring them (except for long-term care facilities, as noted). However, many people, including a significant number of legislators, apparently, believe that witnesses are needed to prevent fraud or if not that, to make sure the document is executed with a certain formality and seriousness of purpose. We had also been told that the California Healthcare Association (the hospitals) had a concern about eliminating the witness rules. Assembly Member Robert Pacheco expressed concern about this issue in the Assembly Judiciary Committee, but voted for the bill. Vice Chair Brewer in Assembly Appropriations also raised it, and voted against the bill. On balance, and considering that the witness rules in existing law are the result of Commission recommendations in the past, the amendments are not a bitter pill.

Other Amendments

The Consumer Attorneys requested a technical amendment in Section 4740, concerning immunities:

> 4740. A health care provider or health care institution acting in good faith and in accordance with generally accepted health care standards applicable to the health care provider or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for any actions in compliance with this division, including, but not limited to, any of the following conduct:
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> (a) Complying with a health care decision of a person ~~apparently having~~ <u>that the health care provider or health care institution believes in good faith has</u> the authority to make a health

> care decision for a patient, including a decision to withhold or withdraw health care.

The staff agreed to this amendment because it removes an ambiguity and is consistent with the good faith standard applicable elsewhere in the bill. This amendment removed the concern expressed by the Consumer Attorneys.

Another amendment has been requested by Marc Hankin to add a general provision from the Power of Attorney Law. Early in the process of drafting the Health Care Decisions Law, the staff reviewed the existing rules in the PAL to see which ones were appropriate for inclusion in the new statute. Some ostensibly general rules in the PAL had no practical application in the health care context; others were clearly needed, although many of them were superseded by provisions drawn from the Uniform Health-Care Decisions Act. Mr. Hankin's concern is with Probate Code Section 4235 concerning a right of consultation:

> 4235. If the principal becomes wholly or partially incapacitated, or if there is a question concerning the capacity of the principal to give instructions to and supervise the attorney-in-fact, the attorney-in-fact may consult with a person previously designated by the principal for this purpose, and may also consult with and obtain information needed to carry out the attorney-in-fact's duties from the principal's spouse, physician, attorney, accountant, a member of the principal's family, or other person, business entity, or government agency with respect to matters to be undertaken on the principal's behalf and affecting the principal's personal affairs, welfare, family, property, and business interests. A person from whom information is requested shall disclose relevant information to the attorney-in-fact. Disclosure under this section is not a waiver of any privilege that may apply to the information disclosed.

The staff believes a limited version of this section could be added to the power of attorney part of the HCDL:

> **§ 4690. Consultation and disclosure**
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> 4690. If the principal becomes wholly or partially incapacitated, or if there is a question concerning the capacity of the principal, the agent may consult with a person previously designated by the principal for this purpose, and may also consult with and obtain information needed to carry out the agent's duties from the principal's spouse, physician, attorney, a member of the principal's family, or other person, including a business entity or government agency, with respect to matters covered by the power of attorney

for health care. A person from whom information is requested shall disclose relevant information to the agent. Disclosure under this section is not a waiver of any privilege that may apply to the information disclosed.

Comment. Section 4690 is drawn from Section 4235 in the Power of Attorney Law, which applied to durable powers of attorney for health care under former law.

CURRENT STATUS OF AB 891

Response to Assembly Judiciary Concerns

As yet, we do not have any specific guidance on how to resolve the concerns of the Assembly Judiciary Committee Chair and consultant. The best we can do at this point is give some impressions from meetings we have had, including the Group of 12 meeting on June 16. We do not know whether revisions along these lines would satisfy the objections or whether other concerns may arise as the discussions proceed. The following should be considered as talking points:

(1) There is concern that too much power is vested by statute in the primary physician. In this view, the physician recommends a medical treatment, determines capacity, and then picks the surrogate. (For a polemic illustrating this viewpoint, see the op-ed piece in the S.F. Daily Journal, April 15, 1999, p. 4, by David Lash and Eric Carlson, Exhibit p. 2.) This, of course, is the existing environment; this is how it works now and how it has worked by custom and practice since time immemorial. The Commission has not set out to create this situation, but has attempted to reinforce sound, ethical practice and regularize it. The family consent rules take a practical approach.

(2) There is concern that a "one size fits all" approach will not work in this context. By this, they mean that additional protections may be needed in cases involving more serious matters. In our discussions, mention was made of "invasive treatment" and administration of psychotropic drugs. Clearly withholding or withdrawal of life-sustaining treatment, nutrition, and hydration are in the serious category. The Commission struggled with this sort of line-drawing when structuring the surrogate committee proposal — broader participation in the committee was required where the decision involved life-sustaining treatment or "critical health care decisions." (See Section 4722.) In addition, a decision on life-sustaining treatment could not be made if there were

any no votes on the surrogate committee. At this point, we do not know what language would be needed to draw the line to the satisfaction of the Assembly Judiciary Committee staff, but we believe it will become apparent at the next meeting of the Group of 12 on July 1.

(3) There is concern about distinguishing between situations where there is family consensus (or at least no known disagreement) and cases where there is disagreement about the proper decision, or perhaps who should be surrogate. The staff strongly believes that this is a nonissue and that further study and consideration of the bill would lead to the conclusion that the recordkeeping, notice, and court review provisions give sufficient protection in cases where there is a dispute. This is not to say that some language changes might not improve the linkage of these rules.

Possible Approaches

The staff would like guidance from the Commission on what amendments would be acceptable, since the bill will need to be amended to meet deadlines before the Commission meets again.

There are, however, two scenarios in which prompt amendment is not required:

(1) **The bill could be made into a two-year bill**, leaving plenty of time to work with interested persons to resolve the family consent issues. However, **we don't think this is a good idea**. Groups in support of the bill want it to move forward. Nor is there any certainty that we can come to a consensus on the issues in this area. There are a number of valuable reforms in the bill, even with this part omitted, that make it desirable to get it enacted this year.

(2) **The bill could be left in its current amended form,** with a gap where the family consent rules should be. If there are no concerns raised in the Senate Judiciary Committee, the bill wouldn't even have to be amended and would not return to the Assembly for concurrence. **This has some appeal to the staff,** if for no other reason than it is a labor-saving option in the short run. However, there are a few other noncontroversial amendments that should be made, as discussed elsewhere, even if we can't reach a consensus on the family consent issues. We hope that when the time comes for hindsight, we will not look back and wish we had taken this approach.

Assuming that these simpler approaches are not appropriate as a first step, the staff needs to know what limits there should be on accepting amendments in the next few weeks. The following principles are offered for Commission discussion, to assist the staff:

(3) **At a minimum, the bill should be amended to apply the basic surrogate decisionmaking guidelines** — first, follow the patient's instructions; if none, then make decisions in accordance with the patient's known desires; if none, then make decisions in accordance with the patient's best interest, taking personal values into account. (See Section 4714 below.) One of the important aspects of AB 891 would be to make the surrogate decisionmaking standards consistent, whether the surrogate is an agent appointed in a power of attorney, named orally by the patient, a court-appointed conservator, the court making decisions under Section 3200, or any other surrogate. When the family consent rules were removed from the bill, the standards applicable to surrogate decisionmakers under that chapter were also removed. However, the concerns have been with the surrogate selection process, not with the standards. If there are no statutory rules concerning who can act as surrogate decisionmaker when there is no agent or conservator, this does not mean the long-standing, case-law sanctioned practice of the medical profession and families will cease. Doctors will continue to rely on close relatives and friends. Parents and children and siblings of incapacitated adults will continue to expect that they are the most appropriate persons to make decisions for their loved ones. And they are right.

Even without the valuable assistance that the Commission's proposed family consent statute could provide, these surrogates will continue to be involved. **Section 4714 should be restored to the bill,** reading as follows:

> 4714. A surrogate shall make a health care decision in accordance with the patient's individual health care 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.

"Surrogate" is defined in Section 4643 as a person authorized "under this division" to make a health care decision. The "under this division" language should be deleted, if we want provisions to apply to surrogates who are acting by case-law authority or tradition, or even if they shouldn't be acting, but are

surrogates-in-fact. A more limited approach would be to apply Section 4714 to persons "acting as surrogates."

In addition, the **surrogate disqualification rule in Section 4715 should be restored** since it is not restricted to the surrogate selection rules:

> 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.

(4) **Is the provision concerning physician determination of capacity severable from the surrogate selection rules?** Section 4710(a) limits the statutory surrogate procedure to cases where the primary physician has determined that the patient lacks capacity. "Capacity" is defined in Section 4609 to mean "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." These rules are consistent with existing practice and general law. That being the case, since physicians do routinely determine capacity, it is not essential that the HCDL specifically provide it. It is helpful, of course, but not critical. The bill includes record-keeping duties and liability and immunity provisions that are all part of a comprehensive statutory scheme. Section 4732 requires that capacity determinations be recorded in the patient's medical records. But, again, it is not essential that the statute provide *who* determines capacity. The staff believes that CHA and CMA like the Commission's original recommendation on these points, but we think they can understand that it is not a change in existing law or a step backward if we need to remove the specific capacity determination rules in response to objections. **The staff proposes to work to save these provisions, but we would agree to remove them, if it satisfied an objection to the bill** and moved us toward agreement on other provisions.

(5) **If a line is drawn between "routine" decisions and "critical" decisions by surrogates, what type of procedure is acceptable for critical cases?** At least two possibilities were mentioned at the Group of 12 meeting. One suggestion was that in critical cases, you would have to go to court. The other approach would be to require more administrative checks and balances, such as by requiring review by another physician or referral to an ethics committee or

consultant. The staff would like to hear the Commission's take on these approaches.

(6) **If a line is drawn between situations where the potential surrogates are in agreement and where there is conflict, what additional rules are acceptable?** As indicated above, the staff thinks the substance of the Commission's recommendation is adequate to deal with situations where the potential surrogates disagree, although there could be additional guidance added. All commentators we have heard express an opinion in the years we have studied these matters agree that doctors stop when the family is fighting. The focus has been on providing a procedure as a last resort for resolution of these issues. The staff assumes the Commission would not want to accept a burdensome procedure for selecting surrogates or involving courts in selecting surrogates, except as a last resort. Any other guidance in this matter would be valuable to the staff.

STATUS OF SURROGATE COMMITTEE PROVISIONS

The staff had scheduled a memorandum on the surrogate committee material for this meeting, but there have been no developments on that front, and we have nothing new to report. It did not seem worthwhile to present the same material to the Commission that you have already approved, after studying the matter for two years or more. Unless we can get some constructive input from those who have opposed the surrogate committee proposal, there does not seem to be much profit in rehashing the subject at this stage.

The Commission will need to decide whether to proceed on the decision made at the April meeting — to submit a recommendation on this issue to the 2000 Legislature. **You don't have to make that decision now, but tentatively, the staff would suggest that the Commission take the issue up at the October meeting.** The staff will attempt to get interested parties, both for and against, to give us additional comments so that the Commission can focus on the best approach.

Respectfully submitted,

Stan Ulrich
Assistant Executive Secretary

☞ **Staff Note.** Family consent (statutory surrogate) provisions from the Commission's recommendation on *Health Care Decisions for Adults Without Decisionmaking Capacity*, 29 Cal. L. Revision Comm'n Reports 1, 111-17 (1999).

CHAPTER 3. HEALTH CARE SURROGATES

§ 4710. Authority of surrogate to make health care decisions

4710. A surrogate who is designated or selected under this chapter may make health care decisions for a patient if all of the following conditions are satisfied:

(a) The patient has been determined by the primary physician to lack capacity.

(b) No agent has been designated under a power of attorney for health care and no conservator of the person has been appointed with authority to make health care decisions, or the agent or conservator is not reasonably available.

Comment. Section 4710 is drawn from Section 5(a) of the Uniform Health-Care Decisions Act (1993). Section 4658 provides for capacity determinations by the primary physician under this division. 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), 7050 (emancipated minor considered as adult for consent to medical, dental, or psychiatric care).

See also Sections 4609 ("capacity" defined), 4613 ("conservator" defined), 4615 ("health care" defined), 4617 ("health care decision" defined), 4625 ("patient" defined), 4629 ("power of attorney for health care" defined), 4631 ("primary physician" defined), 4635 ("reasonably available" defined), 4643 ("surrogate" defined).

Background from Uniform Act. Section 5(a) authorizes a surrogate to make a health-care decision for a patient who is an adult or emancipated minor if the patient lacks capacity to make health-care decisions and if no agent or [conservator] has been appointed or the agent or [conservator] is not reasonably available. Health-care decision making for unemancipated minors is not covered by this section. The subject of consent for treatment of minors is a complex one which in many states is covered by a variety of statutes and is therefore left to other state law. [Adapted from Unif. Health-Care Decisions Act § 5(a) comment (1993).]

§ 4711. Patient's designation of surrogate

4711. A patient may designate an individual as a 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 the stay in the health care institution when the designation is made.

Comment. The first sentence of Section 4711 is drawn from Section 5(b) of the Uniform Health-Care Decisions Act (1993). Both the patient and the surrogate must be adults. See Sections 4625 ("patient" defined), 4643 ("surrogate" defined). "Personally informing," as used in this section, includes both oral and written communications. The second sentence is intended to guard against the possibility of giving effect to obsolete oral statements entered in the patient's record.

See also Sections 4617 ("health care decision" defined), 4619 ("health care institution" defined), 4625 ("patient" defined), 4635 ("reasonably available" defined), 4641 ("supervising health care provider" defined), 4643 ("surrogate" defined).

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

informing the supervising health-care provider. The supervising health-care provider would then, in accordance with Section 7(b) [Prob. Code § 4731], be obligated to promptly record the designation in the individual's health-care record. An oral designation of a surrogate made by a patient directly to the supervising health-care provider revokes a previous designation of an agent. See Section 3(a) [Prob. Code § 4695(a)]. [Adapted from Unif. Health-Care Decisions Act § 5(b) comments (1993).]

§ 4712. Selection of statutory surrogate

4712. (a) Subject to Section 4710, if no surrogate has been designated under Section 4711 or if the designated surrogate is not reasonably available, the primary physician may select a surrogate to make health care decisions for the patient from among the following adults with a relationship to the patient:

(1) The spouse, unless legally separated.

(2) An adult 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 and reside or have been residing together. This individual may be known as a domestic partner.

(3) Children.

(4) Parents.

(5) Brothers and sisters.

(6) Grandchildren.

(7) Close friends.

(b) The primary physician shall select the surrogate, with the assistance of other health care providers or institutional committees, in the order of priority set forth in subdivision (a), subject to the following conditions:

(1) Where there are multiple possible surrogates at the same priority level, the primary physician shall select the individual who appears after a good faith inquiry to be best qualified.

(2) The primary physician may select as the surrogate an individual who is ranked lower in priority if, in the primary physician's judgment, the individual is best qualified to serve as the patient's surrogate.

(c) In determining the individual best qualified to serve as the surrogate under this section, the following factors shall be considered:

(1) Whether the proposed surrogate appears to be best able to make decisions in accordance with Section 4714.

(2) The degree of regular contact with the patient before and during the patient's illness.

(3) Demonstrated care and concern for the patient.

(4) Familiarity with the patient's personal values.

(5) Availability to visit the patient.

(6) Availability to engage in face-to-face contact with health care providers for the purpose of fully participating in the health care decisionmaking process.

(d) The primary physician may require a surrogate or proposed surrogate (1) to provide information to assist in making the determinations under this section and

(2) to provide information to family members and other persons concerning the selection of the surrogate and communicate with them concerning health care decisions for the patient.

(e) The primary physician shall document in the patient's health care record the reasons for selecting the surrogate.

Comment. Section 4712 is a new provision, drawn in part from West Virginia law and the Uniform Health-Care Decisions Act (1993). See W.Va. Code § 16-30B-7 (1997); Unif. Health-Care Decisions Act § 5(b)-(c) (1993). Subdivision (a)(2) is drawn from New Mexico law. See N.M. Stat. Ann. § 24-7A-5(B)(2) (Westlaw 1998). "Adult" includes an emancipated minor. See Fam. Code § 7002 (emancipation). A prospective surrogate and other persons may also seek judicial relief as provided in Sections 4765-4766.

See also Sections 4617 ("health care decision" defined), 4625 ("patient" defined), 4635 ("reasonably available" defined), 4641 ("supervising health care provider" defined), 4643 ("surrogate" defined).

§ 4713. Selection of statutory surrogate

4713. (a) The surrogate designated or selected under this chapter shall promptly communicate his or her assumption of authority to all adults described in paragraphs (1) to (5), inclusive, of subdivision (a) of Section 4712 who can readily be contacted.

(b) The supervising health care provider, in the case of a surrogate designation under Section 4711, or the primary physician, in the case of a surrogate selection under Section 4712, shall inform the surrogate of the duty under subdivision (a).

Comment. Subdivision (a) of Section 4713 is drawn from Section 5(d) of the Uniform Health-Care Decisions Act (1993). The persons required to be notified are the spouse, domestic partner, adult children, parents, and adult siblings. See Section 4712(a)(1)-(5). There is no statutory duty to notify the class of grandchildren or close friends. See Section 4712(a)(6)-(7). However, all surrogates have the duty to notify under subdivision (a), regardless of whether they would have a right to notice.

Subdivision (b) recognizes that the supervising health care provider or primary physician is more likely to know of the duty in subdivision (a) than the surrogate, and so is in a position to notify the surrogate of the duty.

See also Sections 4629 ("primary physician" defined), 4639 ("supervising health care provider" defined), 4643 ("surrogate" defined).

Background from Uniform Act. Section 5(d) [Prob. Code § 4713(a)] requires a surrogate who assumes authority to act to immediately so notify [the persons described in subdivision (a)(1)-(5)] who in given circumstances would be eligible to act as surrogate. Notice to the specified family members will enable them to follow health-care developments with respect to their now incapacitated relative. It will also alert them to take appropriate action, including the appointment of a [conservator] or the commencement of judicial proceedings under Section 14 [Prob. Code § 4750 *et seq.*], should the need arise. [Adapted from Unif. Health-Care Decisions Act § 5(d) comment (1993).]

§ 4714. Standard governing surrogate's health care decisions

4714. A surrogate shall make a health care decision in accordance with the patient's individual health care 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.

Comment. Section 4714 is drawn from Section 5(f) of the Uniform Health-Care Decisions Act (1993). This standard is consistent with the health care decisionmaking standard applicable to agents. See Section 4684.

See also Sections 4617 ("health care decision" defined), 4623 ("individual health care instruction" defined), 4625 ("patient" defined), 4643 ("surrogate" defined).

Background from Uniform Act. Section 5(f) imposes on surrogates the same standard for health-care decision making as is prescribed for agents in Section 2(e) [Prob. Code § 4684]. The surrogate must follow the patient's individual instructions and other expressed wishes to the extent known to the surrogate. To the extent such instructions or other wishes are unknown, the surrogate must act in the patient's best interest. In determining the patient's best interest, the surrogate is to consider the patient's personal values to the extent known to the surrogate. [Adapted from Unif. Health-Care Decisions Act § 5(f) comment (1993).]

§ 4715. Disqualification of surrogate

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.

Comment. Section 4715 is drawn from Section 5(h) of the Uniform Health-Care Decisions Act (1993). See Section 4731 (duty to record surrogate's disqualification). "Personally informing," as used in this section, includes both oral and written communications.

See also Sections 4625 ("patient" defined), 4641 ("supervising health care provider" defined), 4643 ("surrogate" defined).

Background from Uniform Act. Section 5(h) permits an individual to disqualify any family member or other individual from acting as the individual's surrogate, including disqualification of a surrogate who was orally designated. [Adapted from Unif. Health-Care Decisions Act § 5(h) comment (1993).]

§ 4716. Reassessment of surrogate selection

4716. (a) If a surrogate selected pursuant to Section 4712 is not reasonably available, the surrogate may be replaced.

(b) If an individual who ranks higher in priority under subdivision (a) of Section 4712 relative to a selected surrogate becomes reasonably available, the individual with higher priority may be substituted for the selected surrogate unless the primary physician determines that the lower ranked individual is best qualified to serve as the surrogate.

Comment. Section 4716 is drawn from West Virginia law. See W. Va. Code § 16-30B-7 (1997). A surrogate is replaced in the circumstances described in this section by applying the rules in Section 4712. The determination of whether a surrogate has become unavailable or whether a higher priority potential surrogate has become reasonably available is made by the primary physician under Section 4712 and this section. Accordingly, a person who believes it is appropriate to reassess the surrogate selection would need to communicate with the primary physician.

See also Sections 4631 ("primary physician" defined), 4635 ("reasonably available" defined), 4643 ("surrogate" defined).

~~(f) The provisions of this section applicable to witnesses do not apply to a notary who acknowledges an advance health care directive.~~

4673. A written advance health care directive is legally sufficient if all of the following requirements are satisfied:

(a) The advance directive contains the date of its execution.

(b) The advance directive is signed either (1) by the patient or (2) in the patient's name by another adult in the patient's presence and at the patient's direction.

(c) The advance directive is either (1) acknowledged before a notary public or (2) signed by at least two witnesses who satisfy the requirements of Sections 4674 and 4675.

4674. If the written advance health care directive is signed by witnesses, as provided in Section 4673, the following requirements shall be satisfied:

(a) The witnesses shall be adults.

(b) Each witness signing the advance directive shall witness either the signing of the advance directive by the patient or the patient's acknowledgment of the signature or the advance directive.

(c) None of the following persons may act as a witness:

(1) The patient's health care provider or an employee of the patient's health care provider.

(2) The operator or an employee of a community care facility.

(3) The operator or an employee of a residential care facility for the elderly.

(4) The agent, where the advance directive is a power of attorney for health care.

(d) Each witness shall make the following declaration in substance:

"I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the

individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly."

(e) At least one of the witnesses shall be an individual who is neither related to the patient by blood, marriage, or adoption, nor entitled to any portion of the patient's estate upon the patient's death under a will existing when the advance directive is executed or by operation of law then existing.

(f) The witness satisfying the requirement of subdivision (e) shall also sign the following declaration in substance:

"I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law."

(g) The provisions of this section applicable to witnesses do not apply to a notary public before whom an advance health care directive is acknowledged.

4675. (a) If an individual is a patient in a skilled nursing facility when a written advance health care directive is executed, the advance directive is not effective unless a patient advocate or ombudsman, as may be designated by the Department of Aging for this purpose pursuant to any other applicable provision of law, signs the advance directive as a witness, either as one

of two witnesses or in addition to notarization. The patient advocate or ombudsman shall declare that he or she is serving as a witness as required by this subdivision. It is the intent of this subdivision to recognize that some patients in skilled nursing facilities are insulated from a voluntary decisionmaking role, by virtue of the custodial nature of their care, so as to require special assurance that they are capable of willfully and voluntarily executing an advance directive.

(b) A witness who is a patient advocate or ombudsman may rely on the representations of the administrators or staff of the skilled nursing facility, or of family members, as convincing evidence of the identity of the patient if the patient advocate or ombudsman believes that the representations provide a reasonable basis for determining the identity of the patient.

~~4674.~~

4676. (a) A written advance health care directive or similar instrument executed in another state or jurisdiction in compliance with the laws of that state or jurisdiction or of this state, is valid and enforceable in this state to the same extent as a written advance directive validly executed in this state.

(b) In the absence of knowledge to the contrary, a physician or other health care provider may presume that a written advance health care directive or similar instrument, whether executed in another state or jurisdiction or in this state, is valid.

~~4675.~~

4677. A health care provider, health care service plan, health care institution, disability insurer, self-insured employee welfare plan, or nonprofit hospital plan or a similar insurance plan may not require or prohibit the execution or revocation of an advance health care directive as a condition for providing health care, admission to a facility, or furnishing insurance.

~~4676.~~

4678. Unless otherwise specified in an advance health care directive, a person then authorized to make health care decisions for a patient has the same rights as the

patient to request, receive, examine, copy, and consent to the disclosure of medical or any other health care information.

Article 2. Powers of Attorney for Health Care

4680. A power of attorney for health care is legally ~~sufficient if all of the following requirements are satisfied:~~

~~(a) The power of attorney is signed either (1) by the principal or (2) in the principal's name by another adult in the principal's presence and at the principal's direction.~~

~~(b) The power of attorney satisfies applicable witnessing requirements of Section 4673.~~ *sufficient if it satisfies the requirements of Section 4673.*

4681. (a) Except as provided in subdivision (b), the principal may limit the application of any provision of this division by an express statement in the power of attorney for health care or by providing an inconsistent rule in the power of attorney.

(b) A power of attorney for health care may not limit either the application of a statute specifically providing that it is not subject to limitation in the power of attorney or a statute concerning any of the following:

(1) Statements required to be included in a power of attorney.

(2) Operative dates of statutory enactments or amendments.

(3) Formalities for execution of a power of attorney for health care.

(4) Qualifications of witnesses.

(5) Qualifications of agents.

(6) Protection of third persons from liability.

4682. Unless otherwise provided in a power of attorney for health care, the authority of an agent becomes effective only on a determination that the principal lacks capacity, and ceases to be effective on a determination that the principal has recovered capacity.

4683. Subject to any limitations in the power of attorney for health care:

* * * * *

CHAPTER 2. ADVANCE HEALTH CARE DIRECTIVE FORMS

4700. The form provided in Section 4701 may, but need not, be used to create an advance health care directive. The other sections of this division govern the effect of the form or any other writing used to create an advance health care directive. An individual may complete or modify all or any part of the form in Section 4701.

4701. The statutory advance health care directive form is as follows:

ADVANCE HEALTH CARE DIRECTIVE

(California Probate Code Section 4701)

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.

(b) Select or discharge health care providers and institutions.

(c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.

(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

(e) Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at ~~the end. It is recommended but not required that you request two other adults to sign as witnesses. Give a copy~~ *the end. The form must be signed by two qualified*

witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

* * * * * * * * * * * * * * *

PART 1

POWER OF ATTORNEY FOR HEALTH CARE

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

_____

(name of individual you choose as agent)

_____

(address) (city) (state) (ZIP Code)

_____

(home phone) (work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

_____

(name of individual you choose as first alternate agent)

_____

(address) (city) (state) (ZIP Code)

_____

(home phone) (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

_____

(name of individual you choose as second alternate agent)

_____

(address) (city) (state) (ZIP Code)

_____

(home phone) (work phone)

(1.2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

_____

_____

_____

(Add additional sheets if needed.)

(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box ☐, my agent's authority to make health care decisions for me takes effect immediately~~:~~.

(1.4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) AGENT'S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____

_____

(Add additional sheets if needed.)

(1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

PART 2
INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

(2.1) END–OF–LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

☐ (a) Choice Not To Prolong Life

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

☐ (b) Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(2.2) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

(Add additional sheets if needed.)

(2.3) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

(Add additional sheets if needed.)

PART 3
DONATION OF ORGANS AT DEATH
(OPTIONAL)

(3.1) Upon my death (mark applicable box):

☐ (a) I give any needed organs, tissues, or parts, OR
☐ (b) I give the following organs, tissues, or parts only.

_____

(c) My gift is for the following purposes (strike any of the following you do not want):

(1) Transplant
(2) Therapy
(3) Research
(4) Education

PART 4
PRIMARY PHYSICIAN
(OPTIONAL)

(4.1) I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address) (city) (state) (ZIP Code)

_____
(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address) (city) (state) (ZIP Code)

_____

(phone)

* * * * * * * * * * * * * * * *

PART 5

(5.1) EFFECT OF COPY: A copy of this form has the same effect as the original.

(5.2) ~~SIGNATURES~~ *SIGNATURE*: Sign and date the form here:

_____ _____

(date) (sign your name)

_____ _____

(address) (print your name)

_____

(city) (state)

~~(Optional) SIGNATURES OF WITNESSES:~~

(5.3) STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First witness	Second witness
_____	_____
(print name)	(print name)
_____	_____
(address)	(address)
_____	_____
(city) (state)	(city) (state)
_____	_____
(signature of witness)	(signature of witness)
_____	_____
(date)	(date)

(5.4) ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

_____

_____ *(signature of witness)*

(signature of witness)

PART 6

SPECIAL WITNESS REQUIREMENT

(6.1) The following statement is required only if you are a patient in a skilled nursing facility—a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section ~~4673~~ *4675* of the Probate Code.

_____	_____
(date)	(sign your name)
_____	_____
(address)	(print your name)
_____	
(city) (state)	

CHAPTER 3. HEALTH CARE SURROGATES

4711. A patient may designate an adult as a 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 the stay in the health care institution when the designation is made.

CHAPTER 4. DUTIES OF HEALTH CARE PROVIDERS

4730. Before implementing a health care decision made for a patient, a supervising health care provider, if possible, shall promptly communicate to the patient the decision made and the identity of the person making the decision.