

Study L-4000

March 13, 1998

**First Supplement to Memorandum 98-16****Health Care Decisions: Staff Draft Tentative Recommendation  
(Preliminary Part initial draft)**

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Attached to this memorandum is an initial draft of the preliminary part outlining the staff draft tentative recommendation on *Health Care Decisions*. This is the first pass at the preliminary part and it is not complete. This material attempts to outline existing law and explain the changes proposed in the draft statute attached to Memorandum 98-16. As time permits, we will continue to flesh out the discussion and improve the language, as well complete the citations to relevant authorities.

Respectfully submitted,

Stan Ulrich  
Assistant Executive Secretary

# CALIFORNIA LAW REVISION COMMISSION

STAFF DRAFT

TENTATIVE RECOMMENDATION

## Health Care Decisions

[March 1998]

This tentative recommendation is being distributed so that interested persons will be advised of the Commission's tentative conclusions and can make their views known to the Commission. Any comments sent to the Commission will be a part of the public record and will be considered at a public meeting when the Commission determines the provisions it will include in legislation the Commission plans to recommend to the Legislature. It is just as important to advise the Commission that you approve the tentative recommendation as it is to advise the Commission that you believe revisions should be made in the tentative recommendation.

**COMMENTS ON THIS TENTATIVE RECOMMENDATION SHOULD BE RECEIVED BY THE COMMISSION NOT LATER THAN \_\_\_\_\_, 1998.**

The Commission often substantially revises tentative recommendations as a result of the comments it receives. Hence, this tentative recommendation is not necessarily the recommendation the Commission will submit to the Legislature.

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## SUMMARY OF TENTATIVE RECOMMENDATION

This tentative recommendation proposes a new Health Care Decisions Law to consolidate the Natural Death Act and the statutes governing the durable power of attorney for health care, and provide comprehensive rules relating to health care decisionmaking for incapacitated adults. The proposed law, drawing heavily from the Uniform Health-Care Decisions Act (1993), includes new rules governing individual health care instructions, and provides a new optional statutory form for the power of attorney for health care. The proposed law would add procedures governing surrogate health care decisionmakers (“family consent”) where an individual has not appointed an agent and no conservator of the person has been appointed, and procedures for making health care decisions for patients who do not have any surrogate willing to serve.

This recommendation was prepared pursuant to Resolution Chapter 102 of the Statutes of 1997.



1 in appropriate cases, although it also addresses other health care concerns. The  
2 earliest of the statutes was a natural death act, which authorizes a directive,  
3 popularly called a living will, to physicians. The second was a general durable  
4 power of attorney, sometimes in the form of a specially crafted health care durable  
5 power of attorney, which essentially empowers an appointed agent to make  
6 appropriate decisions for an incompetent patient. The agent is bound by directions  
7 contained in the appointing power. Finally, some states have enacted family  
8 consent laws empowering others, typically family, to decide health care matters  
9 absent a directive or power of attorney to guide them. At the end of 1990,  
10 Congress gave these laws new importance by mandating their observance.

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

17 These concerns are addressed by the proposed Health Care Decisions Law.

## 18 BACKGROUND AND OVERVIEW

19 The right of a competent adult to direct or refuse medical treatment is a  
20 constitutionally protected right. This "fundamental liberty interest" is inherent in  
21 the common law and protected by federal and state constitutional privacy  
22 guarantees.<sup>6</sup> The proposed law reaffirms this fundamental right along the lines of  
23 the Uniform Health-Care Decisions Act, which

24 acknowledges the right of a competent individual to decide all aspects of his or  
25 her own health care in all circumstances, including the right to decline health care  
26 or to direct that health care be discontinued, even if death ensues. An individual's  
27 instructions may extend to any and all health-care decisions that might arise and,  
28 unless limited by the principal, an agent has authority to make all health-care  
29 decisions which the individual could have made. The Act recognizes and validates  
30 an individual's authority to define the scope of an instruction or agency as broadly  
31 or as narrowly as the individual chooses.

32 There are four main approaches to health care decisionmaking for patients  
33 lacking capacity that are appropriate for statutory implementation:

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6. See generally *Cruzan v. Commissioner, Missouri Dept. of Health*, 497 U.S. 261 (1990); *Cobbs v. Grant*, 8 Cal. 3d 229, 242, 501 P.2d 1, 104 Cal. Rptr. 505 (1972); *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1015, 195 Cal. Rptr. 484 (1983); *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 195, 209 Cal. Rptr. 220 (1984); *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1137, 225 Cal. Rptr. 297 (1986); *Conservatorship of Drabick*, 200 Cal. App. 3d 185, 206, 245 Cal. Rptr. 840 (1988); *People v. Adams*, 216 Cal. App. 3d 1431, 1437, 265 Cal. Rptr. 568 (1990); *Donaldson v. Van de Kamp*, 2 Cal. App. 4th 1614, 1619, 4 Cal. Rptr 2d 59 (1992); *Thor v. Superior Court*, 5 Cal. 4th, 725, 731, 855 P.2d 375, 21 Cal. Rptr. 2d 357 (1993); *Rains v. Belshé*, 32 Cal. App. 4th 157, 166, 38 Cal. Rptr. 2d 185 (1995).

In the Natural Death Act, the Legislature made the explicit finding that "an adult person has the fundamental right to control the decisions relating to the rendering of his or her own medical care, including the decision to have life-sustaining treatment withheld or withdrawn in instances of a terminal condition or permanent unconscious condition." Health & Safety Code § 7185.5(a). The right is not dependent on statutory recognition and continues to exist outside of statutory provisions.

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

2 California law provides a highly developed guardianship-conservatorship law.<sup>7</sup>  
3 There is also a special procedure for court authorized medical treatment for adults  
4 without conservators.<sup>8</sup> The Lanterman-Petris-Short Act provides a special type of  
5 conservatorship for the gravely disabled.<sup>9</sup> These provisions are not the subject of  
6 this recommendation.<sup>10</sup>

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

8 California's Natural Death Act (NDA) provides for a declaration concerning  
9 continuation of life sustaining treatment in the circumstances of a permanent  
10 unconscious condition. Under the original NDA, the patient executed a "directive  
11 to physicians." Under the new UHCDA, this type of writing is an "individual  
12 instruction" (although the instruction may also be given orally). Case law validates  
13 expressions of the patient's health care desires that would fall under the general  
14 category of a "living will." The proposed law integrates these forms into the  
15 comprehensive statute.

16 **3. Power of Attorney**

17 California has a detailed statute governing durable powers of attorney for health  
18 care and providing a special statutory form durable power of attorney for health  
19 care.<sup>11</sup> The DPAHC requires appointment of an attorney-in-fact ("agent" in the

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7. Prob. Code § 1400 *et seq.* The Guardianship-Conservatorship Law was enacted on Commission recommendation. See *Guardianship-Conservatorship Law*, 15 Cal. L. Revision Comm'n Reports 451 (1980).

8. Prob. Code § 3200 *et seq.*

9. Welf. & Inst. § 5350 *et seq.*

10. Communications to the Commission suggest, however, that the procedure for court-authorized medical treatment and some conservatorship provisions, should be reviewed for consistency with the scope of the proposed Health Care Decisions Law. This matter is reserved for further study.

11. Prob. Code § 4600 *et seq.* This statute and its predecessor in the Civil Code were enacted on Commission recommendation. See:

*Recommendation Relating to Durable Power of Attorney for Health Care Decisions*, 17 Cal. L. Revision Comm'n Reports 101 (1984) (enacted as 1983 Cal. Stat. ch. 1204). For legislative history, see 17 Cal. L. Revision Comm'n Reports 822 (1984); *Report of Assembly Committee on Judiciary on Senate Bill 762*, 17 Cal. L. Revision Comm'n Reports 889 (1984).

*Recommendation Relating to Statutory Forms for Durable Powers of Attorney*, 17 Cal. L. Revision Comm'n Reports 701 (1984) (enacted as 1984 Cal. Stat. chs. 312 & 602). For legislative history, see 18 Cal. L. Revision Comm'n Reports 18-19 (1986); *Report of Assembly Committee on Judiciary on Senate Bill 1365*, 18 Cal. L. Revision Comm'n Reports 45 (1986).

*Recommendation Relating to Elimination of Seven-Year Limit for Durable Power of Attorney for Health Care*, 20 Cal. L. Revision Comm'n Reports 2605 (1990) (enacted as 1991 Cal. Stat. ch. 896). For legislative history, see 21 Cal. L. Revision Comm'n Reports 22 (1991).

*Comprehensive Power of Attorney Law*, 24 Cal. L. Revision Comm'n Reports 111 (1994) (enacted as 1994 Cal. Stat. ch. 307). For legislative history, see 24 Cal. L. Revision Comm'n Reports 567 (1994). The law as enacted, with revised Comments and explanatory text, was printed as *1995 Comprehensive Power of Attorney Law*, 24 Cal. L. Revision Comm'n Reports 323 (1994).

1 statutory form durable power of attorney for health care) to carry out the  
2 principal's wishes as expressed in the power of attorney or otherwise made known  
3 to the attorney-in-fact, but the attorney-in-fact also has authority to act in the best  
4 interest of the principal where the principal's desires are unknown.<sup>12</sup> The power of  
5 attorney for health care rules are generally carried forward in the proposed law.

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

7 As in the case of wills and trusts, most people do not execute a power of attorney  
8 for health care or an "individual instruction" or "living will." Estimates vary, but it  
9 is a safe guess to say that only 10-20% of adults have advance directives.<sup>13</sup>  
10 Consequently, from a public policy standpoint, the law governing powers of  
11 attorney and other advance directives potentially affects far fewer people than a  
12 law on consent by family members and other surrogates. Just as the law of wills is  
13 complemented by the law of intestacy, so the power of attorney for health care  
14 needs an intestacy equivalent — some form of statutory surrogate health care  
15 decisionmaking. This critical area is addressed by the proposed Health Care  
16 Decisions Law.

17 The general power of attorney statutes were recently reviewed and revised on  
18 Commission recommendation.<sup>14</sup> In its report, the Commission noted that it had  
19 "not made a substantive review of the statutes concerning the durable power of  
20 attorney for health care .... [I]t would have been premature to undertake a detailed  
21 review of the health care power statutes before the National Conference of  
22 Commissioners on Uniform State Laws completed its work on the Uniform  
23 Health-Care Decisions Act."<sup>15</sup>

### 24 **POWER OF ATTORNEY FOR HEALTH CARE**

25 The proposed Health Care Decisions Law continues and recasts the existing law  
26 governing the durable power of attorney for health care, including the statutory  
27 form durable power of attorney for health care.<sup>16</sup> For the well-advised or careful  
28 individual who is making sensible arrangements for the time when he or she may

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In the Commission's study resulting in the comprehensive Power of Attorney Law, substantive review of health care decisionmaking issues was deferred for consideration as the second part of the study. This enabled legislative enactment of the comprehensive restructuring of the power of attorney statutes to proceed without further delay and was also necessary in light of other legislative priorities.

12. See Prob. Code § 4720.

13. See *infra* text accompanying notes \_\_\_\_.

14. See 1994 Cal. Stat. ch. 307; 1995 *Comprehensive Power of Attorney Law*, 24 Cal. L. Revision Comm'n Reports 323 (1994).

15. *Id.* at 335.

16. For the central provisions governing the durable power of attorney for health care, see Prob. Code §§ 4600-4752. For the statutory form durable power of attorney for health care, see Prob. Code §§ 4770-4779.

1 be incapacitated, the power of attorney for health care<sup>17</sup> is clearly the best  
2 approach. Expressing desires about health care and naming one or more agents<sup>18</sup>  
3 subject to appropriate standards is the best way to accomplish “incapacity  
4 planning” and seek to effectuate a person’s intent with regard to health care  
5 decisions, especially with regard to life-sustaining treatment.

6 In the new terminology — not so new in practice, but new to the Probate Code  
7 — a power of attorney for health care is one type of “advance health care  
8 directive” (or advance directive).<sup>19</sup> The proposed law restructures the power of  
9 attorney for health care provisions based on a mix of principles from the existing  
10 Power of Attorney Law<sup>20</sup> and the Uniform Health-Care Decisions Act. Where  
11 rules apply only to powers of attorney for health care, the proposed law uses that  
12 terminology. Where rules apply to all written advance health care directives, the  
13 language will vary, but the general substance of the law continues, except as noted.

#### 14 **Execution Formalities**

15 The original durable power of attorney for health care was subject to a number  
16 of restrictions that have been judged to be overly protective. When first enacted,  
17 the durable power of attorney for property was only valid for a year following the  
18 principal’s incapacity.<sup>21</sup> The original durable power of attorney for health care  
19 expired after seven years, except when the expiration date fell in a time of  
20 incapacity.<sup>22</sup> These restrictive rules may have had a role to play when the concepts  
21 were new, but were abandoned as the law progressed and the concepts and  
22 instruments became familiar and even necessary.

23 Now it is recognized that overly restrictive execution requirements for powers of  
24 attorney for health care unnecessarily impede the effectuation of intent. The  
25 progression from more restrictive execution requirements to more intent-

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17. The proposed law uses the term “power of attorney for health care” instead of “durable power of attorney for health care” for convenience. The reference to durability was more important in earlier years, when the idea of an agency surviving the incapacity of the principal was still a novel concept. It should now be clear and, in any event, in the realm of health care decisionmaking, it is common sense that almost all powers of attorney for health care will operate only after the principal becomes incapable of making health care decisions. The substance of the law is clear in the proposed law, notwithstanding the omission of the term “durable.”

18. The proposed law uses the more “user-friendly” term “agent” in place of “attorney-in-fact” used in the existing durable power of attorney for health care statute. However, the terms are interchangeable, as provided in existing law (Prob. Code § 4014(a)) and in the proposed law (proposed Prob. Code § 4607(a)).

19. The comment to UHCDA Section 1(1) notes that the term “appears in the federal Patient Self-Determination Act enacted as sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990 and has gained widespread usage among health-care professionals.”

20. For a discussion of the relation between powers of attorney for health care and other types of powers of attorney under the Power of Attorney Law, see *supra* text accompanying notes \_\_\_\_.

21. 1979 Cal. Stat. ch. 234 (enacting Civ. Code § 2307.1, repealed by 1981 Cal. Stat. ch. 511, § 1).

22. See former Civ. Code § 2436.5, as enacted by 1983 Cal. Stat. ch. 1204, § 10. See also Prob. Code § 4654 (transitional provision concerning former seven-year powers). The proposed law does not provide any special rules for these earlier powers.



1 promoting provisions can also be seen in the development of the Uniform Health-  
2 Care Decisions Act. The original Uniform Rights of the Terminally Ill Act of 1985  
3 (URTIA), based in part on the 1976 California Natural Death Act, required two  
4 witnesses.<sup>23</sup> The Uniform Health-Care Decisions Act, which is intended to replace  
5 URTIA, adopts the principle that no witnesses should be required in a power of  
6 attorney for health care.<sup>24</sup> As a general rule, the proposed law also adopts this  
7 principle in place of the existing requirement of two witnesses or a notarization.<sup>25</sup>

8 Witnessing can be useful, however, even if it is not required. The proposed law  
9 follows the UHCDA in recommending but not requiring witnesses, Witness  
10 requirements can operate as more of an intent-defeating technicality than a  
11 protection against possible fraud.<sup>26</sup> The drafters of the UHCDA viewed technical  
12 execution formalities as unnecessarily inhibiting while at the same time doing  
13 “little, if anything, to prevent fraud or enhance reliability.”<sup>27</sup> The genuineness of  
14 advance health care directives is bolstered by placing reliance on the health care  
15 providers. Recordkeeping plays a critical role. Health care providers are required  
16 to enter the advance directive in the patient’s health care records. Medical ethics  
17 also reinforce the duty to determine and effectuate genuine intent. The proposed  
18 law also provides penalties for violation of statutory duties.<sup>28</sup>

19 However, there are circumstances where additional protections are necessary.  
20 The proposed law continues the special rules applicable to executing a power of  
21 attorney for health care by a patient in a skilled nursing facility.<sup>29</sup> These  
22 restrictions are also applied to other written advance directives, i.e., individual  
23 health care instructions expressing treatment preferences that do not appoint an  
24 agent.

### 25 Statutorily Required Warnings

26 Existing law provides a number of “warnings” that must be included depending  
27 on whether a form durable power of attorney for health care is on a printed form,  
28 from the statutory form, or drafted by an attorney or someone else.<sup>30</sup> There is an

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23. URTIA § 2. The 1989 revision of URTIA continued this requirement.

24. UHCDA § 2(b).

25. Prob. Code §§ 4121-4122, 4700-4701. The statutory form power of attorney for health care cannot be notarized. Prob. Code § 4771 & Comment. Needless to say, these rules can be confusing.

26. This is not to say that more formal requirements are not important in powers of attorney for property, where the possibility of fraud is more of a real concern. The execution formalities in the Power of Attorney Law applicable to non-health care powers of attorney would continue to apply. See Prob. Code §§ 4121 (formalities for executing a power of attorney), 4122 (requirements for witnesses).

27. English & Meisel, *Uniform Health-Care Decisions Act Gives New Guidance*, Est. Plan. 355, 358-59 (Dec. 1994).

28. See *infra* text accompanying notes \_\_\_\_.

29. See Prob. Code §§ 4121-4122, 4701.

30. See Prob. Code §§ 4703 (requirements for printed form), 4704 (warnings in power of attorney for health care not on printed form), 4771 (statutory form), 4772 (warning or lawyer’s certificate), 4774

1 important alternative to complying with the strict execution requirements in  
2 California law. The law recognizes the validity of durable powers of attorney for  
3 health care and similar instruments executed in another state or jurisdiction in  
4 compliance with their law.<sup>31</sup>

5 The existing warning provisions are too confusing and rigid. While there has  
6 been an attempt to educate potential users through concise and simple statements,  
7 the net effect of the existing scheme may have been to inhibit usage. Some form of  
8 introductory explanation is still needed, however, and the optional statutory form  
9 drawn from the UHCDA in the proposed law fulfills this purpose. But lawyers are  
10 no longer instructed on what they must advise their clients or how to sign off with  
11 a warning substitute. The Commission expects that those who prepare printed  
12 forms will copy the language of the optional form or use a reasonable equivalent  
13 without the need to mandate specific language.

#### 14 INDIVIDUAL HEALTH CARE INSTRUCTIONS

15 California does not generally provide for what the UHCDA calls an “individual  
16 instruction” other than through the mechanism of the Natural Death Act,  
17 applicable only to terminal or permanent unconscious cases, and in the context of  
18 appointing and instructing an attorney-in-fact under a durable power of attorney  
19 for health care. The Commission is informed that individuals will execute a  
20 durable power of attorney for health care *without* appointing an attorney-in-fact so  
21 that they can use that vehicle to state their health care instructions. It is also  
22 possible to appoint an attorney-in-fact, but limit the agent’s authority while  
23 expressing broad health care instructions. These approaches may succeed in  
24 getting formal health care instructions into the patient’s record, but the law is not  
25 well-adapted for this purpose, since the duties to comply under the power of  
26 attorney for health care statute revolve around the agent’s decisions and the duty to  
27 comply with them. In this scenario, the power of attorney for health care becomes  
28 a “living will” given effect by custom without any validating or effectuating  
29 statute.

30 The proposed law adopts the individual health care instruction principle of the  
31 UHCDA to make the law clearer, more direct, and easier to use. The option of  
32 giving independent individual health care instructions is also implemented as part  
33 of the optional statutory form. Using the simple and relatively short statutory form  
34 will enable an individual to record his or her select an agent, or do both.

35 [*Staff Note: This part of the discussion will also catalog existing power of*  
36 *attorney rules that would be applied to all advance directives.*]

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(requirements for statutory form). For a number of complicated, technical rules governing earlier printed form requirements, see Prob. Code §§ 4651, 4775.

31. Prob. Code § 4653. A similar rule applies under the Section 7192.5 in the NDA.



1 The leading case of *Barber v. Superior Court*<sup>36</sup> contains a thorough discussion of  
2 the problems:

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

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

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

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

21 ....

22 The authorities are in agreement that any surrogate, court appointed or  
23 otherwise, ought to be guided in his or her decisions first by his knowledge of the  
24 patient's own desires and feelings, to the extent that they were expressed before  
25 the patient became incompetent....

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

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

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

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

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36. 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).

1 Despite the breadth of its language, *Barber* does not dispose of the issues of who  
2 can consent, due to the way in which the case arose — reliance on requests from  
3 the family of the patient as a defense to a charge of murder against the doctors who  
4 removed the patient’s life support. Note also that the court is not in a position to  
5 determine issues such as who is included in the patient’s “family.” It is implicit  
6 that the wife, children, and sister-in-law were all family members. However, the  
7 court’s statement that the “wife was the proper person to act as a surrogate for the  
8 patient” based on the assumption she would have been qualified if judicial  
9 approval had been sought, is not completely consistent with other statements  
10 referring to the “family’s decision” and that the “wife and children were the most  
11 obviously appropriate surrogates,” and speculation on what would have happened  
12 if “the family had insisted on continued treatment.”

13 Nevertheless, *Barber* has been characterized as an “enormously important”  
14 decision: “Indeed, literature generated from within the medical community  
15 indicates that health care providers rely upon *Barber* — presumably every day —  
16 in deciding together with families to forego treatment for persistently vegetative  
17 patients who have no reasonable hope of recovery.”<sup>37</sup>

#### 18 **Current Practice: LACMA-LACBA Pamphlet**

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

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

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

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

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

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37. Conservatorship of Drabick, 200 Cal. App. 3d 185, 198, 245 Cal. Rptr. 840 (1988).



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

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

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

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

#### 14 **Current Practice: Patient Information Pamphlet**

15 A patient information pamphlet (“Your Right To Make Decisions About  
16 Medical Treatment”) has been prepared by the California Consortium on Patient  
17 Self-Determination and adopted by the Department of Health Services for  
18 distribution to patients at the time of admission. This is in compliance with the  
19 federal Patient Self Determination Act of 1990. The PSDA requires the pamphlet  
20 to include a summary of the state’s law on patients’ rights to make medical  
21 treatment decisions and to make advance directives. The California pamphlet  
22 contains the following statement:

23 *What if I'm too sick to decide?*

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

30 Based on the case law, the Commission is not confident that California law says  
31 the *closest* available relative *or friend* can make health care decisions. However, it  
32 may be true in practice that these are the persons doctors will ask, as stated in the  
33 pamphlet.<sup>38</sup>

#### 34 **Alternative Approaches to Statutory Surrogate Priorities**

35 The general understanding is that close relatives and friends who are familiar  
36 with the patient’s desires and values should make health care decisions in  
37 consultation with medical professionals. Wives, brothers, mothers, sisters-in-law,

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38. See, e.g., AMA Code of Medical Ethics § 2.20, at 36 (1994) (“[W]hen there is no person closely associated with the patient, but there are persons who both care about the patient and have sufficient relevant knowledge of the patient, such persons may be appropriate surrogates.”); President’s Comm’n etc., Deciding To Forego Life-Sustaining Treatment 126-27 (1983) (“When a patient lacks the capacity to make a decision, a surrogate decisionmaker should be designated. Ordinarily this will be the patient’s next of kin, although it may be a close friend or another relative if the responsible health care professional judges that this other person is in fact the best advocate for the patient’s interests.”)

1 and domestic partners have been involved implicitly as “family” surrogate  
2 decisionmakers in reported California cases, although no case is exactly on point.  
3 The practice, as described in authoritative sources, is consistent with this  
4 understanding. Courts and legislatures nationwide naturally rely on a family or  
5 next of kin approach because these are the people who are presumed to best know  
6 the desires of the patient and to determine the patient’s best interests.<sup>39</sup>

7 Priority schemes among relatives and friends seem natural. Intestate succession  
8 law<sup>40</sup> provides a ready analogy — thus, the spouse, children, parents, siblings, and  
9 so forth, seem to be a natural order. The same order is established in the preference  
10 for appointment as conservator.<sup>41</sup> But the analogy between health care, life-  
11 sustaining treatment, and personal autonomy on one hand and succession to  
12 property on the other is weak. A health care decision cannot be parceled out like  
13 property in an intestate’s estate. The consequences of a serious health care  
14 decision are different in kind from decisions on how to distribute property.

15 The trend in other states is decidedly in favor of providing statutory guidance,  
16 generally through a priority scheme. The collective judgment of the states would  
17 seem to be that, since most people will not execute any form of advance directive,  
18 the problem needs to be addressed with some sort of default rules, perhaps based  
19 on an intestate succession analogy. As described by Professor Meisel:<sup>42</sup>

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

28 The UHCDA scheme lists the familiar top four classes of surrogates (spouse,  
29 children, parents, siblings), but is less restrictive than many state statutes in several  
30 respects:<sup>43</sup>

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

35 (2) Determinations within classes can be made by majority vote under the  
36 UHCDA. This is not likely to be a common approach to making decisions where

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39. See generally 2 A. Meisel, *The Right to Die* §§ 14.1-14.10 (2d ed. 1995)

40. Prob. Code § 6400 *et seq.*

41. Prob. Code § 1812.

42. 2 A. Meisel, *The Right to Die* § 14.1 at 249-50 (2d ed. 1995)

43. UHCDA Section 5.

1 there are disagreements, but it would be a useful rule enabling decisionmaking  
2 where there are minority class members whose views are unknown or in doubt.

3 (3) An orally designated surrogate, who appears first on the UHCDA priority  
4 list, is an attempt to deal with the fact that a strict statutory priority list does not  
5 necessarily reflect reality. The “orally designated surrogate was added to the Act  
6 not because its use is recommended but because it is how decision makers are  
7 often designated in clinical practice.”<sup>44</sup>

8 (4) The authorization for adults who have “exhibited special care and concern” is  
9 relatively new. Under the common law, the status of friends as surrogates is, in  
10 Professor Meisel’s words, “highly uncertain.”<sup>45</sup> Health and Safety Code Section  
11 1418.8 requires consultation with friends of nursing home patients and authorizes  
12 a friend to be appointed as the patient’s representative. These features are noted  
13 with approval in *Rains v. Belshé*,<sup>46</sup> but the authority is strictly statutory and quite  
14 limited.

#### 15 **Statutory Surrogates Under Proposed Law**

16 The Commission believes that a rigid priority scheme based on an intestate  
17 succession analogy would be too restrictive and not in accord with the  
18 fundamental principle that decisions should be made based on the patient’s desires  
19 or, where not known, in the patient’s best interest. The focus of statutory surrogacy  
20 rules should be to provide some needed clarity without creating technical rules that  
21 would make compliance confusing or risky, thereby bogging the process down or  
22 paralyzing medical decisionmaking. Just as California courts have consistently  
23 resisted judicial involvement in health care decisionmaking, except as a last resort,  
24 the statutory surrogacy scheme should assist, rather than disrupt, existing practice.

25 Professor Meisel describes this fundamental problem with priority classes as  
26 follows:<sup>47</sup>

27 Although the intent of such priority lists is a good one — to eliminate possible  
28 confusion about who has the legal authority to make decisions for incompetent  
29 patients — the result of surrogate-designation pursuant to statute is not only  
30 mechanical but can be contrary or even inimical to the patient’s wishes or best  
31 interests. This would occur, for example, if the patient were estranged from his  
32 spouse or parents. However, it is not clear that the result would be much different  
33 in the absence of a statute because the ordinary custom of physicians sanctioned  
34 by judicial decision, is to look to incompetent patients’ close family members to  
35 make decisions for them. In the absence of a statute, the physician might ignore a

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44. English, \_\_\_\_.

45. 2 A. Meisel, *The Right to Die* §14.4, at 51 (Supp. #1, 1997). *But cf.* *Conservatorship of Drabick*, 200 Cal. App. 3d 185, 204, 245 Cal. Rptr. 840 91988) (“...faced with a persistently vegetative patient and a diagnosis establishing that further treatment offers no reasonable hope of returning the patient to cognitive life, the decision whether to continue noncurative treatment is an ethical one for the physicians and family members or other persons who are making health care decisions for the patient.”)

46. 32 Cal. App. 4th 157, 166, 38 Cal. Rptr. 2d 185 (1995).

47. 2 A. Meisel, *The Right to Die* § 14.4 at 255 (2d ed. 1995) (footnotes omitted).



1 spouse known to be estranged from the patient in favor of another close family  
2 member as surrogate, but because there is nothing in most statutes to permit a  
3 physician to ignore the statutory order of priority, the result could be worse under  
4 a statute than in its absence.

5 In recognition of the problems as well as the benefits of a priority scheme, the  
6 proposed law sets out a default list of statutory surrogates: (1) The spouse, unless  
7 legally separated, (2) children, (3) parents, (4) brothers and sisters, (5)  
8 grandchildren, (6) an individual in a long-term relationship of indefinite duration  
9 with the patient in which the individual has demonstrated an actual commitment to  
10 the patient similar to the commitment of a spouse and in which the individual and  
11 the patient consider themselves to be responsible for each other's well-being  
12 (including a person known as a domestic partner), and (7) close friends.

13 As a general rule, the primary physician is required to select the surrogate, with  
14 the assistance of other health care providers or institutional committees, in the  
15 order of priority as set out in the statute. However, where there are multiple  
16 possible surrogates at the same priority level, the primary physician has a duty to  
17 select the individual who reasonably appears after a good faith inquiry to be best  
18 qualified.<sup>48</sup> The primary physician may select as the surrogate an individual who is  
19 ranked lower in priority if, in the primary physician's judgment, the individual is  
20 best qualified to serve as the patient's surrogate. These rules are directly related to  
21 the fundamental principal that the law should attempt to find the best surrogate  
22 who can make health care decisions according to the patient's known desires or in  
23 the patient's best interests.

24 Providing flexibility based on fundamental principles of self-determination and  
25 ethical standards ameliorates the defects of a rigid priority scheme. The procedure  
26 for varying the default priority rules is not arbitrary but subject to a set of  
27 important statutory standards. In determining which listed person is best qualified  
28 to serve as the surrogate, the following factors must be considered:

29 (1) Whether the proposed surrogate reasonably appears to be best able to make  
30 decisions in accordance with Section 4713.

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

33 (3) Demonstrated care and concern for the patient.

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

35 (5) Availability to visit the patient.

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

38 In addition, the process of applying these standards and making the determination  
39 must be documented in the patient's medical record.

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48. The recommended procedure is drawn, in part, from West Virginia law. See W.Va. Code § 16-30B-7 (1997). Elements are also drawn from New Mexico's implementation of the UHCDA. See N.M. Stat. Ann. § 24-7A-5 (Michie 19\_\_).

1 The recommended procedure also reduces the problem of resolving differences  
2 between potential surrogates. There can be problems under the existing state of  
3 law and custom, as illustrated by cases where family members — e.g., children,  
4 parents, or the patient’s spouse — compete for appointment as conservator of an  
5 incapacitated person. These disputes will still occur and it is difficult to imagine a  
6 fair and flexible statutory procedure that could resolve all issues.

7 As discussed, the UHCDA provides a rigid priority scheme between classes of  
8 close relatives and provides for voting within a class with multiple members.<sup>49</sup> If a  
9 class is deadlocked, then the surrogacy procedure comes to a halt; lower classes do  
10 not get an opportunity to act, although it is possible for a higher class to reassert its  
11 priority, and the evenly split class could resolve the deadlock over time. This type  
12 of procedure seems overly mechanical and lacking in needed flexibility.

13 The Commission also considered the family consensus approach, such as that  
14 provided under Colorado law.<sup>50</sup> In this procedure, the class of potential surrogates,  
15 comprised of close family members and friends, is given the responsibility and  
16 duty to select a surrogate from among their number. It is difficult to judge how  
17 well this type of procedure would work in practice. The concern is that it might  
18 result in too much confusion and administrative burden, without improving the  
19 prospects for effective decisionmaking or resolving disputes. [*Staff Note: Is it*  
20 *worth considering authorizing this type of approach as an alternative within the*  
21 *framework of the priority scheme in the draft?*]

22 The proposed law adopts a presumptive “pecking order” like the UHCDA, but  
23 places the responsibility on the primary physician to select the best situated person  
24 based on standards set out in the statute. This avoids the rigidity of the UHCDA  
25 approach and the indefiniteness and administrative burden of the consensus  
26 approach. Notice of the selection should be given to other family members.  
27 Potential surrogates with serious objections to the selection of the surrogate or the  
28 decisions being made by the surrogate would still have the right to bring a judicial  
29 challenge or seek appointment as a conservator.<sup>51</sup>

30 Like the UHCDA, the proposed law gives priority over the statutory list to a  
31 surrogate who has been designated by the patient. [*Staff Note: The scope of this*  
32 *rule is an issue discussed in the draft attached to Memorandum 98-16, p. B-38.*]

### 33 DECISIONMAKING WHERE NO SURROGATE IS AVAILABLE

34 Providing statutory surrogate rules where a patient has not executed an advance  
35 directive or designated a surrogate, and for whom a conservator of the person has  
36 not been appointed, does not answer all of the problems. The statutory surrogate  
37 rules will not apply to a significant group of incapacitated adults for whom there

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49. UHCDA § 5.

50. See Colo. Rev. Stat. Ann. § 15-18.5-103 (West 1997). Illinois and Louisiana also implement some consensus standards. See generally, 2 A. Meisel, *The Right to Die* § \_\_\_\_.

51. See *infra* text accompanying notes \_\_\_\_.

1 are no potential surrogates because they have no close relatives or friends familiar  
2 with their health care treatment desires or values, or potential surrogates are  
3 unwilling or unable to make decisions.

4 Existing law addresses this problem with respect to “medical interventions” for  
5 patients in the nursing home context,<sup>52</sup> but there is no general surrogacy rule  
6 applicable in these circumstances. The UHCDA does not address this problem.

7 The alternative of appointing a conservator of the person in each of these cases is  
8 not an adequate solution to the problem, as recognized by the Legislature when it  
9 enacted the medical intervention procedure.<sup>53</sup> While it is possible to seek court  
10 approval for medical “treatment” under Probate Code Section 3200 *et seq.*  
11 (authorization of medical treatment for adult without conservator), it is not clear  
12 that this procedure authorizes orders for *withdrawal* of treatment or *refusal* of  
13 consent.<sup>54</sup>

14 The proposed law adopt a procedure based on nursing home medical  
15 intervention procedure. Under this proposal, health care decisions for the  
16 “friendless” incapacitated adult could be made by a “surrogate committee.” The  
17 committee would be made up of the following persons, as appropriate under the  
18 circumstances:

- 19 (1) The patient’s primary physician.
- 20 (2) A registered professional nurse with responsibility for the patient.
- 21 (3) Other appropriate health care institution staff in disciplines as determined by  
22 the patient’s needs.
- 23 (4) One or more patient representatives, who may be a family member or friend  
24 of the patient who is unable to take full responsibility for the patient’s health care  
25 decisions, but has agreed to serve on the surrogacy committee.
- 26 (5) In cases involving major health care decisions, a member of the community  
27 who is not employed by or regularly associated with the primary physician, the  
28 health care institution, or employees of the health care institution.
- 29 (6) In cases involving major health care decisions, a member of the health care  
30 institution’s ethics committee or an outside ethics consultant.

31 In reviewing proposed health care decisions, the surrogate committee would be  
32 required to consider and review all of the following factors:

- 33 (1) The primary physician’s assessment of the patient’s condition.
- 34 (2) The reason for the proposed health care decision.

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52. Health & Safety Code § 1418.8. See *Rains v. Belshé*, 32 Cal. App. 4th 157, 166, 38 Cal. Rptr. 2d 185 (1995) (upholding the constitutionality of the procedure for patients in nursing homes who lack capacity to make health care decisions, “even though they do not have a next of kin, an appointed conservator, or another authorized decision maker to act as their surrogate”).

53. In most cases, the conservator will be the Public Guardian, which may be a non-solution if the Public Guardian’s policy is not to exercise the duty to decide as set down in *Drabick*.

54. Probate Code Section 3208 refers to “authorizing the recommended course of medical treatment of the patient” and “the existing or continuing medical condition.”

1 (3) The desires of the patient, if known. To determine the desires of the patient,  
2 the surrogate committee must interview the patient, review the patient’s medical  
3 records, and consult with family members or friends, if any have been identified.

4 (4) The type of health care to be used in the patient’s care, including its probable  
5 frequency and duration.

6 (5) The probable impact on the patient’s condition, with and without the use of  
7 the proposed health care.

8 (6) Reasonable alternative health care decisions considered or utilized, and  
9 reasons for their discontinuance or inappropriateness.

10 The surrogate committee is required to periodically evaluate the results of  
11 approved health care decisions at least quarterly or whenever there is a significant  
12 change in the patient’s medical condition.

13 The proposed law intends the surrogate committee to try to operate on a  
14 consensus basis. If consensus cannot be reached, the committee is authorized to  
15 approve proposed health care decisions by majority vote. There is an important  
16 exception: proposed health care decisions relating to withdrawal of life-sustaining  
17 treatment cannot be approved if any member of the surrogate committee is  
18 opposed.

#### 19 STANDARDS FOR SURROGATE DECISIONMAKING

20 The existing power of attorney for health care law requires the attorney-in-fact to  
21 “act consistent with the desires of the principal as expressed in the durable power  
22 of attorney or otherwise made known to the attorney-in-fact at any time or, if the  
23 principal’s desires are unknown, to act in the best interests of the principal.”<sup>55</sup> The  
24 UHCDA adopts the same rule as a general standard for all surrogates:

25 [T]he Act seeks to ensure to the extent possible that decisions about an  
26 individual’s health care will be governed by the individual’s own desires  
27 concerning the issues to be resolved. The Act requires an agent or surrogate  
28 authorized to make health-care decisions for an individual to make those decisions  
29 in accordance with the instructions and other wishes of the individual to the extent  
30 known. Otherwise, the agent or surrogate must make those decisions in  
31 accordance with the best interest of the individual but in light of the individual’s  
32 personal values known to the agent or surrogate. Furthermore, the Act requires a  
33 guardian to comply with a ward’s previously given instructions and prohibits a  
34 guardian from revoking the ward’s advance health-care directive without express  
35 court approval.

36 The proposed law, like the UHCDA, applies these standards generally  
37 throughout the statute.

#### 38 DUTIES AND LIABILITIES OF HEALTH CARE PROVIDERS

39 [Not completed.]

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55. Prob. Code § 4720(c).

JUDICIAL REVIEW

California law does not favor judicial involvement in health care decisions. The Power of Attorney Law provides as a general rule that a power of attorney is exercisable free of judicial intervention.<sup>56</sup> The Natural Death Act declares that “in the absence of a controversy, a court normally is not the proper forum in which to make decisions regarding life-sustaining treatment.”<sup>57</sup> In connection with incapacitated patients in nursing homes, the Legislature has found:<sup>58</sup>

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

Appellate decisions also caution against overinvolvement of courts in the intensely personal realm of health care decisionmaking.<sup>59</sup> However, there may be occasions where a dispute must be resolved and an appropriately tailored procedure is needed.<sup>60</sup>

The UHCDA takes a similar approach, but provides less detail than existing law:<sup>61</sup>

[T]he Act provides a procedure for the resolution of disputes. While the Act is in general to be effectuated without litigation, situations will arise where resort to the courts may be necessary. For that reason, the Act authorizes the court to enjoin or direct a health-care decision or order other equitable relief and specifies who is entitled to bring a petition.

The proposed law contains a procedure drawn largely from the Power of Attorney Law.<sup>62</sup> Under this procedure, any of the following persons may file a petition in the superior court: the patient, the patient’s spouse (unless legally

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56. Prob. Code § 4900.

57. Health & Safety Code § 7185.5(e).

58. 1992 Cal. Stat. ch. 1303, § 1(b).

59. [cites]

60. This is consistent with one of the features of the UHCDA as explained in the Prefatory Note:

*Sixth*, the Act provides a procedure for the resolution of disputes. While the Act is in general to be effectuated without litigation, situations will arise where resort to the courts may be necessary. For that reason, the Act authorizes the court to enjoin or direct a health-care decision or order other equitable relief and specifies who is entitled to bring a petition.

61. UHCDA Prefatory Note.

62. See Prob. Code §§ 4900-4948. Because of the placement of the Health Care Decisions Law beginning at Section 4600, the judicial proceedings provisions (Part 5) applicable to non-health care powers of attorney is moved to form a new Part 4 (commencing with Section 4500). The law applicable to non-health care powers remains the same; only the special provisions concerning health care powers of attorney have been removed.

1 separated), a relative of the patient, the patient’s agent or surrogate, the  
2 conservator of the person of the patient, a court investigator, the public guardian of  
3 the county where the patient resides, the supervising health care provider or health  
4 care institution, and any other interested person or friend of the patient. [*Staff*  
5 *Note: the scope of this provision is an issue raised in connection with draft Section*  
6 *4765 in Memorandum 98-16, p. B-55.*] As under existing law, there is no right to a  
7 jury trial.<sup>63</sup>

8 The grounds for a petition are broad, but not unlimited, and include determining  
9 (1) whether the patient has capacity to make health care decisions, (2) whether an  
10 advance health care directive is in effect, and (3) whether the acts or proposed acts  
11 of an agent or surrogate are consistent with the patient’s desires as expressed in an  
12 advance health care directive or otherwise made known to the court or, where the  
13 patient’s desires are unknown or unclear, whether the acts or proposed acts of the  
14 agent or surrogate are in the patient’s best interest. When capacity is to be  
15 determined in judicial proceedings, the provisions of the Due Process in Capacity  
16 Determinations Act<sup>64</sup> are applicable. The standard for reviewing the agent’s or  
17 surrogate’s actions is consistent with the general standard applicable under the  
18 proposed Health Care Decisions Law, as already discussed.<sup>65</sup>

## 19 TECHNICAL MATTERS

### 20 **Location of Proposed Law**

21 The proposed Health Care Decisions Law would be located in the Probate Code  
22 following the Power of Attorney Law. There is no ideal location for a statute that  
23 applies both to incapacity planning options (e.g., the power of attorney for health  
24 care) and to standards governing health care decisionmaking for incapacitated  
25 adults. But considering the alternatives, the Probate Code appears to be the best  
26 location because of associated statutes governing conservatorship of the person,  
27 court authorized medical treatment, and powers of attorney. In addition, estate  
28 planning and elder law practitioners are familiar with the probate code.

### 29 **Severance from Power of Attorney Law**

30 Drafting health care decisionmaking rules as a separate statute should eliminate  
31 or minimize these exceptions and overlays in the Power of Attorney Law (PAL),  
32 thereby improving the organization and usability of both the PAL as it relates to  
33 property and financial matters and the law relating to health care powers. [A  
34 catalogue of PAL provisions relevant to powers of attorney for health care under  
35 existing law will be included here.]

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63. Prob. Code § 4904.

64. Prob. Code §§ 810-813.

65. See *supra* text accompanying notes \_\_\_\_.



1 **Application to Pre-existing Instruments**

2 [Not completed.]

3 **Application to Out-of-State Advance Directives**

4 [Not completed.]

5 **OTHER PROCEDURES**

6 **DNR Orders**

7 The proposed law continues the existing special procedures governing requests  
8 to forego resuscitative measure (DNR orders)<sup>66</sup> with a few technical revisions for  
9 consistency with definitions under the Health Care Decisions Law. The  
10 Commission did not undertake a substantive review of the DNR rules.

11 **Secretary of State's Registry**

12 Existing law requires the Secretary of State to establish a registry for durable  
13 powers of attorney.<sup>67</sup> The registry is intended to provide information concerning  
14 the existence and location of a person's durable power of attorney for health care.  
15 The registry is strictly voluntary. It has no effect on the validity of a power of  
16 attorney for health care,<sup>68</sup> nor is a health care provider required to apply to the  
17 registry for information.<sup>69</sup>

18 The proposed law continues the registry provisions, but in the interest of treating  
19 all advance health care directives equally, provides for registration of individual  
20 health care instructions on the same basis as powers of attorney for health care.  
21 The Commission has not evaluated the registry system, although the Commission  
22 is informed that as of mid-1997 there were fewer than 100 filings and no inquiries  
23 had been directed to the registry system.

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66. See Prob. Code § 4753.

67. Prob. Code §§ 4800-4806. The registry was established pursuant to 1994 Cal. Stat. ch. 1280.

68. Prob. Code §§ 4803-4804.

69. Prob. Code § 4806.