

First Supplement to Memorandum 98-63

Health Care Decisions: Comments on Tentative Recommendation (Prof. English Comments)

Attached to this supplement are detailed comments on the tentative recommendation on *Health Care Decisions for Incapacitated Adults* from Prof. David English, the Commission's consultant, and Reporter for the Uniform Health-Care Decisions Act. Most of his remarks are in response to Staff Notes following sections in the draft recommendation attached to Memorandum 98-63. We plan to cover Prof. English's points as we complete consideration of the Staff Notes at the December meeting. Several of his comments raise issues not discussed in Staff Notes:

§ 4613. Conservator [p. 33, lines 15-27]

Prof. English suggests dropping the reference to "guardian" in this definition: "Conservator" means a court-appointed conservator *or guardian* having authority to make a health care decision for a patient. Alternatively, he suggests adding a sentence to the Comment to the effect that "guardian" is used to take account of language used in other states.

The staff concludes that the term is not necessary and is not worth the explanation required to justify it. Accordingly, we would drop it here and wherever else it appears in the recommendation. Note, however, that this will create an inconsistency between Section 4126 in the Power of Attorney Law relating to nominations of conservators or guardians. For the analogous provision, see Section 4672 in the draft recommendation.

§ 4650. Legislative findings [p. 40, lines 18-35]

Prof. English thinks the statement, continued from the Natural Death Act, is "too narrow," since the recommendation addresses more than withholding or withdrawal of life-sustaining treatment. The statement has been revised to some extent to fit within the proposed Health Care Decisions Law, but the revisions have been conservative because of the history of this statement and the role it has played in some leading cases. See Section 4650 Comment. As stated in earlier materials, the Commission does not favor use of statements of legislative

findings or intent, except in extraordinary circumstances. The Commission's approach is to draft the statute so that it says what it means, without relying on a gloss supplied by an intent or findings statement. This statement could be retired. The new law should be able to stand on its own. On balance, however, the staff still thinks it is useful to continue the findings. They serve as a useful reminder to persons reviewing the recommendation.

The language could be broadened. The staff proposes to revise the section as follows:

(a) An adult has the fundamental right to control the decisions relating to his or her own health care, including the decision to have life-sustaining treatment withheld or withdrawn.

(b) Modern medical technology has made possible the artificial prolongation of human life beyond natural limits. In the interest of protecting individual autonomy, this prolongation of the process of dying for a person for whom continued health care does not improve the prognosis for recovery may violate patient dignity and cause unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the person.

(c) In recognition of the dignity and privacy a person has a right to expect, the law recognizes that an adult has the right to make health care decisions and to instruct his or her physician to continue, withhold, or withdraw life-sustaining treatment, in the event that the person is unable to make those decisions.

(d) In the absence of controversy, a court is normally not the proper forum in which to make health care decisions, including decisions regarding life-sustaining treatment.

§ 4680. Formalities for executing power of attorney [p. 55, lines 4-12]

Prof. English would delete the dating requirement in subdivision (a). He notes that wills and trusts are not required to be dated. California has always required a date in health care powers of attorney. (See former Civ. Code § 2432(a)(2), enacted by 1983 Cal. Stat. ch. 1204, § 10.) The dating rule was generalized to apply to all powers of attorney when the Commission prepared the Power of Attorney Law. However, the language was changed. In 1983 the statute provided that the agent "may not make health care decisions unless ... [t]he durable power of attorney contains the date of its execution." Section 4121 now provides that the power of attorney "is legally sufficient" if the requirements are satisfied. The statute does not invalidate a power of attorney that does not have a date, as did the 1983 statute.

Under the recommendation, an undated advance directive could still be given effect as a statement of the patient's wishes and as a written surrogate designation. If the "soft" dating requirement is omitted, should the statute deal with the issues that arise? For example, Section 6111(b) provides the following rules concerning holographic wills:

(1) If the omission results in doubt as to whether its provisions or the inconsistent provisions of another will are controlling, the holographic will is invalid to the extent of the inconsistency unless the time of its execution is established to be after the date of execution of the other will.

(2) If it is established that the testator lacked testamentary capacity at any time during which the will might have been executed, the will is invalid unless it is established that it was executed at a time when the testator had testamentary capacity.

§ 4688. Application to acts and transactions under power of attorney [pp. 58-59, lines 34-44, 1-10]

Prof. English would delete this provision, which he finds "is beyond comprehension." The intention of the source of this section (Section 4052) is to extend the scope of the Power of Attorney Law as far as permissible. In the property context, the situation is more complex in that the principal, agent, and various kinds of property may be located in a number of jurisdictions. In the health care context, the situation is much simpler. Section 4688 may look like overkill in the health care context, because normally the sole determinant of the applicable law would be the location of the patient. If this section is "beyond comprehension," then it should be fixed or deleted. It may be sufficient to rely on general conflict of laws principles to cover cases where a vacationing Californian's advance directive is offered in Louisiana. Obviously, the Louisiana hospital will not be aware of Section 4688, and if the matter comes before a Louisiana court, it might disregard Section 4688 by refusing to apply California law in any respect. The section focuses on the agent's activities, which does not fit comfortably in the health care context, and it does not apply to advance directives generally, but only to powers of attorney.

Respectfully submitted,

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Assistant Executive Secretary

November 18, 1998

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Re: Health Care Decisions (Memorandum 98-63)

Dear Stan:

Because it has become obvious that the need to administer and grade exams will prevent my attendance at the Commission's December meeting, I concluded that I could be of most help by providing you with written comments on the most recent draft. In preparing these comments, I have worked off Memorandum 98-63 and the attached staff recommendation, focusing primarily on the questions raised in the Staff Notes. I am writing primarily from my perspective as the reporter for the Uniform Health-Care Decisions Act.

Page 31, lines 1-4: Changing "Incapacitated Adults" to "Adults Without Decisionmaking Capacity" in the title is a significant improvement. The new title reduces the emphasis on the patient's impairment, and places it more on the purpose of the statute - to make health care decisions.

Page 31, lines 9-15: Because Part 2, beginning at Section 4670 (p. 49), is entitled "Uniform Health-Care Decisions Act," I agree with Harley Spitler. Calling the whole Act the "Health-Care Decisions Act" is confusing. The title "Health-Care Decisions Law" clarifies that the uniform act is part of a larger whole, which also covers other topics.

Page 33, lines 4-8: I would not change "significant benefits" to "benefits" in the definition of "capacity" (Section 4609). A complete understanding of benefits, etc., should not be necessary for a patient to demonstrate the capacity to make health care decisions. An understanding of the key benefits, etc., is all that should be required. Consequently, if the reference to "significant" means anything at all, it means that more patients will be able to make their own health care decisions. Cutting down on the number of benefits, etc., that must be considered to those that are "significant" may also make it easier for physicians to assess capacity and incapacity.

Page 33, lines 15-27: Please add a sentence in the comment to the definition of "conservator" (Section 4613) noting that the "guardian" referred to in the definition would be a guardian appointed in another state. The Act is limited to decisionmaking for adults, for whom, in California, only conservators may be appointed. Given this limitation, perhaps the reference to "guardians" in the definition of "conservator" ought to be dropped. The uniform act definition of "guardian" referred to both guardians and conservators because we had a large contingent of Californians involved in the drafting process who insisted on employing both terms.

Page 34, lines 13-35: Point 1: I would stick to the Commission draft and not adopt Harley Spitler’s proposed language. The Act is clear enough that refusal of health care is encompassed within the definition of “health care decision” (Section 4617).

Point 2: If the definition of health care decision is intended to refer to all health care decisions, which it is, adding “meaningful” would simply introduce a needless and confusing modifier.

The comment on visitation is better taken. This issue of visitation rights was raised in the drafting of the uniform act, but was rejected as not being of sufficient importance. The Illinois health care power of attorney statute specifically addresses visitation, however. I agree with you that it ought to be covered, if at all, in the sections on authority. If we are going to cover visitation, I would extend the authority to both agents and conservators.

Point 3: With respect to CPR, I would follow the lead of CMA, which has given significant thought to this issue.

Page 35, lines 30-34, Point 2: The reference to a health care provider in this “State” in the definition of “health care provider” (Section 4621) was eliminated from the uniform act based on the reality that health care providers in other states are frequently consulted, for example, if a resident of another state is receiving treatment in California. This deletion was not my idea. I would make the definition consistent with the other California statutes. Restricting the definition to California health care providers does not deter consultation with providers in other states. Also, the Act could not possibly force health care providers in other states to comply with all of the Act’s requirements applicable to health care providers.

Page 37, lines 27-48: All of the issues raised by CHA were discussed in the drafting of the uniform act. There is no perfect solution. The use of the term “primary physician” (Section 4631) was the best compromise. I would leave the definition as is.

Page 38, lines 28-32: In the drafting of the uniform act, we tried various formulations for making the definition of “reasonably available” (Section 4633) more user friendly. We stumbled in our attempt to add more procedural detail based on the reality that what should be required will depend on the particular facts and circumstances. My conclusion is that it would be best to leave the definition alone. Over time, groups such as CMA and CHA will hopefully develop practice guidelines that will respond to the particular facts and circumstances encountered.

Page 39, lines 24-37: The definition of “supervising health care provider” (Section 4639) is not intended to grant rights to non-physicians to act outside accepted health care standards, including ignoring a physician’s orders. As your comment points out, there are numerous situations under the Act where this role might be performed by a non-physician. The definition works when applied in its total context. I recommend that the definition be left as is.

Page 40, lines 18-35: The statement of legislative purpose (Section 4650), which is drawn from the Natural Death Act, seems too narrow. The Act addresses more than the withdrawal and withholding of life sustaining treatment. I have no immediate language to suggest.

This requires some thought. Perhaps Harley Spitler might have some suggested language.

Pages 41-42, lines 44-45, lines 1-8: The items listed in Section 4652 are heavily regulated by other law and are politically sensitive. Even something like including mental health commitment authority in a power of attorney is controversial, as we discovered in connection with New Mexico's enactment of the uniform act. The failure to cover these procedures in this Act does not take away rights. This Act is not exclusive and does not preclude health care decision making by other means or by other law, including common law and constitutional rights to self-determination. However, the title "unauthorized acts" might be too strong. Might "excluded acts" be better?

Page 42, lines 9-15: Were we writing on a clean slate, I would eliminate mercy killing, assisted suicide, and euthanasia from the prohibitions in Section 4653. These terms have been so politicized they have become devoid of legal meaning. The second sentence better expresses the intended limitation. However, the very fact that these terms have become so politicized is the very reason we should retain this section as is.

Pages 42-43, lines 40-46, lines 1-11: Point 1: The language "generally accepted health care standards" was developed in consultation with the AMA and other national health care groups. I would be reluctant to change it.

Point 2: For whatever it's worth, the Uniform Health-Care Decisions Act was developed in close consultation with the Christian Science Church, which sent an advisor to all of our meetings. We made a major effort to be sensitive to the special health care views of religious groups but without express reference to their specific practices. To list one would require that we list all, which would be an impossible task.

Page 44, lines 5-22: Point 1: The uniform act does not try to address the effect of a presumption because the states are all over the map on this issue. The presumption, however, is intended to be a strong one, an intent which is met by your added language in Section 4657 shifting the burden of proof.

Point 2: I agree with your analysis of DPCDA. It only applies to judicial proceedings.

Page 45, lines 26-45: I agree with you. I would delete Section 4659. This section, which negates a health care decision by a substitute if the patient has capacity, originally applied to patients without capacity (see CPC 4724). The effect of this provision with respect to patients without capacity was to stop health care decisionmaking in its tracks. To effectuate the health care decision it was then necessary to either go to court or to make the decision under the emergency exception.

By limiting Section 4659 to patients with capacity, the provision is arguably of no effect. Surrogates can only make a decision for patients without capacity, and it is the rare agency that allows an agent to make a health care decision for a principal with capacity. But even if the agent does have such authority, I would argue that an objection by the principal to the agent's decision constitutes a revocation of the agent's authority. Consequently, even in that limited

circumstance this provision is irrelevant.

The issue of patient objections was extensively debated in the drafting of the uniform act. We ultimately rejected including a provision like Section 4659 and addressed the issue indirectly by (1) requiring that the supervising health care provider communicate the decision to the patient (see Section 4730); and (2) including a strong presumption in favor of the patient's capacity (see Section 4657).

Page 47, lines 29-36: Referring to the background law of agency is not helpful. I am unaware of any other health care power of attorney statute that contains a similar provision. I would delete Section 4662.

Page 50, lines 35-43: Given that this division is limited to adults, under what circumstances could a nomination of a guardian under Section 4672 ever be given effect?

Page 55, lines 4-12: Execution requirements for health care powers of attorney are all over the map. Many, if not most states require no formalities, Illinois requires one witness, other states require two. Some states require notarization, others require either notarization or witnessing. Some states have lists of impermissible witnesses, such as health care providers. Trying to conform our execution requirements to the law of the other states is therefore pointless. The best course is to keep our execution requirements as simple as possible. Most states have statutes validating advance directives meeting the requirements of the state where executed. Also, as I have argued elsewhere (in the Real Property Probate & Trust Journal), conflicts of law principles should compel such recognition even in the absence of statute.

Section 4680 should remain as is, except that I would delete the dating requirement. Including a date is obviously good practice, but its omission should not invalidate the power. If neither a will nor trust need be dated, why do we require dating for a health care power of attorney?

Page 56, lines 43-47: Point 1: The State Bar Committee raises an issue worthy of discussion. Section 4683 authorizes an agent, absent a contrary statement in the instrument, to make decisions with respect to (1) organ and tissue donation; (2) autopsy; and (3) disposition of remains. The argument for not specifically mentioning these powers in the statutory form is that autopsy is rare, arranging a funeral is not a health care decision, and the form already has a place for the patient to make an anatomical gift. The argument in favor of modifying the form to expressly mention these powers is (1) this would make the form consistent with the agent's actual authority; and (2) these powers have been in the current statute and form since the early 1980s. On balance, I agree with the State Bar Committee view.

Pages 58-59, lines 34-44, 1-10: Section 4688 is confusing enough in a property context. In the health care area, this provision is beyond comprehension. I would delete this section.

Page 60, lines 6-50: Point 1: There is a debate in the estate planning profession as to whether revoked wills should be destroyed. I can imagine the same debate with respect to revoked advance directives. The Act should not take a position on this issue.

Point 2: While I am sympathetic to the desires of health care providers for certainty, requiring that a revocation of an advance directive be in writing would be a major step backwards. The Act endeavors to validate all advance directives, including oral designations, and requires all conservators, agents, and surrogates to follow a patient's expressed wishes, even if oral. The same validation should extend to oral revocations.

Point 3: The problem of to whom a revocation can be communicated is a difficult one. At one point, the draft of the uniform act required communication of a revocation to a health care provider in all events. We ultimately concluded that this was too restrictive. Ms. Miller is correct that situations can arise where an unreliable witness might conclude that the patient has revoked an advance directive. However, this risk is reduced to a great extent by the requirement that the patient must have capacity in order to revoke (see Section 4657).

Page 61, lines 21-29: Point 1: While it is a good idea to widely communicate a revocation, the Act requires communication of the revocation only to those most knowledgeable about the patient's care or who are likely to have a copy of the advance directive (Section 4696). Communication to others who have copies of or who otherwise have knowledge of the advance directive is a good idea, but should not be made a requirement.

Page 62, lines 1-9: Point 1: Were we writing on a clean slate, I might prefer the uniform act rule on the effect of dissolution of marriage. However, it is far more important that the rule for advance directives be the same as the California rule for wills. This is the last issue on which we want inconsistent statutes. Leave Section 4697 as is.

Point 2: Perhaps an addition to the comment might satisfy Dr. Miller's concern. This statute is derived from a similar wills provision, which is a rule of construction. Section 4697 does not apply if the principal has made intervening changes to the plan, such as redesignating the spouse as agent following the marital dissolution.

Page 67, lines 1-15: Point 1: Dr. Miller's suggested addition of the phrase "to be effective in pain relief" would be helpful.

Point 2: While it does not fully satisfy Dr. Miller's concern about the boundary between permitted pain relief and assisted suicide, Section 4740 does immunize a provider from criminal liability for complying with an advance directive or the decision of a person with authority.

Page 68, lines 1-29, Point 1: See discussion above. I vote to conform the statutory form to the agent's actual authority.

Point 2: With respect to whole body donations, not only does the form arguably already cover this but these sorts of donation decisions are ordinarily handled directly with the medical school while the donor is still competent.

Page 69, lines 1-13: Point 1: The uniform act provides for two alternate agents because that is what almost all the statutory forms in other states provide. The theory is that one alternate agent is not enough, but providing space to designate three or more would be too cumbersome.

Point 2: The uniform act was approved in 1993, prior to the dominance of managed care, particularly in California. Were we drafting the uniform act today, we might not have included a place to designate a primary physician.

Page 72-73, lines 44-51, 1-27: The question of whether an agent should be required to sign a formal acceptance was extensively debated on the floor during the approval of the uniform act. The issue was resolved by delegating the whole issue to the comments (see page 72, lines 13-42). The comment encourages practitioners to include acceptances in their own forms, but does not require this as part of the statutory form. Requiring an agent to formally accept would add an unnecessary layer of formality and would substantially reduce the number of advance directives executed.

With regard to other issues raised in the Staff Note, please keep the statutory form as simple as possible.

Page 76, lines 1-7: Dr. Miller and CMA wish to substitute “good faith” for “reasonably” in subdivisions (b)(1) and (c)(1). A good faith standard without an accompanying requirement of reasonableness would encourage health care providers to make a selection of a surrogate as required by Section 4712. Also, selecting surrogates is not something in which health care providers have been trained, suggesting that the required standard of care should be lower. On the other hand, a good faith standard without more might allow health care providers to without question select almost anyone on the list.

Note that Section 4740 may be relevant to this issue. This section protects a health care provider acting in good faith as long as such action is in accord with generally accepted health care standards. This section does not impose a reasonableness test. The reasonableness standard in Section 4712 is derived from West Virginia law, not the uniform act. Also, because the uniform act does not authorize a physician to select a surrogate, it might be appropriate to amend Section 4740 to clarify that the protections under that section extend to a physician’s selection of a surrogate.

Page 76-77, lines 43-47, 1-2: Your analysis of the standard under Section 4713 is correct. Consideration of background values and beliefs is required only under the fallback best interests test.

Page 77, lines 17-22: Point 1: The addition of the phrase “having capacity” in Section 4714 is consistent with other additions of that phrase elsewhere in the Act. Please note that Section 4657 presumes that a patient has capacity to disqualify a surrogate.

Point 2: The case for allowing informal means for disqualifying a surrogate is at least as strong as that for allowing informal revocation of an advance directive. The creation of an

advance directive was the choice of the patient; the selection of the patient's surrogate is the choice of the statute and physician.

Page 78, lines 22-31: Points 2, 3: Adding a "diligent search" requirement would help reduce fears that health care institutions will automatically jump to this procedure out of convenience. For this reason, I approve of the change. However, the comment should hint at what is meant by "diligent search." Is more intended than is intended by a phrase such as "reasonable inquiry"?

Page 79, lines 24-32: Without pretending to have any idea as to how it should be phrased, the comment to Section 4722 should say something as to what is meant by "critical health care decisions."

Page 79, lines 38-41: I approve of the requirement in Section 4723(a)(3) that the surrogate committee interview the patient in order to determine the patient's express wishes. However, this provision does raise an issue perhaps requiring clarification, both here and elsewhere in the Act. If the patient does express views at this interview, to what extent are those views binding on the surrogate committee? Section 4725 provides that the various duties of an individual surrogate apply to a surrogate committee and its members. One of these duties is the requirement under Section 4713 to follow the patient's expressed wishes. In drafting the uniform act counterpart to Section 4713, the assumption made, in accordance with traditional doctrine, was that the expressed wishes in question were only those expressed prior to the patient's loss of capacity. However, the National Senior Citizens Law Center correctly points out that just because a person has been determined to be incapacitated does not mean that the person is totally without understanding (page 80, lines 37-41). My conclusion is that wishes expressed prior to loss of capacity should be primary but that current views should receive at least some consideration, particularly if inconsistent with prior views. Perhaps this whole issue might best be addressed in the comments.

Page 80, lines 13-41, Point 2: The traditional role of an ethics committee is to mediate, not arbitrate. In subsection (b), the surrogate committee should be retained as the review body. This would not preclude a facility from asking its ethics committee to review the file or to even become the surrogate committee.

Point 4: The comment made by the Senior Citizens Law Center on communication with the patient is well taken. Please note that in addition to the communication required under Section 4723 to determine expressed wishes, Section 4730 requires that the supervising health care provider, if possible, communicate to the patient the health care decision made and the identity of the person making the decision.

Page 85, lines 1-8: To my mind, the reference in the comment to "treatment that would not offer the patient any significant benefit" is another way of saying "medically ineffective health care." That was the point I was trying to get across when I wrote this comment to the uniform act. My experience in trying to explain the uniform act on the CLE circuit leads me to conclude that the comment is more understandable than the statute. However, most of my speeches were to non-medical audiences. Health care providers may prefer "medically ineffective

health care.”

Page 85, lines 45-46: The uniform act was drafted at a time when the conscience exception was still the dominant concern and futile care was only beginning to be recognized as a problem. Therefore, the committee drafting the uniform act did not fully think through and was unable to anticipate the current debate on futile care. The many comments on the difficulty of applying Sections 4733-4736 to possible instances of futile care are well taken. For example, it is difficult if not impossible to find another health care provider willing to continue the “futile care.” Also, the reference to “continuing care” in 4736 is ambiguous. It was not our intent that the “futile care” be continued. Substituting “palliative care” would be closer to the mark.

I doubt if our Act can solve all of the concerns. On balance, perhaps the best we can do is to substitute palliative care for continuing care in 4736 and allow the other issues to be resolved in another forum.

Page 87, lines 1-9: Adding a new subdivision to Section 4740 immunizing a health care provider for institution for declining to comply with an instruction or health care decision as provided in Section 4736 would be a good addition. See also my comment above to Section 4712 regarding adding language protecting a physician in selecting the appropriate surrogate.

Page 93, lines 4-26: While the comment states that Section 4766 applies to surrogate committees, this should be made clear in the statutory text.

Best wishes at your December meeting.

Sincerely,

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