Study L-4000 December 4, 1998

First Supplement to Memorandum 98-74

Health Care Decisions: Draft Recommendation Revisions (Preliminary Part)

Attached to this memorandum is the updated preliminary part of the draft recommendation on *Health Care Decisions for Incapacitated Adults*. This material has been revised to take account of revisions in the statutory material made at the September meeting. We do not plan to discuss the preliminary part at the December meeting, unless the Commission wants to discuss it.

Respectfully submitted,

Stan Ulrich
Assistant Executive Secretary

HEALTH CARE DECISIONS FOR ADULTS WITHOUT DECISIONMAKING CAPACITY

☞ **Staff Note.** This preliminary part has been revised to reflect revisions approved at the September 1998 meeting. Additional revisions may be needed if the Commission makes further substantive revisions.

California has been a pioneer in the area of health care decisionmaking for adults without decisionmaking capacity, with the enactment of the 1976 Natural Death Act[1] and the 1983 Durable Power of Attorney for Health Care.[2] Legislation in other states over the last 15 years, enactment of the federal Patient Self-Determination Act in 1990,[3] and promulgation of a new Uniform Health-Care Decisions Act in 1993,[4] suggest the need to review existing California law and consider revising and supplementing it.

California law does not adequately address several important areas of the law concerning health care decisionmaking for adults who lack capacity:

(1) Existing law does not provide a convenient mechanism for making health care treatment wishes known and effective, separate from the procedure for appointing an agent.

(2) The principles governing family consent or surrogate decisionmaking in the absence of a power of attorney for health care are not clear.

(3) There are no general rules governing health care decisions for incapacitated persons who have no advance directive or known family or friends to act as surrogates.

(4) Statutes governing court-authorized medical treatment for patients without conservators are unduly limited.

The proposed Health Care Decisions Law provides procedures and standards for making decisions in these situations, and adopts consistent rules governing health care decisionmaking by surrogates, whether they are family members, agents, public or private conservators, surrogate committees, or courts. The proposed law makes many revisions to promote the use and recognition of advance directives, to improve effectuation of patients' wishes once they become incapable of making decisions for themselves, to simplify the statutory form and make it easier to use

---

1. 1976 Cal. Stat. ch. 1439. This was also the year the New Jersey Supreme Court decided the well-known Karen Ann Quinlan case. *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied*, 429 U.S. 922 (1976).

2. 1983 Cal. Stat. ch. 1204, enacted on Commission recommendation. See *infra* note 8.

3. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4206, 4751, 104 Stat. 1388, 1388-115 to 1388-117, 1388-204 to 1388-206. See esp. 42 U.S.C.A. §§ 1395cc(a), 1396a(w)(1) (Westlaw 1998).

4. 9 (Pt. 1) U.L.A. 285 (West Supp. 1998) [hereinafter UHCDA].

and understand, and to modernize terminology. However, the scope of the proposed law is limited: it governs only health care decisions to be made for adults at a time when they are incapable of making decisions on their own and provides mechanisms for directing their health care in anticipation of a time when they may become incapacitated. It does not govern health care decisions for minors or adults having capacity.

NEED FOR REVISED LAW

In a 1991 article entitled *Time for a New Law on Health Care Advance Directives*, Professor George Alexander gives the following overview:[5]

> During the last decade, states have enacted three different kinds of documents to deal with health care of incompetent patients. The legislation's main impetus and central focus have been to provide a procedure to approve life support termination in appropriate cases, although it also addresses other health care concerns. The earliest of the statutes was a natural death act, which authorizes a directive, popularly called a living will, to physicians. The second was a general durable power of attorney, sometimes in the form of a specially crafted health care durable power of attorney, which essentially empowers an appointed agent to make appropriate decisions for an incompetent patient. The agent is bound by directions contained in the appointing power. Finally, some states have enacted family consent laws empowering others, typically family, to decide health care matters absent a directive or power of attorney to guide them. At the end of 1990, Congress gave these laws new importance by mandating their observance.
>
> The statutes differ; provisions of one form conflict with provisions of another form. Most contradictions raise problems, some nettlesome, others destructive of important interests. After more than a decade of experience with such forms, it is time to review the present state of the laws and to coordinate and debug them. In the author's view, a single statute incorporating the best of each of the three types of law is now in order.

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

BACKGROUND AND OVERVIEW

The right of a competent adult to direct or refuse medical treatment is a constitutionally protected right. This "fundamental liberty interest" is inherent in the common law and protected by federal and state constitutional privacy guarantees.[6]

---

5. 42 Hastings L.J. 755, 755 (1991) (footnotes omitted).

6. See generally Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990); Cobbs v. Grant, 8 Cal. 3d 229, 242, 502 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).

The proposed law reaffirms this fundamental right along the lines of the Uniform Health-Care Decisions Act, which

> acknowledges the right of a competent individual to decide all aspects of his or her own health care in all circumstances, including the right to decline health care or to direct that health care be discontinued, even if death ensues. An individual's instructions may extend to any and all health-care decisions that might arise and, unless limited by the principal, an agent has authority to make all health-care decisions which the individual could have made. The Act recognizes and validates an individual's authority to define the scope of an instruction or agency as broadly or as narrowly as the individual chooses.[7]

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

1. Power of Attorney

California has a detailed statute governing durable powers of attorney for health care (DPAHC) and providing a special statutory form durable power of attorney for health care.[8] The DPAHC requires appointment of an attorney-in-fact ("agent" in the language of the statutory form) to carry out the principal's wishes as expressed in the power of attorney or otherwise made known to the attorney-in-fact, but the attorney-in-fact also has authority to act in the best interest of the

---

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.

7. UHCDA Prefatory Note.

8. 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).

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.

principal where the principal's desires are unknown.[9] The rules governing the power of attorney for health care are generally carried forward in the proposed law.

2. Natural Death Act, Living Will

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

3. Statutory Surrogacy

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

4. Court-Appointed Conservator

California law provides a highly developed Guardianship-Conservatorship Law.[11] The Lanterman-Petris-Short Act provides a special type of conservatorship

---

9. See Prob. Code § 4720.

10. See Hamman, *Family Surrogate Laws: A Necessary Supplement to Living Wills and Durable Powers of Attorney*, 38 Vill. L. Rev. 103, 105 n.5 (1993) (reporting 8-15% in 1982, 1987, and 1988 surveys). One intention of the federal Patient Self-Determination Act in 1990, *supra* note 3, was to increase the number of patients who execute advance directives. See Larson & Eaton, *The Limits of Advance Directives: A History and Assessment of the Patient Self-Determination Act*, 32 Wake Forest L. Rev. 249, 257-59 (1997). The educational efforts under the PSDA may have resulted in greater use of powers of attorney for health care, but not significantly. See *id.* at 276-78 (estimates prior to PSDA ranged from 4-28%, mostly in 15-20% range; afterwards, "little or no increase" or "no significant increase"). A Government Accounting Office report found that 18% of hospital patients had advance directives, as compared with 50% of nursing home residents. *Id.* at 275 n.184.

11. 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). For provisions relating to health care, see, e.g., Prob. Code §§ 1880-1898 (capacity to give informed consent to medical treatment), 2354 (medical treatment of conservatee not adjudicated to lack

for the gravely disabled.[12] These provisions are not the focus of this recommendation.[13]

5. Other Judicial Intervention

A special procedure for court-authorized medical treatment is available for adults without conservators.[14] In a related revision, the proposed law conforms the scope of this procedure to the proposed Health Care Decisions Law.

The general power of attorney statutes were recently reviewed and revised on Commission recommendation.[15] In its report, the Commission noted that it had "not made a substantive review of the statutes concerning the durable power of attorney for health care …. [I]t would have been premature to undertake a detailed review of the health care power statutes before the National Conference of Commissioners on Uniform State Laws completed its work on the Uniform Health-Care Decisions Act."[16]

POWER OF ATTORNEY FOR HEALTH CARE

The proposed Health Care Decisions Law continues and recasts the existing law governing the durable power of attorney for health care, including the statutory form durable power of attorney for health care.[17] For the well-advised or careful individual who is making sensible arrangements for the time when he or she may be incapacitated, the power of attorney for health care[18] is clearly the best

---

capacity), 2355 (medical treatment of conservatee adjudicated to lack capacity), 2357 (court-ordered medical treatment).

12. Welf. & Inst. § 5350 *et seq.*

13. Communications to the Commission suggest that the procedure for court-authorized medical treatment and related conservatorship provisions should be reviewed for consistency with the scope of the proposed Health Care Decisions Law. As noted below, this recommendation proposes revisions in Probate Code Sections 3200-3211, and in Section 2355 (medical treatment of conservatee adjudicated to lack capacity); but consideration of broader revisions in the Guardianship-Conservatorship Law is reserved for future study.

14. Prob. Code § 3200 *et seq.*

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

16. *Id.* at 335.

17. 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.

18. For convenience, the proposed law uses the term "power of attorney for health care" instead of "durable power of attorney for health care." 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 durability feature is clear in the proposed law, notwithstanding the omission of the term "durable."

approach. Expressing desires about health care and naming one or more agents[19] subject to appropriate standards is the best way to accomplish "incapacity planning" and seek to effectuate a person's intent with regard to health care decisions, especially with regard to life-sustaining treatment.

In the new terminology — not so new in practice, but new to the Probate Code — a power of attorney for health care is one type of "advance health care directive" (or "advance directive").[20] The proposed law restructures the power of attorney for health care provisions based on a mix of principles from the existing Power of Attorney Law and the Uniform Health-Care Decisions Act. Where rules apply only to powers of attorney for health care, the proposed law uses that terminology. Where rules apply to all written advance health care directives, the language will vary, but the general substance of the law continues, except as noted.

Execution Formalities

The original durable power of attorney for health care was subject to a number of restrictions that are now considered to be overly protective. When first enacted, the durable power of attorney for property was only valid for a year following the principal's incapacity.[21] The original durable power of attorney for health care expired after seven years, except when the expiration date fell in a time of incapacity.[22] These restrictive rules may have had a role to play when the concepts were new, but were abandoned as the law progressed and the concepts and instruments became familiar and even necessary.

Now it is recognized that overly restrictive execution requirements for powers of attorney for health care unnecessarily impede the effectuation of intent. The progression from more restrictive execution requirements to more intent-promoting provisions can also be seen in the development of the Uniform Health-Care Decisions Act. The original Uniform Rights of the Terminally Ill Act of 1985 (URTIA), based in part on the 1976 California Natural Death Act, required two witnesses.[23] The Uniform Health-Care Decisions Act, which is intended to replace URTIA, adopts the principle that no witnesses should be required in a power of attorney for health care, although witnessing is encouraged[24] As a general rule, the

---

19. 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)).

20. 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."

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. See *infra* text accompanying note 86.

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

24. UHCDA § 2(b).

proposed law also adopts this principle in place of the existing requirement of two witnesses or notarization.[25]

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

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

Statutorily Required Warnings

Existing law provides a number of "warnings" that must be included depending on whether a form durable power of attorney for health care is on a printed form, from the statutory form, or drafted by an attorney or someone else.[30] There is an important alternative to complying with the strict execution requirements in California law. The law recognizes the validity of durable powers of attorney for health care and similar instruments executed in another state or jurisdiction in compliance with their law.[31]

The existing warning provisions are too confusing and rigid. While there has been an attempt to educate potential users through concise and simple statements,

---

25. Prob. Code §§ 4121-4122, 4700-4701. The existing statutory form power of attorney for health care must be witnessed; it is not validated by notarization. Prob. Code § 4771 & Comment.

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 significant. 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 67-70.

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 (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 Health and Safety Code Section 7192.5 in the NDA.

the net effect of the existing scheme may have been to inhibit usage. Some form of introductory explanation is still needed, however, and the optional statutory form drawn from the UHCDA in the proposed law fulfills this purpose. But the proposed law no longer attempts to instruct lawyers on how to advise their clients. The Commission expects that those who prepare printed forms will copy the language of the optional form or use a reasonable equivalent without the need to mandate specific language in the statute.

Revocation

A durable power of attorney for health care under existing law can be revoked expressly in writing or by notifying the health care provider orally or in writing, but it is also revoked by operation of law if the principal executes a later power of attorney for health care.[32] This last rule provides administrative simplicity, since a comparison of dates would show which power was in force. Unfortunately, it is also a trap, since a principal may attempt to amend or clarify an earlier power, or designate a new attorney-in-fact, in ignorance of the rule and inadvertently wipe out important instructions. It is also quite difficult to implement this all-or-nothing rule in the context of a broader statute permitting written individual health care instructions and direct surrogate designations.

A better approach is adopted in the proposed law, based on the UHCDA.[33] The intentional revocation rule is similar: a patient with capacity can revoke a designation of an agent only by a signed writing or by personally informing the supervising health care provider; individual health care instructions can be revoked in any manner communicating an intent to revoke. The distinct treatment of agent designations and health care instructions is justified because the patient should have only one agent at a time, and a revocation should be clear and evidenced, whereas health care instructions do not share this feature and can be revised and supplemented without any inherent restriction. Recognizing this practical reality, a later advance directive revokes a prior directive only to the extent of the conflict, thus promoting the fundamental purpose of implementing the patient's intent.

The proposed law continues the existing rule that a person's designation of his or her spouse as agent to make health care decisions is revoked if the marriage is dissolved or annulled.[34]

INDIVIDUAL HEALTH CARE INSTRUCTIONS

California does not authorize what the UHCDA calls an "individual instruction," other than through the mechanism of the Natural Death Act which applies only to patients in a terminal or permanent unconscious condition. Health care instructions

32. Prob. Code § 4727(a), (b), (d).

33. UHCDA § 3.

34. Prob. Code § 4727(e). The designation is revived if the principal and the former spouse are remarried.

may, of course, be given in the context of appointing and instructing an attorney-in-fact under a durable power of attorney for health care. The Commission is informed that, in practice, individuals will execute a durable power of attorney for health care *without* appointing an attorney-in-fact so that they can use that vehicle to effectively state their health care instructions. It is also possible to appoint an attorney-in-fact, but limit the agent's authority while expressing broad health care instructions. These approaches may succeed in getting formal health care instructions into the patient's record, but existing law is not well-adapted for this purpose. Health care providers' duties under the existing durable power of attorney for health care focus on the *agent's* decisions, not the *principal's* instructions.

The proposed law adopts the UHCDA's broader concept of authorizing individual health care instructions. This makes the law clearer, more direct, and easier to use. The option of giving independent health care instructions is also implemented as part of the optional statutory form. Using the simple and relatively short statutory form will enable an individual to record his or her preferences concerning health care or to select an agent, or to do both.

STATUTORY SURROGATES — FAMILY CONSENT

Most incapacitated adults for whom health care decisions need to be made will not have formal written advance health care directives. It is likely that less than one-fifth of adults have executed written advance directives for health care.[35] The law, focusing as it does on execution of advance directives, is deficient if it does not address the health care decisionmaking process for the great majority of incapacitated adults who have not executed written advance directives.

Existing California Law

California statutory law does not provide general rules governing surrogate decisionmaking. However, in the nursing home context, the procedure governing consent to "medical interventions" implies that the "next of kin" can make decisions for incapacitated persons by including the next of kin in the group of persons "with legal authority to make medical treatment decisions on behalf of a patient."[36]

There are supportive statements in case law, but due to the nature of the cases, they do not provide comprehensive guidance as to who can make health care decisions for incapacitated persons. For example, in *Cobbs v. Grant*, the Supreme Court wrote:

> A patient should be denied the opportunity to weigh the risks only where it is evident he cannot evaluate the data, as for example, where there is an emergency or the patient is a child or incompetent. For this reason the law provides that in an emergency consent is implied …, and if the patient is a minor or incompetent, the authority to consent is transferred to the patient's legal guardian or closest avail-

35. See *supra* note 10.

36. Health & Safety Code § 1418.8(c).

able relative …. In all cases other than the foregoing, the decision whether or not to undertake treatment is vested in the party most directly affected: the patient.[37]

But this language is not a holding of the case.[38]

The leading case of *Barber v. Superior Court* [39] contains a thorough discussion of the problems:

> Given the general standards for determining when there is a duty to provide medical treatment of debatable value, the question still remains as to who should make these vital decisions. Clearly, the medical diagnoses and prognoses must be determined by the treating and consulting physicians under the generally accepted standards of medical practice in the community and, whenever possible, the patient himself should then be the ultimate decision-maker.
>
> When the patient, however, is incapable of deciding for himself, because of his medical condition or for other reasons, there is no clear authority on the issue of who and under what procedure is to make the final decision.
>
> It seems clear, in the instant case, that if the family had insisted on continued treatment, petitioners would have acceded to that request. The family's decision to the contrary was, as noted, ignored by the superior court as being a legal nullity.
>
> In support of that conclusion the People argue that only duly appointed legal guardians have the authority to act on behalf of another. While guardianship proceedings might be used in this context, we are not aware of any authority *requiring* such procedure. In the case at bench, petitioners consulted with and relied on the decisions of the immediate family, which included the patient's wife and several of his children. No formal guardianship proceedings were instituted.
>
> ….
>
> The authorities are in agreement that any surrogate, court appointed or otherwise, ought to be guided in his or her decisions first by his knowledge of the patient's own desires and feelings, to the extent that they were expressed before the patient became incompetent.…
>
> If it is not possible to ascertain the choice the patient would have made, the surrogate ought to be guided in his decision by the patient's best interests. Under this standard, such factors as the relief of suffering, the preservation or restoration of functioning and the quality as well as the extent of life sustained may be considered. Finally, since most people are concerned about the well-being of their loved ones, the surrogate may take into account the impact of the decision on those people closest to the patient.…
>
> There was evidence that Mr. Herbert had, prior to his incapacitation, expressed to his wife his feeling that he would not want to be kept alive by machines or "become another Karen Ann Quinlan." The family made its decision together (the directive to the hospital was signed by the wife and eight of his children) after consultation with the doctors.
>
> Under the circumstances of this case, the wife was the proper person to act as a surrogate for the patient with the authority to decide issues regarding further

37. 8 Cal. 3d 229, 243-44, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) (citations omitted).

38. The "closest available relative" statement cites three cases, none of which involve incapacitated adults. Consent on behalf of an incapacitated adult was not an issue in the case, since the patient did not lack capacity, but was claiming that he had not given informed consent. Still, *Cobbs* is cited frequently in later cases involving consent or withdrawal of consent to medical treatment.

39. 147 Cal. App. 3d 1006, 1020-21, 195 Cal. Rptr. 484 (1983).

> treatment, and would have so qualified had judicial approval been sought. There is no evidence that there was any disagreement among the wife and children. Nor was there any evidence that they were motivated in their decision by anything other than love and concern for the dignity of their husband and father.
>
> Furthermore, in the absence of legislative guidance, we find no legal requirement that prior judicial approval is necessary before any decision to withdraw treatment can be made.

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

Nevertheless, *Barber* has been characterized as an "enormously important" decision: "Indeed, literature generated from within the medical community indicates that health care providers rely upon *Barber* — presumably every day — in deciding together with families to forego treatment for persistently vegetative patients who have no reasonable hope of recovery."[40]

Current Practice: LACMA-LACBA Pamphlet

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

> The process suggested in these Guidelines has been developed in light of the following principles established by the California courts and drawn from the Joint Committee's Guidelines for Forgoing Life-Sustaining Treatment for Adult Patients:
>
> (a) Competent adult patients have the right to refuse treatment, including life-sustaining treatment, whether or not they are terminally ill.

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

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

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

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

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

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

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

Current Practice: Patient Information Pamphlet

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

What if I'm too sick to decide?

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

Based on the case law, the Commission is not confident that California law says the *closest* available relative *or friend* can make health care decisions. However, it may be true in practice that these are the persons doctors will ask, as stated in the pamphlet.[41]

41. See also American Medical Ass'n, Code of Medical Ethics § 2.20, at 40 (1997-98) ("[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."); California Healthcare Ass'n, Consent Manual: A Reference for Consent and Related Health Care Law 2-18 (23d ed.

Alternative Approaches to Statutory Surrogate Priorities

The general understanding is that close relatives and friends who are familiar with the patient's desires and values should make health care decisions in consultation with medical professionals. Wives, brothers, mothers, sisters-in-law, and domestic partners have been involved implicitly as "family" surrogate decisionmakers in reported California cases. The practice, as described in authoritative sources, is consistent with this understanding. Courts and legislatures nationwide naturally rely on a family or next of kin approach because these are the people who are presumed to best know the desires of the patient and to determine the patient's best interests.[42]

Priority schemes among relatives and friends seem natural. Intestate succession law[43] provides a ready analogy — thus, the spouse, children, parents, siblings, and so forth, seem to be a natural order. The same order is established in the preference for appointment as conservator.[44] But the analogy between health care, life-sustaining treatment, and personal autonomy on one hand and succession to property on the other is weak. A health care decision cannot be parceled out like property in an intestate's estate. The consequences of a serious health care decision are different in kind from decisions about distributing property.

The trend in other states is decidedly in favor of providing statutory guidance, generally through a priority scheme. The collective judgment of the states would seem to be that, since most people will not execute any form of advance directive, the problem needs to be addressed with some sort of default rules, perhaps based on an intestate succession analogy. As described by Professor Meisel:[45]

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

1996) ("In some circumstances, it may be necessary or desirable to rely upon the consent given by the incompetent patient's 'closest available relative.' The validity of such consent cannot be stated with certainty, but the California Supreme Court has indicated that in some cases it is appropriate for a relative to give consent." [citing *Cobbs v. Grant*]); 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.").

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

43. Prob. Code § 6400 *et seq*.

44. Prob. Code § 1812.

45. 2 A. Meisel, The Right to Die § 14.1, at 249-50 (2d ed. 1995).

The UHCDA scheme lists the familiar top four classes of surrogates (spouse, children, parents, siblings), but is less restrictive than many state statutes in several respects:[46] (1) Class members *may* act as surrogate and need to *assume authority* to do so. It is not clear whether a class member must affirmatively decline to act or may be disregarded if he or she fails to assume authority, but unlike some state statutes, an abstaining class member does not prevent action. (2) Determinations within classes can be made by majority vote under the UHCDA. This is not likely to be a common approach to making decisions where there are disagreements, but could be useful to validate a decision of a majority where there are other class members whose views are unknown or in doubt. (3) Orally designated surrogates are first on the UHCDA priority list, as an attempt to deal with the fact that a strict statutory priority list does not necessarily reflect reality. The "orally designated surrogate was added to the Act not because its use is recommended but because it is how decision makers are often designated in clinical practice."[47] (4) The authorization for adults who have "exhibited special care and concern" is relatively new. Under the common law, the status of friends as surrogates is, in Professor Meisel's words, "highly uncertain."[48] In a special procedure applicable to "medical interventions" in nursing homes, California law requires consultation with friends of nursing home patients and authorizes a friend to be appointed as the patient's representative,[49] but the health care decision is made by an "interdisciplinary team."

Statutory Surrogates Under Proposed Law

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

---

46. UHCDA § 5.

47. English, *Recent Trends in Health Care Decisions Legislation* 17 (1998) (unpublished manuscript, on file with California Law Revision Commission).

48. 2 A. Meisel, The Right to Die §14.4, at 51 (2d ed. Supp. #1 1997). *But cf.* Conservatorship of Drabick, 200 Cal. App. 3d 185, 204, 245 Cal. Rptr. 840 (1988) ("[F]aced 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.")

49. Health & Safety Code § 1418.8. For the purposes of this section, subdivision (c) lists "next of kin" as a person with "legal authority to make medical treatment decisions." See also Rains v. Belshé, 32 Cal. App. 4th 157, 166, 38 Cal. Rptr. 2d 185 (1995) (upholding the procedure and citing with approval the duty to consult with friends and the participation of the patient representative).

Professor Meisel describes this fundamental problem with priority classes as follows:[50]

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

In recognition of the problems as well as the benefits of a priority scheme, the proposed law sets out a default list of adult statutory surrogates: (1) The spouse, unless legally separated, (2) a domestic partner,[51] (3) children, (4) parents, (5) brothers and sisters, (6) grandchildren, and (7) close friends.

As a general rule, the primary physician is required to select the surrogate, with the assistance of other health care providers or institutional committees, in the order of priority as set out in the statute. However, where there are multiple possible surrogates at the same priority level, the primary physician has a duty to select the individual who reasonably appears after a good faith inquiry to be best qualified.[52] 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. These rules are directly related to the fundamental principal that the law should attempt to find the best surrogate who can make health care decisions according to the patient's known desires or in the patient's best interest.

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

---

50. 2 A. Meisel, The Right to Die § 14.4 at 255 (2d ed. 1995) (footnotes omitted).

51. Proposed Probate Code Section 4712(a)(2) defines this class as follows: "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.…"

52. 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 (Westlaw 1998).

(1) Whether the proposed surrogate appears to be best able to make decisions in accordance with the statutory standard (patient's instructions, if known, or if not known, patient's best interest, taking into account personal values).

(2) The degree of the person's 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.

In addition, the process of applying these standards and making the determination must be documented in the patient's medical record. The surrogate is required to communicate his or her assumption of authority to other family members, including the spouse, domestic partner, adult children, parents, and adult siblings of the patient.

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

As discussed, the UHCDA provides a fixed priority scheme between classes of close relatives and provides for voting within a class with multiple members.[53] If a class is deadlocked, then the surrogacy procedure comes to a halt; lower classes do not get an opportunity to act, although it is possible for a higher class to reassert its priority, and the evenly split class could resolve the deadlock over time. This type of procedure seems overly mechanical and lacking in needed flexibility.

The Commission also considered a family consensus approach, such as that provided under Colorado law.[54] In this procedure, the class of potential surrogates, composed of close family members and friends, is given the responsibility and duty to select a surrogate from among their number. It is difficult to judge how well this type of procedure would work in practice. The concern is that it might result in too much confusion and administrative burden, without improving the prospects for effective decisionmaking or resolving disputes. But there is nothing in the proposed law that would prevent a family from voluntarily acting in this fashion, and it is likely that the selected surrogate would satisfy the standards of the flexible priority scheme.

The proposed law adopts a presumptive "pecking order" like the UHCDA, but places the responsibility on the primary physician to select the best-situated person

---

53. UHCDA § 5.

54. 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 § 14.1 *et seq.* (2d ed. 1995 & Supp. #1 1997).

based on standards set out in the statute. This avoids the rigidity of the UHCDA approach and the indefiniteness and administrative burden of the consensus approach. Notice of the selection should be given to other family members. Potential surrogates with serious objections to the selection of the surrogate or the decisions being made by the surrogate would still have the right to bring a judicial challenge[55] or seek appointment as a conservator.

Like the UHCDA, the proposed law gives priority over the statutory list to a surrogate who has been designated by the patient.

DECISIONMAKING WHERE NO SURROGATE IS AVAILABLE

Providing statutory surrogate rules where a patient has not executed an advance directive or designated a surrogate, and for whom a conservator of the person has not been appointed, does not answer all of the problems. The statutory surrogate rules will not apply to a significant group of incapacitated adults for whom there are no potential surrogates because they have no close relatives or friends familiar with their health care treatment desires or values, or because potential surrogates are unwilling or unable to make decisions.

Existing law addresses this problem with respect to "medical interventions" for patients in the nursing home context,[56] but there is no general surrogacy rule applicable in these circumstances. The UHCDA does not address this problem.

The alternative of appointing a conservator of the person in each of these cases is not an adequate solution to the problem, as recognized by the Legislature when it enacted the nursing home medical intervention procedure.[57] While it is possible to seek court approval for medical "treatment" under Probate Code Section 3200 *et seq*. (authorization of medical treatment for adult without conservator), this procedure does not authorize orders for *withdrawal* of treatment or *refusal* of consent.[58]

The proposed law adopts a procedure based in large part on the nursing home medical intervention procedure, but with some important additional protections. Under this proposal, health care decisions for the "friendless" incapacitated adult could be made by a "surrogate committee." It is expected that hospitals and nursing homes will establish a surrogate committee, to take advantage of the statute. In a situation where there is no institutionally founded surrogate committee, or in the rare case where a health care decision needs to be made and

---

55. See *infra* text accompanying notes 74-78.

56. Health & Safety Code § 1418.8. See Rains v. Belshé, 32 Cal. App. 4th 157, 166, 170, 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").

57. 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*.

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

there is no institution involved, the proposed law grants authority to the county health officer or county supervisors to establish a surrogate committee.

The basic committee would be made up of the following three persons:

> (1) The patient's primary physician.
>
> (2) A professional nurse with responsibility for the patient and with knowledge of the patient's condition.
>
> (3) A patient representative or community member. The patient representative may be a family member or friend of the patient who is unable to take full responsibility for the patient's health care decisions, but has agreed to serve on the surrogate committee. A community member is an adult who is not employed by or regularly associated with the primary physician, the health care institution, or employees of the health care institution.

But in cases involving withholding or withdrawing of life-sustaining treatment or other critical health care decisions, the surrogate committee would also be required to include a member of the health care institution's ethics committee or an outside ethics consultant.

The surrogate committee under the proposed law is intended to require the degree of expertise and participation appropriate to the type of health care decision that needs to be made. The proposal provides *minimum* guidelines and is not intended to restrict participation by other appropriate persons, including health care institution staff in disciplines as determined by the patient's needs. The participation of the institutional ethics committee or an outside ethics consultant conforms to the best practice in life-sustaining treatment situations. The inclusion of outside representatives (the patient representative or community member) and, in critical cases, an ethics advisor, provide important protections that are not applicable under the existing nursing home medical intervention scheme.

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

> (1) The primary physician's assessment of the patient's condition.
>
> (2) The reason for the proposed health care decision.
>
> (3) The desires of the patient, if known. To determine the desires of the patient, the surrogate committee must interview the patient, review the patient's medical records, and consult with family members or friends, if any have been identified.
>
> (4) The type of health care to be used in the patient's care, including its probable frequency and duration.
>
> (5) The probable impact on the patient's condition, with and without the use of the proposed health care.
>
> (6) Reasonable alternative health care decisions considered or utilized, and reasons for their discontinuance or inappropriateness.

The surrogate committee is required to evaluate the results of approved health care decisions periodically, as appropriate under applicable standards of care.

The proposed law intends the surrogate committee to try to operate on a consensus basis. If consensus cannot be reached, the committee is authorized to approve

proposed health care decisions by majority vote. There is an important exception: proposed health care decisions relating to withholding or withdrawing life-sustaining treatment cannot be approved if any member of the surrogate committee is opposed. If a surrogate committee becomes hopelessly deadlocked, resort to judicial proceedings may be necessary.

STANDARDS FOR SURROGATE DECISIONMAKING

The existing power of attorney for health care law requires the attorney-in-fact to "act consistent with the desires of the principal as expressed in the durable power of attorney or otherwise made known to the attorney-in-fact at any time or, if the principal's desires are unknown, to act in the best interests of the principal."[59]

The UHCDA adopts the same rule as a general standard for all surrogates:

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

The proposed law, like the UHCDA, applies these standards generally throughout the statute. Thus, the same fundamental standard will apply to all surrogate health care decisionmakers: agents under powers of attorney, surrogates designated by the patient, family and friends who can act as surrogates under general principles codified in the statutory surrogate rules, surrogate committees acting for the "friendless" patient, private conservators and Public Guardians acting for conservatees without the capacity to make health care decisions,[60] and courts deciding cases under the court-authorized health care procedure.[61]

DUTIES OF HEALTH CARE PROVIDERS AND OTHERS

The proposed law sets out a number of specific duties of health care providers, drawn from the UHCDA,[62] that are more detailed than existing law. Since a fundamental feature of the uniform act is reliance on health care professionals to make necessary determinations and to comply with advance directives and health care decisions made by surrogates, the proposed law requires communication with

---

59. Prob. Code § 4720(c).
60. See *infra* text accompanying notes 82-85.
61. See *infra* text accompanying notes 79-81.
62. UHCDA § 7.

the patient, entry in the patient's medical records of the existence of an advance directive (including a copy) or a surrogate designation, and of any revocation or modification. The recordkeeping duties are extremely important since in the clinical setting, the patient's records provide the best means to make advance directives and surrogate designations effective.

The proposed law requires the health care provider and institution to comply with the patient's advance directive and with health care decisions made by the patient's surrogate decisionmaker, to the same extent as if the patient made the decision while having capacity.[63] However, a health care provider may lawfully decline to comply for reasons of conscience or institutional policy. This rule, drawn from the UHCDA,[64] is consistent with the Natural Death Act and case law.[65] If the health care provider declines to comply, however, there is a duty to transfer the patient to another health care institution.

Another important limitation on the health care provider's duty to comply is recognized in the proposed law. The health care provider or institution may decline to provide medically ineffective care or care that is contrary to generally accepted health care standards.[66] As in other cases where compliance can be refused, the health care provider and institution have a duty to provide continuing care until a transfer can be accomplished or until it appears that a transfer cannot be accomplished. But in all cases, appropriate palliative care must be continued.

LIABILITIES OF HEALTH CARE PROVIDERS AND OTHERS

The existing law governing durable powers of attorney for health care provides protection from criminal prosecution, civil liability, and professional disciplinary action for health care providers who in good faith rely on the decision of an attorney-in-fact in circumstances where in good faith the health care provider believes the decision is consistent with the desires and best interests of the principal.[67] Similarly, the Natural Death Act protects health care providers who comply with a declaration in good faith and in accordance with reasonable medical standards.[68]

The proposed law combines and generalizes these rules based on the UHCDA.[69] Health care providers and institutions are protected for actions taken under the law

---

63. These duties are not specified, although they are implicit, in the existing law on durable powers of attorney for health care. See Prob. Code § 4720. A duty to comply with a directive or transfer the patient is provided in the Natural Death Act. See Health & Safety Code § 7187.5 (2d sentence).

64. UHCDA § 7(e).

65. Health & Safety Code § 7190; Conservatorship of Morrison, 206 Cal. App. 3d 304, 310-12, 253 Cal. Rptr. 530 (1988).

66. This is drawn from UHCDA Section 7(f).

67. Prob. Code § 4750.

68. Health & Safety Code § 7190.5.

69. UHCDA § 9(a).

if they act in good faith and in accordance with generally accepted health care standards applicable to them. Specifically listed are compliance with a health care decision by a person apparently having authority to make the decision, declining to comply where a person does not appear to have authority, and complying with an advance directive assumed to be validly executed and not revoked.

The proposed law provides new statutory penalties, based on the UHCDA,[70] for intentional violation of the law in the amount of $2500 or actual damages, whichever is greater, plus attorney's fees. Any person who intentionally forges, conceals, or destroys an advance directive or revocation without consent, or who coerces or fraudulently induces a person to give, revoke, or refrain from giving an advance directive is similarly liable in the amount of $10,000. The statutory penalties are in addition to any other remedies that may exist in tort or contract, and to criminal penalties and professional discipline.

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.[71] 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."[72] In connection with incapacitated patients in nursing homes, the Legislature has found:[73]

> 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. However, there may be occasions where a dispute must be resolved and an appropriately tailored procedure is needed.

The UHCDA takes a similar approach, but provides less detail than existing law:[74]

> [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

---

70. UHCDA § 10.
71. Prob. Code § 4900.
72. Health & Safety Code § 7185.5(e).
73. 1992 Cal. Stat. ch. 1303, § 1(b).
74. UHCDA Prefatory Note.

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.[75] Under this procedure, any of the following persons may file a petition in the superior court: the patient, the patient's spouse (unless legally separated), a relative of the patient, the patient's agent or surrogate, the conservator of the person of the patient, a court investigator, the public guardian of the county where the patient resides, the supervising health care provider or health care institution, and any other interested person or friend of the patient. As under existing law, there is no right to a jury trial.[76]

The grounds for a petition are broad, but not unlimited, and include determining (1) whether the patient has capacity to make health care decisions, (2) whether an advance health care directive is in effect, and (3) whether the acts or proposed acts of an agent or surrogate (including a surrogate committee) are consistent with the patient's desires as expressed in an advance health care directive or otherwise made known to the court or, where the patient's desires are unknown or unclear, whether the acts or proposed acts of the agent or surrogate are in the patient's best interest. When capacity is to be determined in judicial proceedings, the provisions of the Due Process in Capacity Determinations Act[77] are applicable. The standard for reviewing the agent's or surrogate's actions is consistent with the general standard applicable under the proposed Health Care Decisions Law, as already discussed.[78]

COURT-AUTHORIZED MEDICAL TREATMENT

The court-authorized medical treatment procedure was enacted on Commission recommendation in 1979.[79] The original intent of this procedure, as described in

---

75. See Prob. Code §§ 4900-4947. 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 are 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.

76. Prob. Code § 4904.

77. Prob. Code §§ 810-813.

78. See *supra* text accompanying note 59.

79. Prob. Code §§ 3200-3211, enacted by 1979 Cal. Stat. ch. 726, § 3; *Recommendation Relating to Guardianship-Conservatorship Law*, 14 Cal. L. Revision Comm'n Reports 501, 577-78 (1978); *Guardianship-Conservatorship Law with Official Comments*, 15 Cal. L. Revision Comm'n Reports 451, 540-41, 870-76 (1980). The procedure was repealed and reenacted in 1990 when the new Probate Code replaced the former Probate Code. See 1990 Cal. Stat. ch. 79, § 14. Coverage was extended to mental health, operative in 1991. See 1990 Cal. Stat. ch. 710, § 12; *Recommendation Relating to Court-Authorized Medical Treatment*, 20 Cal. L. Revision Comm'n Reports 537 (1990).

Some additional amendments have been made to the original procedure, mainly as a result of the Due Process in Competency Determinations Act (DPCDA) (1995 Cal. Stat. ch. 842, §§ 9-11), which revised the

the Commission's Comment preceding Probate Code Section 3200, was as follows:

> The provisions of this part afford an alternative to establishing a conservatorship of the person where there is no ongoing need for a conservatorship. The procedural rules of this part provide an expeditious means of obtaining authorization for medical treatment while safeguarding basic rights of the patient: The patient has a right to counsel.… The hearing is held after notice to the patient, the patient's attorney, and such other persons as the court orders.… The court may determine the issue on medical affidavits alone if the attorney for the petitioner and the attorney for the patient so stipulate.… The court may not order medical treatment under this part if the patient has capacity to give informed consent to the treatment but refuses to do so.…

The authority of the court, or a surrogate appointed by the court, to authorize medical treatment under the Section 3200 procedure is not as broad as a conservator with full powers, an agent under a power of attorney for health care, or a statutory surrogate under the proposed Health Care Decisions Law. Where the conservatee has been adjudicated to lack the capacity to give informed consent to medical treatment, a conservator under Section 2355 can authorize removal of life-sustaining treatment (i.e., refuse consent to further treatment), if the decision is made in good faith and is based on appropriate medical advice.[80]

The Section 3200 procedure has not been interpreted by the appellate courts to permit withholding or withdrawing life support. The statutory language is clearly directed toward care needed to maintain health. It permits an order authorizing the "recommended course of medical treatment" and "designating a person to give consent to the recommended course of medical treatment" if all of the following are determined from the evidence:[81]

> (1) The existing or continuing medical condition of the patient requires the recommended course of medical treatment.
>
> (2) If untreated, there is a probability that the condition will become life-endangering or result in a serious threat to the physical or mental health of the patient.
>
> (3) The patient is unable to give an informed consent to the recommended course of treatment.

The reference to the probability that the condition will become life-endangering is not designed to address the situation of the patient in a persistent vegetative state whose continued existence is not seriously threatened. Since the Section 3200 procedure is not designed to deal with end-of-life decisionmaking, there is no statutory procedure available for making decisions in the best interest of a patient in a

---

procedural rules in Sections 3201, 3204, and 3208 related to determinations of capacity to make health care decisions ("give informed consent").

80. Conservatorship of Drabick, 200 Cal. App. 3d 185, 216-17, 245 Cal. Rptr. 840 (1988); see also Conservatorship of Morrison, 206 Cal. App. 3d 304, 309-10, 253 Cal. Rptr. 530 (1988).

81. Prob. Code § 3208.

persistent vegetative state, short of appointment of a conservator with full powers under Section 2355. Appointment of a conservator is usually not a feasible alternative because of the expense and the lack of a person willing to serve as the conservator of the person.

The proposed law would remedy this problem by amending the court-authorized medical treatment procedure to cover withholding or withdrawing life-sustaining treatment. These revisions would make the court's authority to order treatment (or appoint a person to make health care decisions) consistent with the scope of other surrogates' authority under the proposed Health Care Decisions Law. While the proposed law makes clear, consistent with case law, that resort to the courts is disfavored, and should only be a last resort when all other means of resolving the issue have failed, the law still needs to provide an effective and consistent remedy for the difficult cases that cannot be resolved short of judicial proceedings.

CONSERVATOR'S RESPONSIBILITY TO MAKE HEALTH CARE DECISIONS

As discussed above, the proposed law adopts a general standard for making health care decisions by surrogates, including conservators, both private and public. The Commission is not proposing in this recommendation to overhaul the health care provisions in the Guardianship-Conservatorship Law.[82] However, it is important to conform Probate Code Section 2355 governing health care decisions for conservatees who have been adjudged to lack capacity to make health care decisions. The amendments adopt some terminology of the proposed law, so that it is clear that all health care decisions are covered, including withholding and withdrawal of life-sustaining treatment, and adds the requirement that the conservator is to make decisions based on the conservatee's desires, if known, or based on a determination of the conservatee's best interest, taking into account the conservatee's personal values known to the conservator.

The proposed revision is consistent with *Conservatorship of Drabick*.[83] Incapacitated patients

> retain the right to have appropriate medical decisions made on their behalf. An appropriate medical decision is one that is made in the patient's best interests, as opposed to the interests of the hospital, the physicians, the legal system, or someone else.… To summarize, California law gives persons a right to determine the scope of their own medical treatment, this right survives incompetence in the sense that incompetent patients retain the right to have appropriate decisions made on their behalf, and Probate Code section 2355 delegates to conservators the right and duty to make such decisions.

Use of the terms "health care" and "health care decision" from the proposed Health Care Decisions Law makes clear that the scope of health care decisions that

82. See *supra* note 11.

83. 220 Cal. App. 3d 185, 205, 245 Cal. Rptr. 840 (1988) (footnotes omitted).

can be made by a conservator under this section is the same as provided in the Health Care Decisions Law.

The importance of the existing statutory language concerning the exclusive authority of the conservator and the duty this places on the conservator was also emphasized in *Drabick*:[84]

> The statute gives the conservator the exclusive authority to exercise the conservatee's rights, and it is the conservator who must make the final treatment decision regardless of how much or how little information about the conservatee's preferences is available. There is no necessity or authority for adopting a rule to the effect that the conservatee's desire to have medical treatment withdrawn must be proved by clear and convincing evidence or another standard. Acknowledging that the patient's expressed preferences are relevant, it is enough for the conservator, who must act in the conservatee's best interests, to consider them in good faith.

The intent of the rule in the proposed law is to protect and further the patient's interest in making a health care decision in accordance with the patient's expressed desires, where known, and if not, to make a decision in the patient's best interest, taking personal values into account. The necessary determinations are to be made by the conservator, whether private or public, in accordance with the statutory standard. Court control or intervention in this process is neither required by statute, nor desired by the courts.[85]

TECHNICAL MATTERS

Location of Proposed Law

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

Severance from Power of Attorney Law

Drafting health care decisionmaking rules as a separate statute should eliminate or minimize the numerous exceptions and overlays in the Power of Attorney Law (PAL), thereby improving the organization and usability of both the PAL as it

---

84. *Id.* at 211-12.

85. See, e.g., Conservatorship of Morrison, 206 Cal. App. 3d 304, 312, 253 Cal. Rptr. 530 (1988); .*Drabick*, 200 Cal. App. 3d at 198-200.

relates to property and financial matters and the law relating to health care powers.[86]

Application to Out-of-State Advance Directives

Existing law recognizes the validity of certain advance directives executed under the law of another state, or executed outside California in compliance with California law, both as to powers of attorney for health care[87] and declarations of a type permitted by the Natural Death Act.[88] The proposed law consolidates these rules and applies them to all written advance directives, thus treating individual health care instructions the same as powers of attorney.

Application to Pre-existing Instruments

The proposed law would apply to all advance directives, as broadly defined in the new law, beginning on January 1, 2000. It is unlikely that circumstances could arise where the new law would invalidate older powers of attorney or declarations under the Natural Death Act, but the proposed law makes clear that it does not affect the validity of an older instrument that was valid under prior law. The new law would not revive instruments that are invalid under existing law.[89] However, where a surrogate is required to take into account the wishes of a patient, it may be appropriate to consider and evaluate expressions of the patient's health care wishes stated in a now obsolete form.

OTHER PROCEDURES

DNR Orders

The proposed law continues the existing special procedures governing requests to forgo resuscitative measure (DNR orders)[90] with a few technical revisions for

---

86. The general rule in Probate Code Section 4050 provides that the PAL (Division 4.5 of the Probate Code) "applies to" various types of powers of attorney, including DPAHCs under Part 4 (commencing with Section 4600). Section 4051 provides that the general agency rules in the Civil Code apply to "powers of attorney" unless the PAL provides a specific rule. Section 4100 provides that Part 2 governing "Powers of Attorney Generally" applies to all powers under the division, subject to special rules applicable to DPAHCs. The general rules on creation and effect of powers of attorney are set out in Sections 4120-4130, modification and revocation are governed by Sections 4150-4155, qualifications and duties of attorneys-in-fact are in Sections 4200 — these rules apply in general to all types of powers.

Several PAL sections have special additional health care rules or exceptions: §§ 4122(d) (witnesses), 4123(d) (permissible purposes), 4128(c)(2) (warning statement), 4152(a)(4) (exercise of authority after death of principal), 4203(b) (attorney-in-fact's authority to appoint successor), 4206(c) (relation to court-appointed fiduciary)). As an exception to the general rule, Section 4260 provides that Article 3 (§§ 4260-4266) of Chapter 4 concerning authority of attorneys-in-fact does not apply to DPAHCs.

87. Prob. Code § 4653; see also Section 4752 (presumption of validity regardless of place of execution).

88. Health & Safety Code § 7192.5; see also Section 7192 (presumption of validity).

89. For example, some durable powers of attorney for health care executed between January 1, 1984, and December 31, 1991, were subject to a seven-year term (which could be extended if the term expired when the principal was incapacitated). See Prob. Code § 4654. Practically speaking, it is virtually certain that this class of powers will have expired by January 1, 2000.

90. See Prob. Code § 4753, enacted by 1994 Cal. Stat. ch. 966, § 3.

consistency with definitions under the Health Care Decisions Law. The Commission did not undertake a substantive review of the recently enacted DNR rules.

Secretary of State's Registry

Existing law requires the Secretary of State to establish a registry for durable powers of attorney.[91] The registry is intended to provide information concerning the existence and location of a person's durable power of attorney for health care. The registry is strictly voluntary. It has no effect on the validity of a power of attorney for health care,[92] nor is a health care provider required to apply to the registry for information.[93]

The proposed law continues the registry provisions, but in the interest of treating all advance health care directives equally, provides for registration of individual health care instructions on the same basis as powers of attorney for health care. The Commission has not evaluated the registry system, although the Commission is informed that as of late-1998 there were fewer than 100 filings and no inquiries had been directed to the registry system.

91. Prob. Code §§ 4800-4806. The registry was established pursuant to 1994 Cal. Stat. ch. 1280.
92. Prob. Code §§ 4804-4805.
93. Prob. Code § 4806.