Study L-4003 February 3, 2000

Memorandum 2000-5

Family Consent in Health Care Decisionmaking for Adults

This memorandum considers issues that have been raised concerning the draft Recommendation on *Family Consent in Health Care Decisionmaking for Adults*. At the November 1999 meeting, the Commission deferred approval of the draft to permit further review of a number of issues raised at the meeting. For reference purposes, a copy of the draft recommendation is attached following the Exhibit.

In addition, we have received some written proposals, which are attached in the Exhibit:

Overview

True to his word to the Commission at the November meeting, Eric Carlson, of Bet Tzedek, has supplied a draft proposal that would satisfy his concerns. (He summarizes the proposal at Exhibit p. 1.) In general, he has opted for the approach of the Uniform Health-Care Decisions Act of 1993, with some significant modifications, such as adopting the Commission's priority list over the uniform act's, and making the priority list more rigid.

The uniform act was also the starting point for the Commission's drafting, beginning in 1997. The Commission revised and reshaped the uniform act to fit into California law, taking into account important California case law and the views of interested persons, as well as the comments of the Commission's consultant, Prof. David English, who was also the reporter for the uniform act.

Priority Schemes

The basic feature of Mr. Carlson's proposal is a rigid surrogate priority scheme. (See Exhibit pp. 3-4.) He sets out surrogate classes "that resemble the categories used in intestacy statutes." (Exhibit p. 1.) These are the same classes named in the Commission's draft recommendation — the difference being the

rigidity of the priority scheme. It is no coincidence that surrogate priority schemes resemble intestate succession priorities or the order of appointment of conservators. All of these default rules attempt to describe the likely order in which family members are closest to the subject individual. There is not universal agreement even on this general level, however, as an examination of the law in different states will demonstrate.

A rigid priority scheme will necessarily yield the wrong person, in some percentage of case. This is not a problem for intestate succession. Dividing property among relatives within certain degrees of relationship can't be "wrong" — it is an arbitrary policy decision that accomplishes the goal of giving property to the typical objects of the decedent's bounty and avoids escheating the property to the state. Health care decisionmaking is not like intestate succession. Only the list of default decisionmakers is similar to intestate takers. The analysis and policy-making cannot stop with a list.

It is essential to keep in mind the fundamental principle that should guide our thinking: unlike disposition of property, the goal here is to find the person who is best suited to exercise the *patient's* right to make health care decisions. This is *not* a right or privilege of any of the listed surrogate candidates. It is the patient's right — that is why the decisionmaking standard in case law and now in Probate Code Section 4714 focuses first on the stated and known desires of the patient.

The Carlson proposal is drawn in part from Section 5 of the Uniform Health-Care Decisions Act. (See UHCDA excerpt at Exhibit pp. 9-11.) But the uniform act operates differently from the rigid list proposed by Mr. Carlson. The Carlson draft of Section 4712(a) says that a "surrogate is designated from … the list … in the listed order of priority." It is not clear to the staff how "is designated" is intended to operate. Does this mean that there is a search among each class, starting at the top? If so, who conducts this search?

The UHCDA provides that the persons in the priority list "may act as surrogate." The priority list establishes the basic rankings, but the practical operation of the scheme depends on a listed person coming forward and "assuming authority." We would expect that in the usual case, the person who assumes authority as surrogate would be the same person that would be selected under Section 4712 in the draft recommendation.

What should happen where the person assuming authority under the UHCDA or "designated" under the Carlson proposal does not meet the

standards set out in Section 4712(c) of the draft recommendation? The staff believes that this question needs to be addressed in some form.

John Doherty, AIDS Legal Services, writes in support of the Carlson proposal, but suggests consideration of a rule requiring a spouse or domestic partner acting as surrogate to seek appointment as a conservator if a majority of the patient's children disagree with the surrogate's decision. (Exhibit pp. 7-8.) He recommends this rule as a way to "alleviate some concerns generated by the strictness of the designation method." The staff does not believe this would add much to the Carlson proposal. If there is a dispute, then any of the interested persons is able to petition for a conservatorship or use other remedies. To require institution of a conservatorship is overkill, since the children could use the procedure in the Health Care Decisions Law itself or petition directly for a court-ordered health care decision under Probate Code Section 3200 *et seq.* Nor is it clear why Mr. Doherty would limit his proposal to disagreements between a majority of children and the spouse or domestic partner. The staff has offered for discussion a broader "escape hatch" rule, which is set out below as draft Section 4717.

Voting by Classes

The Carlson proposal elaborates on the majority-rule-within-class feature of the UHCDA. If there are competing surrogate candidates who disagree on a health care decision, the surrogate is the one who is supported by a majority of class members communicating to the supervising health care provider. (See subdivision (b), Exhibit p. 4). This would most appropriately apply to the classes of children, siblings, and grandchildren; we are not sure how the scheme would work as applied to friends. Mr. Carlson describes the majority rule feature as a common-sense approach. If there is an even division among communicating class members, the class and all below it are disqualified as surrogates, unless one of them is appointed as a conservator of the person of the patient. (See subdivision (c), Exhibit p. 4.) If there is an even division, the Carlson proposal permits the supervising health care provider to explain "relevant options and considerations to members of that priority level, in order to facilitate the possible reaching of consensus." (*Id.*) The staff doubts that the majority rule scheme, either in its simpler UHCDA version or the more complicated Carlson version, will work very well in practice. The Carlson version mixes up selection of the surrogate with approval of a health care decision. The surrogate should be selected to make

decisions. The class should not be voting on decisions which are then matched to a competing surrogate, if for no other reason than it may never be clear who the surrogate is, and the class would have to be polled every time a decision is needed.

In the past, the Commission considered and rejected this approach as unrealistic and mechanical. It may be common sense in a lot of areas, but this is not one where people are voting for a candidate or deciding motions in a club. Voting by classes does not apply any substantive standard to determination of the surrogate. In effect, it treats the decisionmaking process as if it were a right of the class. It may also be unrealistic to expect such a clockworks proposal to be adequately effectuated in the clinical setting. We hope to hear from the medical community on these proposals.

Does the Commission wish to re-evaluate its rejection of the UHCDA approach? If so, serious consideration should be given to adopting the "may act as surrogate" language of UHCDA Section 5(a) in place of the apparently mandatory language in the Carlson proposal.

For the sake of discussion, the staff offers a scheme combining the mechanical features of the Carlson-UHCDA approach with the standards-based rules in the Commission's draft recommendation. (See draft language at end of memorandum.) The assumption of authority within the priority list would result in a nomination of a surrogate. The primary physician (in consultation with ethics consultants or committees) would then be able to reject the nominee, based on standards like those in the draft recommendation. This would be consistent with medical ethics and existing principles as reflected in the California Healthcare Association's *Consent Manual*. This type of rule would mediate the potential for selecting the wrong person under a rigid hierarchy scheme, while also addressing the concern of Mr. Carlson and Mr. Pone that the physician is given too much authority under the draft recommendation.

In summary, there are three general approaches before us:

1. Flexible, standards-based surrogate selection, founded on medical ethics and existing practice, and reinforced by specific statutory standards and recordkeeping and notice requirements. This is the approach in the attached draft recommendation.

2. Mechanical surrogate selection scheme, with no statutory ethical standards. The role of the physician is apparently limited to explaining the situation and seeking agreement after there is discord.

3. Mechanical surrogate selection scheme, mediated by the physician's duty to apply statutory standards before accepting the nomination of the surrogate. This is a combination of schemes 1 and 2.

Court Proceedings

Under the Carlson proposal, if there is a draw among "voting" class members, that class and all lower classes are disqualified from further participation and the matter is bumped to the courts, where someone will be expected to be appointed as a conservator of the person with authority to make health care decisions. (The citation to Section 1880 on Exhibit p. 4 would not appear to be adequate, but we assume the intention is to incorporate the full panoply of conservatorship procedures, and empower decisionmaking as provided in Section 2355.)

Discussions at the November meeting also raised this issue. Daniel Pone, consultant to the Assembly Judiciary Committee, listed a number of concerns, including a clear remedy where there is disagreement between surrogates or potential surrogates.

The staff believes that the judicial remedies are clearly set out in the new Health Care Decisions Law. See Prob. Code §§ 4750-4771 (operative July 1, 2000). Section 4765 permits the following persons to petition: (a) the patient, (b) the patient's spouse, unless legally separated, (c) a relative of the patient, (d) the patient's agent or surrogate, (e) the conservator of the person of the patient, (f) the court investigator of the county where the patient resides, (g) the public guardian of the county where the patient resides, (h) the supervising health care provider or health care institution involved with the patient's care, and (i) any other interested person or friend of the patient. Section 4766 permits filing a petition for any of the following purposes:

> (a) Determining whether or not the patient has capacity to make health care decisions.
>
> (b) Determining whether an advance health care directive is in effect or has terminated.
>
> (c) Determining whether the acts or proposed acts of an agent or surrogate are consistent with the patient's desires as expressed in an advance health care directive or otherwise made known to the

court or, where the patient's desires are unknown or unclear, whether the acts or proposed acts of the agent or surrogate are in the patient's best interest.

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

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

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

In addition to this broad procedure, an interested person can petition for appointment of a conservator of the person of the patient, can petition for court authorized medical treatment, or employ any other remedy suitable in the case. **The staff does not believe that any new judicial procedures need to be added to the Health Care Decisions Law.** It may be useful, however, to provide additional cross-references or to trigger court proceedings. But we should be very reluctant to start routinely imposing burdensome procedures. This approach is undesirable and simply won't work. The Legislature has recognized and the courts have repeatedly stated that the courts are not normally the proper forum for making health care decisions, in the absence of a controversy. See, e.g., Prob. Code § 4650 & Comment. If there is a controversy, the existing procedures are perfectly adequate to resolve the issues.

In an effort to provide some additional guidance, however, we could attempt implementing a limited non-judicial (or pre-judicial) procedure, perhaps along these lines:

§ 4717. Objection to surrogate's selection or decisionmaking

4717. (a) If a surrogate has been selected pursuant to Section 4712, an individual holding a higher priority pursuant to subdivision (a) of Section 4712 may object to the selection of the surrogate or to a health care decision made by the surrogate, as provided in this section.

(b) The objector shall deliver a written objection to the primary physician and to the surrogate, stating the reasons for the objection.

(c) On learning of the objection, the primary physician, along with other health care providers or institutional committees, shall attempt to meet with the surrogate and objector in order to resolve the dispute. Until the dispute is resolved or the objection is withdrawn, the authority or decision of the surrogate is suspended.

(d) This section provides an optional procedure for formalizing an objection to surrogate selection or decisionmaking. Nothing in this section is intended to discourage other forms of communication and attempts to reach a consensus among the interested individuals.

This draft is offered for discussion. It is phrased for consistency with the version of Section 4712 in the draft recommendation, but it could be adapted to encourage mediation within a class or where there are objections from lower classes in the priority list.

Physician's Role

Mr. Carlson asks "how can a physician possibly make an objective determination of the individual 'best qualified' to be surrogate?" (Exhibit p. 2.) The answer is clear. Section 4712(b)-(f) of the draft recommendation (p. 12 of attached draft) provide a set of explicit standards and require documentation of the reasons for the selection. These standards provide concrete rules that relate directly to the fundamental purpose of selecting a surrogate: to find the person who is most likely to be the one the patient would have selected, i.e., the person who can best make decisions the patient would make if he or she could. Mr. Carlson's proposal ignores this fundamental rule. His draft appears to be focused on removing physicians from the process. His approach is typified by his claim that "[m]any physicians automatically would select an individual who agrees with the physician's recommended course of action." (Exhibit p. 2.)

Mr. Carlson raises the specter of the "HMO-dominated health care world in which the physician has limited contact with the patient" and argues that physicians "cannot be expected to select the individual 'best qualified' to be surrogate." If that is the concern, then the draft Section 4712(b)(1) has the answer: the surrogate is selected based on the priority list in subdivision (a). At this basic level, the only difference between the draft priority list and the Carlson proposal (other than the description of the class in subdivision (a)(7)) is whether there will be majority rule when there is conflict within the surrogate class.

A June 19, 1999, letter from Dr. Robert D. Orr, speaking for the California Medical Association's Council on Ethical Affairs, provides a useful overview of the important progress that would be made by the Commission's draft of Section 4712:

> Our Council very strongly supports the retention of this section. Currently, without statutory guidance on this issue, physicians follow tradition and seek family consensus or, failing consensus, endeavor to identify the person who knows the patient best and has demonstrated caring for the patient. That is, the proposal merely codifies current practice. But the proposal does [two] additional very important things:
>
> (a) It gives formal recognition to the moral standing of domestic partners. It is not uncommon currently for such individuals to be pushed to the sidelines by estranged family.
>
> (b) It gives statutory guidance to physicians in the selection of a surrogate when there is more than one individual who might qualify or think they might qualify. Currently, physicians are on their own in deciding [whom] to choose. We believe it is this non-directed physician authority to which critics appeal when they claim that physicians may merely choose the family member who agrees with them. Therefore the flexibility and statutory guidance given in [Section] 4712 (b) and (c) is a major improvement over the current practice.

Some are concerned that too much power would be vested by statute in the primary physician (notwithstanding the reality that in clinical practice, these functions are commonplace). The Commission has not set out to create this situation, but has attempted to reinforce sound, ethical practice and bring the procedure into the open. The Commission's recommendations in this area were drafted in the light of practical experience and common expectations. If there are no statutory rules concerning who can act as surrogate decisionmaker when there is no agent or conservator, this does not mean the long-standing, case-law sanctioned practice of the medical profession and families will cease. Doctors will continue to rely on close relatives and friends. Parents and children and siblings of incapacitated adults will continue to expect that they are the most appropriate persons to make decisions for their loved ones. And they are correct.

Type of Treatment

Concern has been expressed that a "one size fits all" approach is inappropriate, and that additional protections may be needed in cases involving

more serious treatments. In our discussions, mention was made of "invasive treatment" and administration of psychotropic drugs. Clearly withholding or withdrawal of life-sustaining treatment, nutrition, and hydration are in the serious category. Routine or common treatments, or "medical interventions" in the terminology of Health and Safety Code Section 1418.8, would be in a lesser category.

The Commission struggled with this sort of line-drawing when structuring the surrogate committee proposal — broader participation in the committee was required where the decision involved life-sustaining treatment or "critical health care decisions." (Section 4722 in original recommendation, 29 Cal. L. Revision Comm'n Reports at 119.) In addition, a decision on life-sustaining treatment could not be made if there were any no votes on the surrogate committee. At this point, we still do not know what language would be needed to draw the line in the family consent statute to the satisfaction of the Assembly Judiciary Committee staff. Discussions in the working group last year suggest that health care professionals have some difficulty with drawing a line based on the type of treatment. In the clinical setting, the real issue is the appropriateness of a treatment in the circumstances of the patient's condition and the patient's life circumstances. Generally speaking, particular treatments within the applicable standards of practice cannot be classed so as to meet the concerns we have heard. For example, depending on the circumstances, a tracheotomy is invasive, but may be considered routine, while administration of an antibiotic may have major consequences. It would not be appropriate to attempt a statutory catalog of medical treatments in an effort to arrange them in different procedural classes.

At the November 1999 meeting, the subject of applying different procedures in different treatment categories was discussed, but the staff has not yet found a way to implement these ideas. We have examined some of the regulations concerning "informed consent," as suggested, but have not yet discovered any useful principles for statutory implementation. There are highly detailed rules in the regulations governing different types of health care providers, but they should not and need not be added to the statutes. The more general regulations, such as those concerning patients' rights, do not make any meaningful distinctions based on the "seriousness," "invasiveness," or importance of the treatment. We find ourselves again looking at very general language, such as "serious" or "major" — but with what effect? The rules in the draft recommendation as well as those proposed by Mr. Carlson and in the UHCDA

apply to the most serious cases. If we were to find a way to distinguish "lesser" health care decisions, the result would presumably be to exempt them from the surrogate decisionmaking rules. The staff does not believe that is the intention of those who have raised this issue. But the only consequence we foresee would be to adopt the sort of simpler procedure based on the "interdisciplinary team" that is empowered to make "medical intervention" decisions under the Epple bill. (Health & Safety Code § 1418.8.) We will continue to pursue this issue, if desired, but the staff would like additional guidance.

Under proposed Section 4712, the goal is to select the best decisionmaker, not to determine a treatment. The nexus between the type of treatment and selection of the appropriate surrogate decisionmaker is not direct, and is different in kind from what applies in the situation of a "friendless" patient. Under Section 4712, we are trying to find the best *person* to make health care decisions the patient is unable to make, whatever the decisions may be. In effect, the statute is designed to find the person that would be most likely to have been selected by the patient if the patient had executed an advance directive naming a health care agent — it is a substituted judgment approach. The person selected as surrogate is then subject to the standards for surrogate decisionmaking that require fidelity to the patient's wishes and beliefs, and in the absence of knowledge of the patient's preferences, a determination of the patient's best interest. We recognize that in a number of cases, the medical team will have arrived at a conclusion concerning the recommended treatment and cannot act (barring emergency conditions) unless an authorized person can give consent. While this may telescope the two issues, even here the standards and procedure governing selection of the statutory surrogate are distinct and separate from the procedure governing the making of the health care decision for the patient.

Staff Recommendation

Based on the Commission's study of these issues since early 1996, and discussions with many interested persons, the staff does not believe the Carlson proposal is acceptable because it is too inflexible and omits critical standards. Surrogate decisionmaking is not equivalent to property division in intestate succession. **The staff believes that removal of all flexibility from the surrogate selection scheme would be a step backward. Consequently, we prefer the options in the following order:**

(1) The draft recommendation in the November 1999 form (with possible additional features, such as draft Section 4717 discussed above).

(2) A combination of the Carlson proposal and the standards-based rule, as set out in the rough draft below.

(3) Leave this subject uncodified — that is, drop this subject, at least in the near future.

It may be possible to adopt some of the UHCDA-Carlson features to address some of the concerns expressed by Mr. Carlson and Mr. Pone. At the November meeting, the Commission asked for a revised draft that would "give greater weight to the priority list and to permit recognition of a different surrogate only on a finding that persons ranked higher are not qualified to act as surrogate." To accomplish this goal, draft Section 4712 could be revised as follows:

§ 4712. Statutory surrogate

4712. (a) Subject to Sections 2355 (authority of conservator) and 4685 (authority of agent under power of attorney for health care), if no surrogate has been designated under Section 4711 or if the designated surrogate is not reasonably available, a surrogate determined pursuant to this section may ~~be selected to~~ make health care decisions for the patient ~~from among~~.

(b) Subject to Section 4713, preference to act as surrogate health care decisionmaker for the patient is given in the following order of priority to the following adults with a relationship to the patient:

(1) The spouse, unless legally separated.

(2) An adult in a long-term relationship of indefinite duration with the patient in which the individual has demonstrated an actual commitment to the patient similar to the commitment of a spouse and in which the individual and the patient consider themselves to be responsible for each other's well-being and reside or have been residing together.

(3) Children.

(4) Parents.

(5) Brothers and sisters.

(6) Grandchildren.

(7) ~~Close friends.~~ Individuals with a close personal relationship to the patient.

(b) A surrogate shall communicate his or her assumption of authority to the supervising health care provider and to all adults described in paragraphs (1) to (5), inclusive, of subdivision (a) who can readily be contacted. The supervising health care provider shall inform the surrogate of the duty under this subdivision. *[Note: This subdivision is from Section 4713 in the draft recommendation.]*

(c) If more than one member of a priority class assumes authority to act as surrogate, and the supervising health care provider is informed that they do not agree on a health care decision, the surrogate supported by the majority of the members of the class who have communicated their views to the supervising health care provider has authority and shall be recognized as the surrogate. *[Note: This is a simplified version of Section 4712(b) of the Carlson proposal.]*

(d) If there is no majority in favor of a surrogate under subdivision (c), the members of that priority class and all individuals in lower classes are disqualified from assuming authority under this section. *[Note: This is a simplified version of Section 4712(c) of the Carlson proposal.]*

§ 4713. Disqualification of surrogate *[Note: This section is drawn from language that was in draft recommendation Section 4712.]*

4713. (a) If a surrogate who assumes authority under Section 4712 does not meet the standards provided in this section, the primary physician, after consultation with other health care providers or institutional committees and other interested persons, may refuse to accept his or her authority.

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

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

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

~~(c) In determining the individual best qualified to serve as the surrogate under this section,~~

(b) To determine whether an individual is qualified to act as a surrogate under Section 4712, the following factors shall be considered and applied:

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

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

(3) Demonstrated care and concern for the patient.

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

(5) Availability to visit the patient.

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

~~(d)~~ (c) An individual may not ~~be selected~~ act as a surrogate if the individual's competence or motives are questionable.

~~(e)~~ (d) The primary physician may require a surrogate or proposed surrogate (1) to provide information to assist in making the determinations under this section and (2) to provide information to family members and other persons concerning the selection of the surrogate and communicate with them concerning health care decisions for the patient.

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

Miscellaneous Issues

Mr. Carlson proposes requiring the surrogate who assumes authority to execute a written verification under penalty of perjury that notice has been given to other adults in the top five surrogate classes. (See Section 4713 as revised at Exhibit p. 6.) This goes beyond the UHCDA provision and the draft recommendation. If this proposal answers a real need, the staff would accept it.

The revision of Section 4716 in the Carlson proposal (Exhibit p. 6) will depend on what scheme the Commission settles on.

Schedule

Earlier, the Commission decided to seek enactment of a "family consent" bill in the 2000 session. (See Minutes of October 1999 Meeting, pp. 10-11.) Finalizing the recommendation was deferred until the November 1999 meeting, to allow additional time for comments from interested persons. At the November meeting, the Commission decided to continue working to resolve issues raised by Mr. Carlson and Mr. Pone, and necessarily deferred approving a final recommendation until the issues in this memorandum can be addressed. In the interim, the staff requested bill drafts from Legislative Counsel to meet drafting deadlines (one draft contains the November draft recommendation; the other is a spot bill). We have also sought potential authors for the bill, but it has been difficult to generate much enthusiasm in legislative staff circles since the content of the bill is still unsettled. By the time the Commission has been able to resolve the issues to its satisfaction, it will probably be too late to get a bill in this year — February 25 is the bill introduction deadline. Of course, if a legislator were sufficiently interested in the subject and in agreement with the Commission's

fundamental approach, the language can always be worked out and amended in later after the bill is introduced.

The staff is not optimistic about moving forward this year. In view of the importance of this subject and the intricacies of the drafts and various alternatives, it may be better to continue working on the draft and circulate a new proposal as a tentative recommendation over the summer. This would give all the interested persons time to analyze the proposal and give the Commission their comments.

Respectfully submitted,

Stan Ulrich
Assistant Executive Secretary

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January 11, 2000

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Re: Family Consent in Health Care Decisionmaking; Commission Memorandum 99-82

Dear Stan:

Attached to this letter are proposed revisions to Memorandum 99-82. The proposed revisions set up the following decisionmaking framework:

- If a patient has not designated a surrogate, a surrogate is designated through priority levels that resemble the categories used in intestacy statutes.
- Disagreements between individuals in the same priority level are resolved on a majority-rules basis, using language from the Uniform Health-Care Decisions Act. If such individuals are evenly divided, no surrogate is designated, although any individual remains free to seek decisionmaking authority by petitioning for a conservatorship of the person.
- The authority of a surrogate designated by priority level is terminated if another individual is granted health care decisionmaking authority through a conservatorship of the person, or if termination of authority is ordered through the petition process established by the 1999 Health Care Decisions Law.
- A designated surrogate must notify interested parties (primarily the patient's family members) of the surrogate's assumption of authority, and must provide the health care provider with verification of this notification. This notification obligation must be communicated to the surrogate by the health care provider.

The proposed revisions set up a common-sense approach to the designation of a surrogate -- a priority mechanism is employed, disputes are resolved through a majority-rules principle, and court petitions can be used to break ties or to intervene in cases in which the priority mechanism leads to a bad result.

We believe that the proposed revisions are far superior to the current language of Memorandum 99-82, which essentially authorizes the patient's physician to select the individual "best qualified" to be surrogate. Such authority violates a basic principle of health care decisionmaking: under longstanding legal principles, a physician provides medical expertise but ultimate decisions are made by the patient or patient's representative:

> [T]hese standards [relating to patients' rights] cannot exist in a social and moral vacuum, thereby encouraging a form of medical paternalism under which the physician's determination of what is "best," *i.e.*, medically desirable, controls over patient autonomy. Doctors have the responsibility to advise patients fully of those matters relevant and necessary to making a voluntary and intelligent choice. Once that obligation is fulfilled, if the patient rejected the doctor's advice, the onus of that decision would rest on the patient, not the doctor. Indeed, if the patient's right to informed consent is to have any meaning at all, it must be accorded respect even when it conflicts with the advice of the doctor or the values of the medical profession as a whole.[1]

In practical terms, how can a physician possibly make an objective determination of the individual "best qualified" to be surrogate? Many physicians automatically would select an individual who agrees with the physician's recommended course of action. More conscientious physicians would struggle with the obvious conflict of interest inherent in the current language of Memorandum 99-82, not to mention the difficulty of drawing conclusions regarding the character of a patient's relatives and friends.

In short, physicians cannot be expected to select the individual "best qualified" to be surrogate, particularly in an HMO-dominated health care world in which the physician has limited contact with the patient. A court is the logical entity to adjudicate disputes in the relatively rare instances when a priority mechanism will not resolve matters.

We applaud you and the Commission for your careful consideration of these issues. Please feel free to call with questions or suggestions.

Sincerely,

Eric M. Carlson, Esq.
Director, Nursing Home Advocacy Project

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[1] *Thor v. Superior Court*, 5 Cal. 4th 725, 742-43, 21 Cal. Rptr. 2d 357, 368 (1993) (citations omitted).

Family Consent in Health Care Decisionmaking in Adults
Commission Memorandum 99-82

Proposed Revisions

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January 11, 2000

SECTION 1. Section 4712 is added to the Probate Code, to read:

4712. (a) Subject to Sections 2355 (authority of conservator) and 4685 (authority of agent under power of attorney for health care), if no surrogate has been designated under Section 4711 or if the designated surrogate is not reasonably available, a surrogate is designated from ~~may be selected to make health care decisions for the patient from among~~ the following list of adults with a relationship to the patient, in the listed order of priority:

(1) The spouse, unless legally separated.

(2) An adult in a long-term relationship of indefinite duration with the patient in which the individual has demonstrated an actual commitment to the patient similar to the commitment of a spouse and in which the individual and the patient consider themselves to be responsible for each other's well-being and reside or have been residing together. ~~This individual may be known as a domestic partner.~~

(3) Children.

(4) Parents.

(5) Brothers and sisters.

(6) Grandchildren.

(7) Individuals with a close personal relationship to the patient. ~~Close friends~~.

(b) If more than one member of a priority level assumes authority to act as surrogate, and the supervising health care provider is informed that those members do not agree on a health care decision, the supervising health care provider shall comply with the decision of a majority of the members of that priority level who have communicated their views to the provider, by accepting as a surrogate the majority-group member who has assumed authority to act as surrogate. The health care provider's obligation to obtain informed consent shall extend only to those members who assume authority to act as surrogate.[1]

(c) If, based on views communicated to the supervising health care provider, the members of a priority level are evenly divided concerning a health care decision, the members of that priority level, and all individuals at a lower priority level, are disqualified from making the decision, unless and until one or more of those individuals is granted authority over the patient's health care decisions pursuant to Section 1880. In the case of an even division within a priority level, the supervising health care provider may explain relevant options and considerations to members of that priority level, in order to facilitate the possible reaching of consensus.

(d) If, pursuant to Section 4766(d), the authority of an agent or surrogate is terminated, the priority list of subsection (a) shall be applied without reference to the individual whose authority has been terminated.

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

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

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

[1] The majority-rules concept of subsections (b) and (c) is based on section 5(e) of the Uniform Health-Care Decisions Act, which is the source of some of the language.

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

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

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

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

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

~~(5) Availability to visit the patient.~~

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

~~(d) An individual may not be selected as a surrogate if the individual's competence or motives are questionable.~~

~~(e) The primary physician may require a surrogate or proposed surrogate (1) to provide information to assist in making the determinations under this section and (2) to provide information to family members and other persons concerning the selection of the surrogate and communicate with them concerning the selection of the surrogate and communicate with them concerning health care decisions for the patient.~~

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

SECTION 2. Section 4713 is added to the Probate Code, to read:

4713. (a) The surrogate designated ~~or selected~~ under this chapter shall promptly communicate his or her assumption of authority to all adults described in paragraphs (1) to (5), inclusive, of subdivision (a) of Section 4712 who can readily be contacted, and provide written verification to the supervising health care provider, under penalty of perjury, that the required communication has been performed.[2]

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

SECTION 3. Section 4716 is added to the Probate Code, to read:

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

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

[2] The language of a verification form could be developed by health care providers or, if deemed necessary, specified by statute.

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January 13, 2000

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

Re: Family Consent in Health Care Decisionmaking; Commission Memorandum 99-82

Dear Stan:

Attached to this letter are additional comments to Memorandum 99-82. I have spoken with Eric Carlson at Bet Tzedek Legal Services and am in support of his comments and recommendations. However, I had an additional paragraph that could be incorporated into Section 4712 of Mr. Carlson's proposed revisions in order to alleviate some concerns generated by the strictness of the designation method.

The purpose of my comments are to give the Commission one possible way to add additional safeguards against questionable surrogate decisions. The proposal would:

- Require a surrogate of priority level 1 or 2 to seek authority over the patient's health care decisions pursuant to Section 1880, if a majority of the children disagree with the surrogate's decision.
- Limit this safeguard to disagreements between priority levels 1, 2, and 3.
- Encourage mediation by the supervising health care provider in these disputes.

Thanks in advance for your time and consideration.

Sincerely,

John F. Doherty
Directing Attorney

Family Consent in Health Care Decisionmaking in Adults
Commission Memorandum 99-82

Proposed Revisions

Submitted By: John Doherty, Esq.
AIDS Legal Services
San Jose, CA
(408) 280-2406

January 13, 2000

Insert the following language into the proposed revisions submitted by Eric Carlson:

SECTION 1. Section 4712 is added to the Probate Code, to read:

(d) If, based on views communicated to the supervising health care provider, a majority of the children of the patient are in disagreement with a surrogate of priority level 1 or 2, as described by subdivision (a) of this Section, the members of that priority level, and all individuals at a lower priority level, are disqualified from making the decision, unless and until one or more of those individuals is granted authority over the patient's health care decisions pursuant to Section 1880. In this event, the supervising health care provider may explain relevant options and considerations to these parties, in order to facilitate the possible reaching of consensus.

(~~d~~e) If, pursuant to Section 4766(d), the authority of an agent or surrogate is terminated, the priority list of subsection (a) shall be applied without reference to the individual whose authority has been terminated.

Excerpt from Uniform Health-Care Decisions Act (1993)

SECTION 5. DECISIONS BY SURROGATE.

(a) A surrogate may make a health-care decision for a patient who is an adult or emancipated minor if the patient has been determined by the primary physician to lack capacity and no agent or guardian has been appointed or the agent or guardian is not reasonably available.

(b) An adult or emancipated minor may designate any individual to act as surrogate by personally informing the supervising health-care provider. In the absence of a designation, or if the designee is not reasonably available, any member of the following classes of the patient's family who is reasonably available, in descending order of priority, may act as surrogate:

(1) the spouse, unless legally separated;

(2) an adult child;

(3) a parent; or

(4) an adult brother or sister.

(c) If none of the individuals eligible to act as surrogate under subsection (b) is reasonably available, an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, and who is reasonably available may act as surrogate.

(d) A surrogate shall communicate his or her assumption of authority as promptly as practicable to the members of the patient's family specified in subsection (b) who can be readily contacted.

(e) If more than one member of a class assumes authority to act as surrogate, and they do not agree on a health-care decision and the supervising health-care provider is so informed, the supervising health-care provider shall comply with the decision of a majority of the members of that class who have communicated their views to the provider. If the class is evenly divided concerning the health-care decision and the supervising health-care provider is so informed, that class and all individuals having lower priority are disqualified from making the decision.

(f) A surrogate shall make a health-care decision in accordance with the patient's individual instructions, if any, and other wishes to the extent known to the surrogate. Otherwise, the surrogate shall make the decision in accordance with the surrogate's determination of the patient's best interest. In determining the patient's best interest, the

surrogate shall consider the patient's personal values to the extent known to the surrogate.

(g) A health-care decision made by a surrogate for a patient is effective without judicial approval.

(h) An individual at any time may disqualify another, including a member of the individual's family, from acting as the individual's surrogate by a signed writing or by personally informing the supervising health-care provider of the disqualification.

(i) Unless related to the patient by blood, marriage, or adoption, a surrogate may not be an owner, operator, or employee of [a residential long-term health-care institution] at which the patient is receiving care.

(j) A supervising health-care provider may require an individual claiming the right to act as surrogate for a patient to provide a written declaration under penalty of perjury stating facts and circumstances reasonably sufficient to establish the claimed authority.

Comment

Subsection (a) authorizes a surrogate to make a health-care decision for a patient who is an adult or emancipated minor if the patient lacks capacity to make health-care decisions and if no agent or guardian has been appointed or the agent or guardian is not reasonably available. Health-care decision making for unemancipated minors is not covered by this section. The subject of consent for treatment of minors is a complex one which in many states is covered by a variety of statutes and is therefore left to other state law.

While a designation of an agent in a written power of attorney for health care is preferred, situations may arise where an individual will not be in a position to execute a power of attorney for health care. In that event, subsection (b) affirms the principle of patient autonomy by allowing an individual to designate a surrogate by personally informing the supervising health-care provider. The supervising health-care provider would then, in accordance with Section 7(b), be obligated to promptly record the designation in the individual's health-care record. An oral designation of a surrogate made by a patient directly to the supervising health-care provider revokes a previous designation of an agent. See Section 3(a).

If an individual does not designate a surrogate or if the designee is not reasonably available, subsection (b) applies a default rule for selecting a family member to act as surrogate. Like all default rules, it is not tailored to every situation, but incorporates the presumed desires of a majority of those who find themselves so situated. The relationships specified in subsection (b) include those of the half-blood and by adoption, in addition to those of the whole blood.

Subsection (c) permits a health-care decision to be made by a more distant relative or unrelated adult with whom the individual enjoys a close relationship but only if all family members specified in subsection (b) decline to act or are otherwise not reasonably available. Consequently, those in non-traditional relationships who want to make certain that health-care decisions are made by their companions should execute powers of attorney for health care designating them as agents or, if that has not been done, should designate them as surrogates.

Subsections (b) and (c) permit any member of a class authorized to serve as surrogate to assume authority to act even though there are other members in the class.

Subsection (d) requires a surrogate who assumes authority to act to immediately so notify the members of the patient's family who in given circumstances would be eligible to act as surrogate. Notice to the specified family members will enable them to follow health-care developments with respect to their now incapacitated relative. It will also alert them to take appropriate action, including the appointment of a guardian or the commencement of judicial proceedings under Section 14, should the need arise.

Subsection (e) addresses the situation where more than one member of the same class has assumed authority to act as surrogate and a disagreement over a health-care decision arises of which the supervising health-care provider is informed. Should that occur, the supervising health-care provider must comply with the decision of a majority of the members of that class who have communicated their views to the provider. If the members of the class who have communicated their views to the provider are evenly divided concerning the health-care decision, however, then the entire class is disqualified from making the decision and no individual having lower priority may act as surrogate. When such a deadlock arises, it may be necessary to seek court determination of the issue as authorized by Section 14.

Subsection (f) imposes on surrogates the same standard for health-care decision making as is prescribed for agents in Section 2(e). The surrogate must follow the patient's individual instructions and other expressed wishes to the extent known to the surrogate. To the extent such instructions or other wishes are unknown, the surrogate must act in the patient's best interest. In determining the patient's best interest, the surrogate is to consider the patient's personal values to the extent known to the surrogate.

Subsection (g) provides that a health-care decision made by a surrogate is effective without judicial approval. A similar provision applies to health-care decisions made by agents (Section 2(f)) or guardians (Section 6(c)).

Subsection (h) permits an individual to disqualify any family member or other individual from acting as the individual's surrogate, including disqualification of a surrogate who was orally designated.

Subsection (i) disqualifies an owner, operator, or employee of a residential long-term health-care institution at which a patient is receiving care from acting as the patient's surrogate unless related to the patient by blood, marriage, or adoption. This disqualification is similar to that for appointed agents. See Section 2(b) and Comment.

Subsection (j) permits a supervising health-care provider to require an individual claiming the right to act as surrogate to provide a written declaration under penalty of perjury stating facts and circumstances reasonably sufficient to establish the claimed relationship. The authority to request a declaration is included to permit the provider to obtain evidence of claimed authority. A supervising health-care provider, however, does not have a duty to investigate the qualifications of an individual claiming authority to act as surrogate, and Section 9(a) protects a health-care provider or institution from liability for complying with the decision of such an individual, absent knowledge that the individual does not in fact have such authority.

FAMILY CONSENT IN HEALTH CARE DECISIONMAKING FOR ADULTS

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] the 1983 Durable Power of Attorney for Health Care,[2] and the 1999 Health Care Decisions Law.[3] However, California law does not yet adequately address a number of important issues in the law concerning health care decisionmaking for adults who are unable to make decisions for themselves.

This recommendation proposes amendments to the new Health Care Decisions Law to recognize the role of close family members and friends in making decisions for adults without decisionmaking capacity and to codify ethical standards for selecting the best surrogate decisionmaker where there is no authorized agent under a power of attorney for health care or conservator with health care decisionmaking powers.

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 health care directives.[4] The law,

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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. See former Prob. Code § 4600 *et seq.* (repealed by 1999 Cal. Stat. ch. 658, § 38). 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).

3. 1999 Cal. Stat. ch. 658, enacted on Commission recommendation. See *Health Care Decisions for Adults Without Decisionmaking Capacity*, 29 Cal. L. Revision Comm'n Reports 1 (1999). For legislative history, see 29 Cal. L. Revision Comm'n Reports 604-05 (1999).

4. 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 (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,

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. The right of incapacitated adults to have appropriate decisions made when they cannot do so[5] should be recognized in the law.

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 them in the group of persons "with legal authority to make medical treatment decisions on behalf of a patient."[6]

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*,[7] 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 available 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.

While this language is not a holding of the case,[8] *Cobbs* has frequently been cited in later cases involving consent or withdrawal of consent to medical treatment, and

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particularly 42 U.S.C.A. §§ 1395cc(a), 1396a(w)(1) (Westlaw 1998)) 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.

5. For a persuasive articulation of this perspective, see *Conservatorship of Drabick*, 220 Cal. App. 3d 185, 245 Cal. Rptr. 840 (1988):

> 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.

6. Health & Safety Code § 1418.8(c).

7. 8 Cal. 3d 229, 243-44, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) (citations omitted).

8. 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.

in medical decisionmaking guidelines routinely used in the medical profession and distributed to patients.

The leading case of *Barber v. Superior Court* [9] 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 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.

9. 147 Cal. App. 3d 1006, 1020-21, 195 Cal. Rptr. 484 (1983).

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."[10]

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.
>
> (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.

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

(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 is likely in practice that these are the persons doctors will ask, as stated in the pamphlet.[11]

11. 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 2-17 (26th ed. 1999) ("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.").

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.[12]

Priority schemes among relatives and friends seem natural. Intestate succession law[13] 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.[14] 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:[15]

> 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.

The Uniform Health-Care Decisions Act[16] lists the familiar top four classes of surrogates (spouse, children, parents, siblings), but is less restrictive than many state statutes in several respects:[17]

(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

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12. See generally 2 A. Meisel, The Right to Die §§ 14.1-14.10 (2d ed. 1995).
13. Prob. Code § 6400 *et seq*.
14. Prob. Code § 1812.
15. 2 A. Meisel, The Right to Die § 14.1, at 249-50 (2d ed. 1995).
16. 9 (Pt. 1) U.L.A. 285 (West Supp. 1998) [hereinafter UHCDA].
17. UHCDA § 5.

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, in 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."[18]

(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."[19] 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,[20] but the health care decision is made by an "interdisciplinary team."

Statutory Surrogates — "Family Consent" — 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 based on the patient's desires or, where not known, should be made 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.

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18. English, *Recent Trends in Health Care Decisions Legislation* 17 (1998) (unpublished manuscript, on file with California Law Revision Commission); see also English, *The Health-Care Decisions Act Represents a Major Advance*, 133 Tr. & Est. 32, 37 (May 1994).

19. 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.").

20. 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:[21]

> 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 from the patient, (2) a domestic partner,[22] (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 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.[23] An individual who is positioned lower in the statutory list may be selected as the surrogate if, in the individual is best qualified to serve as the patient's surrogate, based on a number of statutory standards. These rules are directly related to the fundamental principal that the law should attempt to find the best surrogate — the person 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:

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21. 2 A. Meisel, The Right to Die § 14.4 at 255 (2d ed. 1995) (footnotes omitted).

22. 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.…"

23. The recommended procedure is drawn, in part, from West Virginia law. See W.Va. Code § 16-30B-7 (Westlaw 1999). 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 Section 4714.

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

(3) Demonstrated care and concern for the patient.

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

(5) Availability to visit the patient.

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

The statute also makes clear that an individual may not be selected as a surrogate if the individual's competence or motives are questionable.[24]

Moreover, the process of applying these standards and making the required determinations 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 should reduce 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, however, 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.[25] 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.[26] 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.

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24. This standard is drawn from the California Healthcare Ass'n, Consent Manual 2-17 (26th ed. 1999).

25. UHCDA § 5.

26. 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).

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 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. The surrogate is required to communicate the assumption of surrogate's authority to other adults in the first five categories of statutory surrogates: spouse, domestic partner, children, parents, and siblings. Potential surrogates or other interested persons 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[27] or seek appointment of a conservator.

Like the UHCDA, the proposed law gives priority over the statutory list to a surrogate who has been designated by the patient.[28]

27. See Prob. Code § 4750 *et seq.*

28. See Prob. Code § 4711 (patient's designation of surrogate).

PROPOSED LAW

☞ **Note.** For the reader's convenience, this report includes the complete text of Chapter 3 (commencing with Section 4711) of Part 2 of Division 4.7 of the Probate Code (as enacted by 1999 Cal. Stat. ch. 658, operative July 1, 2000), as proposed to be amended. Unchanged provisions from the Health Care Decisions Law are so indicated in the section heading.

CHAPTER 3. HEALTH CARE SURROGATES

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

4711. A patient may designate an adult as a surrogate to make health care decisions by personally informing the supervising health care provider. An oral designation of a surrogate shall be promptly recorded in the patient's health care record and is effective only during the course of treatment or illness or during the stay in the health care institution when the designation is made.

Comment. The first sentence of Section 4711 is drawn from Section 5(b) of the Uniform Health-Care Decisions Act (1993). Both the patient and the surrogate must be adults. See Sections 4625 ("patient" defined), 4643 ("surrogate" defined). "Adult" includes an emancipated minor. See Fam. Code § 7002 (emancipation). "Personally informing," as used in this section, includes both oral and written communications. The second sentence is intended to guard against the possibility of giving effect to obsolete oral statements entered in the patient's record.

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

Background from Uniform Act. While a designation of an agent in a written power of attorney for health care is preferred, situations may arise where an individual will not be in a position to execute a power of attorney for health care. In that event, [Prob. Code § 4711] affirms the principle of patient autonomy by allowing an individual to designate a surrogate by personally informing the supervising health-care provider. The supervising health-care provider would then, in accordance with Section 7(b) [Prob. Code § 4731], be obligated to promptly record the designation in the individual's health-care record. An oral designation of a surrogate made by a patient directly to the supervising health-care provider revokes a previous designation of an agent. See Section 3(a) [Prob. Code § 4695(a)]. [Adapted from Unif. Health-Care Decisions Act § 5(b) comments (1993).]

Prob. Code § 4712 (added). Selection of statutory surrogate

SECTION 1. Section 4712 is added to the Probate Code, to read:

4712. (a) Subject to Sections 2355 (authority of conservator) and 4685 (authority of agent under power of attorney for health care), if no surrogate has been designated under Section 4711 or if the designated surrogate is not reasonably available, a surrogate may be selected to make health care decisions for the patient from among the following adults with a relationship to the patient:

(1) The spouse, unless legally separated.

(2) An adult in a long-term relationship of indefinite duration with the patient in which the individual has demonstrated an actual commitment to the patient similar to the commitment of a spouse and in which the individual and the patient

consider themselves to be responsible for each other's well-being and reside or have been residing together.

(3) Children.

(4) Parents.

(5) Brothers and sisters.

(6) Grandchildren.

(7) Close friends.

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

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

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

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

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

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

(3) Demonstrated care and concern for the patient.

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

(5) Availability to visit the patient.

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

(d) An individual may not be selected as a surrogate if the individual's competence or motives are questionable.

(e) The primary physician may require a surrogate or proposed surrogate (1) to provide information to assist in making the determinations under this section and (2) to provide information to family members and other persons concerning the selection of the surrogate and communicate with them concerning health care decisions for the patient.

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

Comment. Section 4712 is a new provision, drawn in part from West Virginia law and the Uniform Health-Care Decisions Act (1993). See W.Va. Code § 16-30B-7 (Westlaw 1999); Unif. Health-Care Decisions Act § 5(b)-(c) (1993). Subdivision (a)(2) is drawn in part from New Mexico law. See N.M. Stat. Ann. § 24-7A-5(B)(2) (Westlaw 1999). The person described in subdivision (a)(2), commonly known as a "domestic partner," may or may not satisfy the definition in Family Code Section 297. Qualification under subdivision (a)(2) is intended only to apply to the surrogate decisionmaking rules in this division, the Health Care Decisions Law.

"Adult" includes an emancipated minor. See Fam. Code § 7002 (emancipation). A prospective surrogate and other persons may also seek judicial relief as provided in Sections 4765-4766. Subdivision (d) recognizes existing practice. See California Healthcare Ass'n, Consent Manual 2-17 (26th ed. 1999).

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

Prob. Code § 4713 (added). Notice to other potential surrogates

SEC. 2. Section 4713 is added to the Probate Code, to read:

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

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

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

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

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

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

Prob. Code § 4714 (unchanged). Standard governing surrogate's health care decisions

4714. A surrogate, including a person acting as a surrogate, shall make a health care decision in accordance with the patient's individual health care instructions, if any, and other wishes to the extent known to the surrogate. Otherwise, the surrogate shall make the decision in accordance with the surrogate's determination of the patient's best interest. In determining the patient's best interest, the surrogate shall consider the patient's personal values to the extent known to the surrogate.

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

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

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

Prob. Code § 4715 (unchanged). Disqualification of surrogate

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

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

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

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

Prob. Code § 4716 (added). Reassessment of surrogate selection

SEC. 3. Section 4716 is added to the Probate Code, to read:

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

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

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

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