#L-703 7/9/82

Memorandum 82-69

Subject: Study L-703 - Consent to Health Care

In January we distributed a draft of the Uniform Health Care Consent Act [January 1982 Draft] for review and comment. (A copy of this draft is attached to this memorandum.) This draft of the Uniform Act has been superseded by a later version prepared for consideration this summer at the annual meeting of the Uniform Law Commissioners.

The letters we have received in response to the request for comments on the January 1982 draft of the Uniform Act are attached as exhibits to this memorandum.

The staff has prepared a draft of a recommendation drawn in part from the January 1982 draft of the Uniform Act. The staff proposes that this recommendation be approved for printing, incorporating any changes made at the meeting. We would then be in a position to introduce a bill on this subject in the 1983 session of the Legislature.

General Reaction to Draft Uniform Health Care Consent Act

The prefatory note to the Uniform Health Care Consent Act [January 1982 Draft] characterizes the act as procedural and narrow in scope. It is primarily concerned with who can consent to health care, whether for oneself or for others.

The general reaction of those who submitted comments on the uniform act was negative insofar as concerns adopting the complete act. Some thought the uniform act too narrow or inflexible. See Exhibit 1 (California Hospital Association), Exhibit 3 (California Nurses Association), and Exhibit 9 (Luther Avery). Others found it to be unnecessary or largely duplicative of existing law. See Exhibits 2 (California Medical Association), Exhibit 7 (Department of Aging), Exhibit 8 (Rodney Atchison and Susan Nevelow Mart), and Exhibit 11 (Kenneth James Arnold). A minority consider the uniform act desirable. See Exhibit 4 (National Retired Teachers Association and American Association of Retired Persons) and Exhibit 5 (Frederick Bold, Jr.).

As discussed in Memorandum 82-4, considered at the January 1982 meeting of the Commission, the power to appoint a health care representative was of particular interest to the staff, since there is doubt

concerning whether health care providers will rely on consent to health care given by an attorney in fact under a power of attorney. It was suggested that a power of appointment would be a useful procedure short of appointing a conservator or obtaining court approval to health care.

The provisions of the Uniform Health Care Consent Act [January 1982 Draft] relating to appointment of a health care representative (Section 6) and disqualification of persons otherwise able to consent (Section 8) received the most favorable reactions from the persons who commented. See Exhibits 1, 3, 7, 8, 9, 11, and 13. Specific comments are considered in the discussion of policy issues which follows.

Policy Questions

Scope of Recommendation

The attached staff draft is limited to provisions for the appointment of a health care representative and for disqualifying certain persons from the power to consent to health care for another. The other aspects of the Uniform Health Care Consent Act [January 1982 Draft] are adequately covered by existing California law. Some commentators have suggested that the Commission consider the whole area of consent and the question of what is informed consent. See, e.g., Exhibit 3 (California Nurses Association). However, the staff believes that a recommendation in this area should be limited in scope if it is to have any chance of being enacted.

Need for Power of Appointment of Health Care Representative

The Uniform Health Care Consent Act [January 1982 Draft] states in the Prefatory Note and in the Comment to Section 6 that the power to appoint a health care representative is consistent with the Uniform Durable Power of Attorney Act and that Section 6 is unnecessary in a jurisdiction that has enacted the Uniform Durable Power of Attorney Act. This act was enacted in California in 1981 on Commission recommendation. See Civil Code §§ 2400-2407. However, the staff is not convinced that the Uniform Durable Power of Attorney Act was designed to deal with health care decisions, notwithstanding the ex post facto comments in the later draft uniform act. It is highly probable that many health care providers would refuse to rely on consent given by an attorney in fact in a case where the principal has become incompetent. Accordingly, the staff believes that there is a definite need for the power to appoint a health care representative.

As a corollary to this view, the staff proposes in the staff draft that it be made clear that an attorney in fact is not empowered to make health care decisions for the principal unless the power of attorney complies with the formalities of the appointment of a health care representative.

In What Ways Should Power of Health Care Representative be Limited?

The California Nurses Association expresses some concern over the provision in the draft uniform act that permits the health care representative to consent to health care for an appointor who is capable of consenting. See Exhibit 3. CNA suggests that the health care representative be empowered to act only if the appointor becomes incapable of consenting. The staff draft does not so limit the power of the health care representative. The appointor is permitted to revoke an appointment orally or in writing at any time or to revoke any specific authority in an appointment. In addition, the appointor is free to set forth in the appointment any limitations on the authority of the health care representative that he or she desires.

The California Nurses Association also suggests that the duration of appointments be subject to a five-year limit. The staff draft rejects this suggestion for the same reason. The appointor is free to limit the appointment when it is made or to revoke it at any time thereafter.

You should note that Section 2438 in the staff draft limits the authority of a health care representative in several sensitive areas, such as commitment to a mental hospital or consent to experimentation.

The staff draft gives the health care representative the same power to consent for the appointor as the health care representative has to consent to his or her own health care. In our view, this gives the health care representative power to "pull the plug," unless the appointment limits the authority of the representative. One criticism of the January 1982 Draft of the Uniform Act was that it prevented this type of decision by a health care representative. See Exhibit 1 (letter of February 26, 1982). The draft of the Uniform Health Care Consent Act prepared for consideration this summer does not so limit the health care representative, but instead provides that it does not affect the law relating to withdrawing or withholding life-sustaining procedures from a terminally ill individual.

Who Should be Qualified to be a Health Care Representative?

The staff draft permits any adult to be appointed as a health care representative. Mr. Luther J. Avery suggests in Exhibit 9 that there is a danger if persons with a financial interest in a decision to withhold medical care or to prolong life can be appointed as health care representatives. In this connection, the Commission should consider Health and Safety Code Section 7188.5 which provides that a directive to withhold or withdraw life-sustaining procedures under the Natural Death Act is not effective if the declarant is a patient in a skilled nursing facility unless one of the witnesses to the directive is a patient advocate or ombudsman designated by the Department of Aging. Does the Commission wish to provide any special limits on who may be appointed as a health care representative in response to this concern?

Qualifications of Witness to Appointment

The staff draft provides no special qualifications for a witness to an appointment of a health care representative except that the witness must be a person other than the health care representative. The National Notary Association suggests in Exhibit 13 that the witness should be "an impartial third party, such as a Notary Public." The staff recommends against this suggestion since it would add some expense and practical complications. There is no notarization requirement under the Uniform Durable Power of Attorney Act or under the Natural Death Act.

Need for Power to Disqualify Persons Otherwise Empowered to Consent

Section 2436 in the staff draft is drawn from Section 8 of the Uniform Health Care Consent Act [January 1982 Draft] which permits a person to disqualify another person from consenting to health care for him or her. Several commentators approved of this provision. See Exhibits 8, 9, and 11. The California Nurses Association suggests that it is only useful to disqualify a person who could consent to health care for another who becomes incapable of consenting. See Exhibit 3. The staff is unsure of the practical utility of or need for this section. The Comment to Section 8 of the uniform act states that "a full recognition of individual autonomy requires . . . that he also be authorized to say who he does not want to act for him." Should this provision be retained in the recommendation?

Respectfully submitted,

Stan G. Ulrich
Staff Counsel

Memo 82-69

Exhibit 1

California Hospital Association
1023 12th Street Sacramento, CA 95814 916/443-7401

February 10, 1982

John H. DeMoully
Executive Secretary
California Law Revision Commission
4000 Middlefield Road, Room D-2
Palo Alto, CA 94306

Dear Mr. DeMoully:

Thank you for the opportunity to review the proposed working draft of a Uniform Health Care Consent Act.

At this point in time I can offer two comments only:

1. I am not convinced that California patients would benefit from the adoption of a Uniform Act in general.

2. The proposed draft does not appear to offer the provider the same degree of flexibility presently in usage by custom and practice, with respect to obtaining consent involving incompetent patients, but appears to more strictly require additional written documentation which may have the effect of further restricting the managerial/physician decision-making prerogatives currently in place.

I am pleased to assist further should you so desire.

Let me know your thoughts.

Incidentally, I am unfamiliar with the attorneys listed as comprising the Drafting Committee. Do you have any further background regarding the committee members?

Sincerely,

Keith W. Walley

Keith W. Walley
Vice President for Corporate
Management and Development

KWW:eml

February 24, 1982

Keith W. Walley
Vice President for Corporate
Management and Development
California Hospital Association
1023 - 12th Street
Sacramento, CA 95814

Dear Mr. Walley:

I appreciate your prompt response to our request for comments on the working draft of a Uniform Health Care Consent Act. This act is being developed by a drafting committee of the National Conference of Commissioners on Uniform State Laws. The members of the Conference consist of practicing attorneys, law professors, and others appointed to the Conference by the various states. I do not readily have available background information regarding the committee members.

You indicate you believe that the adoption of the Uniform Act in general would not be to the benefit of California patients. In this connection, you may be interested in the enclosed article which appeared in an issue of the CTLA Forum (published by the California Trial Lawyer's Association) which I received today. I do not agree with the conclusions of the writer of this article.

Vol. XI, No. 10
Dec. '81

Even though you conclude that the Uniform Act is unnecessary, there may be one provision of the Uniform Act that you might conclude would be useful in California. This is the provision (Section 6) that authorizes an individual to appoint another to serve as a health care representative and to make health care decisions on his or her behalf. Do you believe that such a provision might be useful in California?

In the ordinary, nonemergency case, medical treatment may be given to an adult only with that person's informed consent. If the person lacks the capacity to give informed consent or is otherwise unable to give informed consent, a substitute decision-making process is necessary. One alternative is the establishment of a conservatorship of the person so that the court or conservator may make medical decisions for the conservatee. In addition, Probate Code Sections 3200-3211 provide a procedure for court authorization of medical treatment where the patient has no conservator and there is no ongoing need for a conservatorship.

The existing law contains no provision that expressly permits a competent person to appoint a health care representative to make health care decisions for the person making the appointment should the person making the appointment become unable to make the decisions. The recently enacted Uniform Durable Power of Attorney Act (1981 Cal. Stats. ch.

511, enacting Civil Code §§ 2400-2407) does not specifically deal with this matter; and, since it is unclear whether a durable power of attorney may cover health care decisions, a health care provider would run some risk in relying on the authority of a durable power of attorney with respect to health care decisions. The lack of express statutory authority to designate a health care representative may require resort to a court proceeding to designate a person to make health care decisions. This would be the case, for example, where there is no family member who could make the decisions. Enactment of such express authority would avoid the need for a court proceeding and would permit a competent person to designate a health care representative that the person trusts to make health care decisions.

Sincerely,

John H. DeMoully
Executive Secretary

JHD:jcr

California Hospital Association
1023 12th Street Sacramento, CA 95814 916/443-7401

February 26, 1982

John H. DeMoully
Executive Secretary
California Law Revision Commission
4000 Middlefield Road, Room D-2
Palo Alto, CA 94306

Dear Mr. DeMoully:

Thank you for your letter of February 24, 1982.

With respect to Section 6, such a provision may be helpful, but, I think, only in limited circumstances. What is excluded from Section 6 is the very real problem for providers in dealing with troublesome life and death situations.

I do agree with your comment regarding the Uniform Durable Power of Attorney Act--it simply does not address the issue of medical care and consent.

Again, thank you for your response.

Sincerely,

Keith W. Walley

Keith W. Walley
Vice President for Corporate
Management and Development

KWW:eml

Memo 82-69

Exhibit 2

CALIFORNIA MEDICAL ASSOCIATION

731 Market Street / San Francisco, California 94103 / 415·777-2000

April 15, 1982

John H. DeMoully
Executive Secretary
California Law Revision Commission
4000 Middlefield Road, Room D-2
Palo Alto, CA 94306

Dear Mr. DeMoully:

This is in response to your request for comments on the working draft of the Uniform Health Care Consent Act soon to be considered by the National Conference of Commissioners on Uniform State Law.

CMA staff has reviewed the material and has concluded that while there is no overall objection to the document, considerable doubt exists as to whether enactment of this Uniform Act is necessary or useful from a California perspective, even though the bill would preserve state law options in most respects.

Since California already has statutory provisions relating to consent to health care on behalf of minors and disabled persons, there does not seem to be a compelling need for this legislation as it would affect this State. In fact, it might well be inferior to California's existing statutory and case law framework.

We appreciate the opportunity to comment on the material and hope that these general observations will be helpful to your Commission.

Sincerely,

Jack M. Light
Associate Executive Director

JML:us

Memo 82-69 Exhibit 3

IRENE C. AGNOS, RN, Government Relations Director

California Nurses Association

April 8, 1982

GOVERNMENT RELATIONS OFFICE • 921 Eleventh Street, Suite 902, Sacramento, CA 95814 • (916) 446-5019

Mr. John H. De Moully
Executive Secretary
California Law Revision Commission
4000 Middlefield Road, Room D-2
Palo Alto, CA 94306

Dear Mr. De Moully:

Thank you for the opportunity to comment on the working draft of a Uniform Health Care Consent Act. While the draft is limited in scope to the issue of substitute consent, CNA views this as an important first step in the development of a substantive consumer oriented informed consent act based on individual freedom of choice and right to self determination. The fundamental weakness of the proposal is its limited scope.

Health care providers are uncertain about the legality of a third party consent for a temporarily incompetent adult who lacks capacity due to trauma, medication, or confusion in a non-emergent situation. However, the larger issue of substantive content is more compelling.

As nurses, we are all too aware that informed consents are less than informed. One reason is provider ignorance of the legal requirements set out in Cobbs v Grant 8 C3d 229 (1972) and Thomas v Truman 27 C3d 285 (1980) for disclosure of risks, benefits, and alternatives to consenting and risks of not consenting. Another serious problem is the readability of consents. A study reported in the New England Journal of Medicine in April 1980 found that five of five consent forms studied at five major LA institutions required the reading level of an undergraduate or graduate student, four of five read as a scientific journal and one of five read as an academic journal. The study concluded that the consent forms should be written for the seventh grade reader. So too, the verbal information the patient receives from a physician is equally esoteric to the average health care consumer. Often there are not translators available for foreign speaking patients. And finally, the vast majority of patients are still intimidated to ask questions of their primary health care provider even though patients are beginning to participate to a greater extent in their health care. These are but a few of the reasons patients are not adequately informed.

CNA is supportive of a statutory framework for informed consent disclosures authorization to consent and emergency exceptions. What information a person receives is the fundamental issue, not who should receive it and make a decision based upon it. We do not support the draft in its present form.

Attached please find our comments on the proposed draft. We hope that they are helpful.

Sincerely,

Lorenza M. Valvo

Lorenza M. Valvo, R.N., J.D.
Government Agency Representative

LMV/lw

CALIFORNIA NURSES ASSOCIATION

COMMENTS ON THE UNIFORM HEALTH CARE CONSENT ACT

Section 1. Definitions

(3) Health Care:

The use of a broad definition of health care rather than a limited definition of medical care is important. It reflects not only the reality of primary care in which nurse practitioners, physician assistants, and nurse midwives assume primary responsibility for patient care but also the individual's right to choose practitioners. Further, the definition recognizes the distinction between medical care which is the treatment of disease and health care which is the promotion and maintenance of health and prevention of disease. The breadth of definition includes alternative health care practices in addition to traditional western medical practices.

(4) Health Care Provider:

This definition remains silent on the issue of licensure. In so doing, as noted in the Law Commission Draft comments, it covers those individuals practicing in other states which do not require certification and licensure. Additionally, in not specifying certain practitioners, it allows for the evolution and expansion of current roles and health care practitioners.

Section 2. Individuals Authorized to Consent to Health Care

CNA recommends the use of both the masculine and feminine pronoun throughout the act.

Section 3. Individuals Incapable of Consenting

While we agree that the threshold judgment regarding capacity to consent rests with the primary health care provider, we don't find the shifting of decision-making authority to a third party sufficient protection of individual freedom and choice. The patient, the provider and the third party would be more adequately protected if the judgment that a patient lacked present capacity to consent were documented based on objective psycho-social and/or physical criteria. Lacking in this section is a standard against which to measure incapability. Defining the term as the inability to understand and knowingly,rationally, and voluntarily act on the information required for an informed consent adds protection for the patient and the provider by providing such a standard. Another mechanism for protection of the patient's freedom and the provider's professional judgment would be a concurring opinion by another provider.

The problem of temporary incapacity to consent presents itself often in more subtle ways than the easy to document incapacity of a confused elderly patient admitted to the hospital with a fractured hip. A difficult situation was presented to the ER staff of a southern California hospital. The patient suffered a witnessed head trauma and was brought to the ER via an ambulance summoned by his neighbor. On arrival, he refused treatment. Since the patient was not in imminent danger of death or bodily harm, he was not treated. The next day he was brought to the ER in a coma with a subdural hematoma. In retrospect, one seriously questions whether the patient had the ability to understand the consequences of not consenting to treatment.

Certainly the mechanism of shifting the decision-making to a third person would have allowed for early intervention in this situation. In using the definition suggested for incapability, the provider could have questioned the patient's understanding of the consequences of his refusal to treatment, the provider could document a history of a witnessed head trauma and the provider could have obtained a concurring opinion regarding the patient's capacity to consent or refuse treatment. This procedure does little to delay shifting the ability to consent to another decision maker but goes a long way toward providing more protection to both the patient and the provider.

Section 4. Individuals Who May Consent to Health Care for Others

While we agree that the ranking of family members becomes somewhat arbitrary, practically, it would be easier to implement. A California court in Farber v Olkon 40 C2d 503 1953 suggested the following order of preference among next of kin for obtaining a substituted consent: spouse, parent, adult child, adult sibling, uncle or aunt, grandparent.

Another family member could challenge the statutory presumption of priority. Just as in disagreements among relatives of the same affinity, a showing that the appointed person was not acting in the best interests of the patient should be required and explicitly stated.

Further, if the patient's condition does not permit the time to obtain judicial resolution of disagreement among persons of the same affinity and the situation is not a true emergency, some mechanism should exist to permit treatment based on the disputed substitute consent and insulate the provider from liability for failure to obtain informed consent if the care rendered is deemed best by the provider under the circumstances and another provider concurs.

Section 5. Delegation of Power to Consent to Health Care for Another

No additional comments.

Section 6. Health Care Representative

CNA objects to the section as written because it is overly broad and therefore subject to widespread abuse. The patient certainly may always consult with another prior to making a decision regarding his/her health care and medical treatment yet still maintain control over the decisional process.

This concept is useful in the limited circumstance in which a competent person may wish to appoint a representative to consent on his/her behalf in the event that she/he becomes incapable of consenting at a future date. We suggest that the appointment become operative only if the condition of incapability is met. We suggest the writing have a time limit of five years at which time the appointment could be renewed or another representative could be appointed. The appointment should be revocable at any time.

Additionally, a copy of the writing authorizing substituted consent should be filed with the provider at the time the individual or the representative consents to treatment, to be part of the medical, hospital or clinic record.

The issue not addressed in this section is the procedure to determine that a person who was temporarily incapable of consenting is currently capable of consenting or refusing treatment or capable of revoking the representative's authority.

Section 7. Court Ordered Health Care or Court Ordered Appointment of a Representative

It would be useful to define and include emergency exceptions to this section.

Section 8. Disqualification of Authorized Individuals

Again, this concept is useful in the limited circumstance in which a competent person may wish to disqualify individuals who would be statutorily authorized to consent in the event that the person subsequently becomes incapable of consenting. At admission, the patient should submit a copy of this document to be included as part of the medical record.

Section 9. Responsibility of the Health Care Provider

If the patient or the patient's representative in the case of the patient's incapability, were requested to submit a copy of the patient's authorization to the provider, it would alleviate the problem of treating patient's without authorized substituted consent.

Section 10. Availability of Medical Information

In any circumstance in which substituted consent becomes necessary, the health care provider must not be afforded the therapeutic privilege. Therapeutic privilege applies only when the provider has reason to believe that disclosure may have adverse psychological or physical effects on the patient. Certainly, in a substitute consent situation, this is not at issue. Therefore, full and complete disclosure must be required.

LMV/lw
4/7/82

Memo 82-69 Exhibit 4

NATIONAL RETIRED TEACHERS ASSOCIATION

AMERICAN ASSOCIATION OF RETIRED PERSONS

CALIFORNIA JOINT STATE LEGISLATIVE COMMITTEE

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1271 B Pine Creek Way
Concord, CA 94520

April 8, 1982

John H. Demoully, Executive Secretary
California Law Revision Commission
4000 Middlefield Road, Room D-2
Palo Alto, CA 94306

Dear Mr. DeMoully:

The 'UNIFORM HEALTH CARE CONSENT ACT' draft conforms to the objectives of our associations and the committee endorses the concept as well as the expeditious enactment in whole.

We recognize that the California legislative bodies, the legal profession and/or other involved word smiths may wish to amend the language of the draft. However, as long as the general thrust of the draft is not altered, we are disposed to accept such procedure.

Sincerely,

Paul W. Avery
Member, CJSLC

CC: Frank Freeland

Memo 82-69 Exhibit 5

BOLD AND POLISNER
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FREDERICK BOLD, JR.
JEFFREY D. POLISNER
STEPHEN H. WHITELAW

WILLIAM C. HOWARD
OF COUNSEL

February 16, 1982

California Law Revision Commission
4000 Middlefield Road, Room D-2
Palo Alto, CA 94306

RE: Uniform Health Care Consent Act

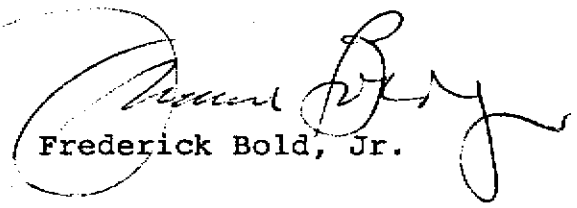
Gentlemen:

I respectfully submit the following comments on draft distributed on January 29, 1982.

1. The proposed act will improve the California law on consent to medical treatment.

2. The drafting is poor. The many cross-references and qualifications (in the style of the Internal Revenue Code) can be eliminated by competent draftsmanship (such as characterizes the excellent work of your Commission).

Yours very truly,



Frederick Bold, Jr.

FB:cw

Memo 82-69 Exhibit 6

Pathology Practice Association

1225 8th Street, Suite 590
Sacramento, California 95814
(916) 446-2651

2000 St. NW, Suite 200
Washington, D.C. 20036
(202) 887-5144

March 9, 1982

John H. DeMoully
Executive Secretary
California Law Revision Commission
4000 Middlefield Road, Room D-2
Palo Alto, California 94306

Dear Mr. DeMoully:

Thank you for asking me to comment on the working draft of a Uniform Health Care Consent Act. The field of medical care consents is not my major field of endeavor and I cannot state whether such legislation is needed in California.

From the standpoint of a health care practitioner in California I have the impression that current law and regulations are workable in this state.

The draft law appears realistic but, as a practicing pathologist, I observe the lack of consideration for the requirements of a consent for performance of autopsy. A section on that should be included in the draft and in many instances available relatives are not in the immediate vicinity clarification is needed as to what constitutes legal authorization of an autopsy when the person authorized to give the consent cannot be present and sign a form. This is one are where there is lack of uniformity in the current practice where some considered a witnessed telephone call adequate and others insist on a telegram delivered in writing.

Sincerely yours,

Kai Kristensen, M.D.
President

KK:dd

Memo 82-69 Exhibit 7

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF AGING
1020 19th STREET
SACRAMENTO, CALIFORNIA 95814

(916) 323-6681

April 6, 1982

California Law Revision Commission
4000 Middlefield Road, Room D-2
Palo Alto, CA 94306

Re: Comment on Uniform Health Care Consent Act

Greetings:

The Uniform Health Care Consent Act attempts to address the problem created when an incapacitated individual (without a legal representative) requires health care. The problems facing physicians and family members are very real, however I don't believe this Act would be an improvement over existing California law for a couple of reasons.

First, California has just enacted a simplified procedure for obtaining court authorization of medical treatment for an adult who doesn't have a conservator, California Probate Code Sections et seq. This law has only been in effect since January 1, 1981. It provides for filing a court petition authorizing medical treatment when the patient is unable to give "informed consent" to such treatment. This new procedure should be studied before the law in this area is again revised.

Secondly, some of the standards articulated in the Act are disturbing. For example, §3 states:

> "An individual authorized under this Act may consent to health care, unless, in the opinion of the health care provider, the individual is incapable of making a rational decision regarding the proposed health care."

The right to make an "irrational" decision is not one that, in my opinion, should be so lightly released. Almost any decision made by a lay person regarding medical treatment arguably could be characterized as irrational if not based on medical data. The reference to expert medical judgment comes at too great a cost to individual autonomy, in my opinion.

I do believe certain elements of the Act merit close study in light of existing California law. For example, Section 6 which sets up the procedure for appointment of a "health-care representative", should be looked at in light of the "durable power of attorney" law that the California Law Revision Commission was instrumental in getting enacted.

I hope these comments are of some assistance. Please keep me advised regarding the status of this issue.

Sincerely,

Bruce Hagel

BRUCE HAGEL
Legal Services Developer

BH:rm

cc: Ed Feldman, Deputy District Attorney,
Nursing Home Abuse Section, County
of Los Angeles

Memo 82-69

Exhibit 8

ATCHISON & ANDERSON
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LOS GATOS OFFICE
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April 7, 1982

California Law Revision Commission
4000 Middlefield Road
Room D-2
Palo Alto, California 94306

Re: Uniform Health Care Consent Act

California Law Revision Commission:

The enactment of the entire Uniform Health Care Consent Act is not necessary. Many of the provisions of the Act have already been enacted into law in California, some quite recently. In particular, extensive legislation has been passed regarding the ability of minors to consent to health care (Civil Code Sections 25.5-25.9 and 34.5-34.10); court appointment of someone to consent for adults without conservators, who are incapable of giving informed consent themselves (Probate Code Sections 3200-3211); the Uniform Durable Power of Attorney Act already allows delegation of authority unrevoked by incompetency (Civil Code Sections 2400-2407); Good Samaritan and Emergency Care statutes codify the common law in California on tort liability in emergency situations (Bus. & Prof. Code Sections 2395, 2397).

Certain sections of the proposed legislation, however, should be enacted in California because they either cover gaps in the existing law or state clearly policies presently only inferential from case law.

Section 2 of the Uniform Act does not need to be enacted into law since it restates existing California law. Minors can consent to medical treatment under the same circumstances as those provided in Section 2(2)(i), (ii), (iii), and (iv). See Civil Code Sections 60-70, 34.6, 25.6, and 25.7. In California minors can consent to care for the prevention and treatment of pregnancy (Civil Code Section 34.5), minors over 12 can consent to the treatment of communicable diseases and venereal diseases (Civil Code Section 34.7), minors over 12 can consent to medical care related to the diagnosis and treatment of rape (Civil Code Section 34.8), minors can consent to medical care relating to the diagnosis and treatment of conditions related to sexual assault (Civil Code Section 34.9), and minors over 12 may consent to counseling treatment and medical care related to a drug or alcohol problem (Civil Code Section 34.10). All of these sections have provisions exempting the parents from contractual liability for payment for services minors consent to. Payment is a subject the Uniform Health Care Consent Act does not address.

The enactment of Section 3 as a separate section is not necessary if the entire Uniform Health Care Consent Act is not enacted. Case law in California seems to place the determination in the physician's hands. Cobbs v. Grant (1972) 8 Cal.3d 229.

Section 4(a) makes explicit who may consent to health care for others. Section 4(a)(1) is presently covered in California law by Probate Code Sections 3200 through 3211. The provisions of Section 4(a)(2) seem to have been assumed by the Law Revision Committee comments to the Probate Code sections above: "if a person is incompetent or is otherwise unable to give informed consent and has no conservator, the physician may be willing to proceed with the consent of the person's nearest relative. (Citation to Cobbs v. Grant, supra). However, if treatment is not available because of a question of the validity of the consent, court intervention may be needed to authorize the treatment and to protect medical personnel and facilities from later legal action based upon asserted lack of consent". The Probate Code sections require attorneys representing both the petitioner and the patient, notice, and hearing. (Probate Code Sections 3205, 3206).

An addition to the Civil Code similar to section 4(a)(2), specifying which persons could make an informed consent without recourse to the Court would facilitate medical treatment in many cases. Any interested person could still petition the Court for authorization in the event that there was no spouse, parent, adult child, or adult sibling available to make an informed consent. I would redraft this section, and several other sections of the Uniform Health Care Consent Act discussed below, as set forth at the end of this letter.

Section 4(b) is broader in scope than the analogous California statute (Civil Code Section 25.8). This section allows parents or guardians to authorize any adult person in whose care the child is left to consent on the child's behalf, if the authorization is in writing. Civil Code Section 25.8 could be expanded to include adult siblings of the minor as persons capable of delegating consent. The requirement of a writing is not, I feel, that onerous, considering the many exceptions to a minor's inability to consent and the general emergency exception. For the reasons outlined above, the enactment of Section 4(b) is not necessary. Section 5 covers an analogous subject, and for the reasons stated above, it is not necessary to enact Section 5.

Section 6 is modeled on the Uniform Durable Power of Attorney Act. This act has been adopted in California as Civil Code Sections 2400 and following. The Uniform Durable Power of Attorney Act does not directly address the question of delegating consent to health care, but the concept is not inconsistent with the powers granted in the Act. An appointment of this sort would, according to the comments accompanying the draft of the Health Care Consent Act, would be given effect without this section. Therefore there seems to be no need for separate enactment of this section.

Section 7 is covered in California by Probate Code Sections 3200-3211. The existing sections seem superior in terms of detail, although Section 7(c) has no counterpart in the Probate Code and such an emergency provision might be beneficial.

Section 8 should be enacted, along with Section 4(a), to allow an individual to disqualify someone statutorily allowed to consent.

Section 9 has no counterpart in present California codes. Similar provisions do exist under California case law. See Maben v. Rankin (1961) 55 Cal.2d 139 (the good

faith of the doctor regarding a husband's consent is presumed). I do not think a separate section is necessary, since the only additions being proposed here are for close relatives or persons who can produce a writing to consent for an individual. The good faith of the doctor in accepting these representations seems already covered by case law.

Section 10 would already seem to be required by California case law under the Informed Consent Doctrine. See Cobbs v. Grant, (supra). You cannot make an informed consent, either for yourself or for another, without sufficient information to act. However, Section 10 should be enacted as part of Section 4(a). This will make clear the fact that the person statutorily authorized to consent stands in the shoes of the patient, and obviates any danger of an evidentiary privilege being waived.

The limitation clause of Section 11 should be enacted as part of the Section 4a, allowing certain individuals to consent for an adult incapable of consenting for himself.

MODEL SECTION CIVIL CODE

(a) Consent to health care for an individual who is, in the opinion of the attending physician or surgeon, incapable of giving an informed consent to the proposed health care, may be given by:

(1) A person authorized to consent to health care under the Uniform Durable Power of Attorney Act (Civil Code Section 2400-2407);

(2) A guardian or conservator of the person or a representative previously appointed by a court under Probate Code Section 3200-3211;

(3) If there is no known person who can consent under (1) or (2), then any one of the following may consent: spouse, parent, adult child, or adult sibling.

(b) An individual who is capable of making an informed consent may disqualify any person in (a)(1) or (3) from consenting to health care for him if:

(1) The disqualification is in writing signed by the individual, and designating those disqualified;

(2) A doctor or surgeon with knowledge of a written disqualification shall not accept consent to health care from an individual disqualified;

(3) An individual who knows he has been qualified to consent to health care for another shall have no authority over any provision of this Act.

(c) An individual authorized to consent for another pursuant to this section has the same right to receive information regarding the proposed health care and to consent to the disclosure of medical records to him and to any health care practitioner authorized under the present California law to receive information, as does the individual for whom he is acting. Disclosure of the medical records to an individual authorized to consent for another is not a waiver of an evidentiary privilege.

(d) This section does not authorize:

(1) An individual to consent to the diagnosis or treatment of another for a mental illness or to the commitment of another to any hospital or mental health facility for observation, diagnosis, or treatment unless in compliance with other state law;

(2) An individual to consent to any health care prohibited by the law of this state.

(e) This section does not affect any requirement of notice to others of proposed health care under any other law of this state, nor does this Act affect any other law of the state specifying when consent is required.

I hope these commments will be useful.

Very truly yours,

RODNEY R. ATCHISON

SUSAN NEVELOW MART

Exhibit 9

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WARREN T. PRATT

February 25, 1982

California Law Revision Commission
4000 Middlefield Road, Room D-2
Palo Alto, CA 94306

UNIFORM HEALTH CARE CONSENT ACT

Gentlemen:

These comments are with reference to the January 1982 Draft Uniform Health Care Consent Act ("The Act").

In my opinion, your Commission should solicit comment from the State Bar of California, Section of Legal Services and its Committee on Legal Problems of the Aging (555 Franklin Street, San Francisco, California 94102, Attention: Harvey Freed, Esq.). The Section of Legal Services has committees on Legal Services to the Poor and to the Handicapped who would also be significant contributors.

The issues go beyond the purportedly narrow scope of The Act. Regardless of whether The Act addresses the substantive issue of consent, that issue and the more pervasive issue of "due process" is involved. In addition, it is not possible to limit the isue to "procedure." Assuming the primary aim "is to provide authorization to consent to health care," how does one conclude an issue is mere procedure, when the procedures may lead to an act resulting in medical care or withdrawal of medical care with a permanent result? I disagree with the attempt to limit the scope of The Act and the attempt to avoid the "substantive" issues of what is informed consent, whether consent is required and whether there is a right to refuse treatment.

At least is the area of "Natural Death" and the "Right to Die;" the controversies are legion. The law of California as exemplified by the California Natural Death Act (California Health and Safety Code Section 7108) is unsatisfactory. In my opinion, all of the issues still unresolved in the area of suicide, euthanasia and natural death would or should be solved by the Uniform Health Care Consent Act.

I disagree with the statement (page iii) that the "who" questions of consent do not, in the routine cases, present serious unresolved moral issues." In my experience, the "who question" is frequently: can the institution or the medical practitioner rendering the medical treatment also consent? Can the institution or medical practitioner determine that conditions exist where consent is unnecessary; that is a moral question in which an "institutional consent" is substituted for the informed consent of an individual? The Act's failure to provide for "extraordinary cases such as terminal illness, organ donation, and the treatment of mental illness," in my opinion, excludes the great majority of the matters involving the moral issues and the great majority of matters about which there would be legal controversy and where there is need for better definition of substantive rights and procedure alternatives.

I disagree with the assumption of the drafters of The Act that we benefit from a uniform act to deal with "cases which occur daily and routinely in medical practice" and by ignoring all other matters. The obvious problem is that what is routine daily occurrence to a medical practitioner will vary among medical practitioners (not all doctors are competent to deal with problems of mental health, alcoholism, nutrition - in fact I venture the guess the majority are not any more competent on those subjects than are lawyers) and what is routine to the medical practitioner is a personal crisis to the patient and a religious problem for Christian Scientists and Jehovah's witnesses.

Unless The Act will address itself to <u>all issues</u>, especially the "exceptional" cases, it is my opinion society is better off leaving the whole area to the "murkiness of custom" than attempting a uniform statutory solution. I recognize my recommendations may require a new study of commitment procedures for mental illness. However, that area of the law can be vastly improved and would benefit from extension of the proxy decisionmaker concept in the The Act.

Moreover, the assumption that consent to routine matters are noncontroversial is absurd in the face of the fact that there are public debates over the ability of minors to obtain medical advice relating to controceptive devices and over the ability of minors to terminate pregnancy without consent or knowledge of their parent or guardian (and all of the other areas of controversy in the footnote to Section 2 of The Act at page 4).

The concept of a substitute decisionmaker with power to consent on behalf of the patient is truly controversial. The concept is fraught with great opportunity for good and for evil. Immediately, one asks whether some training or background should

be required, and should persons be licensed or otherwise regulated? For example, the medical doctor might be an appropriate person to exercise the power to consent whereas the nuring home operator might not.

While The Act purports to be limited in scope, certainly the definition of "health care" in Section 1(3) does not refer to that limitation. It would seem to me that, at the least, the definition should cross reference to the limitations in Section 11.

In Section 4(a)(2), I would recommend a priority of consent be established since in my experience there is frequent controversy over medical treatment.

The Section 4(c) concept of the person delegated authority exercising the power of the delegator, as well as Section 5, brings to mind the parent with an incorrigible child (need health care?) and the ability of the parent to delegate authority to an institution. Somehow, that picture conjures up the danger of children being institutionalized for medical care that will be nothing more than a privately maintained juvenile detention center. Perhaps the same rights a minor has in the juvenile juctice process need to be afforded to any situation involving in-patient treatment of more than temporary duration.

The Section 6 concept of a health care representative is an inviting concept. It is simple. However, what if the appointee will benefit financially from the decision to withhold medical care or to provide medical care? Is there no limitation on the power of the appointee arising out of the fact the appointee might benefit if the patient were to die? Is there no limit so that the representative cannot be a nursing home operator who will benefit from prolongation of the patient's life regardless of the wishes of the patient (expressed prior to the appointment)? What if every nursing home operator required every new patient to provide an appointment to act as health care representative as a condition of admission?

In Section 7, we have an incomplete consideration of the problems. All of the issues involved in mental health commitment are potentially involved in Section 7 proceedings. Why should the statutory language be less precise when the court is ordering a representative to authorize brain surgery than where the issue is commitment for treatment of a mental health problem?

Section 8 permitting disqualification of persons selected by the patient is a needed provision in the law.

Section 9 permitting the health care provider to act or refuse to act in "good faith" without liability is too lenient a standard. At the very least, I would add a provision that says:

> "(c) A health care provider who acts or declines to act in reliance on facts alleged to establish the good faith of the health care provider under Section 9(a) or (b) shall in any litigation have the burden of establishing the good faith by evidence that is clear and convincing and more than a mere preponderance of the evidence."

Yours sincerely,

LUTHER J. AVERY

LJA:bal/7292c
cc: Mark Aaronson, Esq.

Memo 82-69

Exhibit 10

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COUNTY COUNSEL

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March 29, 1982

California Law Revision Commission
4000 Middlefield Road, Room D-2
Palo Alto, CA 94306

Re: Draft Uniform Health Care Consent Act

Dear Commissioners:

We have briefly reviewed the Draft Uniform Act and note no significant difficulties from the point of view of administering governmental health programs (County hospitals, immunizations, etc.). Our initial concern over the use of the term "guardian" in Section 4(a)(1) of the draft was resolved by reference to California Probate Code §1490(a).

Thank you for the opportunity to review this draft.

Very truly yours,

John B. Clausen
County Counsel

By: John Milgate
Deputy County Counsel

JM:te

KENNETH JAMES ARNOLD
ATTORNEY AT LAW
369 Harvard Street
San Francisco, California 94134

April 11, 1982

California Law Revision Commission
4000 Middlefield Road, Room D-2
Palo Alto, CA 94306

Dear People:

Re: Draft, Uniform Health Care Consent Act

I would suggest that, before further drafting, existing law be collated and that only those provisions of the draft not covered by existing law be considered, including any amendments that might be required to existing law. (The constant enactment of duplicative statutes is to me a pain in the neck.)

For example, isn't the matter covered by Section 1, subdivisions 1 and 5, now adequately covered by CC §25? What do these new provisions accomplish, other than to duplicate existing law? And why do we have to have another statute defining health care provider (see, e.g., CCP §§ 364(f)(1) and 340.5, plus a number of other statutes all containing the same definition)? Couldn't we have just one section, for example, if the proposed act is to be included in the Civil Code, why not amend CC § 14 to include the definition? This is also true of Section 1, subdivision 6, which in any event seems overly broad for the matter covered in the act. Finally, defining a word or term by the word or term itself is the poorest kind of definition, as any lexicographer will tell you ("A health care provider is a person providing health care").

Section 2 contains matter that is already covered by CC §§ 34.5, 34.6, 34.7, 34.8, 34.9, and 34.10. To the extent Section 2 goes beyond these sections, wouldn't it be better simply to amend the appropriate existing code section?

Section 3 disturbs me a great deal; not only from what it purports to say, but from its ambiguity as well. For example, in the comment it says that a person is incompetent or incapable of making a rational decision regarding proposed health care if he's rendered unconscious. What's that got to do with the section? If he's unconscious, he can't make any decision rational or otherwise. Too, in the comment to Section 1 it says that health care includes for instance nursing care. Under Section 3 a person providing nursing care (who may not be licensed if I understand the comments) may override a patient's decision if the nursing care person thinks it's

not a rational decision. What standards are this nursing care person going to apply? After all, what's rational to one man is irrational to another. I think the term "rational decision" is screaming for definition, or, at least, the setting forth of standards by which the rationality of the decision is to be weighed. But I would suggest deletion of Section 3 and of all references to it and its limitations in the other sections.

With respect to Section 4, I would suggest that a careful comparison first be made between what the section would do and how it differs from the procedure set forth in the Guardianship and Conservatorship Act (Prob C §§ 1400-3803). Only after this is done can the provisions of Section 4 be considered realistically.

Section 5 appears to be a good idea, but I would need to know what the facts are, that is, what situations exist that this section is trying to resolve.

Section 6, except to the extent it refers to and incorporates the limitation in Section 3, also seems okay, except for subdivision (h) - why do we say "is not incapable" (a double negative) instead of simply saying "is capable"?

Section 7 also seems okay, but I would have to study it very carefully to determine what it will do. For example, it uses the term "incapable of consenting" without reference to any other section. Here, we have to do some reverse reasoning; we must say a person who is incapable of consenting is any person other than one listed in Section 2 as capable of consenting, and Section 2, by referring to Section 3, is not all that clear. Other terms, like "reasonable notice," are ambiguous and invite lawsuits. Why not specify what notice is required? CCP §1010 requires the notice to be in writing, so why not use the notice period applicable to notices of motion in CCP §1005? With respect to subdivision (c), how is the court's order dispensing with notice obtained - by oral ex parte motion, by written ex parte motion, or how? The hearing, I would assume, would be calendared by the court clerk; the judge doesn't normally come into contact with the case until immediately before the hearing; I would suggest that the application for the order (CCP §1003) dispensing with notice be obtained by written ex parte application, and that the subdivision so provide. Finally, with respect to subdivision (d), "If the court finds" - does this contemplate formal or at least written findings? If so, are the findings to be set forth in the order, or do we just assume that if the judge grants the petition it found all these things (see CC § 3548 ("The law has been obeyed") and Ev C § 664 ("It is presumed that official duty has been regularly performed. . . ."). I would prefer that the subdivision require the order to set forth the findings.

Section 8 is good.

Section 9 is a problem. Subdivision (a) doesn't make sense to me. If the consent must be in writing (Section 6) or the appointment made by court order, which must always be made or

entered in writing (CCP §1003), how can one act in good faith if he acts without seeing the written consent or an authenticated copy of the court's order, or an abstract if entered in writing only. Subdivision (b), of course, would fall if Section 3 were deleted.

Section 10 is okay, except for the bracketed statement at the end, which I don't understand. If the individual is acting on behalf of the patient, why can't he waive the privilege just as the patient can? Moreover, the implication of the bracketed statement appears to be contrary to the second paragraph of the comment.

With respect to Section 11, the last phrase in subdivision (a) beginning with line 4, and subdivisions (c) and (d) are substantially of no help to anyone. You're suggesting that a person go plowing through the 28 or 29 other codes to determine whether they contain anything in conflict with the proposed act. It seems to me that that is what the drafter of the act should do and then specifically refer the reader to the sections that apply or are to take precedence.

The remaining sections require no comment from me.

In conclusion, I would suggest that the act not be adopted. If it contains any legitimate provisions (as opposed to merely providing further protection to health care providers), I would suggest that they be isolated from the act and separately considered for adoption - either by amending existing code sections or by new legislation or by both.

I hope my comments are helpful, and I apologize if my comments appear abrupt. Lack of time prevents my suggesting alternative provisions.

Very truly yours,

Kenneth James Arnold

Kenneth James Arnold

Memo 82-69 Exhibit 12

THE STATE BAR OF CALIFORNIA

DEPARTMENT OF SECTIONS AND COMMITTEES
555 FRANKLIN STREET
SAN FRANCISCO, CALIFORNIA 94102
TELEPHONE (415) 561-8220

March 11, 1982

Mr. Juan C. Rogers
California Law Revision Commission
4000 Middlefield Road, Room D-2
Palo Alto, CA 94306

Dear Mr. Rogers:

I have forwarded the draft on the Uniform Health Care Consent Act to Patricia Lee, Acting Legal Services Director, as suggested by Mr. Avery in your letter of March 9, 1982.

Sincerely yours,

Pres Soberon

(Mrs.) Pres Soberon
Administrative Assistant

PS:lm

cc: Patricia Lee, Legal Services (w/ enc.)

Memo 82-69 Exhibit 1

MILTON G. VALERA
PRESIDENT

DEBORAH M. THAW
EXECUTIVE DIRECTOR

NATIONAL NOTARY ASSOCIATION

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WOODLAND HILLS, CALIFORNIA 91364-1186 USA
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February 18, 1982

Mr. John H. DeMoully
Executive Secretary
California Law Revision Commission
4000 Middlefield Road, Room D-2
Palo Alto, CA 94306

Dear Mr. DeMoully:

Thank you for requesting the input of the National Notary Association in regard to the draft of the Uniform Health Care Consent Act.

Our only recommendation pertains to the "Comment" portion of Section 6 (page 14), where a document for appointment of a health-care representative is proposed. To avoid possible conflicts of interest, it would be prudent to specify that the witness to the document be a person other than the appointee named in the document. To protect the interests of the signer, the witness, of course, should be an impartial third party, such as a Notary Public.

Please contact me if you have any questions on this point.

Sincerely,

Milton G. Valera
President

MGV:ss
020524

Enclosure

#L-703

STAFF DRAFT

RECOMMENDATION

relating to

APPOINTMENT OF A HEALTH CARE REPRESENTATIVE

Background

Medical care may be given to an adult in the ordinary, nonemergency situation only with the person's informed consent.[1] If the person is incapable of giving informed consent, a substitute decision-making process is necessary. The authority to consent is vested in the person's closest available relative[2] or, if a conservatorship of the person has been established, the court or conservator may make the necessary decisions.[3] Short of establishing a conservatorship, there is statutory authority for obtaining a court order for medical treatment for a person who is unable to give informed consent.[4]

Existing law does not, however, provide an opportunity for a competent person to anticipate the possibility of a need for substituted consent by appointing another person as a health care representative. A person may execute a durable power of attorney that remains effective even if the principal becomes incompetent, thereby avoiding the need for establishing a court-supervised conservatorship.[5] A power of attorney,

1. See Cobbs v. Grant, 8 Cal.3d 229, 242-44, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) (dictum); 4 B. Witkin, Summary of California Law Torts §§ 199-205, at 2485-91 (8th ed. 1974); see also Welf. & Inst. Code §§ 5326.2-5326.5 (consent provisions relating to treatment of mental illness of persons involuntarily detained).

2. See Cobbs v. Grant, 8 Cal.3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) (dictum).

3. See Prob. Code §§ 2354 (medical treatment of conservatee not adjudicated to lack capacity to give informed consent), 2355 (medical treatment of conservatee adjudicated to lack capacity to give informed consent), 2356 (limitations), 2357 (court ordered medical treatment).

4. See Prob. Code §§ 3200-3211.

5. See Civil Code §§ 2400-2407. For background on this statute, see Recommendation Relating to Uniform Durable Power of Attorney Act, 15 Cal. L. Revision Comm'n Reports 357-62 (1980).

durable or not, is primarily a device for managing property.[6] It is unlikely that many health care providers would be willing to rely on the consent given by an attorney in fact under a durable power of attorney relating to the health care of the principal. Consistent with the right to execute a durable power of attorney and to nominate a conservator,[7] a person should be able to appoint another to act as a health care representative, subject to whatever limitations on the power to consent or refuse consent to health care the appointor wishes to impose.

Recommendations

The Law Revision Commission recommends enactment of a statute that specifically permits the appointment of a health care representative and that deals with the unique problems in this area.

The proposed law would have the following features:

(1) Any adult or emancipated minor[8] of sound mind may appoint an adult as a health care representative. The appointment may specify limitations and qualifications on the powers of the health care representative and may include instructions to the health care representative.

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6. See W. Johnstone & G. Zillgitt, California Conservatorships § 1.13, at 6-7 (Cal. Cont. Ed. Bar 1968); 1 B. Witkin, Summary of California Law Agency and Employment §§ 120-122, at 730-31 (8th ed. 1973). But see Spitler, California's "New" Durable Power of Attorney Act--The Second Time Around, 3 CEB Est. Plan. R. 41, 43-45 (1981) (medical decisions under durable power of attorney act). Nothing in the Prefatory Note or Comments to the Uniform Durable Power of Attorney Act (1979) recognizes the existence of any authority in an attorney in fact to make health care decisions. The disclosure statement required by Civil Code Section 2400(b) to be in durable power of attorney forms printed in this state refers only to the power to deal with property.

7. Prob. Code § 1810 (court to appoint nominee of proposed conservatee unless not in best interests).

8. Under Civil Code Section 62, emancipated minors are persons under the age of 18 who have entered into a valid marriage (whether or not the marriage was terminated by dissolution), who are on active duty with the armed forces of the United States, or who have received a court declaration of emancipation pursuant to Civil Code Section 64. Emancipated minors are by statute considered to be adults for the purpose of consenting to medical, dental, or psychiatric care, without parental consent, knowledge, or liability. Civil Code § 63(a). See also Civil Code §§ 25.6 (consent by married minor), 25.7 (consent by minor in armed services). The proposed law does not permit appointment of a health care representative by an independent minor, i.e., a minor 15 or older who is living separate and apart from his or her parents and is managing his or her financial affairs. See Civil Code § 34.6.

(2) The appointment of a health care representative must be in writing, signed by the appointor, and witnessed by a person other than the health care representative.[9] The appointment does not become effective until it is signed by the health care representative at the request of the appointor.

(3) The health care representative has a general duty to act in the best interests of the appointor in carrying out the instructions in the appointment and is subject to any limitations provided by statute[10] or in the appointment. In exercising this authority the health care representative may consent or refuse to consent to health care for the appointor[11] to the same extent that the appointor could consent or refuse to consent to his or her own health care.[12]

(4) If the health care representative is unwilling to follow instructions set forth in the appointment, the health care representative is precluded from exercising authority and must so notify the appointor, and the appointor's legal representative and health care provider, if any are known to the health care representative.

(5) The appointor may revoke the appointment or any specific authority of the health care representative at any time, either orally or in writing, if the appointor is of sound mind.

(6) An interested person[13] may obtain court review of the acts or proposed acts of the health care representative and a court may revoke

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9. The proposed law contains a suggested form for the appointment.

10. The statute provides that the health care representative is subject to any directive under the Natural Death Act and is not authorized to consent to commitment to a mental health treatment facility, to the use of an experimental drug, or to convulsive treatment or sterilization. Comparable limitations are found in Probate Code Sections 2356 (limitations on powers of guardian or conservator) and 3211 (limitations on court-authorized medical treatment).

11. Health care is broadly defined to mean any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

12. The health care representative is also permitted access to information and medical records that the appointor would have.

13. Interested persons include health care representative, appointor, the spouse or any child of the appointor, the conservator of the person of the appointor, and the public guardian.

the appointment if the health care representative is failing to perform properly the duties under the appointment.[14]

(7) A person may disqualify another from consenting to the person's health care. The disqualification must be in writing, signed by the person executing it, and must designate the persons who are disqualified. The disqualification does not prevent a health care provider from relying on a consent given by the disqualified person, however, unless the disqualification is known to the health care provider.

(8) Health care providers are protected from any civil or criminal liability and from professional disciplinary action for acting or refusing to act based on a good faith belief as to the health care representative's authority.

Proposed Legislation

The Commission's recommendations would be effectuated by enactment of the following measure:

An act to amend Section 2356 of, and to add Article 5 (commencing with Section 2430) to Chapter 2 of Title 9 of Part 4 of Division 3 of, the Civil Code, relating to consent to health care.

The people of the State of California do enact as follows:

---

14. A court determination can also be obtained whether the appointment is still effective or has terminated and the court may require the health care representative to report his or her acts pursuant to the appointment.

Civil Code § 2356 (amended). Termination of agency

SECTION 1. Section 2356 of the Civil Code is amended to read:

2356. (a) Unless the power of an agent is coupled with an interest in the subject of the agency, it is terminated by any of the following:

(1) Its revocation by the principal.

(2) The death of the principal.

(3) The incapacity of the principal to contract.

(b) Notwithstanding subdivision (a), any bona fide transaction entered into with such agent by any person acting withhout actual knowledge of such revocation, death, or incapacity shall be binding upon the principal, his or her heirs, devisees, legatees, and other successors in interest.

(c) Nothing in this section shall affect the provisions of Section 1216.

(d) With respect to a power of attorney, the provisions of this section are subject to the provisions of Article 3 (commencing with Section 2400) of Chapter 2.

(e) With respect to a proxy given by a person to another person relating to the exercise of voting rights, to the extent the provisions of this section conflict with or contravene any other provisions of the statutes of California pertaining to the proxy, the latter provisions shall prevail.

(f) With respect to an appointment of a health care representative, the provisions of this section are subject to the provisions of Article 5 (commencing with Section 2430) of Chapter 2.

Comment. Subdivision (f) is added to Section 2356 to make clear that the provisions concerning health care representatives prevail over the provisions of subdivisions (a) and (b) of Section 2356. Under Section 2431, the appointment of a health care representative may remain effective even though the appointor later becomes incapable of consenting. See also Section 2437 (protection of health care provider from liability).

10040

Civil Code §§ 2430-2441 (added). Health Care Representative

SEC. 2. Article 5 (commencing with Section 2430) is added to Chapter 2 of Title 9 of Part 4 of Division 3 of the Civil Code, to read:

Article 5. Health Care Representative

§ 2430. Definitions

2430. As used in this article:

(a) "Adult" means an individual 18 or more years of age.

(b) "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

(c) "Health care representative" means a health care representative appointed under this article.

Comment. Section 2430 broadly defines health care and provides definitions of other terms that facilitate drafting of this article.

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§ 2431. Appointment of health care representative

2431. (a) An adult or a person who is an emancipated minor under Section 62 may appoint an adult as a health care representative under this article if at the time the appointment is made the appointor is of sound mind.

(b) An appointment of a health care representative shall be in writing and shall be signed by the appointor and by a witness who is a person other than the health care representative.

(c) The appointment is not effective until the health care representative accepts the appointment by signing the writing that makes the appointment.

(d) Unless the appointment otherwise specifically provides, the appointment is effective whether or not the appointor becomes incapable of consenting to health care.

Comment. Subdivision (a) of Section 2431 limits the availability of this article to adults and to emancipated minors who are treated as adults for the purpose of consenting to health care. See Section 63(a) (emancipated minor treated as adult for purpose of consenting to health care). Under Section 62, an emancipated minor is one who has entered into a valid marriage, is on active duty with the armed forces of the United States, or has received a judicial declaration of emancipation. See also Sections 25.6 (consent by married minor), 25.7 (consent by minor on active duty).

Subdivisions (b) and (c) specify the formalities for appointing a health care representative. See also Section 2441 (form for appointment).

Subdivision (d) provides the general rule that an appointment continues even after the appointor becomes incapable of giving informed consent. See also Section 2356 (power of agent upon incapacity of principal).

§ 2432. Authority of health care representative

2432. (a) Subject to any limitations in the appointment and except as otherwise provided in this article, a health care representative may consent or refuse to consent to health care of the appointor to the same extent as the health care representative could consent or refuse to consent to his or her own health care.

(b) In making all decisions under subdivision (a), the health care representative shall act in good faith and in the best interests of the appointor so as to carry out any instructions expressed in the appointment.

(c) Unless the appointment provides otherwise, a health care representative who is reasonably available and willing to act has priority to give consent or refuse to consent to health care of the appointor.

Comment. Subdivision (a) of Section 2432 provides for the broadest possible authority of a health care representative, except as limited by statute or in the appointment. Subject to these limitations, a health care representative may make any decision relating to the appointor's health care that the representative could make with reference to his or her own health care. See also Sections 2438 (limitations), 2441 (form for appointment).

Subdivision (b) makes clear that the health care representative has a duty to carry out any instructions expressed in the appointment. Where the health care representative cannot in good faith and in the best interests of the appointor follow the instructions, the health care representative may not exercise any further authority under the instructions. See Section 2434.

Subdivision (c) makes clear that a health care representative, as the voluntarily selected agent of the appointor, has primary authority in health care decisions. Of course, an appointor who is of sound mind has authority to overrule the health care representative or to revoke his or her authority. See Section 2435. The appointment of a conservator of the person for the appointor does not affect the authority of the health care representative, but the conservator is authorized to petition the court in connection with the acts or omissions of the health care representative. See Section 2439.

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§ 2433. Availability of medical information

2433. A health care representative has the same right as the appointor to receive information regarding the proposed health care and to consent to the disclosure of medical records to the health care representative and to any proposed health care provider.

Comment. Section 2433 makes clear that the health care representative can obtain and disclose information as necessary to exercise the authority given the health care representative.

§ 2434. Resignation or refusal of health care representative to act

2434. A health care representative who resigns or is unwilling to follow the instructions in the appointment may not exercise any further authority under the appointment and shall so inform all of the following:

(a) The appointor, whether or not the appointor is capable of giving consent to health care.

(b) The appointor's legal representative, if any, known to the health care representative.

(c) The appointor's health care provider, if any, known to the health care representative.

Comment. Section 2434 makes clear that the authority of the health care representative can be exercised only in a manner consistent with the instructions (if any) stated in the writing appointing the health care representative. The section also requires that notice be given to specified persons of a resignation or unwillingness to follow the instructions.

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§ 2435. Revocation of appointment or authority of health care representative

2435. (a) A person who has appointed a health care representative and is of sound mind may do either of the following:

(1) Revoke the appointment of the health care representative by notifying the health care representative orally or in writing.

(2) Revoke any authority granted to the health care representative in any particular circumstances by notifying the health care provider orally or in writing.

(b) A health care representative may exercise the authority granted in an appointment until the health care representative knows of the revocation of the appointment or the authority.

Comment. Although Section 2435 does not permit the appointor to revoke the appointment or the authority if the appointor no longer has a sound mind, a court may revoke the appointment if the health care representative fails to perform duties in accord with the appointment or is unfit to do so. See Section 2439.

§ 2436. Disqualification of persons to consent to health care

2436. (a) A person who has the capacity to appoint a health care representative pursuant to this article may disqualify other persons from consenting to health care for him or her. The disqualification shall be in writing, shall be signed by the person executing the disqualification, and shall designate the persons who are disqualified.

(b) A health care provider with knowledge of a disqualification executed pursuant to subdivision (a) may not accept a health care decision from the disqualified person involving the health care of the person who executed the disqualification.

(c) A person who knows that he or she has been disqualified pursuant to subdivision (a) may not make a health care decision for the person who executed the disqualification.

Comment. Section 2436 gives a person the ability to disqualify a person (such as a close relative) who would otherwise have authority under case law to give consent to health care on behalf of the person executing the disqualification. See also Section 2437(d) (health care provider not liable for refusal to follow direction of person believed to be disqualified from consenting to health care on behalf of another).

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§ 2437. Protection of health care provider from liability

2437. A health care provider is not subject to criminal prosecution, civil liability, or professional disciplinary action based on any of the following:

(a) If the health care provider relies on the consent or refusal of consent to health care by a health care representative who the health care provider believes in good faith is authorized by this article to consent to health care.

(b) If the health care provider refuses to follow the direction of a health care representative who the health care provider believes in good faith is not capable of giving informed consent.

(c) If the health care provider refuses to follow the direction of a health care representative whose appointment or authority the health care provider believes in good faith has been revoked.

(d) If the health care provider refuses to follow the direction of a person who the health care provider believes in good faith has been disqualified from consenting to health care on behalf of another person.

Comment. Section 2437 implements this article by protecting the health care provider who acts in good faith in reliance on the provisions of this article.

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§ 2438. Limitations on application of article

2438. (a) This article does not authorize a health care representative to consent to any of the following on behalf of the appointor:

(1) Commitment to a mental health treatment facility.

(2) Prescribing or administering an experimental drug (as defined in Section 26668 of the Health and Safety Code).

(3) Convulsive treatment (as defined in Section 5325 of the Welfare and Institutions Code).

(4) Sterilization.

(b) The provisions of this article are subject to any valid and effective directive of the patient under Chapter 3.9 (commencing with Section 7185) of Part 1 of Division 7 of the Health and Safety Code (Natural Death Act).

(c) This article does not affect any requirement of notice to others of proposed health care under any other law.

(d) This article does not affect the law governing medical treatment in an emergency.

(e) Except as provided in subdivision (c) of Section 2432 and Section 2436, nothing in this article affects the law governing when one person may consent to health care of another.

Comment. Subdivisions (a) and (b) of Section 2438 are comparable to Probate Code Sections 2356 (limitations on powers of guardian or conservator) and 3211 (limitations on court-authorized medical treatment). Subdivision (c) is new. Subdivision (d) makes clear that consent of a health care representative is not required in an emergency situation. See generally Cobbs v. Grant, 8 Cal.3d 229, 243, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) (consent implied in emergency). See also Bus. & Prof. Code §§ 2395 (emergency care at scene of accident), 2397 (emergency care in office or hospital). Subdivision (e) makes clear that this article has no effect on the law that determines who may consent on behalf of another (such as a close relative), but such a person will not have priority over a health care representative (Section 2432) and such a person may be disqualified as one who can consent (Section 2436).

§ 2439. Court enforcement of duties of health care representative

2439. (a) Article 4 (commencing with Section 2410) applies to an appointment of a health care representative.

(b) For the purpose of applying Article 4 (commencing with Section 2410) as provided in subdivision (a):

(1) "Attorney in fact" as used in Article 4 means the health care representative.

(2) "Conservator of the estate of the principal" as used in Article 4 means the conservator of the person of the individual who appointed the health care representative.

(3) "Power of attorney" as used in Article 4 means the writing appointing the health care representative.

(4) "Principal" as used in Article 4 means the individual who appointed the health care representative.

Comment. Section 2439 makes applicable to the appointment of a health care representative the procedure provided for court enforcement of duties of an attorney in fact under a power of attorney. This provides a procedure whereby a court may (1) determine whether the appointment of the health care representative is still effective or has terminated, (2) pass on the acts or proposed acts of the health care representative, or (3) compel the health care representative to submit a report of his or her acts as health care representative to the appointor, the spouse of the appointor, the conservator of the person of the appointor, or to such other person as the court in its discretion may require. See Section 2412. The court also may revoke the appointment under Section 2412 if all of the following are established: (1) The health care representative has violated or is unfit to perform the fiduciary duties under the appointment, (2) the appointor lacks capacity to give or to revoke an appointment, and (3) the termination of the appointment is in the best interests of the appointor.

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§ 2440. Limitation of power of attorney

2440. (a) An attorney in fact may not consent to health care nor act as a health care representative unless the power of attorney meets the requirements of this article.

(b) Nothing in this article affects the validity of any consent to health care given prior to January 1, 1984, and the validity of any such consent to health care is determined by the law applicable prior to January 1, 1984.

Comment. Subdivision (a) of Section 2440 makes clear that a power of attorney, durable or otherwise, is not sufficient to enable the attorney in fact to consent to health care unless the formalities of this article are satisfied. See Section 2431 (signature of witness and written acceptance by health care representative). This subdivision rejects the view that a power of attorney under the Uniform Durable Power of Attorney Act (see Sections 2400-2407) authorizes consent to health care.

Subdivision (b) makes clear that nothing in this article affects the validity of any consent to health care given prior to January 1, 1984. However, on and after January 1, 1984, subdivision (a) makes clear that consent to health care may not be given under a power of attorney unless the power of attorney meets the requirements of this article.

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§ 2441. Form for appointment

2441. An appointment of a health care representative shall be in substantially the following form:

APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I, _____ (name),

being of sound mind, voluntarily appoint _____ (name)

(whose current telephone number is _____)

and whose current address is _____)

as my health care representative authorized to act for me in all matters of health care, except as otherwise specified in this appointment.

This appointment is subject to the following special conditions:

_____

_____

_____

_____

Should I become incapable of giving informed consent to my health care, this appointment /__/ remains effective

/__/ terminates

_____
(signature of appointor)

_____
(address)

_____
(date)

- -

Statement of Witness

I certify that this appointment was signed by the person making this appointment. I have witnessed the signing of this appointment by that person at his or her request.

_____
(signature of witness)

_____
(address)

- -

Acceptance by Health Care Representative

I, _____, understand that
(name)
acceptance of this appointment as health care representative means that I have a duty to act in good faith and in the best interest of the person appointing me, and that I also have a duty to follow any special instructions in the appointment. In the event I cannot do so I will exercise no further power under the appointment and will inform the person appointing me, his or her legal representative if known to me, and his or her health care provider if known to me.

_____
(signature of health care representative)

_____
(address)

_____
(date)

Comment. Section 2441 provides a suggested form for appointment of a health care representative that complies with the requirements of this article.