#L-703 10/27/82

First Supplement to Memorandum 82-82

Subject: Study L-703 - Appointment of Health Care Representative

At the September meeting, the Commission considered comments received on the staff draft of the Recommendation Relating to Appointment of a Health Care Representative. (See Memorandum 82-82; another copy has been sent for consideration at this meeting.) The Commission decided to seek additional comments on this recommendation before deciding whether to propose legislation in this area. The comments we have received as a result of this second distribution of the draft recommendation are attached to this memorandum. We are informed that some persons may attend the meeting to make comments orally.

At the September meeting, the Commission did not consider the specific suggestions for revision beginning at page 4 of Memorandum 82-82. This material should be considered along with the following suggestions before any recommendation is approved to print.

General Reactions to Draft Recommendation

Several letters decline to make any specific or new comments. See Exhibits 2 (from Mr. James E. Ludlam on behalf of California Hospital Association), 3 (from Mr. Keith W. Walley, California Hospital Association), 4 (Mr. Jack M. Light, California Medical Association). The California Nurses Association forwarded a copy of comments on the draft Uniform Health Care Consent Act circulated last January. Mr. Light (Exhibit 4) reports that legal counsel for the California Medical Association "has noted that the proposed legislation might be somewhat inferior to California's existing statutory and case law framework." Inasmuch as the recommendation under consideration is new to California law and does not replace any aspect of existing law, we suspect that this remark was directed at the more comprehensive uniform act.

Mr. Paul Gordon Hoffman (Exhibit 1) suggests that the Commission deal with a matter that is the subject of a current criminal case. The staff recommends against this suggestion.

Consideration of Specific Comments

The following discussion considers comments made on specific provisions in the draft recommendation. You should refer to the copy of the recommendation attached to Memorandum 82-82.

Consent by Closest Available Relative

The first paragraph of the text of the recommendation states that "authority to consent is vested in the person's closest available relative" citing dictum in Cobbs v. Grant, 8 Cal.3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972). Mr. Lawrence J. Nelson objects to this statement and to citing Cobbs. See Exhibit 6. We are aware that this is weak authority at best. However, it has been cited previously by the Commission in the Comment to Probate Code Section 3201 (petition for court authorization for medical treatment of person unable to give informed consent):

> If the 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. See id. [Cobbs v. Grant] . . . .

We suspect that the statement in the recommendation reflects existing practice. See, e.g., Meyers, Informed Consent to Medical Treatment and the Incompetent Patient Under California's New Conservatorship Law, 11 CTLA Forum 283, 284 (1981). The statement in question is not critical to the recommendation, but does help give an overview of the context in which the recommendation is made. What does the Commission wish to do?

On a related point, Ms. Lorenza M. Valvo suggests on behalf of the California Nurses Association (Exhibit 5) that the statute provide a "statutory ranking of next of kin for obtaining substitute consent when there is no health care representative appointed." After consideration of the comments on the draft of the Uniform Health Care Consent Act distributed last January, the Commission decided to limit this recommendation to the subject of appointment of health care representatives. The omission of any provision dealing generally with who can consent is therefore intentional and the staff would recommend no change.

§ 53.100. Definitions

Mr. Nelson (Exhibit 6) suggests that "person" be defined to include a self-sufficient minor under Civil Code Section 34.6. Minors living separate and apart from their parents and managing their own financial affairs were intentionally not included in this definition. A person

called upon to rely on consent of a health care representative could not be certain that the minor was living separate and apart and managing his or her own financial affairs when the appointment was made. The staff recommends against this suggestion.

§ 53.110. Appointment of health care representative

Mr. Nelson (Exhibit 6) would require that the appointor "understand the nature and consequences of his or her appointment" in addition to being of sound mind. Mr. Nelson's comment to this suggested revision indicates that he would apply the standard applicable to consent to medical treatment to the appointment of a health care representative. The Commission has previously considered such a suggestion. The last paragraph of the Comment to Section 53.110 makes clear that the standard for appointing a health care representative should not be the same as the standard for giving consent to a particular treatment. The staff recommends no change.

The California Nurses Association (Exhibit 5) would bar health care providers from being witnesses to the appointment. Section 53.110(b) only precludes the health care representative from being a witness. The staff does not perceive any serious need for this limitation and recommends against it.

Mr. Nelson (Exhibit 6) would revise Section 53.110(e) to limit the authority of a health care representative to act only where the appointor lacks capacity or is unable to give informed consent. This would require the health care provider to determine another issue before relying on a decision made by the health care representative. In practical effect, the staff sees no problem since a person who can give informed consent can overrule a decision of a health care representative as provided in Section 53.150. In addition, the appointment may limit the authority of the health care representative. The staff recommends no change.

§ 53.120. Authority of health care representative

Mr. Nelson (Exhibit 6) would revise subdivision (c) of this section to provide that the health care representative has priority over any other person legally authorized to make health care decisions for the appointor. The staff would not make this change. We do not see its purpose. Presumably the health care representative would also have priority over those not legally authorized to make health care decisions for another.

Mr. Keith W. Walley (Exhibit 3) states that it is important to clarify this section, and Section 53.180, concerning whether they "authorize or prohibit the Health Care Representative from responding to issues dealing with problems involving life and death situations." The staff believes that the draft is clear in light of the definition of "health care decision" in Section 53.100. Note that a similar concern was raised by Mr. Harley Spitler as discussed in Memorandum 82-82 at page 4. If the Commission decides to make this type of clarifying change, we would suggest language like that proposed by Mr. Spitler.

§ 53.130. Availability of medical information

Mr. Nelson (Exhibit 6) suggests that other provisions relating to confidentiality of medical records should be amended to conform to this section. See, e.g., Civil Code §§ 56-56.37. This section was drafted in this manner in an effort to avoid the need to amend the multitude of statutes relating to confidentiality of medical information. The staff would make no change.

The California Nurses Association (Exhibit 5) suggests that the therapeutic privilege should not apply to the disclosure of information to the health care representative. The therapeutic privilege should apply "only when the provider has reason to believe that disclosure may have adverse psychological or physical effects on the patient." The staff is sympathetic to this point, but we have avoided the issue of what constitutes full disclosure for the purpose of informed consent. We would prefer not to get involved in this issue in this statute.

§ 53.160. Disqualification of persons from making health care decisions

Mr. Nelson (Exhibit 6) would delete this section. His argument is that since a close relative of an incompetent adult has no power to consent to health care, there is no need for a provision permitting disqualification. The staff would retain this section. While there may not be good case law authority for the proposition that a close relative may consent to health care, we believe the practice exists. This section would also allow the disqualification of a parent and there is authority for the proposition that a parent who has legal responsibility to maintain an incompetent adult child has the power to consent. See Farber v. Olkon, 40 Cal.2d 503, 509, 254 P.2d 520 (1953).

§ 53.180. Limitations on application of this part

Mr. Nelson (Exhibit 6) suggests several changes in this section. He would add the word "elective" before "sterilization" in subdivision (a)(4). Although no rationale is provided, we assume that this change is suggested in recognition of cases like Maxon v. Superior Court, 135 Cal. App.3d 626 (1982). This case held that a statute prohibiting courts from authorizing sterilization of a conservatee was inapplicable where the purpose of the proposed surgery is to "protect the life of the incompetent rather than to prevent her from bearing children." The staff believes the case law will adequately deal with this situation and so would not make the change suggested. The Comment to Section 53.180 cites Probate Code Section 2356 (limitations on powers of guardian or conservator) which was the statute interpreted in Maxon. However, if the Commission believes this is a problem that should be dealt with by statute, we could revise subdivision (a)(4) to refer to "Sterilization that is not medically or surgically necessary for the treatment of a life-endangering disease." This standard is drawn from Maxon. The staff would like to avoid writing a particular standard into the statute.

Mr. Nelson would also add a paragraph to subdivision (a) of this section that would have the effect of preventing the health care representative from withholding or withdrawal treatment pursuant to a directive to physicians under the Natural Death Act. The staff would not make this change. If the intention is to prevent the health care representative from making decisions that would result in death, the recommendation is intentionally not so limited. Subdivision (b) makes clear that a directive under the Natural Death Act would prevail over decisions of a health care representative.

Mr. Nelson also suggests that psychosurgery be added to the list of unauthorized treatments. A similar point was made by Mr. John C. Lamb in Exhibit 2 attached to Memorandum 82-82. The staff proposes to add the following paragraph to subdivision (a):

> (5) Psychosurgery (as defined in Section 5325 of the Welfare and Institutions Code).

Welfare and Institutions Code Section 5325(g) provides the following definition:

> . . . . Psychosurgery is defined as those operations currently referred to as lobotomy, psychiatric surgery, and behavioral surgery and all other forms of brain surgery if the surgery is performed for the purpose of any of the following:
>
> (1) Modification or control of thoughts, feelings, actions, or behavior rather than the treatment of a known and diagnosed physical disease of the brain.
>
> (2) Modification of normal brain function or normal brain tissue in order to control thoughts, feelings, actions, or behavior.
>
> (3) Treatment of abnormal brain function or abnormal brain tissue in order to modify thoughts, feelings, actions or behavior when the abnormality is not an established cause for those thoughts, feelings, actions or behavior.
>
> Psychosurgery does not include prefrontal sonic treatment wherein there is no destruction of brain tissue. The Director of Mental Health shall promulgate appropriate regulations to assure adequate protection of patients' rights in such treatment.

This would appear to be consistent with the powers of a conservator of the person, since Welfare and Institutions Code Section 5326.6 provides in part that "[P]sychosurgery, wherever administered may be performed only if . . . [t]he patient gives written informed consent to the psychosurgery." It should also be noted that Section 53.180(a)(3) in the draft recommendation precludes consent to "convulsive treatment" as defined in Section 5325 of the Welfare and Institutions Code. However, a guardian or conservator of a patient who has been adjudicated to lack the capacity to give written informed consent may consent to convulsive treatment pursuant to Welfare and Institutions Code Section 5326.7.

The question of consent to medical experiments is more difficult. Health and Safety Code Section 24175 permits substituted consent for medical experiments that are "related to maintaining or improving the health of the human subject or related to obtaining information about a pathological condition of the human subject." A conservator of the person is empowered to give such consent, and arguably the freely selected health care representative should have the same power. Section 53.180(a)(2) as currently drafted precludes the health care representative from prescribing or administering an experimental drug. However, using experimental drugs may be part of medical experimentation as defined in Health and Safety Code Section 24174. This limitation in Section 53.180(a)(2) was drawn from Probate Code Section 3211 (limitations on court-ordered medical treatment). It appears, however, that a conservator may consent

to administering of an experimental drug if the protections of the relevant parts of the Health and Safety Code are observed. See Health and Safety Code §§ 24174 (medical experiment defined), 24175(b) (consent to medical experiment by conservator of person), 26668.3 (consent to use of experimental drug); Prob. Code §§ 2356 (limitations on consent by conservator), 3211 (limitations on court-ordered treatment). If the Commission believes that the health care representative should have powers as broad as a conservator in this area, then the limitation in Section 53.180(2) concerning experimental drugs should be eliminated and a provision like the following should be added:

> A health care representative may consent to a medical experiment (as defined in Section 24174 of the Health and Safety Code) or to the use of an experimental drug (as defined in Health and Safety Code Section 26668) only as provided in Chapter 1.3 (commencing with Section 24170) of Division 20 and Article 4 (commencing with Section 26668) of Chapter 6 of Division 21 of the Health and Safety Code.

Respectfully submitted,

Stan G. Ulrich
Staff Counsel

EXHIBIT 1

HOFFMAN
SABBAN &
BRUCKER
LAWYERS

450 North
Roxbury Drive
Beverly Hills
California 90210
(213) 274-1152

September 23, 1982

OUR FILE:

Mr. 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 your letter of September 20 relating to the staff draft of the recommendation relating to appointment of a health care representative, togehter with its enclosures.

Subsequent to the time that I submitted my comments, an issue arose in Los Angeles which should be considered in connection with the recommendation, should the Commission decide to pursue the matter. Alternatively, you may wish to consider making a revision to the Directive to Physicians.

I understand that criminal charges have been filed against two physicians in the Kaiser Permanente Hospital system. These physicians removed all life support systems, including intravenous tubes supplying liquids and nutrients. The basis of the criminal complaint was that by removing the intravenous tubes, the patient was "starved to death." The District Attorney is attempting to distinguish the removal of intravenous tubes supplying liquids and nutrients from the removal of other life support systems.

I believe that this is a matter which the Commission should deal with immediately.

Very truly yours,

Paul Gordon Hoffman

PGH:sk

EXHIBIT 2

MUSICK, PEELER & GARRETT
A LAW PARTNERSHIP INCLUDING PROFESSIONAL CORPORATIONS
ONE WILSHIRE BOULEVARD
LOS ANGELES, CALIFORNIA 90017
TELEPHONE (213) 629-7600
TELEX 67-7451
TELECOPIER (213) 624-1376

NEWPORT BEACH OFFICE
SUITE 900
4000 MACARTHUR BOULEVARD
NEWPORT BEACH, CALIFORNIA
(714) 752-6100

DENVER OFFICE
SUITE 1500
718 SEVENTEENTH STREET
DENVER, COLORADO
(303) 825-5721

ELVON MUSICK 1890-1968
LEROY A. GARRETT 1906-1983

WASHINGTON, D.C. OFFICE
SUITE 1175 RING BUILDING
1200 EIGHTEENTH STREET N.W.
WASHINGTON, D.C.
(202) 775-1427

WRITER'S DIRECT DIAL NUMBER
213-629-7695

September 30, 1982

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

Dear Mr. Rogers:

Many thanks for your letter of August 4th sending a copy of the staff draft of the California Law Revision Commission's recommendation relating to the appointment of a health care representative.

Upon receipt of this material we transmitted it to the staff of the California Hospital Association. At this point they have determined that they will not take a position on the matter so all we can say is - thanks for letting us know and we would appreciate being put on the mailing list for future developments on this matter.

Very truly yours,

James E. Ludlam
for MUSICK, PEELER & GARRETT

JEL:k

cc: Mr. James Devine
Mr. Keith W. Walley
Mr. Charles F. Forbes
Mr. David E. Willett, Legal Counsel
California Medical Association

EXHIBIT 3

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

October 7, 1982

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

Dear Mr. Rogers:

Thank you for your letter of October 5, 1982.

While I have no specific comments to make at this point in time with respect to the draft recommendations attached to your letter, I do believe it would be important to clarify Section 53.120, and consequently Section 53.180 as these sections would authorize or prohibit the Health Care Representative from responding to issues dealing with problems involving life and death decisions.

Again, thank you for the information.

Sincerely,

Keith W. Walley

Keith W. Walley
Vice President for Corporate
Management and Development

KWW:eml

CALIFORNIA MEDICAL ASSOCIATION

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

October 8, 1982

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

Dear Mr. Rogers:

Thank you for again giving us the opportunity to comment on the Law Revision Commission's recommendation. We note that the draft is essentially similar to the one which was submitted to us earlier this year and our viewpoint remains essentially the same.

We have no overall objection to the material, but in view of the fact that 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 in California. Our Legal Counsel has noted that the proposed legislation might be somewhat inferior to California's existing statutory and case law framework.

Again, we are grateful that you have given us the opportunity to comment on the material.

Sincerely,

Jack M. Light
Associate Executive Director

JML/fe

CC: Willis W. Babb

EXHIBIT 5

IRENE C. AGNOS, RN, Government Relations Director

California Nurses Association

October 14, 1982

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

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

Dear Mr. De Moully:

Thank you for the opportunity to review and comment on the Commission's Recommendations Relating to the Appointment of a Health Care Representative.

Essentially, this draft and the Uniform Health Care Consent Act are similar in the major issues presented.

Specifically, we are concerned that Section 53.110 does not require that the health care provider be noticed of the Health Care Representative's appointment nor does it preclude a health care provider from being a witness. Section 53.120 provides no statutory ranking of next of kin for obtaining substitute consent when there is no health care representative appointed. This would also provide internal consistency with Section 53.160. Section 53.130 does not specifically preclude the health provider's therapeutic privilege in cases of substituted consent.

For a more detailed analysis of the CNA concerns briefly stated above, I have attached the CNA April 7, 1982 comments on the Uniform Health Care Consent Draft. Our previous comments identify other problem areas, rationale, and recommendations which are also applicable to this draft.

Sincerely,

Lorenza M. Valvo

Lorenza M. Valvo, RN, JD
Government Agency Representative

LMV/lw

California Nurses Association

IRENE C. AGNOS, RN, Government Relations Director

GOVERNMENT RELATIONS OFFICE • 921 Eleventh Street, Suite 902, Sacramento, CA 95814 • (916) 446-3

April 8, 1982

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, 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

LAW OFFICES
HANSON, BRIDGETT, MARCUS, VLAHOS & STROMBERG
333 MARKET STREET, SUITE 2300
SAN FRANCISCO, CALIFORNIA 94105
(415) 777-3200

RAYMOND L. HANSON (RET.)
GERALD D. MARCUS
ROSS E. STROMBERG
RONALD C. PETERSON
DUANE B. GARRETT
TED C. KRUMLAND
PAUL A. GORDON
GERALD M. HINKLEY
STEVEN V. SCHNIER
STEPHEN L. TABER
STEPHEN B. PECK
KIM T. SCHOKNECHT
HARRY SHULMAN
THOMAS C. GEISER
JACQUELYN J. GARMAN
SYLVIA L. SPEARS
PATRICIA A. SERVENTI
RICHARD A. JUDD

ARTHUR T. BRIDGETT
JOHN J. VLAHOS
WILLIAM J. BUSH
DAVID J. MILLER
LAURENCE W. KESSENICK
RAY E. McDEVITT
MICHAEL A. DUNCHEON
CRAIG J. CANNIZZO
THEODORE A. HELLMAN
JOAN L. CASSMAN
ALLAN D. JERGESEN
ROBERT L. RUSKY
DIANE W. CARTER
PETER N. GRANT
JOEL S. GOLDMAN
LAWRENCE J. NELSON
DAVID W. BAER
PAUL T. SMITH

NEWPORT BEACH OFFICE
SUITE 1530
660 NEWPORT CENTER DRIVE
NEWPORT BEACH, CALIFORNIA 92660
(714) 720-1750

PENINSULA OFFICE
SUITE 220
TWO PALO ALTO SQUARE
PALO ALTO, CALIFORNIA 94304
(415) 494-9211

OF COUNSEL
THOMAS C. LYNCH
DONALD H. MAYNOR

IN REPLY REFER TO:
SAN FRANCISCO OFFICE

October 22, 1982

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

Enclosed is a document reflecting the revisions which we suggest be made in the staff draft of the recommendation relating to appointment of a health care representative. Any additions we have made to the staff's text have been underlined while any deletions have been struck out by dashes.

We detect two major deficiencies in the staff recommendation. First, we do not believe it is desirable, much less necessary, to allow a competent adult to delegate to a third party the authority and power to give informed consent to medical treatment even if the patient-appointor is still competent. Even though the appointor would have the power to overrule the decision of the health care representative in such a situation, we do not believe the representative should be involved at all. The choice for or against recommended medical treatment may be confusing, troubling, even agonizing. Nonetheless, it should be made whenever possible by the person whose life, health and body will be directly affected by the choice that is made. Accordingly, our revisions limit exercise of the authority of the health care representative to those situations in which the appointor is unable to give his or her own informed consent to treatment.

Second, we do not agree with the statement in the background section of the staff report that legal authority to consent to medical treatment on behalf of an incompetent adult who lacks

a conservator is vested in that adult's "closest relative." Reliance on Cobbs v. Grant as authority supporting this statement is misplaced. First, the statement in Cobbs about the authority of the "closest available relative" is dicta. Second, the cases cited in Cobbs as precedent for this proposition say nothing about the authority of the closest relative to consent on behalf of his or her incompetent relative. Third, we are aware of no other case that is reliable authority for the proposition that the closest relative has the ability to render a valid consent on behalf of an incompetent adult. Accordingly, we have excised the sections allowing for disqualification of any relative from making treatment decisions for his or her incompetent, adult relative. In short, there is no need to take away from someone what he does not possess.

We hope our suggestions will prove useful to the Commission in its consideration of the staff report. If we can be of further assistance or offer clarification of our suggestions, please contact us.

Respectfully submitted,

Lawrence J. Nelson

LJN/jrw
Enclosure

PART 2.2. HEALTH CARE REPRESENTATIVE

§53.100. Definitions

§53.100. As used in this part:

(a) "Health care decision" means consent, refusal to consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

(b) "Health care representative" means a health care representative appointed under this part.

(c) "Person" means an individual who is 18 or more years of age or who is an emancipated minor under Section 62 or a self-sufficient minor under Section 34.6.

§53.110. Appointment of health care representative

§53.110. (a) A person may appoint another person as a health care representative under this part if at the time the appointment is made the appointor is of sound mind and understands the nature and consequences of his or her appointment of a health care representative.

(b) An appointment of a health care representative shall be in writing and shall satisfy both of the following requirements:

(1) The appointment shall be signed either (A) by the appointor or (B) in the appointor's name by some other person in the appointor's presence and by the appointor's direction.

(2) The appointment shall be signed by at least two persons other than the health care representative each of whom witnessed either (A) the signing of the appointment by the appointor or (B) the appointor's acknowledgment either that the appointor signed the appointment or that the appointment is the appointor's.

(c) Each witness who signs the appointment shall certify both of the following:

(1) That the witness believes that the appointor was of sound mind at the time the appointor signed or acknowledged the appointment.

(2) That the witness has no knowledge of any facts indicating that the appointment was procured by duress, menace, fraud, or undue influence.

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

(e) The health care representative has authority to exercise the powers of his or her appointment as provided in this part only when the appointor lacks the capacity or is unable to give informed consent to medical treatment. ~~Unless the appointment otherwise specifically provides, the appointment is effective whether or not the appointor remains of sound mind or is or becomes incapable of making health care decisions.~~

Comment. Subdivision (a) of Section 53.110 permits an adult or emancipated or self-sufficient minor (see Section 53.100(c) defining "person") to appoint another adult or emancipated minor as a health care representative empowered to make health care decisions on behalf of the appointor. See Section 53.120 (authority of health care representative).

Subdivisions (b), (c), and (d) provide the formalities for appointing a health care representative. The requirements of subdivision (b) are the same as provided for witnessed wills by Probate Code Section 201.010 as proposed in a separate recommendation. See Recommendation Relating to Wills and Untestate Succession, 16 Cal. L. Revision Comm'n Reports (1982). Subdivision (c) provides a requirement drawn from the official form for "Proof of Subscribing Witness [To Will or Codicil]" (form approved by the Judicial Council, revised January 1, 1976). See also Section 53.210 (form for appointment).

Under subdivision (a) the appointor must be of sound mind at the time the appointment is made and have the same mental capacity as one would when giving a valid informed consent. Thus, the appointment of a health care representative requires the same mental capacity as one would have to give a valid informed consent to medical treatment. Subdivision (e) makes clear that as long as the appointor has the capacity to give informed consent to medical treatment, the health care representative has no authority to exercise any of the powers enumerated in this part. The choice for or against any given medical treatment is so personal that a proxy decision maker should be utilized only when the patient himself or herself is unable to make the choice. ~~If the appointor thereafter becomes of unsound mind, subdivision (e) provides that the appointment continues in force unless the appointment specifically provides that it terminates if the appointor becomes of unsound mind.~~

~~See also Section 2356 (power of agent upon incapacity of principal). Subdivision (e) also makes clear that the appointment is effective whether or not the appointor has the capacity to give informed consent at the time the appointment is made or later loses that capacity. Appointment of a health care representative requires a lesser capacity than the capacity to give informed consent.~~

§53.120. Authority of health care representative

§53.120. (a) Subject to any limitations or instructions in the appointment and except as otherwise provided in this part, a health care representative may make health care decisions for the appointor to the same extent as the health care representative could make health care decisions for himself or herself.

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

(c) Unless the appointment provides otherwise, a health care representative who is reasonably available and willing to act has priority over any other person legally authorized to make health care decisions for the appointor.

§53.130. Availability of medical information

§53.130. 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. Civil Code §§56 et seq. and Health and Safety Code §§25250 et seq. should be amended to conform to this part.

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

§53.140. 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 conservator of the person, if any, known to the health care representative.

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

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

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

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

(2) Revoke any authority of the health care representative or a health care decision made by the health care representative 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.

~~§53.160. Disqualification of persons from making health care decision~~

~~§53.160. (a) A person may disqualify another person from making health care decisions for him or her if at the time the disqualification is made the person making the disqualification is of sound mind.~~

~~(b) A disqualification under this section shall be in writing and shall satisfy both of the following requirements.~~

~~(1) The disqualification shall be signed either (A) by the person making it or (B) in that person's name by some other person in the presence of and by the direction of the person making the disqualification.~~

~~(2) The disqualification shall be signed by at least two persons each of whom witnessed either (A) the signing of the disqualification by the person making it or (B) that person's acknowledgment either that he or she signed the disqualification or that the disqualification is his or her act.~~

~~(c) Each witness who signs the disqualification shall certify both of the following: (1) That the witness believes the person making the disqualification was of sound mind at the time the person signed or acknowledged the disqualification.~~

~~(2) That the witness has no knowledge of any facts indicating the disqualification was procured by duress, menace, fraud, or undue influence.~~

~~(d) A health care provider with knowledge of a disqualification made pursuant to this section may not rely on a health care decision from the disqualified person involving the health care of the person who made the disqualification.~~

~~(e) A person who knows that he or she has been disqualified pursuant to this section may not make a health care decision for the person who made the disqualification.~~

~~(f) A person who has made a disqualification under this section and is of sound mind may revoke the disqualification by a signed writing or, with respect to a particular health care decision, by notifying the health care provider orally or in writing.~~

§53.170. Protection of health care provider from liability

§53.170. 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 a health care decision made by a health care representative who the health care provider believes in good faith is authorized by this part to make health care decisions.

(b) If the health care provider refuses to follow a health care decision 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 a health care decision 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 a health care decision of a person who the health care provider believes in good faith has been disqualified from making health care decisions on behalf of another person.

(e) If the health care provider relies on a health care decision made by a person who was once disqualified but whom the health care provider believes in good faith has been restored to the authority to make health care decisions on behalf of another person by the revocation of the disqualification.

§53.180. Limitations on application of this part

§53.180. (a) This part 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) Elective sterilization.

(5) Withholding or withdrawal of treatment pursuant to a directive under Chapter 3.9.

(6) Psychosurgery.

(b) The provisions of this part 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 part does not affect any requirement of notice to others of proposed health care under any other law.

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

(e) Except as provided in subdivision (c) of Section 53.120, ~~and Section 53.160~~, nothing in this part affects the law governing when one person may make health care decisions on behalf of another.

Comment. Subdivision (a) and (b) of Section 53.180 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, 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 part 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 53.120) ~~and such a person may be disqualified as one who can consent (Section 53.160)~~.

§53.190. Court enforcement of duties of health care representative

§53.190. (a) Article 4 (commencing with Section 2410) of Chapter 2 of Title 9 of Part 4 of Division 3 applies in cases where a health care representative has been appointed.

(b) For the purpose of applying Article 4 (commencing with Section 2410) of Chapter 2 of Title 9 of Part 4 of Division 3 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.

§53.200. Limitation of power of attorney

§53.200. (a) An attorney in fact may not make a health care decision nor act as a health care representative unless the power of attorney meets the requirements of this part.

(b) Nothing in this part affects the validity of any health care decision made prior to January 1, 1984, and the validity of any such health care deicsion in determined by the law that would be applicable if this part had not been enacted.

§53.210. Form for appointment

§53.210. 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 limitations on the authority of the health care representative and instructions concerning exercise of that authority:

_____
_____
_____
_____
_____
_____
_____

I understand that this appointment becomes effective only if I lack the capacity or am unable myself to give informed consent to medical treatment. ~~Should I become incapable of giving informed consent to my health care, this appointment~~

/---/ ~~remains effective.~~

/---/ ~~terminates.~~

I understand that so long as I am of sound mind I may (1) revoke this appointment or authority by notifying the health care representative orally or in writing and (2) revoke any authority of the health care representative or any health

care decision made by the health care representative by notifying the doctor or other health care provider orally or in writing.

_____
(signature of appointor)

_____
(street address)

_____
(city, state)

_____
(date)

Statement of Witness

I certify that this appointment was signed by the person making it or that it was acknowledged by that person to be his or her appointment. I also certify that I believe that the person making this appointment is of sound mind and that I have no knowledge of any facts indicating that this appointment was procured by duress, menace, fraud, or undue influence.

_____ (signature of witness)	_____ (signature of witness)
_____ (street address)	_____ (street address)
_____ (city, state)	_____ (city, state)
_____ (date)	_____ (date)

Acceptance by Health Care Representative

I, _____ (name), understand that 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 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 conservator of the person if known to me, and his or her health care provider if known to me.

_____
(signature of health care representative)

_____
(street address)

_____
(city, state)

_____
(date)

Comment. Section 53.210 provides a form for appointment of a health care representative that complies with the requirements of this part.

~~§53.220. Form for disqualification~~

~~§53.220. A disqualification of a person from making health care decisions for another person shall be in substantially the following form:~~

~~DISQUALIFICATION OF PERSON FROM MAKING HEALTH CARE DECISIONS~~

~~I,_____,~~
~~(name)~~
~~being of sound mind, disqualify the following person from making health care decisions on my behalf:~~

~~_____~~
~~(name of person disqualified)~~

~~_____~~
~~(street address if known)~~

~~_____~~
~~(city, state, if known)~~

~~I understand that, unless I revoke this disqualification, the person named above is disqualified from making health~~

care decisions on my behalf in any circumstances. I understand that so long as I am of sound mind I may revoke this disqualification by a signed writing or by notifying my doctor or other health care provider orally or in writing.

_____
(signature of person making disqualification)

_____
(street address)

_____
(city, state)

_____
(date)

Statement of Witnesses

I certify that this disqualification was signed by the person making it or that it was acknowledged by that person to be his or her disqualification of the named person. I also certify that I believe that the person making this disqualification is of sound mind and that I have knowledge of any facts indicating that this disqualification was procured by duress, menace, fraud, or undue influence.

_____	_____
(signature of witness)	(signature of witness)
_____	_____
(street address)	(street address)
_____	_____
(city, state)	(city, state)
_____	_____
(date)	(date)