

Memorandum 96-66

Health Care Decisions: Natural Death Act

This memorandum presents an overview of the existing Natural Death Act, compares it to the new Uniform Health-Care Decisions Act, and raises a number of policy and drafting issues.

When the Commission last visited this topic, you approved the concept of moving the Natural Death Act (NDA) from the "Dead Bodies" division of the Health and Safety Code to the Probate Code so that it would be associated with the statutes governing the durable power of attorney for health care. The Commission needs to consider what changes in the NDA are desirable, particularly in light of the revisions proposed in the new Uniform Health-Care Decisions Act (UHCDA). (A copy of the UHCDA was attached to Memorandum 96-34, presented at the May meeting.) After the initial review of the NDA, the staff plans to prepare memorandums on specific subjects in order to focus on policy and drafting issues.

As the Commission works through the NDA, you should give some thought to whether the act should retain its separate character, should be combined with the durable power of attorney for health care, or superseded by a new statute based on the UHCDA. Until the issues have been fully discussed and tentative decisions made on modifications to the NDA, however, it is too early to determine the final structure of the statutes. This will be determined to a significant degree by the extent and nature of the changes the Commission decides to recommend, since some matters may not fit comfortably within the structure of the durable power of attorney for health care statute. Specifically, the "living will" concept embodied in the NDA would not be too hard to incorporate into the structure of the durable power of attorney for health care, but the surrogacy rules from the UHCDA (family consent law and related rules) would be more difficult to accommodate in the power of attorney structure.

A fundamental issue is whether there should be a special document aimed only at withdrawal of life support for persons in a terminal or permanent unconscious condition. By focusing on this one important issue, the NDA

declaration is unequivocal. This can be a distinct advantage in the hospital arena since it avoids interpretive problems inherent in more flexible documents. On the other hand, the availability of too many types of instruments can also be confusing and defeat the purpose of the law. The UHCDA is far broader than its predecessor, the Uniform Rights of the Terminally Ill Act (1989) (URTIA), and the NDA (which was amended in 1991 to adopt many features of the URTIA). As a general matter, the staff thinks it is most profitable to continue the evolution of the NDA by adopting the broad rules of the UHCDA concerning the ability of a competent adult to make advance instructions concerning future health care decisions. If this approach is adopted, the NDA-type of “living will” will not be a separate creature with its own special statutory form.

At this stage, we want to consider only the issues relating to the NDA declaration and flag other issues for later consideration. The existing NDA (Health & Safety Code §§ 7185-7194.5) is set out below, with staff commentary under each section discussing its source, comparing it to related provisions in the UHCDA, and raising issues that come to mind.

NDA § 7185. Short title

7185. This act shall be known and may be cited as the Natural Death Act.

The short title dates from the original, pioneer NDA of 1976. The name was retained even though the act was substantially amended in 1991 to adopt much of the URTIA, and could have been renamed at that time to reflect its overall consistency with the uniform act. This title really is not appropriate if the statute is expanded to cover other types of decisions as permitted under the existing California durable power of attorney for health care (DPAHC) or the UHCDA. There is some question whether the name should be retained even if the separate identity of the NDA declaration is preserved.

NDA § 7185.5. Legislative findings and declarations

The NDA contains a set of legislative findings that provide an important context for the act and have also provided useful legislative history guiding interpretation by the courts:

7185.5. (a) The Legislature finds that an adult person has the fundamental right to control the decisions relating to the rendering

of his or her own medical care, including the decision to have life-sustaining treatment withheld or withdrawn in instances of a terminal condition or permanent unconscious condition.

(b) The Legislature further finds that modern medical technology has made possible the artificial prolongation of human life beyond natural limits.

(c) The Legislature further finds that, in the interest of protecting individual autonomy, such prolongation of the process of dying for a person with a terminal condition or permanent unconscious condition for whom continued medical treatment does not improve the prognosis for recovery may violate patient dignity and cause unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the person.

(d) In recognition of the dignity and privacy that a person has a right to expect, the Legislature hereby declares that the laws of the State of California shall recognize the right of an adult person to make a written declaration instructing his or her physician to withhold or withdraw life-sustaining treatment in the event of a terminal condition or permanent unconscious condition, in the event that the person is unable to make those decisions for himself or herself.

(e) The Legislature further declares that, in the absence of controversy, a court normally is not the proper forum in which to make decisions regarding life-sustaining treatment.

(f) To avoid treatment that is not desired by a person in a terminal condition or permanent unconscious condition, the Legislature declares that this chapter is in the interest of the public health and welfare.

These statements, in some form, should most probably be included in any revision, although as the scope of the law changes, some of these statements may need to be revised.

In *Conservatorship of Drabick*, 200 Cal. App. 3d 185, 206, 245 Cal. Rptr. 840, 853 (1988), involving the power of a conservator to terminate life support for a comatose conservatee, the court cited the legislative intent of the original NDA:

The California Legislature has also recognized the right to control one's own medical treatment and declared it to be fundamental. In Health and Safety Code section 7186, which contains the findings and declarations underlying the Natural Death Act, "[t]he Legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition." While we do not suggest that this legislative

finding was expressly intended to control the interpretation of the Probate Code's conservatorship provisions, the finding is sufficient evidence of the existence of the right and its recognition as fundamental by the people of the State through their elected representatives.

In *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1137, 225 Cal. Rptr. 297, 302 (1986), involving the right of a competent adult who was not in a terminal condition, the court cites Section 7186 of the original NDA as follows: "Although addressed to terminally ill patients, the significance of this legislation is its expression as state policy 'that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care....'"

In *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 194-95, 209 Cal. Rptr. 220, 224-25 (1984), involving a competent adult with serious incurable but not terminal illnesses, the court wrote:

California has also enacted the Natural Death Act ... which provides in part: "The Legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition."

In *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1015-16, 195 Cal. Rptr. 484, 489-90 (1983), the court wrote:

In this state a clearly recognized legal right to control one's own medical treatment pre-dated the Natural Death Act. A long line of cases, approved by the Supreme Court in *Cobbs v. Grant* (1972) 8 Cal. 3d 229, [104 Cal. Rptr. 505, 502 P.2d 1], have held that where a doctor performs treatment in the absence of an informed consent, there is an actionable battery. The obvious corollary to this principle is that a competent adult patient has the legal right to refuse medical treatment.

It is clear from the legislative findings and declaration provided in Health and Safety Code section 7186, that the Legislature recognized such a right to control one's medical treatment, especially in circumstances such as presented here.

....

Therefore we conclude that Health and Safety Code section 7188 does not represent the exclusive basis for terminating life-support equipment in this state. Nor is a diagnosis of "brain dead" a condition precedent to the cessation of such treatment.

NDA § 7186. Definitions

Section 7186 provides a set of definitions to be used under the NDA “unless the context otherwise requires.” Where useful in the following discussion, we have set out the comparable language from the UHCDA definitions side-by-side with the existing NDA definition:

Attending physician [NDA § 7186(a)]

California NDA § 7186 ...

(a) “Attending physician” means the physician who has primary responsibility for the treatment and care of the patient.

UHCDA § 1 ...

(13) “Primary physician” means a physician designated by an individual or the individual’s agent, guardian, or surrogate, to have primary responsibility for the individual’s health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes the responsibility.

The UHCDA revised this term because

“attending physician” could be understood to refer to any physician providing treatment to the individual, and not to the physician whom the individual, or agent, guardian, or surrogate, has designated or, in the absence of a designation, the physician who has undertaken primary responsibility for the individual’s health care.

UHCDA § 1 comment. Adoption of this term depends in part on the extent to which the surrogacy rules are adopted. It is interesting to note, however, that the concept the patient designating the responsible physician was in the original 1976 California NDA, which included language defining “attending physician” as the physician “selected by, or assigned to, the patient.” (Former Health & Safety Code § 7187(a).) This phrase was omitted when the NDA was revised in 1991 for greater consistency with the 1989 URTIA. Now the concept is back in the UHCDA definition of “primary physician.”

Declaration [NDA § 7186(b)]

(b) “Declaration” means a writing executed in accordance with the requirements of subdivision (a) of Section 7186.5.

The name of the advance directive document is not too important, but it is probably annoying to the public, not to mention the health care and legal

establishments, when the names are changed every 10 years or so. On the other hand, as the function and scope of the instrument is changed, a new name takes on a greater importance, and helps notify potential users that it is a new creature. Originally, the 1976 NDA provided for a “directive to physicians” and this term is sometimes still used interchangeably with the “declaration” under the NDA, although they are quite different instruments. The UHCDA adopts the more modern term “advance health care directive” which includes all types of documents and both oral and written instructions. If the NDA is continued as a separate document, then we will need to continue this type of definition, but otherwise it would properly be subsumed under the definition of “advance health care directive.”

Health care provider [NDA § 7186(c)]

(c) “Health care provider” means a person who is licensed, certified, or otherwise authorized by the law of this state to administer health care in the ordinary course of business or practice of a profession.

The NDA definition of “health care provider” is identical to Probate Code Section 4615 in the DPAHC statute. The UHCDA restricts this term to an *individual*. The reason for this change is not given in the uniform act comments. The staff’s preliminary review does not reveal any problem with using the broader definition in existing law. Conversely, we would need to be very careful in restricting the definition to individuals without a thorough review of possible consequences.

Life-sustaining treatment [NDA § 7186(d)]

(d) “Life-sustaining treatment” means any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the process of dying [or an irreversible coma or persistent vegetative state].

The 1991 NDA substantially revised this definition to conform to the URTIA, except that the bracketed clause is unique to the NDA. This language has the effect of giving the NDA a broader scope than URTIA. The definition is not used in the UHCDA since the act is not limited to such situations, but covers all types of health care decisions (as shown in the second column below). The relevant definitions in the UHCDA are comparable to definitions in Probate Code Sections 4609 and 4612 of the DPAHC, with some differences highlighted:

California DPAHC §§ 4609, 4612

4609. “Health care” means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual’s physical or mental condition and includes decisions affecting the principal after death.

4612. “Health care decision” means consent, refusal of consent, or withdrawal of consent to health care, or a decision to begin, continue, increase, limit, discontinue, or not to begin any health care.

UHCDA § 1 ...

(5) “Health care” means any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect an individual’s physical or mental condition.

(6) “Health-care decision” means a decision made by an individual or the individual’s agent, guardian, or surrogate, regarding the individual’s health care, including:

(i) selection and discharge of health-care providers and institutions;

(ii) approval or disapproval of diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and

(iii) directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care.

Ideally, one comprehensive definition of these terms should apply to this group of rules. It is not clear whether a special definition of “life-sustaining treatment” will be needed. The judgment of the Uniform Commissioners was that the comprehensive Uniform Health-Care Decisions Act should completely replace the more limited declaration under the Uniform Rights of the Terminally Ill Act along with its limited definitions. Whether California should follow this same path remains to be seen.

Permanent unconscious condition [NDA § 7186(e)]

(e) “Permanent unconscious condition” means an incurable and irreversible condition that, within reasonable medical judgment, renders the patient in an irreversible coma or persistent vegetative state.

This definition does not appear in any of the uniform acts or in the 1976 NDA or the DPAHC. Its obvious function is to expand the much more limited coverage of the earlier NDA which applied only to terminal conditions. The broader definitions and coverage of the DPAHC and the UHCDA do not require this feature. “Permanent unconscious condition” is always paired with “terminal condition” in the NDA (see discussion of § 7186(j) below).

Person [NDA § 7186(f)]

(f) “Person” means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, government, governmental subdivision or agency, or any other legal or commercial entity.

Probate Code Section 56 provides a general definition of “person” that varies in wording, but not in substance: “... an individual, corporation, government or governmental subdivision or agency, business trust, estate, trust, partnership, limited liability company, association or other entity.” The definition in the UHCDA is the same as the NDA, but adds governmental “instrumentality” without explanation. Given the breadth of the definition in Section 56, we do not think further changes need to be made.

Physician [NDA § 7186(g)]

(g) “Physician” means a physician and surgeon licensed by the Medical Board of California or the Osteopathic Medical Board of California.

The Probate Code does not define “physician.” The DPAHC uses the term without defining it or uses the phrase “physician and surgeon” which is a term of art meaning a licensed medical doctor. It would be better to adopt the definition in the NDA and apply it to the DPAHC. The staff believes that the term “physician and surgeon” is awkward when used in these statutes and impairs the readability of already complicated statutes. In some contexts, a literal reading can lead a person to think that two signatures or approvals are required: one from a physician and one from a surgeon. (See, e.g., Prob. Code § 4753(b): “A ‘request to forego resuscitative measures’ shall be a written document, signed by the individual, or a legally recognized surrogate health care decisionmaker and a physician and surgeon, that directs....”) Consistent and comprehensive use of the defined term “physician” as set out in Section 7186(g) should avoid these problems. Further investigation may lead to a better expression, but the basic idea is to use the single word “physician.”

Qualified patient [NDA § 7186(h)]

(h) “Qualified patient” means a patient 18 or more years of age who has executed a declaration and who has been diagnosed and certified in writing by the attending physician and a second

physician who has personally examined the patient to be in a terminal condition or permanent unconscious condition.

This subdivision also demonstrates the undesirability of placing (or repeating) substantive requirements in definitions. This definition is a modified version of URTIA Section 1(7): "... a patient [18] or more years of age who has executed a declaration and who has been determined by the attending physician to be in a terminal condition." Issues concerning emancipated minors are discussed *infra*.

State [NDA § 7186(i)]

(i) "State" means a state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States.

This subdivision is the same as UHCDA Section 1(15). Probate Code Section 74 provides a general definition of "state" that varies in wording, but not in substance. Obviously, this sort of general provision would not be retained in any act placed in the Probate Code. This follows the usual practice for any uniform act recommended by the Commission.

Terminal condition [NDA § 7186(j)]

(j) "Terminal condition" means an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, within reasonable medical judgment, result in death within a relatively short time.

This definition is the same as URTIA Section 1(9) except that the phrase "within reasonable medical judgment" replaces "in the opinion of the attending physician" in the uniform act.

One interesting aspect of both subdivisions (e) ("permanent unconscious condition") and this definition is the use of the concept "within reasonable medical judgment," which was continued from the original 1976 NDA. Presumably the drafters of the 1991 NDA revisions intentionally rejected the URTIA language. The UHCDA, like the DPAHC, does not rely so heavily on definitions for important substantive rules, but instead places the relevant standards in the substantive provisions. For example, in UHCDA Section 5 concerning when the decision of a surrogate may be relied upon, the uniform act applies a personal standard: "... if the patient has been determined by the primary physician to lack capacity" Who decides who is to make health care

decisions and by what standards are fundamental issues that run throughout this study. There can be a crucial difference between a statutory rule that protects a good faith and reasonable decision of a designated person or health care professional and a rule that applies an abstract principle such as “reasonable medical judgment.”

NDA § 7186.5. Declaration governing life-sustaining treatment

Substantive rule [NDA § 7186.5(a)]

(a) An individual of sound mind and 18 or more years of age may execute at any time a declaration governing the withholding or withdrawal of life-sustaining treatment. The declaration shall be signed by the declarant, or another at the declarant’s direction and in the declarant’s presence, and witnessed by two individuals at least one of whom may not be a person who is entitled to any portion of the estate of the qualified patient upon his or her death under any will or codicil thereto of the qualified patient existing at the time of execution of the declaration or by operation of law. In addition, a health care provider, an employee of a health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, or an employee of an operator of a residential care facility for the elderly may not be a witness.

Who may execute instrument. There are inconsistencies in the statutes concerning who can execute particular documents. We will not try to resolve them in this memorandum, but the goal should be to have uniform rules to the extent possible and appropriate. Section 7186.5(a), for example, is limited to persons age 18 and over. The DPAHC, however, relies on the general power of attorney rules permitting execution by any person with the capacity to contract, thus incorporating the rules concerning emancipated minors. See generally Fam. Code §§ 6500 *et seq.* (minors), 7000 *et seq.* (Emancipation of Minors Law), 7050(e)(1) (consent to medical care), (e)(2) (delegation of power); Prob. Code §§ 4121, 4700. (As noted in an earlier memorandum, the staff does not recommend considering issues relating to health care decisionmaking for unemancipated minors.) The UHCDA refers to “an adult or emancipated minor.” In California, the law relating to emancipated minors should take care of itself, and explicit statutory reference should not be necessary, but in this area of the law, it should be clear and consistent.

Witnessing. The two-witness requirement is fairly standard for important documents in California. The rule and its limitations on who may be a witness should be standardized to the extent possible. However, there may be reasons to preserve some differences. For example, a DPAHC under the general rules may be notarized or signed by two witnesses, whereas the *statutory form* DPAHC requires two witnesses. Compare Prob. Code §§ 4700(b) & 4121(c) with § 4773. The request to forego resuscitative measures (the DNR “do not resuscitate” form) is signed by the individual (or “legally recognized surrogate health care decisionmaker”) and a physician. Prob. Code § 4753(b). The NDA declaration requires two witnesses. The UHCDA, on the other hand, does not require any witnesses or notarization (see UHCDA § 2 & comment), although the optional form provides spaces for two witnesses to “encourage the practice.” (UHCDA § 4 & comment). This approach of the UHCDA applies to appointment of health care agents, execution of the “Advance Health-Care Directive” form, and the giving of an “individual instruction” under the terms of the act.

The uniform act aims to effectuate the individual’s intent without relying too much on execution formalities. The drafters viewed formalities as unnecessarily inhibiting while at the same time doing “little, if anything, to prevent fraud or enhance reliability.” English & Meisel, *Uniform Health-Care Decisions Act Gives New Guidance*, Est. Plan. 355, 358-59 (Dec. 1994). The genuineness of advance directives is bolstered by placing reliance on the health care providers as a general rule, although, as noted, witnesses are encouraged in the form. The act relies on recordkeeping — entering the advance directive in the patient’s health care records — and conformance with medical ethics as affirmative rules to determine and effectuate genuine intent, and provides that anyone

who intentionally falsifies, forges, conceals, defaces, or obliterates an individual’s advance health-care directive or a revocation of an advance health-care directive without the individual’s consent, or who coerces or fraudulently induces an individual to give, revoke, or not to give an advance health-care directive, is subject to liability to that individual for damages of \$[2,500] or actual damages resulting from the action, whichever is greater, plus reasonable attorney’s fees. [UHCDA § 10(b).]

Regardless of whether it is desirable to minimize strict execution formalities, as in the UHCDA, **the staff doubts that it is possible** to eliminate the two-witness requirement and associated restrictions in California. If the Commission

is interested, we can continue to investigate the options, but otherwise, the staff proposes to work on the level of making execution formalities as clear and consistent as we can.

There is an important alternative to complying with the strict execution requirements in California law. The law recognizes the validity of durable powers of attorney for health care and similar instruments executed in another state or jurisdiction in compliance with their law. Prob. Code § 4653. A similar rule applies under the Section 7192.5 in the NDA.

Declaration form [NDA § 7186.5(b)]

(b) A declaration shall substantially contain the following provisions:

DECLARATION

If I should have an incurable and irreversible condition that has been diagnosed by two physicians and that will result in my death within a relatively short time without the administration of life-sustaining treatment or has produced an irreversible coma or persistent vegetative state, and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Natural Death Act of California, to withhold or withdraw treatment, including artificially administered nutrition and hydration, that only prolongs the process of dying or the irreversible coma or persistent vegetative state and is not necessary for my comfort or to alleviate pain.

If I have been diagnosed as pregnant, and that diagnosis is known to my physician, this declaration shall have no force or effect during my pregnancy.

Signed this ____ day of _____, ____

Signature _____

Address _____

The declarant voluntarily signed this writing in my presence. I am not a health care provider, an employee of a health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, or an employee of an operator of a residential care facility for the elderly.

Witness _____

Address _____

The declarant voluntarily signed this writing in my presence. I am not entitled to any portion of the estate of the declarant upon his or her death under any will or codicil thereto of the declarant now existing or by operation of law. I am not a health care provider, an employee of a health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, or an employee of an operator of a residential care facility for the elderly.

Witness _____

Address _____

There is something to be said for preserving a relatively simple single-purpose form of a “living will” even if the much broader features of the UHCDA are adopted. The statutory form in Section 4 of the UHCDA provides the following default rules directed mainly to “end-of-life decisions”:

PART 2

INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(6) END-OF-LIFE DECISIONS: I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

(a) Choice Not To Prolong Life

I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, OR

(b) Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

(7) ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld, or withdrawn in accordance with the choice I have made in paragraph (6) unless I

mark the following box. If I mark this box [], artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

(8) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

(9) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

(Add additional sheets if needed.)

Note that the declaration under the NDA is focused on one result — the withdrawal of life-sustaining treatment — whereas the UHCDA form provides a mechanism for achieving a variety of preset results or modifying them. Thus, paragraph (6) of the UHCDA form puts a high premium on checking the right box.

As we know from working on the DPAHC, the statutory form DPAHC, and the general power of attorney forms, there is a persistent tension between providing brief, easily understood, standard directions, on one hand, and more detailed directions that cover all possibilities, on the other. Forms that rely on check boxes or initialing desired statements or crossing-out unwanted provisions are typically easier to understand and use, and therefore promote the purpose of the statute, but ease of execution can lead to mistakes and abuse. Forms that are more protective may require written statements and include lengthy warnings and certifications to attempt to ensure that the person executing the form really means to do so, but become too complicated or confusing. Simpler, standard forms are far more likely to be accepted and accurately interpreted by the health care providers than are lengthy, lawyerish forms that address all possible health care scenarios and include essays on the meaning of life.

Past experience, most recently with the durable power of attorney revisions, suggests that there is no ideal resolution to the problem. (Some of the compromises in the DPAHC statute will need to be rethought when the

Commission looks at that law.) At this point, **the staff would like to know** whether the Commission is inclined to preserve the single-purpose NDA declaration as an option to the UHCDA omnibus form or replace it with a UHCDA-style omnibus form. Another aspect of this problem is whether or the extent to which the existing statutory form DPAHC should be preserved or replaced by the UHCDA-style form — Part 1 of the UHCDA form provides for creation of a power of attorney for health care and appointment of an agent. (This memorandum does not attempt to consider that issue.)

Recordkeeping [NDA § 7186.5(c)]

(c) A physician or other health care provider who is furnished a copy of the declaration shall make it a part of the declarant's medical record and, if unwilling to comply with the declaration, promptly so advise the declarant.

The duty of relevant medical personnel to make advance directives part of the patient's record is an important step in effectuating the patient's intent. This subdivision was drawn from URTIA Section 2(e), but the provision requiring an unwilling physician to inform "any individual designated to act for the declarant" was omitted due to the more limited coverage of the NDA.

The UHCDA imposes greater affirmative duties on health care providers going beyond mere recordkeeping. For example, UHCDA Section 7(b) provides:

A supervising health-care provider who *knows of the existence* of an advance health-care directive, a revocation of an advance health-care directive, or a designation or disqualification of a surrogate, shall promptly *record its existence* in the patient's health-care record and, if it is in writing, shall *request a copy* and if one is furnished shall *arrange for its maintenance* in the health-care record. [Emphasis added.]

Adoption of this and associated provisions from the UHCDA would fill a gap in existing California law, since the DPAHC provisions do not specify a duty to record the existence of or a copy of the power of attorney for health care or provide for any communication of the physician's unwillingness to comply with its provisions.

Another limitation in the NDA version of the rule is that it does not adequately deal with the problem of notifying an incapacitated patient or the patient's representatives of the physician's unwillingness to comply with the declaration. These problems are addressed in the UHCDA.

NDA § 7187. Skilled nursing facility or long-term health care facility

7187. A declaration shall have no force or effect if the declarant is a patient in a skilled nursing facility as defined in subdivision (c) of Section 1250, or a long-term health care facility as defined in subdivision (a) of Section 1418, at the time the declaration is executed unless one of the two witnesses to the declaration is a patient advocate or ombudsman as may be designated by the State Department of Aging for this purpose pursuant to any other applicable provision of law.

This section is a prime candidate for generalization. Existing law contains a number of variant expressions of this type of limitation. See, e.g., Prob. Code § 4701(e) (limiting execution of DPAHC for patient in skilled nursing facility but not long-term health care facility). These provisions need to be collected, reexamined, and conformed to the appropriate, current terminology.

The policy of providing extra protection for patients, particularly elder patients, in custodial care has been a feature of the law since the 1976 NDA and was implemented in the original DPAHC in 1984. This policy was strengthened as recently as 1995 when Section 4701 of the DPAHC was amended to also require the signature of a patient advocate where the power of attorney is notarized instead of witnessed.

NDA § 7187.5. When declaration becomes operative

This is the fundamental operative section in the NDA. It is similar to URTIA Section 3, but provides more protective technicalities, as indicated in the underscored language, and has a broader scope since it applies to permanent unconscious conditions as well as terminal conditions:

California NDA § 7187.5

A declaration becomes operative when (a) it is communicated to the attending physician and (b) the declarant is diagnosed and certified in writing by the attending physician and a second physician who has personally examined the declarant to be in a terminal condition or permanent unconscious condition and no longer able to make decisions regarding administration of life-sustaining treatment. When the declaration becomes operative, the attending physician and other health care providers shall act in accordance with its provisions or comply with the transfer requirements of Section 7190.

URTIA § 3

A declaration becomes operative when (i) it is communicated to the attending physician and (ii) the declarant is determined by the attending physician to be in a terminal condition or permanent unconscious condition and no longer able to make decisions regarding administration of life-sustaining treatment. When the declaration becomes operative, the attending physician and other health care providers shall act in accordance with its provisions and with the instructions of a designee under Section 2(a) or comply with the transfer requirements of Section 8.

Section 7187.5 again presents the issue of how to make the law more consistent and seek to implement important parts of the UHCDA. If a separate NDA declaration is retained as a special alternative to a broader advance directive drawn from the UHCDA and perhaps a special statutory form DPAHC, then it is difficult to justify continuation of the strict requirements for determining when the NDA declaration becomes operative. The approach of the DPAHC is to rely on good-faith determinations by the health care provider and attorney-in-fact and confirmation of the identity and status of the attorney-in-fact. (See, e.g., Prob. Code §§ 4750, 4751.) And as we have seen, the UHCDA tends to avoid strict technical rules.

But it cannot be ignored that the NDA was amended only in 1991 and the sponsors and the Legislature obviously had the URTIA version before them. It is possible to explain the differences between the approach of the NDA on one hand and the URTIA and DPAHC on the other by looking at the significant distance the 1991 NDA amendments traveled from the 1976 NDA. **The staff recommends reconsideration of the two-physician rule in Section 7187.5.**

NDA § 7188. Revocation

7188. (a) A declarant may revoke a declaration at any time and in any manner, without regard to the declarant's mental or physical condition. A revocation is effective upon its communication to the attending physician or other health care provider by the declarant or a witness to the revocation.

(b) The attending physician or other health care provider shall make the revocation a part of the declarant's medical record.

This section is identical to URTIA Section 4. This provision is fairly straightforward, as compared to the comparable provision in UHCDA Section 3 which, due to the broader scope of that act, needs to cover revocation of oral and written advance directives and both statements as to care and appointment of agents. (The UHCDA addresses the duty to record the revocation and other actions in a separate section, which helps limit the confusion.) The final form of the revocation rule will depend on whether the NDA retains its separate existence. See also Prob. Code § 4727 (revocation of DPAHC).

NDA § 7189. Determination that declarant is in terminal or permanent unconscious condition

7189. Upon determining that the declarant is in a terminal condition or permanent unconscious condition, the attending physician who knows of a declaration shall record the determination and the terms of the declaration in the declarant's medical record and file a copy of the declaration in the record.

This section is the same as URTIA Section 5, except for the addition of references to "permanent unconscious condition." The subject of recording information is covered in the UHCDA in Section 7, which collects provisions governing the obligations of health care providers under the act. This approach may be more useful for health care providers than scattering duties throughout other statutes.

NDA § 7189.5. Patient's right to make decisions concerning life-sustaining treatment

This section is similar to URTIA Section 6, but contains some important variations, particularly in subdivision (c):

California NDA § 7189.5

(a) A qualified patient may make decisions regarding life-sustaining treatment as long as the patient is able to do so.

(b) This chapter does not affect the responsibility of the attending physician or other health care provider to provide treatment for a patient's comfort care or alleviation of pain.

(c) The declaration of a qualified patient known to the attending physician to be pregnant shall not be given effect as long as the patient is pregnant.

URTIA § 6

(a) A qualified patient may make decisions regarding life-sustaining treatment so long as the patient is able to do so.

(b) This [Act] does not affect the responsibility of the attending physician or other health-care provider to provide treatment, including nutrition and hydration, for a patient's comfort care or alleviation of pain.

(c) Life-sustaining treatment must not be withheld or withdrawn pursuant to a declaration from an individual known to the attending physician to be pregnant so long as it is probable that the fetus will develop to the point of live birth with continued application of life-sustaining treatment.

The situation is quite different under the UHCDA. The subject of subdivision (a) is covered by rules in Section 2 that an individual can give health care instructions and in Section 7 governing who has the authority to make health care decisions in particular circumstances. The staff believes that the UHCDA

addresses the issue fairly well, particularly in light of the more complicated set of conditions it governs, as compared with the NDA or the DPAHC.

The UHCDA does not seem to contain a rule like that in Section 7189.5(b) as to the implicit duty to provide comfort care and alleviation of pain, except that the optional form contains a clause on the subject, as quoted above in the discussion of Section 7186.5(b).

The UHCDA does not attempt to provide a rule concerning pregnant patients as set forth in NDA Section 7186.5(c) and URTIA Section 6(c). **The question arises whether the existing rule should be revised** in light of the more flexible URTIA rule or abandoned in light of the UHCDA. Further research should be done on this point if the Commission decides to pursue it.

NDA § 7190. Duties of health care provider unwilling to comply with chapter

7190. An attending physician or other health care provider who is unwilling to comply with this chapter shall take all reasonable steps as promptly as practicable to transfer care of the declarant to another physician or health care provider who is willing to do so.

This provision is the same as URTIA Section 8. Section 7 of the UHCDA provides a more detailed duty:

(e) A health-care provider may decline to comply with an individual instruction or health-care decision for reasons of conscience. A health-care institution may decline to comply with an individual instruction or health-care decision if the instruction or decision is contrary to a policy of the institution which is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health-care decisions for the patient.

(f) A health-care provider or institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective health care or health care contrary to generally accepted health-care standards applicable to the health-care provider or institution.

(g) A health-care provider or institution that declines to comply with an individual instruction or health-care decision shall:

(1) promptly so inform the patient, if possible, and any person then authorized to make health-care decisions for the patient;

(2) provide continuing care to the patient until a transfer can be effected; and

(3) unless the patient or person then authorized to make health-care decisions for the patient refuses assistance, immediately make

all reasonable efforts to assist in the transfer of the patient to another health-care provider or institution that is willing to comply with the instruction or decision.

The staff recommends adoption of rules based on the UHCDA statement as a general rule. This would also fill a gap in the DPAHC statute which does not say what happens if the health care provider is unwilling to follow the instructions of the attorney-in-fact.

NDA § 7190.5. Liability and professional discipline

7190.5. (a) A physician or other health care provider is not subject to civil or criminal liability, or discipline for unprofessional conduct, for giving effect to a declaration in the absence of knowledge of the revocation of a declaration.

(b) A physician or other health care provider, whose action under this chapter is in accord with reasonable medical standards, is not subject to criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction if the physician or health care provider believes in good faith that the action is consistent with this chapter and the desires of the declarant expressed in the declaration.

This section is drawn from URTIA Section 9. The rules have been rewritten in UHCDA Section 9. As elsewhere, we would hope to provide one comprehensive set of rules, as in the UHCDA, but it is premature to deal with these issues here.

NDA § 7191. Specified conduct as misdemeanor; Prosecution of specified conduct as unlawful homicide

7191. (a) A physician or other health care provider who willfully fails to transfer the care of a patient in accordance with Section 7190 is guilty of a misdemeanor.

(b) A physician who willfully fails to record a determination of terminal condition or permanent unconscious condition or the terms of a declaration in accordance with Section 7189 is guilty of a misdemeanor.

(c) An individual who willfully conceals, cancels, defaces, or obliterates the declaration of another individual without the declarant's consent or who falsifies or forges a revocation of the declaration of another individual is guilty of a misdemeanor.

(d) An individual who falsifies or forges the declaration of another individual, or willfully conceals or withholds personal knowledge of a revocation under Section 7188, with the intent to

cause a withholding or withdrawal of life-sustaining treatment contrary to the wishes of the declarant, and thereby, because of that act, directly causes life-sustaining treatment to be withheld or withdrawn and death to thereby be hastened, shall be subject to prosecution for unlawful homicide as provided in Chapter 1 (commencing with Section 187) of Title 8 of Part 1 of the Penal Code.

(e) A person who requires or prohibits the execution of a declaration as a condition for being insured for, or receiving, health care services is guilty of a misdemeanor.

(f) A person who coerces or fraudulently induces an individual to execute a declaration is guilty of a misdemeanor.

(g) The sanctions provided in this section do not displace any sanction applicable under other law.

This section has developed from the original 1976 NDA and was influenced by Section 10 of the URTIA. Similar and variant rules appear in the DPAHC statute (Prob. Code § 4726) and in UHCDA Section 10. As indicated elsewhere, we would aim for a general comprehensive set of provisions on criminal and civil liability.

NDA § 7191.5. Effect on insurance or annuity; condition for insurance or health care; effect on patient's right to decide

7191.5. (a) Death resulting from the withholding or withdrawal of a life-sustaining treatment in accordance with this chapter does not constitute, for any purpose, a suicide or homicide.

(b) The making of a declaration pursuant to Section 7186.5 does not affect in any manner the sale, procurement, or issuance of any policy of life insurance or annuity, nor does it affect, impair, or modify the terms of an existing policy of life insurance or annuity. A policy of life insurance or annuity is not legally impaired or invalidated by the withholding or withdrawal of life-sustaining treatment from an insured, notwithstanding any term to the contrary.

(c) A person may not prohibit or require the execution of a declaration as a condition for being insured for, or receiving, health care services.

(d) This chapter creates no presumption concerning the intention of an individual who has revoked or has not executed a declaration with respect to the use, withholding, or withdrawal of life-sustaining treatment in the event of a terminal condition or permanent unconscious condition.

(e) This chapter does not affect the right of a patient to make decisions regarding use of life-sustaining treatment, so long as the

patient is able to do so, or impair or supersede a right or responsibility that a person has to effect the withholding or withdrawal of medical care.

(f) This chapter does not require any physician or other health care provider to take any action contrary to reasonable medical standards.

(g) This chapter does not condone, authorize, or approve mercy killing or assisted suicide or permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

(h) The rights granted by this chapter are in addition to, and not in derogation of, rights under any other statutory or case law.

Subdivisions (a)-(f) are nearly identical to URTIA Section 11, with the addition of references to “permanent unconscious condition.” In subdivision (g), the NDA language “assisted suicide or permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying” is substituted for “euthanasia” in the URTIA provision. The UHCDA provides a newer alternative statement of the rule in Section 13(d): “This [Act] does not authorize mercy killing, assisted suicide, euthanasia, or the provision, withholding, or withdrawal of health care, to the extent prohibited by other statutes....”

These rules should be generalized. The provisions concerning insurance are missing in the DPAHC and that gap should be filled.

NDA § 7192. Presumption of validity of declaration

7192. In the absence of knowledge to the contrary, a physician or other health care provider may presume that a declaration complies with this chapter and is valid.

This section is the same as URTIA Section 12. The UHCDA rule is phrased in terms of an immunity from liability for acting in good faith and in accordance with generally accepted health-care standards and “complying with an advance health-care directive and assuming that the directive was valid when made and has not been revoked or terminated.” This standard, like the rule in Section 4750 of the DPAHC, provides more guidance than the NDA-URTIA rule and appears to be more useful.

NDA § 7192.5. Validity of declarations executed in another state

7192.5. An instrument governing the withholding or withdrawal of life-sustaining treatment executed in another state in compliance

with the law of that state or of this state is valid for purposes of this chapter.

This section has the same purpose as URTIA Section 13 and is particularly important in view of the more stringent execution requirements of the NDA. The DPAHC recognizes foreign durable powers of attorney in Probate Code Section 4653, and also validates powers executed elsewhere that comply with California rules. The UHCDA takes a different approach in Section 2)h): “An advance health-care directive is valid for purposes of this [Act] if it complies with this [Act], regardless of when or where executed or communicated.” This rule works in the UHCDA because it does not impose onerous execution requirements, whereas the existing California rules are needed to avoid invalidating instruments that are valid under the law of sister states and other jurisdictions.

NDA § 7193. Effect of Durable Power of Attorney for Health Care

7193. A Durable Power of Attorney for Health Care shall prevail over a declaration executed pursuant to this chapter unless expressly provided otherwise in the Durable Power of Attorney for Health Care.

The need for this type of provision depends on whether the declaration retains a separate existence. If the Commission decides to pursue the UHCDA approach of treating “individual instructions”(oral and written) and powers of attorney together as “advance directives,” then this type of bright line rule will disappear. See also Prob. Code § 4753(h) (relationship of DNR order to DPAHC and NDA).

NDA § 7193.5. Instruments to be given effect

7193.5. The following instruments shall be given effect pursuant to the provisions of this chapter:

(a) An instrument executed before January 1, 1992, that substantially complies with subdivision (a) of Section 7186.5.

(b) An instrument governing the withholding or withdrawal of life-sustaining treatment executed in another state that does not comply with the law of that state but substantially complies with the law of this state.

The challenging transitional issues will be addressed when a draft has taken form. The NDA transitional rule as provided in subdivision (a) will not be too complicated, but the DPAHC transitional rules need to be simplified if they are to be understandable. (See Prob. Code §§ 4650, 4651, 4654.)

Subdivision (b) is akin to the rule in Section 4653 of the DPAHC, discussed under Section 7192.5 above. It should be combined with that rule.

NDA § 7194. Severability clause

7194. If any provision of this chapter or its application to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this chapter which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are severable.

Probate Code Section 11 provides a general severability rule, making this provision unnecessary. Eliminating the special severability rule in favor of the general rule is standard procedure when the Commission adds uniform acts to the Probate Code. See, e.g., the list of uniform acts in Prob. Code § 2 Comment.

NDA § 7194.5. Conformity with Uniform Rights of the Terminally Ill Act

7194.5. To the extent that a provision of this chapter conforms to the Uniform Rights of the Terminally Ill Act, that provision shall be applied and construed to effectuate its general purpose to make uniform the law with respect to the subject of this chapter among states enacting it.

If the Commission approves revisions to the NDA that are more consistent with the UHCDA, then reference should be made to the newer act, however it would be possible to refer to both URTIA and UHCDA if significant rules are drawn from both acts. Probate Code Section 2 provides as a general rule that provisions that are the same in substance as a provision of a uniform act are to be construed to effectuate the general purpose to make the law uniform. Technically, the special variation in Section 7194.5 is unnecessary in light of the general rule.

Respectfully submitted,

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