Memorandum 98-63

Health Care Decisions: Comments on Tentative Recommendation

This memorandum considers comments we have received on the tentative recommendation concerning Health Care Decisions for Incapacitated Adults (June 1998). Major issues raised by the commentators are summarized and discussed in this memorandum. Their comments are considered in detail in Staff Notes following relevant sections in the attached staff draft recommendation. We appreciate the substantial expenditure of time the commentators have spent in reviewing and commenting on the tentative recommendation.

The staff anticipates that the Commission will decide to make a number of important revisions, and some additional research and technical analysis of the draft need to be done before a final recommendation can be printed. At this meeting, the Commission should be able to complete its review of the comments we have received. The staff will wrap up drafting on the final recommendation, and the Commission will be able to approve its recommendation to the Legislature at the December 10-11 meeting. As part of this process, it may be beneficial to circulate redrafts of the most important provisions if the Commission decides to make significant changes in response to the comments. Since there is no consensus about what should be done with the more controversial provisions, without seeking additional review and comment, we may find that revised provisions are just as objectionable as the ones they would replace.

The following letters are attached to this memorandum:

Exhibit pp.

1. Ronald B. Miller, M.D., U.C. Irvine College of Medicine (April 27, 1998) . . 1
2. Lawrence J. Schneiderman, M.D., U.C. San Diego School of Medicine
   (May 4, 1998) ..................................................... 8
4. Ronald D. Orr, M.D., Loma Linda University Medical Center (August
   4, 1998) .............................................................. 11
6. Leah V. Granof, for Advance Directive Committee of State Bar Estate
   Planning, Trust and Probate Law Section Executive Committee
   (August 17, 1998) .................................................. 21
The comments were generally supportive, although a significant number of writers raised fundamental concerns about the surrogate committee procedure and the authority given the primary physician to determine the most appropriate surrogate from the statutory list. Several commentators focused only on the provisions they found objectionable, while a number of others made suggestions for improvement in a variety of sections. Overall, we conclude that the revision is seen as a worthwhile project. Simplification of the advance directive rules did not meet with any objection, and no one objected to replacement of the existing durable power of attorney and Natural Death Act with the advance health care directive.

Comments from health care professionals were generally favorable, but they did raise a number of important issues. Dr. Ronald B. Miller compliments the Commission “on a job extremely well done” and says he would “certainly want to support a new Health Care Decisions Law even if my many suggestions for improvement are not incorporated.” (Exhibit p. 7.) Dr. Robert D. Orr (Exhibit p. 11) writes that the proposal would “address many of the problems with I
encounter as a bedside ethics consultant every week.” The California Healthcare Association has a number of concerns, but is “impressed with the quality of the proposed legal revisions.” (Exhibit p. 66.) The California Medical Association commends the Commission and staff “for your outstanding work in promulgating this important law. If enacted, it will rectify the gaps, inconsistencies, and confusion that exist under California’s current patchwork of laws.” (Exhibit p. 60.)

Comments from practicing lawyers and bar groups were also favorable, for the most part, but raised a number of critical issues. Leah Granof, writing for the Advance Directive Committee of the State Bar Estate Planning, Trust and Probate Law Section, notes that the Committee “unanimously applauds, commends and compliments” the Commission on the tentative recommendation. The Committee finds it “scholarly, concise and easy to read” and was “pleased that so many of our suggestions were incorporated into the recommendation.” (Exhibit p. 21.) Jeannette Hahm, Chair of the Probate, Trusts and Estates Section of the Beverly Hills Bar Association, writes (Exhibit p. 44):

[W]e commend the … Commission in its efforts to provide comprehensive rules dealing with health care issues and decision making for incapacitated adults. We realize that this is a very difficult and highly personal area of the law that is riddled with sensitive issues. Practically speaking, many of the health care decisions required to be made on a daily basis may not be readily resolvable, but we appreciate the goal of the proposed legislation to establish an orderly decision-making process to resolve these difficult health care decisions.

Stuart D. Zimring has some serious concerns, but he reports that he has been following the evolution of the Commission’s recommendations and has “in general, been supportive of those efforts.” (Exhibit p. 51.) Elizabethanne Miller Angevine commends the Commission “for the effort to make health care decision making by surrogates more available to the majority of our populace who do not have written medical decision making planning.” (Exhibit p. 53.)

Comments from watchdog groups and public interest litigators were more negative or critical: Eric M. Carlson, Director of the Nursing Home Project, Bet Tzedek, expresses appreciation for the “Commission’s work on this important topic” (Exhibit p. 31.), while remaining highly critical of the core provisions concerning surrogacy for the “friendless” and the determination of the most
appropriate surrogate from the statutory list. Bet Tzedek’s fundamental concern is that health care providers should play an advisory role and should never have authority to make or dictate a health care decision. The National Senior Citizens Law Center was noncommittal about the tentative recommendation as a whole, preferring to submit comments on the assumption that the Commission will propose legislation including the surrogate committee concept. (Exhibit p. 47.)

MAJOR ISSUES

The following material considers a number of major issues that were raised in the comment letters. As noted above, a host of technical and minor issues are discussed in the Staff Notes following relevant provisions in the attached draft. (In some cases, you may have difficulty locating the reference point in the draft because some writers directed comments to earlier drafts and others directed comments to page and line numbers, which are different in the attached staff draft. If you need to pinpoint a reference, you may need to refer to your copy of the tentative recommendation.)

Primary Physician’s Authority To Select Most Appropriate Statutory Surrogate — § 4712 (pp. 74-76)

A number of commentators object in varying degrees to the role the primary physician is given under Section 4712 to select the best qualified statutory surrogate. They do not consider the specific substantive standards in subdivisions (b) and (c) to be sufficient protection. Legal service and nursing home patient advocates object on principle to affording physicians a role that may bear on making health care decisions, even if it is indirect and subject to statutory standards. They do not believe the statutory standards would be effective in practice, particularly in view of their “subjective” nature. There is a suspicion that a physician will select a surrogate, not based on the statutory standards, but in order to find a person who agrees with the physician’s recommendations, thus permitting the substitution of the physician’s judgment for the patient’s. They argue that this scheme would create a conflict of interest that is contrary to California case law. We will not repeat all of their arguments here, but direct your attention to the attached letters. (See Bet Tzedek, Exhibit pp. 25-27; California Advocates for Nursing Home Reform, Exhibit p. 41.)

Ruth E. Ratzlaff would “be more comfortable if there was a way to have the matter reviewed by a facility’s bio-ethics committee if the family disagreed with
the doctor’s choice of surrogate.” (Exhibit p. 10.) She recognizes the problem that the proposal is trying to address, but is “troubled that a primary physician is put in a decisionmaking role in selecting a surrogate other than a person who would rank highest in the statutory priority.” She wonders if the doctor wouldn’t “select a surrogate based on that surrogate’s agreement with the doctor’s assessment.”

Stuart D. Zimring finds that the “formalization of Surrogate Health Care Decisionmakers, as currently proposed in Section 4712 creates serious concerns.” (Exhibit p. 51.) He is concerned with relying on the primary physician to make the selection, and concurs completely with the comments of Eric Carlson, of Bet Tzedek. But he is also concerned with the “concept of Statutory Surrogacy itself” as discussed in the next section.

The Executive Committee of the Probate, Trusts and Estates Section of the Beverly Hills Bar Association, however, “particularly likes the statutory surrogates rules: these rules provide guidelines for the health care provider in choosing a decision maker while giving the health care provider the necessary flexibility in making his or her decision.” (Exhibit p. 44.) However, the Committee expresses some general concerns about the effect of the “practice of health care becoming more impersonal, the doctor-patient relationship is not as it used to be.” This concern has been expressed by Commissioners at past meetings, as well.

Dr. Robert D. Orr finds that the surrogate priority list “is a very good concept, and the guided flexibility given to the primary physician is superb.” (Exhibit p. 11.)

Elizabethanne Miller Angevine writes that “[f]undamentally this is a much needed and beneficial provision.” (Exhibit p. 56.) She would like to see the recordkeeping duties tightened up, however, particularly with regard to any application of the “reasonably available” standard. (See the Staff Note following Section 4633.) She also suggests adoption of some burden shifting rules so that if certain steps are performed and recorded, the burden would shift to a person who is attempting to show that no reasonable effort to find the person was made. This is an interesting proposal and has some appeal. The staff thinks the recordkeeping duties need to be tightened up and made more explicit — several writers expressed concern about this aspect of the tentative recommendation. We do not know whether it is advisable to provide detailed rules on burden-shifting, however.
The California Medical Association, however, expresses qualified support: “[W]hile continuing to question the need for, and value of, a statutory surrogacy law, CMA can support such a law with the proposed provision enabling a primary physician to select the most appropriate surrogate in certain circumstances.” (Exhibit p. 60.) CMA remains opposed to the “reasonably appears after a good faith inquiry” standard applicable in the determination of who is the best surrogate candidate under Section 4712, as discussed in the Staff Note following that section. We understand that CMA sees a potential for liability in this language, but the problem we face in connection with the scheme in Section 4712 is that many commentators think it is too loose, or easily evaded, or really no standard at all. The staff thinks the existing statement is a good standard from a policy perspective, and should be retained, even though it may make a majority of our commentators unhappy for a variety of reasons.

The California Healthcare Association would reverse the priority of the concepts in Section 4712, providing authority for the physician to select the surrogate based on the statutory factors, with the priority scheme as a fallback. (Exhibit p. 69, ¶ 23.)

Often the need for a surrogate arises when there is a decision to be made and insufficient time to explore many options. It is likely under conditions where there is a sense of urgency, that the priority scheme will be misused because time constraints and staff concerns will discourage health care providers from thoroughly exploring the priorities to reach the most appropriate person as a surrogate. In addition, the priority scheme, even when physician discretion is permitted, is often the source of discord when the person requiring a surrogate is in a homosexual or domestic partner relationship.

Anecdotal reports suggest that in practice many health care providers may take the practical and humane approach of looking first to the individuals present who fit the sort of substantive criteria set out in Section 4712(c), without attempting to find all family members who might be able to give consent under the Cobbs v. Grant dictum (“closest available relative”).

As discussed in the preliminary part of the recommendation (see pp. 9-16 in the attached draft), the law is vague. The federally mandated Patient Information Pamphlet says “your doctor will ask your closest available relative or friend to help decide what is best for you.” (Id. at 12.) One of the major purposes of the Commission’s recommendation is to provide greater guidance while preserving
important flexibility in this area, with the underlying goal of achieving the goal of best effectuating the patient’s intent. The rules in Section 4712 are consistent with the general understanding as reflected in the Patient Information Pamphlet, and would provide meaningful authority as well as important standards.

Some commentators think there is too much discretion given physicians by Section 4712, although they are ignoring the reality as reflected in the Patient Information Pamphlet. Others think the priority scheme will operate too mechanically, even with the built-in flexibility. **The staff thinks the flexibility under the standards in subdivisions (b) and (c) is crucial.** These rules derive from the best practice under existing law and custom. There may be additional improvements than can be made in the language of the standards. In addition, the statute needs to make abundantly clear that application of the standards and the findings made by the primary physician are to be recorded.

**Order of Statutory Surrogates — § 4712(a) (p. 74)**

Ruth E. Ratzlaff (Exhibit p. 10) applauds the recognition of domestic partners, but believes the priority should be second, just after spouses.

Stuart D. Zimring is concerned with the “concept of Statutory Surrogacy itself.” He thinks the formalization and setting down a hierarchy will create a serious problem for persons living in non traditional relationships. This is true whether they are “same sex” or heterosexual couples and regardless of the age of the individuals. In such circumstances, to place the domestic partner as sixth in the hierarchy does a disservice to the commitment of the relationship and may well create contentious and adversarial situations where [none] need otherwise exist.

(Exhibit p. 51.) The Commission is aware of this issue and, of course, the way the tentative recommendation attempts to address the problem inherent in a hierarchy of statutory surrogates is to provide qualification standards which, in Section 4712, are applied by the primary physician. The standards soften the rigidity of a hierarchy. If the standards are knocked out because of objections to permitting anyone connected with health care to make these determinations (notwithstanding that they are being made countless times every day throughout California in the absence of statutory recognition or standards), then of course the hierarchy is objectionable for being too rigid or wrongly ordered.
Mr. Zimring relates his experience which suggests he should be in support of the rule in Section 4712:

On a number of occasions I have been involved representing parties where it was clear from all of the indicia of the relationship that the domestic partner was the one who should have health care decisionmaking capacity. However, when a medical crisis arose, the health care providers turned to blood relations who often did not approve of the relationship (a scenario especially true in same-sex relationships). Under such circumstances the blood relations use the medical crisis as a means of “getting even” with the domestic partner by not only stripping them of their decision making capacity, but also prohibiting them from visiting the ill partner or otherwise being involved.

(Exhibit p. 52.) Mr. Zimring states that it would be a “serious disservice” to the populace of California “where non traditional relationships abound” by formalizing a hierarchy. However, he concludes by suggesting that a hierarchy be established as a matter of law, without the power to adjust priorities, and that the domestic partner (subdivision (a)(6)) and the spouse be given the same top priority position.

The State Bar Advance Directive Committee renews its concern that a “life partner” should be in the second position following the spouse. (Exhibit pp. 22-23.) As a compromise, the Committee suggests deleting subdivision (a)(7) and replacing it with the uniform act language:

If none of the individuals eligible to act as surrogate [under paragraphs (1)-(6)] is reasonably available, an adult who has exhibited special care and concern for the patient, who is familiar with the patient’s personal values, and who is reasonably available may act as surrogate.

Section 5 of the UHCDA has a two-tier system, with the spouse, adult children, parents, and adult siblings prioritized in the first tier, and an adult who has exhibited special care and concern (etc.) in the second tier. The second tier surrogate can act only if none of the first tier candidates is reasonably available. Another feature helps this scheme operate: a surrogate is called upon to assume authority and notify members of the patient’s family. This was our starting point in developing “family consent” rules, but it was felt to be too rigid, and the Commission approved the rules in Section 4712 (drawn in part from a recent West Virginia statute), after briefly considering a family consensus scheme like
the one enacted in Colorado. The staff does not see that adopting the UHCDA approach is any different than adopting the order of the tentative recommendation. The UHCDA rule requires that none of the higher priority surrogate candidates be “reasonably available” before the friend or partner can qualify. If there is concern about the rigidity of the priority scheme, that is not solved by adopting the less flexible UHCDA approach.

The staff believes, however, that a crucial part of the Advance Directive Committee’s proposal is to move the “life partner, long term relationship” category to the second position. If this is done, then one of the primary objections to the priority scheme is resolved because the presumptively closest relationship would have a higher priority than potentially more distant relationships, geographically and socially. However, it still doesn’t take care of the problems where siblings disagree or where the standards listed in Section 4712 would lead to a better choice than the priority scheme.

In light of the comments we have received on this issue, which consistently urge moving the “life partner” or “domestic partner” category up in the priority scheme, the staff recommends that this category be moved to the second position. We think this is appropriate whether the statute contains flexible standards or some other approach.

Surrogate Committee for the “Friendless” Patient — §§ 4720-4726 (pp. 78-81)

The California Medical Association “supports the concept” of a surrogate committee. (Exhibit p. 60.) “Medical decisionmaking for such patients has long been extremely problematic, and CMA applauds the Commission for having developed a workable solution to this previously intractable dilemma.”

The Executive Committee of the Probate, Trusts and Estates Section of the Beverly Hills Bar Association thinks that the “surrogate committee is a very good idea” and agrees with the majority and unanimity rules in Section 4724. (Exhibit p. 44.)

Dr. Robert D. Orr finds that this is a “much needed addition.” (Exhibit p. 11.) He writes:

I am convinced that the proposed committee format gives adequate protection from inappropriate or premature decisions to limit treatment for a vulnerable and friendless patient. I believe that the proposed surrogate committee would formalize and authorize what is actually happening in practice now, and it would prevent
or discourage the occasional instances where individual physicians may now unilaterally decide to limit treatment.

Dr. Lawrence J. Schneiderman, on the other hand, writes that Section 4720 is “evidence of a singular confusion about what takes place in a healthcare setting.” (Exhibit p. 8.) He is concerned about the scope of the surrogate committee procedure:

Does this draft seriously mean all healthcare decisions? … An enormous number of day-to-day decisions are made by physicians. To require the kinds of involvement by other parties set forth in the document would be impractical. I believe this document should limit itself to healthcare decisions involving [forgoing] of life-sustaining treatment.

(Id. & Exhibit p. 12, emphasis in original.) While the primary concern and the focus of most of our discussions in this area has been on life-sustaining treatment, the underlying issue concerns health care decisionmaking generally for adults who lack capacity, as well as advance planning techniques for anticipating the need for a decisionmaker and providing appropriate direction to the surrogate decisionmaker. The legal principle in question is the same. Informed consent is required (except in an emergency) before treatment can be administered. This principle is not limited to issues of withholding or withdrawal of life-sustaining treatment. If a patient does not have capacity and has no family or surrogate decisionmaker, how can consent be given (or withheld)? This issue is not limited to life-sustaining treatment issues. The surrogate committee rules are consistent with the Epple bill approach, which applies to any “medical intervention that requires informed consent.” Health & Safety Code § 1418.8(a), (d) (see pp. 105-07 in attached draft). The statute does not envision that a committee will be convened daily to make the minutest decision, but rather that a course of treatment or a critical decision would be made by the committee, just as consent would be obtained in other circumstances.

Dr. Schneiderman is concerned that the committee would actually be making the decision: “Decisions by committees are notoriously devoid of responsibility.” (Exhibit pp. 8-9.) He proposes revising Section 4721 to effectively give the physician the decisionmaking authority subject to a duty to consult and obtain approval of the committee. He would use the institutional ethics committee. Dr.
Schneiderman may be correct about the diffusion of responsibility on a committee, but the intent of the proposal is to place the authority with the surrogate committee in a case where there is no other available decisionmaker. We could perhaps meet some of Dr. Schneiderman’s concerns if we were to adopt a dual committee approach: (1) Routine “medical interventions” would be handled by the Epple bill “interdisciplinary team” approach (attending physician, registered professional nurse with responsibility for the patient, other appropriate staff, and “where practicable” a patient representative). (2) Major or critical decisions, including decisions concerning life-sustaining treatment, would be the responsibility of the surrogate committee.

Eric M. Carlson, Bet Tzedek, finds the proposal “much too casual and manipulable, given the life-and-death issues that may be at stake.” (Exhibit p. 28.)

Patricia L. McGinnis, Executive Director of California Advocates for Nursing Home Reform (CANHR), expresses a number of concerns with the surrogate committee proposal, “not the least of which is that it … relies substantially (and erroneously) on” the Epple bill and would repeal it. (Exhibit p. 41-43.) CANHR opposed the Epple bill, but Ms. McGinnis is concerned that some important protections in Section 1418.8 have been lost in the translation to the surrogate committee process. This is not the intent, and where clarification is needed, the staff recommends that appropriate language be added. For example, the recordkeeping rules (e.g., Section 4732) need to make clear that the determinations of incapacity, and the nature and basis of the decisions of the surrogate committee, will be documented and recorded; access to the patient’s records, including such documentation, under Section 4676 should also apply to the “patient representative.” The suggestion (Exhibit p. 42) that the recommendation would eliminate due process protections existing under Section 1418.8(j) permitting the patient to obtain judicial review of a “medical intervention” is unfounded, since proposed Sections 4765 and 4766 cover this subject and more.

Ms. McGinnis writes that CANHR opposes the surrogate committee proposal and instead recommends amending the court-authorized medical treatment procedure in Probate Code Section 3200 et seq. to cover life-sustaining treatment issues. This, of course, the Commission is also recommending. (See pp. 117-25 in the attached draft.)
Composition of Surrogate Committee — Section 4722(b) (p. 79)

Dr. Ronald B. Miller is concerned that the “regularly associated with” language in Section 4722(b)(5) would eliminate community members who serve on ethics committees and even an independent ombudsman. (Exhibit p. 5.)

Dr. Lawrence J. Schneiderman thinks there are “several faulty and impractical suggestions made in this section.” (Exhibit p. 9.) He would replace the standard for the community member in subdivision (b)(5) — “who is not employed by or regularly associated with” the health care providers — with “who has no personal or financial conflict of interest, i. e., a community representative on an ethics committee.” He reasons:

It is important to note that the best surrogate committee would be a regularly scheduled, knowledgeable, and experienced ethics committee. It is not enough simply to have “outsiders” review complicated medical-ethical decisions, but rather individuals who are aware of ethical complexities and bring this knowledge and experience to the decision.

Eric M. Carlson, writing for Bet Tzedek, objects that the surrogate committee would be comprised primarily of health care providers. (Exhibit pp. 27-28.) He argues that this would violate the patient’s rights to privacy and due process. “The proposed process is much too casual and manipulable, given the life-and-death issues that may be at stake.” Noting that the precedent for the surrogate committee is the Epple bill interdisciplinary team, he finds it significant that that procedure is limited to “relatively nonintrusive and routine, ongoing medical intervention, which may be afforded by physicians in nursing homes; it does not purport to grant blanket authority for more severed medical interventions such as medically necessary, one-time procedures which would be carried out at a hospital or acute care facility” — quoting the characterization of the Epple bill procedure in a dictum in *Rains v. Belshé*, 32 Cal. App. 4th 157, 186, 38 Cal. Rptr. 2d, 202 (1995). He is correct about the limitations in Health and Safety Code Section 1418.8. But we are not arguing a case before the Court of Appeal. The scope of the surrogate committee statute is intentionally broader than the Epple bill. If the Epple bill covered all types of health care decisions, all that would need to be done is expand the type of institutions it covers. But the Commission recognizes that the interdisciplinary team approach is not adequate for end-of-life decisions — hence the search for the appropriate composition of the
surrogate committee and setting correct standards governing its decisionmaking. We don’t know whether this or some other variety of a surrogate committee may be held unconstitutional. Before Rains no one knew or a fact whether Section 1418.8 was constitutional.

Mr. Carlson does not think that including a “patient representative” on the committee would remedy the constitutional defects. (Exhibit p. 29)

First, any patient representative would be outvoted by the health care providers on the surrogate committee. Second, there is no explanation how a “patient representative” even could exist for an individual who, by definition, has no surrogate. The mention of a “patient representative” in section 4722 … is a way of ignoring the underlying problem — in most cases, an individual without a surrogate has no one who could act as a “patient representative.”

The patient representative is a person who represents the patient. It is not intended to be the legal representative (i.e., surrogate) of the patient. The patient representative could be a family member or a friend who is unwilling to act as surrogate, as explicitly stated in Section 4722(a)(4), so it is inaccurate to say that you can’t have a patient representative if you don’t have a surrogate. A patient representative may also be a person who regularly serves this function as a volunteer or as a member of a nonprofit organization. The category is meant to be flexible. Mr. Carlson is right, however, that there would be cases where there is no patient representative. And if the constitutionality or advisability of the surrogate committee proposal depends on the presence of a patient representative, then it would fail. But the staff does not think that is the case. The important function of an independent person without a potential conflict of interest is served by both the patient representative and the community member, and by the requirement that decisions to withhold or withdraw of life-sustaining treatment must be made by a unanimous committee.

Mr. Carlson finds that the surrogate committee proposal is an “overreaction to problems that should be addressed through the amendment of currently-existing procedures,” namely expanding the court’s authority under Probate Code Section 3200 (see pp. 117-25 in the attached draft) and by mandating that Public Guardians “consider the refusal of life-sustaining treatment in appropriate circumstances” (see pp. 114-15 in the attached draft). (Exhibit p. 30.) He rejects the argument that courts are ill-suited and should be reluctant to get involved in major treatment decisions.
Herbert Semmel, writing for the National Senior Citizens Law Center, is concerned with reducing institutional dominance of the surrogate committee. (Exhibit pp. 47-49.)

One of the principal problems with surrogate committees as proposed is the close relationship between most of the committee members and the management of the nursing facility or RCF [residential care facility]. Institutions may have conflicts between the institutional interest and that of the resident in some situations. Decisions which seem routinely medical may have underlying motives that are not in the interest of the patient. For example, tube feeding may be sought by a nursing home as a convenience for an understaffed facility unwilling to provide the necessary assistance to a resident who can swallow but needs to be fed.

... Section 4722 loads the committee with persons affiliated with the institution.... The physician [in a nursing home] may be disposed to defer to the wishes of management. Since it is the institution that selects the community member, the community member is likely to have ties to management.

Although it is often wise to have a variety of persons who treat the resident contributing to the deliberations of the surrogate committee, there is no reason why the committee voting process should be dominated by members affiliated with the institution. Therefore, we recommend that it be mandatory that the committee consist of, and be limited to, (1) the primary physician, (2) a member of the health care institution staff engaged in providing services to the resident and who has knowledge of the resident’s condition (including a nurse’s aide), (3) a patient representative ... (if available after a diligent search) and (4) a community representative ....

(Exhibit pp. 47-48.) In order to make sure the community representative is independent of the institution, Mr. Semmel suggests that the statute should require that the “community member be designated by the local affiliate of the State Long-Term Care Ombudsman Program. These programs operate largely through volunteers, many of whom visit the facility regularly and who may already be familiar with the resident involved in the surrogate decision. In addition, no payment should be made to the community representative by the institution for service on the surrogate committee or for any other reason.”

Mr. Semmel points out that “few nursing homes and virtually no RCFs have ethics committees, and few will undertake the expense of payment of an outside
ethics consultant.” (Exhibit p. 48.) Although the standard is not crystal clear, Section 4722(b)(6) requires participation by the ethics committee member or ethics consultant.

Elizabethanne Miller Angevine suggests that the family should be able to nominate the patient’s attorney or other people to be a part of the surrogate committee. (Exhibit p. 57.) “I have been asked by many out-of-town medical agents to represent them in bio-ethics meeting. I’ve never been allowed by the facility to do this…. Often I know more about my client’s medical wishes [than] do distant family members.” The staff thinks this is a good suggestion. It may not apply in very many cases, since if there is an agent or a caring family, we would expect them to act as surrogate or make an effort to work with the surrogate committee, but it could be useful in situations where they cannot be present at the surrogate committee meeting. A conceivable danger might be that the surrogate committee could become unwieldy if many distant family members start naming representatives to serve on the committee.

In consideration of these comments and suggestions, the staff concludes that it may be necessary to have two types of surrogate committees: one for long-term care facilities and another for acute care hospitals. Starting with the list in Section 4722:

For long-term care facilities:

(b) The surrogate committee shall include the following individuals:
(1) The patient’s primary physician.
(2) A registered professional nurse or nurse’s aid with responsibility for the patient and with who is engaged in providing services to the patient and who has knowledge of the patient’s condition.
(3) Other appropriate health care institution staff in disciplines as determined by the patient’s needs.
(4) One or more A patient representatives representative, who may be a family member or friend of the patient who is unable to take full responsibility for the patient’s health care decisions, but has agreed to serve on the surrogate committee, or an adult named by the patient’s agent or surrogate who is unable to participate in the surrogate committee.
(5) In cases involving critical health care decisions, a A member of the community, who is selected by the [Office of the State Long-Term Care Ombudsman], and who is not employed
compensated by or regularly associated with the primary physician, or the health care institution, or employees of the health care institution.

(6) (5) In cases involving critical health care decisions, a member of the health care institution’s ethics committee, if any, or an outside ethics consultant.

For acute care hospitals:

(b) The surrogate committee shall include the following individuals:

1. The patient’s primary physician.
2. A registered professional nurse or nurse’s aid with responsibility for the patient and who is engaged in providing services to the patient and who has knowledge of the patient’s condition.
3. Other appropriate health care institution staff in disciplines as determined by the patient’s needs.
4. One or more patient representatives, who may be a family member or friend of the patient who is unable to take full responsibility for the patient’s health care decisions, but has agreed to serve on the surrogate committee.
5. In cases involving critical health care decisions, a member of the community who is not employed by or regularly associated with the primary physician, the health care institution, or employees of the health care institution.
6. In cases involving critical health care decisions, a member of the health care institution’s ethics committee or an outside ethics consultant.

Mr. Semmel suggests that voting be limited to four persons in the long-term care setting: the physician and nurse and the patient representative and community member. (Exhibit p. 48-49.) He would require two community members if there is no patient representative, apparently to keep the balance between health care professionals and “lay persons.” The staff is not opposed to this approach, although we would only require the second community member in critical health care decisions. Otherwise, the committee might be too cumbersome.

Other comments concerning the voting procedure are discussed in the Staff Note following Section 4724 (p. 81 in attached draft).
A Note on Ethics and Patient Representatives

Perhaps we should pause and consider the following, from *Rains v. Belshé*, 32 Cal. App. 4th 157, 183 n.6 (1995):

In this vein, we also need not give any particular credence to those suggestions of counsel, supported by opinions and editorial articles from newspapers, that physicians will abuse their powers and subject patients to unnecessary procedures under section 1418.8. The parade of horribles conjured up by counsel bears little relation to the prevailing ethics of the medical profession and ignores the need for participation by a patient representative under the statute. Further, we need not, and will not in this case, grant judicial notice or any dispositive weight to sensational suggestions in popular news articles which are not relevant to the statute under consideration, lacking evidentiary foundation. [citations omitted]

Conscience, Ineffective Care, Futile Care — Sections 4734-4736 (pp. 84-85)

There remains some tension between (1) the duty to continue care under Section 4736(b), and (2) the provisions permitting health care providers to decline to comply with a health care decision under Section 4734 for reasons of conscience (whether personal or an institutional policy based on conscience) and the right to decline to provide ineffective care or care contrary to generally accepted standards under Section 4735. There is also a general statement in Section 4654 to the effect that the statute does not “authorize or require” provision of health care contrary to generally accepted health care standards. The Commission discussed these problems at some length at the April meeting, but did not arrive at a solution — this is reflected in the statement in the Comment recognizing the potential conflict in duties.

The issue of futile treatment is not an easy one. Professor Meisel writes that there is a “substantial and ever-growing debate among physicians and medical ethicists about the existence of an obligation to provide ‘futile’ medical treatment.” 2 A. Meisel, The Right to Die § 19.1, at 530 (2d ed. 1995). The AMA Code of Medical Ethics added a statement on this subject in June 1994:

**Futile Care.** Physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patients. Patients should not be given treatments simply because they demand them. Denial of treatment should be justified by reliance on openly stated ethical principles and acceptable standards of care …, not on the concept of “futility,” which cannot be meaningfully defined.
Dr. Ronald B. Miller raises several concerns about the interrelation between
the conscience exception in Section 4734 and the duty to provide continuing care
in Section 4736(b). (Exhibit p. 6.) Dr. Miller notes that

there is substantial discussion within the medical and bioethics
professions regarding possible development of clinical practice
guidelines for dealing with “futility,” but I believe we are far from
consensus on this matter. …[W]hen there is a disagreement as to
whether or not a health care intervention is “futile,” it may be the
price the medical profession and society have to pay to provide that
intervention in order not to lose the confidence of the public since
trust is essential to effective health care.

Dr. Miller does not think it is clear that continuing care under Section 4736(b)
does not include futile care. (Exhibit, p. 6.) He would revise the continuing care
rule by adding “or until it is evident that the transfer cannot reasonably be
accomplished.”

The California Healthcare Association thinks it is unlikely another institution
will accept a transfer where the situation involves futility. (Exhibit p. 70, ¶ 29.)
“Requiring the transfer of a patient under these conditions is onerous, unduly
burdensome and likely to be unsuccessful, thereby subjecting the institution
and/or provider to potential liability.” CHA suggests “incorporating language
that addresses the patient’s ability to be transferred” and “authorizing judicial
intervention in these circumstances, on a case by case basis.”

The California Medical Association is concerned that the obligation to
provide continuing care under Section 4736(b) will override the authority in
Section 4735 to decline to provide ineffective health care or care contrary to
generally accepted health care standards. (Exhibit p. 62.) The result would be that
ineffective care would be required even though the patient cannot be transferred
to another facility (which is likely the case in this type of situation). “CMA
believes that demands for excessively invasive, aggressive or inappropriate care
need not always be followed, even if a patient cannot be transferred.” To resolve
the potential conflict, CMA recommends making the rule in Section 4736(b)
subject to the rule in Section 4735.

Eric M. Carlson, writing for Bet Tzedek, thinks there is “no reason” for the
recommendation to evade the issue. (Exhibit p. 31.) He recommends revising
Section 4736 “so that, when a transfer cannot be arranged, the provider or
institution must comply with the patient’s decision.” Of course, the patient’s
decision may not be known. But where it is, and the patient has directed futile treatment, Mr. Carlson’s suggestion is not much of a solution.

The staff still does not know how best to resolve the issues that have been raised. The CMA proposal would make clear that the ineffective care rule prevails. Another approach would be to try to delineate the meaning of “continuing care” in Section 4736(b), perhaps by referring to continuing palliative care and basic life-support or stabilizing treatment. But we are leery of being too specific in this statute on this issue. There are federal statutes concerning “dumping” and probably a number of state and federal regulations that bear on the issue. It is not the intention of the Health Care Decisions Law to govern the practice of medicine or set detailed treatment guidelines. We think the sections in question are drafted with the idea of being in general conformity with state and federal law governing medical practice and with developing principles of medical ethics.

Anatomical Gifts

Bruce Hudson Towne is concerned about the authority of surrogates (especially a surrogate committee) to make anatomical gifts. (Exhibit p. 59.) From his experience, many people strongly oppose giving their agent authority to make anatomical gifts. While some oppose it for religious reasons, others just have a “gut level aversion.” He questions whether surrogates should have this authority. Apparently, he would restrict the authority to agents given explicit authority under a power of attorney for health care, and would not permit anatomical gifts to be made by a statutory surrogate under Section 4710 et seq. (family consent statute) or a surrogate committee under Section 4720 et seq. (“the friendless”). His concern where health care professionals have a role in the decisionmaking process is that there is a possibility that there is an interest in “harvesting” the patient’s organs.

This is a serious point, but the staff does not think the tentative recommendation provides a general authorization for anatomical gifts. Under Section 4683, the authority is only granted to agents under powers of attorney for health care, who are given authority for three types of post-death actions: (1) dispositions under the Uniform Anatomical Gift Act, (2) authorization of an autopsy, and (3) disposition of remains. (The optional statutory form in Section 4701 also provides a place for the patient to make anatomical gifts — for some concerns about this part of the form, see the Staff Note following Section 4701 in
the attached draft.) The proposed law does not provide any authority for statutory surrogates or surrogate committees to make anatomical gifts. Nor do we think it is implied in the statute. If the Commission thinks it is needed, however, we could add reassurance in appropriate Comments to sections dealing with the authority of surrogates.

The situation is somewhat different under existing Section 4609 which defines “health care” to include certain “decisions affecting the principal after death.” This language was included to avoid a hypertechnical argument. That doesn’t concern us here, because the proposed definition of health care in Section 4615 does not continue this language.

The only remaining substantive issue, we think, is whether the agent under a power of attorney for health care should automatically have the power to make anatomical gifts unless the power is restricted, or, as Mr. Towne may be suggesting, whether the authority needs to be explicit in the power of attorney. Existing law automatically grants the authority to the agent and the staff is inclined to continue existing law. Does the Commission want to require explicit authority on this point?

As we consider Mr. Towne’s point, it became apparent that there is an inconsistency between the grant of authority to the agent in Section 4683 and the structure of Part 3 of the optional statutory form. The form is structured to permit the person to check a box which results in making the anatomical gift. There is only a “yes” box. The person executing the form does not have a place to say “no.” If no box is checked and the advance directive appoints an agent, what is the agent’s authority? If a box is checked, what is the agent’s authority. This technical question is discussed further in the Staff Note following Part 3 of the statutory form in Section 4701.

Respectfully submitted,

Stan Ulrich
Assistant Executive Secretary
April 27, 1998

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

RE: Personal Recommendation’s and Comments on the April 1998 Staff Draft (for the California Law Revision Commission) of Health Care Decisions for Incapacitated Adults.

Dear Mr. Ulrich:

I very much appreciated the opportunity to attend the April 23rd meeting of the Commission, to make comments then, and to add further comments at this time as we discussed on April 24th. I believe you and the Commission are to be commended for an excellent current draft of the Health Care Decisions Law (HCDL) – based upon the Uniform Health-Care Decisions Act of 1993 (UHCD) – which is to be submitted to the Legislature. I will comment sequentially on the draft text (rather than making comments in order of importance) to facilitate your review of my comments.

**Title:** First, let me support your intent to have the title of the law indicate its scope, though I fear the term “incapacitated” in the revised title, “Health Care Decisions for Incapacitated Adults” may not be understood by the public. One could change the title to “Health Care Decisions for Adults Incapable of Making Decisions for Themselves” (probably the best title for public understanding) or to “Health Care Decisions for Adults who Lack or Have Lost Decision Making Capacity”, or to be somewhat briefer, “Health Care Decisions for Adults Lacking Decision Making Capacity”.

**Section 4653:** As discussed at the meeting, I believe Dr. Orr would disagree with Mr. Harley Spitler’s recommendation to delete the phrase “so as to permit the natural process of dying” because Dr. Orr believes the phrase emphasizes why it is justifiable to withhold or withdraw health care. I agree with Alice Mead, who recommended omitting the phrase
“pursuant to an advance health care directive or by a surrogate” (page B-14, line 5) because one could interpret the sentence as written to mean that the only way one may withdraw health care is if withdrawal is directed in an advance health care directive or requested by a surrogate. Perhaps it would be best to follow Mr. Skagg’s suggestion that one insert a period after the word “euthanasia” and begin a new sentence, phrased positively, “It does permit withholding or withdrawing of health care so as to permit the natural process of dying.” Finally, regarding this section, I agree with Alice Mead that it makes good sense to delete the words “mercy killing” since they are so variably interpreted.

**Section 4654:** As you know from his e-mail of April 22, Bob Orr hoped that the HCDL could somewhere include a statement that “a Jehovah Witness wallet card requesting no transfusion [is] a morally binding document which should be followed even if the patient were unconscious.” He noted it might be included in Section 4780, but you indicated preference not to alter that section on DNR requests (and Bob also felt that might not be the proper section for it anyway). He also mentioned Sections 4700 and 4701, and you noted that a patient could write a request not to receive transfusions under Item 9 of the Advance Health Care Directive (AHCD) on page B-35, Lines 1-5. I believe, however, that Dr. Orr hoped the matter could be explicitly mentioned in the HCDL, and thus I wonder if it might be included under Section 4654 on page B-14. Section 4654 points out that “This division does not authorize or require...health care contrary to generally accepted health care standards...”, and the matter of following a Jehovah Witness wallet card requesting no transfusion might reasonably fit in this Section (as an exception) were you to agree that it would be appropriate to make it explicit in the law.

**Section 4657:** This section states “a patient is presumed to have capacity to make a health care decision...”, but I believe Vicki Michel has pointed out that though this is ethically correct, Sections 811 and 812 of the Probate Code could be interpreted to indicate capacity needs to be demonstrated. Probate Code Section 811 states “...a person lacks the capacity to make a decision unless the person has the ability to communicate verbally, or by any other means, the decision, and understand and appreciate to the extent relevant, all of the following:...” and Section 812 states, “A determination that a person is of unsound mind or lacks the capacity to make a decision or do a certain act, including, but not limited to, the incapacity to make medical decisions...” and goes on to list a number of cognitive attributes. It is my understanding that the author of the Senate Bill 730 which I believe was the basis of these sections of the Probate Code, was willing to amend the law to sustain the presumption of capacity (in the absence of evidence to the contrary), but I am not aware that the law has been amended, and thus I wonder whether there is need for a conforming revision in this regard.

**Section 4659:** As written, the Section deals with a patient who has capacity, and notes that capacity moots a directive in the AHCD. Is it not important also to address the circumstance in which the person objects, but does not have capacity? Unless I am confusing the California with the Illinois law I believe the original DPAHC legislation allowed an objection to trump a directive in a DPAHC which was written when the
patient had capacity, even if the patient no longer had capacity at the time of the objection. I believe this should be specifically addressed in view of the prior law, even though I was not enamored of the prior law. Furthermore, I can imagine a patient writing a Ulysses contract into his AHCD to request that treatment be withdrawn (under a certain circumstance) even if after losing capacity the patient were to object.

Section 4665: Is there not a contradiction between lines 19-24 and lines 33-34 on page B-18? I interpret lines 19-24 to suggest that the new law would apply “to all advance health care directives”, and thus would override a prior directive, but lines 33-34 state “nothing in this division affects the validity of an advance health care directive executed before January 1, 2000, that was valid under prior law.”

Section 4681: In line 40 of page B-24, would it be helpful to add the words, “of a directive”, between “execution” and the word “formality”? 

Section 4695 and 4696: Some have advocated that when an AHCD is revoked, it should be destroyed, and deleted from medical records. I believe this is inappropriate, not only because knowing there had been an advance directive, one might search fruitlessly for it had it been destroyed and removed from the record, but furthermore, because it might have directed medical care at a time in the past, and thus might be important for documentation were that medical care subsequently questioned. Thus, I have recommended when an AHCD is revoked, that a line should be drawn though each page of the AHCD, and the principal or the individual witnessing the revocation or correcting medical records to that effect, should sign and date a statement next to the line on each page, stating “revoked on ______”, and of course the date of revocation should appear in the blank. If the directive was revoked orally by the principal, and the health care professional were correcting records by noting the AHCD was revoked, he or she might wish a witness to sign the document as well.

Section 4696: This section indicates the individual informed of a revocation should communicate that fact “to the supervising health care provider and to any health care institution where the patient is receiving care”. I suggest we add the clauses “and to any provider or institution known or thought likely to have a copy of the now revoked directive, and to a provider or institution thought likely to provide health care to the patient in the future.”

Section 4697 states “If the agent’s authority is revoked solely by subdivision (a), it is revived by the principal’s remarriage to the agent.” I wonder if it could be revived also by a specific request for a new or amended AHCD by the principal. That is, should law preclude an individual from appointing his former spouse as an agent if that is his or her wish?

Section 4701: I agree with Kate Christensen that patients might unknowingly harm themselves by marking the box (line 26 on page B-34 in Subsection 7 on artificial nutrition and hydration) because of their failure to understand the medical circumstances
in which they might prefer nutrition and hydration to be forgone. Thus, one might wish to omit lines 24-28 and simply allow people (if they thought of it and if they wished to receive nutrition and hydration under all circumstances,) to indicate that in Subsection 9 (page B-35, lines 4-5).

Under Subsection 8 (line 30 on page B-34) I would add the words, “to be effective in pain relief,” between the words “even if” and “it hastens my death”. Without this addition, a person might misinterpret the section to suggest that he or she were requesting euthanasia of the health care provider.

Is it permissible in Subsection 9 on page B-35 to write a DNR request under “Other wishes” (in order to make the DNR request durable)? And if it is not permissible to do so, shouldn’t this be stated explicitly?

Under Subsection 11, I believe it would be helpful to have space for a third or even a fourth alternate primary physician on page B-36 after line 9?

In Subsection 13 (page B-36, lines 15 on) I believe it would be best for witnesses to be required, rather than optional, because of the importance of the AHCD.

I also believe it would be wise to have spaces for the primary and any alternate agent to sign their acceptance or acknowledgment of their responsibility under the AHCD. Finally, I believe we should allow space for the principal to indicate that he or she has revoked the advance directive, and the date of doing so, and the individuals notified. This might also be an appropriate place to have a space to indicate the date and location of a new AHCD if the individual wishes to prepare one rather than simply revoking the prior one.

Section 4712: Stan, you indicated some would like to place surrogate number 6 before surrogates numbers 1-5, but a decision seemed to have been made not to alter the list at this time. On the other hand, I wonder whether it would be well to indicate in line 44 regarding surrogate number 6 that this individual could be given priority amongst surrogates if determined (in good faith by the health care provider, i.e., the primary physician) to be best qualified.

Under this same Section, on page B-41, I believe that Alice Mead made a convincing argument that we should delete the word “reasonably” in both lines 5 and 12 since this indicates a higher standard than “good faith”, and the higher standard might be very difficult for a primary physician to achieve.

Section 4713: In line 29, page B-42, I would add the words, “or values or beliefs”, after the words “other wishes” and before the words “to the extent known to the surrogate”. I believe such substituted judgments should take priority over “best interests” even though some substituted judgments might even be judged not to be in the “patient’s best interests” by the surrogate or primary physician.

Section 4714: Is it the intent of this Section that “A patient at any time may disqualify another person” even if the patient at the time is lacking in decision-making capacity?

Section 4720: Should one further define (line 40, page B-42) “not reasonably available”? 

4
Section 4721: I suppose one might interpret lines 11-13 on page B-44 to suggest that it is the primary physician who may appoint a surrogate committee, but I agree with Mr. Skaggs that it should be explicit who should appoint the surrogate committee. As Dr. Orr has noted in the past, this might be relatively straight forward in a hospital setting (where quite possibly the Ethics Committee would either take on the responsibility or appoint a surrogate committee, and it might even be relatively straight forward in a nursing home as under the Eppele Bill, but as Dr. Orr noted, it might be much more complex in a homeless shelter or in a residential facility (whereas if the individual had a home, he or she probably would have someone to serve as a surrogate).

I agree with the Commission that the procedure “should replace the Eppele Bill”.

Section 4722: I strongly support the recommendation of Dr. Linda Daniels and the Bioethics Committee of the San Diego County Medical Society that “it is very important that the nurse (line 11 on page B-44) be knowledgeable about the patient, and not have mere supervisory responsibility”. I also agree with the second point in their memorandum of April 1, 1998, that subsection 5 (lines 17-19 on page B-45) could eliminate appropriate community members or employees who serve on the Ethics Committee, and might even eliminate the independent ombudsman.

If it is “not intended to restrict participation by other appropriate persons” (line 23 page B-45) would it not be appropriate to list examples of “other appropriate persons” in subsection 6?

Section 4723: What is meant by “the type of health care” on line 16, B-46? Is this intended to mean “curative” or “palliative” or is it intended to mean a type of health care intervention?

Section 4724: The notion that a single member of the surrogate committee could block or veto withholding or withdrawing life-sustaining treatment certainly generated substantial discussion. In general I agree with Dr. Orr that this would be inappropriate, but I also agree with Mr. Spitler that such decisions are extremely important and the committee certainly should strongly reconsider its position if there is a member opposed. Mr. Spitler indicated he did not “have any really constructive way to change this”, but Linda Daniels and some members of her Committee “felt that some type of super majority vote would be sufficiently protective of vulnerable patients”. And, as you know, I recommended that if a single member were opposed and this could not be resolved by further consideration by the committee, a new committee might be appointed. This may not be practical in all settings, but I think it is analogous to appointing a new jury after a mistrial.

Section 4730: I applaud the requirement of informing an incapacitated patient of decisions made for him or her, but this once again raises the question of whether an incapacitated patient can trump an agent’s decision (as I think was the case in a prior iteration of the DPAHCC).

Sections 4733, 4734, 4735, 4736: as you know all too well, these sections generated quite substantial debate and heat, and the Commission’s decision to await public
comment before considering these sections, may well be wise. On the other hand, I believe we must avoid applying the term “an objection of conscience” to the circumstance in which a physician or a hospital declares a health care intervention “futile”, “inappropriate”, or “non-beneficial” (and then declines to provide it for reasons of “conscience”). Indeed, there is substantial discussion within the medical and bioethics professions regarding possible development of clinical practice guidelines for dealing with “futility”, but I believe we are far from consensus on this matter. Further, I agree with Dr. Kate Christiansen, who recently stated that when there is a disagreement as to whether or not a health care intervention is “futile”, it may be the price the medical profession and society have to pay to provide that intervention in order not to lose the confidence of the public since trust is essential to effective health care.

Line 11 on page B-50 indicates the provider or institution must “provide continuing care to the patient until a transfer can be accomplished”, and it is not clear that “continuing care” does not include “futile care”. Furthermore, particularly if the latter is the case, I believe such care should not be mandated by law “until a transfer can be accomplished” if such transfer cannot be accomplished. Thus, I would add the clause, “or until it is evident that such transfer cannot reasonably be accomplished” to line 11.

The Staff comment on line 17, page B-50 states “nothing in this section requires administration of ineffective care”, and if this is decided upon it should probably be stated explicitly in Section 4736.

Part IV, Sections 4780-4786: The Staff note (line 10, page B-62) asks whether DNRs should be “treated as advance directives”. I believe that they should be, but that there ought to be mandated reconsideration if there is any change in the person’s health status, and perhaps every six months even in the absence of change. If it is decided that DNRs should not be treated as advance directives, then I think we must state that the patient may not write it into his advance directive. (e.g., in Subsection 9 on Page B-35)

The title of Part IV uses the word, “forego”, and I believe the word should be spelled “fargo” without the “e”, despite the fact that the President’s Commission spelled it with the “e”. It is my understanding that this is the general agreement amongst bioethicists and when spelled with the “e” the word means “to go before”.

Line 27, page B-62 mentions the “patient identification number”, and since this is the first time the phrase has been used, its meaning should probably be amplified as in line 32 on page B-64.

Section 4800: Line 1, page B-65 indicates, “The Secretary of State may charge a fee to each registrant in an amount such that, when all fees charged to registrants are aggregated, the aggregated fees do not exceed the actual cost of establishing and maintaining the registry.” I am concerned that such costs may be so large that they should not be borne by registrants alone. That is, since health care providers and society generally may benefit financially from such registration (e.g., in not providing undesired healthcare or in avoiding paramedic fire-wagons or ambulances speeding to resuscitate a patient who does not wish to be resuscitated, and perhaps worse becoming involved in a vehicle accident, and even worse causing an unnecessary death). Thus, I fear the potential for a registration fee being economic discrimination unless the fee is absolutely nominal.
Section 4802: Lines 21-22 on page B-65 state “A healthcare provider may not honor a written advance healthcare directive until it receives a copy from the registrant”, to which one might ask why oral statements are sufficient in other circumstances? Further, I fear this statement (relative to the potential for an error by the registry stating over the telephone what an AHCD directs) could be construed as extending to other circumstances. Once again, I think a “good faith” understanding of a patient’s advance directive should suffice, and that one should not always have to see the actual written directive, especially under emergency conditions or under circumstances that a copy of the directive cannot be obtained in a reasonable period of time. Perhaps we should simply recommend that the Registry fax a copy to the healthcare provider. It would then have received a copy, albeit not from the registrant, and it would be perfectly appropriate for the provider to honor the directive.

Conclusion: Once again, despite the length of these comments, I wish to compliment the Commission on a job extremely well done, and certainly want to support a new Health Care Decisions Law even if my many suggestions for improvement are not incorporated. I truly appreciate the opportunity to comment and look forward to future drafts and the opportunity for future comment. Please do not hesitate to contact me if any of my comments are unclear or if I can be of help in any other way.

Sincerely yours,

Ronald B. Miller, M.D.
Clinical Professor of Medicine
Director, Program in Medical Ethics

cc: Roger J. Purdy
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May 4, 1998

Stanley Ulrich
Assistant Executive Secretary
California Law Revision Commission
4000 Littlefield Road, Room D-1
Palo Alto, CA 94303-4739

Dear Mr. Ulrich,

Linda Daniels, MD, JD gave me a copy of the California Law Revision Commission Draft, Chapter 4, Healthcare Decisions for Patients Without Surrogates, Section 4720-3, 4725 for my comments.

As Co-Chair of the University of California San Diego Medical Center (UCSDMC) Ethics Committee and as a physician with over 25 years experience in clinical ethics, I have some concerns about the draft language at this time.

Chapter 4. Section 4720 Application of chapter: The statement reads: "This chapter applies to healthcare decisions where a healthcare decision needs to be made for a patient …" Does this draft seriously mean all healthcare decisions? If so, it is evidence of a singular confusion about what takes place in a healthcare setting. An enormous number of day-to-day decisions are made by physicians. To require the kinds of involvement by other parties set forth in the document would be impractical. I believe this document should limit itself to healthcare decisions involving withdrawal of life-sustaining treatment.

Section 4721. Referral to Surrogate Committee. The statement reads: "A patient's primary physician may obtain approval for proposed healthcare decision by referring the matter to a surrogate committee before the healthcare decision is implemented." Use of the term "referring the matter" suspiciously suggests that the surrogate committee will be empowered to
make a decision. Decisions by committees are notoriously devoid of responsibility. My suggestion is the following: "The patient's primary physician may obtain approval for proposed healthcare decision by consulting a surrogate committee, i.e. an ethics committee before the healthcare decision is implemented.

Section 4722. Composition of Surrogate Committee. In my opinion, there are several faulty and impractical suggestions made in this section. The most important point is in number 5, which should read: "In cases involving major healthcare decisions, a member of the community who has no personal or financial conflict of interest, i.e. a community representative on an ethics committee..." It is important to note that the best surrogate committee would be a regularly scheduled, knowledgeable, and experienced ethics committee. It is not enough simply to have "outsiders" review complicated medical-ethical decisions, but rather individuals who are aware of ethical complexities and bring this knowledge and experience to the decision.

Section 4723. Standards of Review by Surrogate Committee. Here I would suggest that 6b read as follows: "The ethics committee shall review the decisions and provide follow-up reviews on a reasonable basis in accordance with the patient's medical condition.

One small point with respect to Chapter 3. I am surprised that the useful term "substituted judgment," with respect to choosing a surrogate decision-maker as enunciated in the 1983 California Appellate Court decision, Barber v. Los Angeles Superior Court is never mentioned.

I hope these comments are helpful to you, please do not hesitate to contact me if you have any questions or comments.

Sincerely,

[Signature]

Lawrence Schneiderman, M.D.

LJS:sm

cc: Linda Daniels, MD, JD
California Law Revision Commission
4000 Middlefield Road, Room D-1
Palo Alto, CA 94303-4739

Re: Tentative Recommendation -
Health Care Decisions for Incapacitated Adults

July 16, 1998

Dear Commissioners:

I have reviewed your tentative recommendation on Health Care Decisions for Incapacitated Adults. My practice emphasizes planning for aging and incapacity, and I concur with your observation that only 20% of Californians make written Advance Directives.

That's one reason I'm concerned about your recommendation of priorities among surrogates when no Advance Directive is present. (This topic is covered on page 15 of the Tentative Recommendation.) I applaud the Commission's recognition of domestic partners as a potential surrogate. I believe, however, that the domestic partner should be just after the spouse in order for the recognition to have a beneficial effect.

I am also troubled that a primary physician is put in a decision-making role in selecting a surrogate other than a person who would rank highest in the statutory priority. I don't believe medical students or interns and residents are given training on how to make these decisions. Consequently, if the primary physician's values were different than the patient's, the doctor might select a surrogate based on that surrogate's agreement with the doctor's assessment.

I don't have a better alternative to offer, because these decisions are often made in times of urgency. I would be more comfortable if there was a way to have the matter reviewed by a facility's bio-ethics committee if the family disagreed with the doctor's choice of surrogate.

Thank you for the opportunity to respond to your recommendation.

Sincerely,

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MEMO

TO: Stan Ulrich, California Law Revision Commission
FAX 650-494-1827

DATE: August 4, 1998

RE: Comments on “Health Care Decisions for Incapacitated Adults”

Since I have had several opportunities to comment on earlier drafts of this tentative proposal, I will not clutter your mail with long comments. But I do want to reiterate my earlier impression that this proposal, if enacted, will address many of the problems which I encounter as a bedside ethics consultant every week.

The surrogate priority list is a very good concept, and the guided flexibility given to the primary physician is superb.

The surrogate committee for the “friendless” is also a much needed addition to California statute. I was disappointed and concerned to receive a copy of the April 30 letter to you from Leah Granof of the Estate Planning, Trust and Probate Section of the State Bar of California with its recommendation for court action in each case instead of the committee suggested. I hope that this sentiment represents a minority opinion. I know that practicing physicians would very strongly prefer to keep the decisions within the institution unless unresolvable conflict requires judicial intervention. I am convinced that the proposed committee format gives adequate protection from inappropriate or premature decisions to limit treatment for a vulnerable and friendless patient. I believe that the proposed surrogate committee would formalize and authorize what is actually happening in practice now, and it would prevent or discourage the occasional instances where individual physicians may now unilaterally decide to limit treatment.

Thank you for requesting comment, and thank you for your fine work.

[Signature]
August 17, 1998

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


Dear Stan:

Thanks for sending me the above materials at Bluff.

This letter covers the minutes of the C.L.R.C. June 4, 1998 meeting and the above memo and T.R.

I. EXHIBIT TO MEMO 98-42.

A. Probate Code § 3200:

I strongly favor and prefer the definitions in Section 4615 of the tentatively proposed Health Care Decisions Law.

B. § 3203:

To clarify “other interested person in (c), I suggest adding “( ) The patient’s agent under the patient’s durable power of attorney for health care or health care directive.”

C. § 3204:

1. Change opening lines to read:

   “The petition shall state, as set forth in a declaration of the patient’s physician attached thereto, all of the following that are known to the petitioner at the time the petition is filed.”

   The “declaration” should most certainly be that of the patient’s physician. We certainly don’t want some useless declaration of the patient’s barber or drinking buddy!

   2. (h) is much too wordy. I would delete: “knowingly and intelligently” in lines 4 & 5; “by means of a rational thought process” in line 6.
D. § 3206: In (a): Comma after word “patient” in second line, delete “and” in third line, add “and the patient’s agent under the patient’s durable power of attorney for health care or health care directive.” at end of third line.

In (c)(1): Change second and third sentences to read: “declaration of the patient’s physician attached to the petition or presented to the court.”

E. § 3207: Delete “medical” in second line and add “of the patient’s physician” after “declarations” in second line.

F. § 3208: In (b)(1): Add “to the petitioner” at end of third line.

G. § 3208: In (b): Delete “a” and substitute “the” in line 14, page 107.

H. § 3211(e): My reading of “(e)” is that the patient’s advance health care directive can both authorize and direct the “convulsive treatment” and sterilization referred to in “(c)” and “(d).” Because this has been a subject of considerable controversy, I suggest changing (e) to read as follows:

“The patient’s advance health care directive can authorize or direct the patient’s agent to either authorize or direct the patient’s “convulsive treatment” under “(c)” or the patient’s sterilization under “(d).”

II. JUNE 1998 TENTATIVE RECOMMENDATION.

A. Add word “LAW” to title in line 4.

B. § 4609: “significant” is a troublesome adjective in line 23. I would delete it.

C. § 4617: I very much like this sentence of your comment:

Thus, like former law, this section encompasses 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.

So, I would expand “(c)” to read:

(c) Directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care; and directions to begin, continue, increase, limit, discontinue, or not to begin any health care.
D. § 4621: In line 22, I would change “by the law of this state” to read “by law” or “by the law of any state.”

E. § 4627: Delete “and surgeon” in line 32. Every “surgeon” is a physician!

F. § 4652: Stan, as you know from my prior writings, I have always had U.S. Constitutional problems with this section since the first U.S. Supreme Court decision. I strongly believe (a), (b), (c) and (d) violate my “liberty interest” that I have under the 14th Amendment. Stated in a different manner, I believe that I have a U.S. Constitutional right to (a), (b), (c) and (d); and that neither California nor any other state can diminish or destroy that right. Neither you personally nor C.L.R.C. have ever addressed this issue. The comment is ridiculous: All the comment says is: That is the way it always has been in California!

Let’s take a case I had in actual practice:

**Facts:** P has a history of severe depression: unable to work; stays in bed, can’t sleep; won’t eat; medication has not helped. Under his physician’s supervision, P has a form of convulsive treatment and/or psychosurgery (commonly called “shock treatment” or “shock therapy”).

When P comes to me for a DPAHC, he is primarily concerned that he might become mentally incapacitated and deeply depressed. He wants to be certain that his Agent can both authorize and direct the same course of convulsive treatment and/or psychosurgery that previously cured his severe depression.

So, I draft P’s DPAHC as he wished.

Both you and C.L.R.C. should revisit this problem. If not, you will continue to look ridiculous on this issue.

“(e)” should remain as an unauthorized act because it concerns another potential person: the unborn fetus!

G. § 4662: Change “may” to “shall.”

H. § 4665(a): I believe that there is an inconsistency between (a) and (d).

Subdivision (d) is very clear, namely, “an advance health care directive executed before January 1, 2000, that was valid under prior law” is not affected and remains valid.

However, Subdivision (a) says the contrary:

(a) On and after January 1, 2000, this division applies to all
advance health care directives, including but not limited to durable
powers of attorney for health care and declarations under the
former Natural Death Act (former Chapter 3.9 (commencing with
Section 7185) of Part 1 of Division 7 of the Health and Safety
Code), regardless of whether they were given or executed before,
on, or after January 1, 2000.

So these two subdivisions have to be clarified. Something like this in Subdivision (a):

(a) On and after January 1, 2000, this division applies to all
advance health care directives, including but not limited to durable
powers of attorney for health care and declarations under the
former Natural Death Act (former Chapter 3.9 (commencing with
Section 7185) of Part 1 of Division of the Health and Safety Code),
regardless of whether they were given or executed before, on, or
after January 1, 2000, excepting any advance health care directive
executed before January 1, 2000, that was valid under prior law
remains valid.

I. § 4697:

1. “(a)”: change to read:

A decree of annulment, divorce, dissolution of marriage, or legal
separation revokes a prior designation of a spouse as agent unless
otherwise specified in the decree or in a power of attorney for health care.
This is the same as Section 3(d) of the UHCDA.

2. “(b)”: As written, “(b)” is contrary to the real world experience of any
person, woman or man, who has been through a bitter divorce, followed by a reconciliation and
remarriage to the same spouse.

I favor deleting “(b).” If P wants to appoint the remarried spouse as agent, that’s fine. let P create
a new DPAHC!

J. § 4701: “Part 2” on page 59 needs revision.

1. Prelude: For some inexplicable reason, I never focused upon the first two opening
sentences of Part 2; and focused only upon 2.1, 2.2 and 2.3.

From my perspective Part 2 is the second most important part of the statutory form - that is why
it is Part 2. The most important part of the form is Part 1 which designates the agent. Part 3 is
optional. Part 4 is optional. Part 5, after the signature of the principal, is optional. Part 6 pertains only to a patient advocate or ombudsman.

2. My suggestion.

A. The first two opening sentences of Part 2 are not necessary and should be deleted because the instructions in 2.1, 2.2 and 2.3 should always be completed by the principal ("P"). That is my first and primary suggestion.

B. My first alternate suggestion is: delete the first opening sentence of Part 2 because it is both wrong and will be confusing to many principals. Then, I would change the second sentence to read:

“You may strike any wording you do not want in this part of the form”

Please note that this sentence is not necessary because the 4th sentence of the opening “Explanation” (page 56, lines 19-20) says:

“If you use this form, you may complete or modify all or any part of it”

However, I prefer leaving in my above sentence so as to make it very clear to the P that the P can strike any working not wanted. That will be especially helpful to laymen and unsophisticated attorneys who are using the form.

Also, in “Part 2,” under 2.1(a)(1), I suggest “within a relatively short time” should have a comment on page 63. Something like this:

“A relatively short time is not an absolute length of time. The length of time will vary in duration greatly depending entirely upon the patient’s medical condition and prognosis as determined by the patient’s primary physician.”

§ 4712(a):

Change “(1)” to read:

“The Patient’s spouse unless that spouse is living separate and apart from the patient with no intention of resuming the marital relationship with the patient”
The major problem here is the word “legally”. That requires, in California, a judicial legal separation proceeding. See Cal. Family Code Secs. 2300 et seq.

Here again “(1)”, as written, does not reflect the real world. Very few spouses get a judicial legal separation. Countless more spouses simply split, move out, live separate and apart for many reasons some of which are:

1. Religious: Roman Catholics for example
2. Legal expense: many spouses simply do not want to pay the cost of a legal separation
3. Miscellaneous: reasons that defy rational explanation cause many spouses to simply break up

Change “(7)” to read:

(7) An adult who has exhibited special care and concern for the patient, who is familiar with the patient’s personal values, and who is reasonably available to act as surrogate

§ 4722(b): Add “committee” after “surrogate”

Prob. Code § 2105(f): I favor the definition of “Terminal Condition” in Section 7186(j) of the Health and Safety Code. So, I would add “within a relatively short time” at the end of 7186(j)

You should consider placing this definition of “Terminal Condition” in the general definition section as §4642.

Prob. Code § 2355(a): Strike “because” in line 30 and substitute “for”

Prob. Code § 2356(b): My reading of “(e)” is that the patient’s advance health care directive can both authorize and direct the “convulsive treatment” and sterilization referred to in “(c)” and “(d).” Because this has been a subject of considerable controversy, I suggest changing (e) to read as follows:

“The patient’s advance health care directive can authorize or direct the patient’s agent to either authorize or direct the patient’s “convulsive treatment” under “(e)” or the patient’s sterilization under “(d).”
III. PART 7. CAPACITY DETERMINATIONS AND HEALTH CARE DECISIONS FOR ADULT WITHOUT CONSERVATOR

A. Opening Comment: I strongly favor merging the Section 3200 procedure into the Health Care Decisions Law.

B. Prob. Code § 3200: I believe that the following statement in the Comment is not accurate:

“The definition of “health Care Decision” in subdivision (b) makes clear, as used in other provisions in this part, that court-authorized health care decisions include end-of-life decisions. See Section 3208(c)”

Neither subdivision (b) nor Section 3208(c) deal with “end-of-life decisions”. To clarify subdivision (b), I suggest adding the following as subdivision (b)(4):

“End-of-life decisions”

C. Prob. Code § 3203: While the principal’s agent is clearly an “interested person” under 3203(c), I suggest adding the following as 3203(d):

“(d) the Principal’s Agent”

and renumbering (d), (e) and (f)

D. Prob. Code § 3204: Delete “a medical declaration” in line 28 and substitute “a declaration of the patient’s physician”

E. Prob. Code § 3206

1. Add “and the patient’s Agent” in line 21

2. Add the following as (b)(3) and (b)(4):

   (b)(3) The patient
   (b)(4) The patient’s Agent

3. Change (c)(1) to read:

   (1) The existing medical facts and circumstances set forth in the petition or in a declaration of the patient’s physician attached to the petition or presented to the court
F. Prob. Code § 3208:
   1. Change “a) to “the” in line 14
   2. Change “were” to “where” on p. 108, line 11

G. Prob. Code § 3211: See my comment under § 3211(e) supra. So, I would change
3211(e) to read:
   (e) The patient’s advance health care directive can authorize or
   direct the patient’s Agent to either authorize or direct the patient’s
   “convulsive treatment” under (c) or the patient’s sterilization under
   (d)

IV. C.L.R.C. MEMORANDUM 98-42 DATED MAY 27, 1998

A. EX2 § 3200: I prefer the “Staff Note” approach, namely to define “medical
   treatment” to mean “health care” as defined in Section 4615 of the tentatively proposed health
   Care Decisions Law

B. EX4 § 3203: Same change as in Section § 3203 supra.

C. EX4 § 3204:
   1. Delete “[medical] declaration” in first line and substitute “a declaration of
      the patient’s physician”
   2. Delete brackets around “medical” in (a)
   3. Delete brackets around “medically” in (b)
   4. Delete brackets around “medically available” in (e)
   5. Delete brackets around “an informed” in (f)

D. EX5 § 3206
   1. Same changes as in Section § 3206 supra.

E. EX6 § 3208
   1. Delete brackets around “give an informed” in (a)(3) and (b)(2)
F. EX 8 § 3208.5
   1. Delete brackets around "give informed" in four places in (a), (b) and (c)
   2. Delete brackets around "accepted " in (b)
   3. Change "a" to "the" in fourth line of (b)

G. Ex9 §3211: Same changes as in I-H. Supra

Sincerely,

[Signature]
Harley J. Spilker

HJS:DP

cc: Granof
    Rae
    English
    Deeringer
Stan Ulrich  
California Law Revision Commission  
4000 Middlefield Road, Room D-1  
Palo Alto, California  94303-4739

Re: Statutory Advance Health Care Directive Form  
Proposed Probate Code §4701

Dear Stan:

On Monday, August 10, 1998, at 4:00 p.m., the Advance Directive Committee of the Estate Planning, Trust and Probate Law Section of the State Bar Executive Committee participated in a telephone conference to review the California Law Revision Commission’s Tentative Recommendations on Health Care Decisions for Incapacitated Adults which was distributed June 1998. This is in response to your solicitation for comments to be sent to you no later than August 31, 1998.

Participating in the meeting were Chairman, Leah V. Granof, Leslie Barnett, Libby Barrabee, Ronald Berman, Fay Blixt, Professor David English, Matthew Rae, Harley Spitler, and Bruce Towne. The Committee unanimously applauds, commends and compliments you on the Tentative Recommendation. It is scholarly, concise and easy to read. It was pleased that so many of our suggestions were incorporated into the recommendation.

The Committee had the following suggestions:

1. **Section 4683 (Page 51). Scope of Agents Authority:**

   §4683(b) allows the agent to make decisions about anatomical gifts, autopsy and direction of disposition of remains. However, the Advance Health Care Directive form produced at §4701 does not provide a section which addresses the designation of donation of organs at death, autopsy or disposition of remains.
The Committee in general, most particularly the Elder Law attorneys, find this addition to be useful in their practice.

Fay Blix of our Committee drew this to our attention and she assumed the responsibility for the suggested amendments which I enclose. The other members of the Committee have not seen these amendments. They are in agreement in principle, they have not seen the text.

Notice that changes are made: Page 57, lines 11 and 12 should be deleted and replaced with the following:

"Part 3 of this form lets you leave instructions for your agent to follow after your death regarding your intentions to donate bodily organs and tissues, the disposition of your remains and whether or not you would authorize an autopsy."

Page 60, part 3 should be amended as follows: (Please see attachment which Ms. Blix and I suggest as Optional).

2. Section 4712. Selection of Statutory Surrogate (Page 65):

The Committee has expressed to the CLRC in past comments and correspondence that it has been and is in favor of putting a "life partner" or "long term relationship" category as number 2 after spouses. That continues to be our preference.

The Committee understands that there is strong opposition to this position and as a compromise it recommends that 4712(a)(7) be deleted and be replaced with Section 5(c) of the Uniform Act which reads as follows:

"If none of the individuals eligible to act as surrogate is reasonably available, an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, and who is reasonably available may act as surrogate."
3. **Section 4735. Rights to Decline to Provide Ineffective Care:**

In the Background From Uniform Act following the Section, you define "Medically ineffective health care", as used in this section, as treatment which would not offer the patient any significant benefit.

The Committee recommends that this definition be inserted in the Chapter 1, Definitions and General Provisions, page 35 of the Staff Draft Statute.

These comments have not been reviewed by the Advance Directive Committee of the Estate Planning, Trust and Probate Law Section of the State Bar Executive Committee, because no regular meeting is scheduled before the solicitation deadline.

Naturally, I and my Committee are available to you if you need further comment or explanation.

Sincerely,

[Signature]

Leah V. Granof

LVG/dm/8/133

Enclosure

cc: All Members of the State Bar Executive Committee Special Projects - Advance Directives Committee (with enclosure)
PART 3
INSTRUCTIONS FOLLOWING MY DEATH
(OPTIONAL)

(3.1) Donation of Organs at Death
Upon my death (mark applicable box):
☐ (a) I give any needed organs, tissues, or part; or
☐ (b) I give the following organs, tissues or parts only ____________________________

☐ (c) My gift is for the following purposes (strike any of the following you do not want):
  (1) Transplant
  (2) Therapy
  (3) Research
  (4) Education

(3.2) Autopsy (mark the applicable box)
I ☐ do ☐ do not want my agent to consent to an autopsy of my body.

(3.3) Disposition of my body
Upon my death (mark the applicable box):
☐ (a) I wish to be buried in a casket.
   Name of mortuary: __________________________________________
   Type of service: __________________________________________
   Location of service: ________________________________________
   Casket: ☐ open ☐ closed
   Location of burial: _________________________________________
   Type of burial service: _____________________________________
☐ (b) I wish to be cremated.
   Name of mortuary/cremation society: _________________________
   Type of service: __________________________________________
   Disposition of ashes: ______________________________________

☐ (c) Other: ________________________________________________
   ________________________________________________________
August 18, 1998

California Law Revision Commission
4000 Middlefield Road, Room D-1
Palo Alto, California 92303-4739

Re: Comments on Tentative Recommendation #L-4000,
Relating to Health Care Decisions for Incapacitated Adults

Dear Law Revision Commission Members:

We submit the following comments on Tentative Recommendation
#L-4000, relating to health care decisions for incapacitated adults.

I. The Tentative Recommendation Delegates an Improper Degree
   of Authority to Health Care Providers.

The principal problem with the Tentative Recommendation is its improper
delегation of authority to physicians and other health care providers. Most
significantly, section 4712 allows a physician to select a patient's surrogate,
and section 4722 authorizes a "surrogate committee" comprised principally
of health care providers to make a patient's health care decisions.

This delegation of authority conflicts with longstanding California law,
which mandates a separation in the decision-making process between health
care providers (generally physicians) and the party ultimately responsible
for the health care decision. Under the informed consent doctrine, a doctor
or health care provider recommends a particular course of treatment, based
on his or her expertise, and the patient or patient's representative decides
whether or not to accept the recommendation. See, e.g., Cobbs v. Grant, 8
Cal. 3d 229, 104 Cal. Rptr. 505 (1972). The health care provider assuredly
does not have the authority to dictate the decision to be made by a patient
or patient's representative.

As stated in Thor v. Superior Ct., 5 Cal. 4th 725, 735-36, 21 Cal. Rptr. 2d
357, 363-64 (1993), "[w]hile the physician has the professional and ethical
responsibility to provide the medical evaluation upon which informed
consent is predicated, the patient still retains the sole prerogative to make
the subjective treatment decision based upon an understanding of the
circumstances. . . . A doctor might well believe that an operation or form
of treatment is desirable or necessary, but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception.” In Thor, a physician sought an order which would have authorized the physician to force a quadriplegic prisoner to receive food and medication, although the prisoner had refused both the food and the medication. The California Supreme Court denied the request, holding that the physician had no right to dictate the prisoner’s decision:

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

5 Cal. 4th at 742-43, 21 Cal. Rptr. 2d at 368 (citations omitted).

The seminal California cases in this area emphasize that health care providers are professional advisers, and their professional judgment ultimately is subject to the decision of the patient or patient’s representative. “[H]uman beings are not the passive subjects of medical technology.” Conservatorship of Drabick, 200 Cal. App. 3d 185, 208, 245 Cal. Rptr. 840, 854 (1988). Accordingly, a decision to refuse treatment “is not a medical decision for [i] physicians to make.” Bouvia v. Superior Ct., 179 Cal. App. 3d 1127, 1143, 225 Cal. Rptr. 297, 305 (1986). “If the right of the patient to self-determination is to have any meaning at all, it must be paramount to the interests of the patient’s hospital and doctors.” Bartling v. Superior Ct., 163 Cal. App. 3d 186, 195, 209 Cal. Rptr. 220, 225 (1984).

II. The Tentative Recommendation Improperly Allows Physicians to Select a Patient’s Surrogate.

Health care providers frequently have conflicts with patients or patients’ representatives regarding the care to be provided (or not provided) to the patient. For example, in Thor, Bouvia and Bartling (all cited above), the relevant health care provider refused and/or challenged the patient’s decision. Nonetheless, section 4712(b) of the Tentative
Recommendation calls for the patient’s primary physician to select a surrogate, in two separate ways:

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

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

If section 4712(b) of the Tentative Recommendation were to become law, a primary physician could dictate the decision to be made on behalf of an incompetent individual, by selecting a surrogate in agreement with the physician’s recommendation. If, as happens frequently, at least one of an incompetent patient’s family members or friends were to disagree with the others, the physician essentially could override the will of the majority of the family members and friends, by selecting a dissenter as the surrogate.

It is recognized that section 4712(c) lists factors that are to be considered by a primary physician in selecting a surrogate. In practice, however, these factors would do little to prevent a physician from selecting a surrogate most deferential to the physician and the physician’s opinions. This is particularly true given the subjective nature of the listed factors — for example, “whether the proposed surrogate reasonably appear to be best able to make decisions” in accordance with the patient’s wishes or best interests, “demonstrated care and concern for the patient,” and “familiarity with the patient’s personal values.” Proposed Sections 4712(c)(1), (3) and (4) of the Tentative Recommendation.

III. The Tentative Recommendation Improperly Allows a Committee of Health Care Providers to Make All Medical Decisions for an Incapacitated Patient.

A. The Surrogate Committee Process Would Violate a Patient’s Rights to Privacy and Due Process.

Sections 4720 through 4726 of the Tentative Recommendation call for the creation of a “surrogate committee” to determine all medical decisions for a patient who is considered mentally incapacitated by the primary physician. The surrogate committee would be comprised primarily of health care providers.
The proposed process is much too casual and manipulable, given the life-and-death issues that may be at stake. It is hard to imagine the disposition of an individual's assets by an ad hoc committee of professionals (whether they be physicians, lawyers, accountants, or some other profession), chosen in some unspecified way by a health care institution. In fact, there likely would be justifiable outrage if money ever were to be distributed by such a committee. Why then should a patient's life-and-death decisions regarding medical treatment be turned over to such a clearly flawed process?

The Tentative Recommendation states that judicial intervention in health care decision-making is disfavored in California. See Tentative Recommendation, pp. 20, 38. This statement, however, is presumably based upon the appellate opinions that have found that judicial intervention is unnecessary when a surrogate is available. See, e.g., Conservatorship of Drabick, 200 Cal. App. 3d at 198, 245 Cal. Rptr. at 847 ("Courts . . . become involved only when no one is available to make decisions for a patient or when there are disagreements."); Barber, 147 Cal. App. 3d at 1022, 195 Cal. Rptr. at 493 ("requiring judicial intervention in all cases is unnecessary and may be unwise"). These cases thus do not support the Tentative Recommendation's delegation of authority to the ad hoc surrogate committee.

The only precedent for the surrogate committee is section 1418.8 of the Health and Safety Code, which authorizes an "interdisciplinary team" to authorize the "administration of [a] medical intervention" to a nursing facility resident. Cal. Health & Safety Code § 1418.8(a). Significantly, the scope of section 1418.8 is limited:

[B]y its own terms[, it] applies only to the relatively nonintrusive and routine, ongoing medical intervention, which may be afforded by physicians in nursing homes; it does not purport to grant blanket authority for more severe medical interventions such as medically necessary, one-time procedures which would be carried out at a hospital or acute care facility, as to which compliance with Probate Code section 3200 et seq. would still be required, except in emergency situations.

Rains v. Belshé, 32 Cal. App. 4th 157, 186, 38 Cal. Rptr. 2d 185, 202 (1995). By contrast, the Tentative Recommendation proposes to give a "surrogate committee" authority over any and all medical decisions, including the decision to stop life-sustaining treatment.

If the Tentative Recommendation were to become law, the "surrogate committee" process likely would be deemed unconstitutional, based on its infringement of privacy rights and the deprivation of due process. Such constitutional challenges to section 1418.8 were rejected in Rains primarily because the provision of routine medical attention to nursing home
residents was seen as uniformly beneficial to the residents involved. See Rains, 32 Cal. App. 4th at 166-87, 38 Cal. Rptr. 2d at 188-202. The same cannot be said of the serious medical procedures -- or terminations of medical treatment -- which could be authorized by a “surrogate committee” envisioned by the Tentative Recommendation.

The inclusion in the surrogate committee of a “patient representative,” as proposed by the Tentative Recommendation, does not remedy the constitutional defects of the surrogate committee scheme. First, any patient representative would be outvoted by the health care providers on the surrogate committee. Second, there is no explanation how a “patient representative” even could exist for an individual who, by definition, has no surrogate. The mention of a “patient representative” in section 4722 of the Proposed Recommendation is a way of ignoring the underlying problem -- in most cases, an individual without a surrogate has no one who could act as a “patient representative.”

B. The Amendment of Existing Law Is Preferable to the Adoption of the Ad Hoc Surrogate Committee.

The Tentative Recommendation alleges on several occasions that the current law governing conservatorships and Probate Code § 3200 petitions is inadequate. According to the Tentative Recommendation, conservatorships cannot address life-and-death decisions because Public Guardian’s offices around the state may choose to ignore their duty under Drabick to consider those life-and-death decisions. Tentative Recommendation, p. 17 n.56. The Tentative Recommendation also claims that the Probate Code § 3200 process is inadequate because it cannot authorize an order for the refusal of life-sustaining treatment. Tentative Recommendation, p. 17. The Tentative Recommendation quotes language supporting the proposition that existing Probate Code procedures are too cumbersome for routine use, although the quotation refers only to the inadequacy of Probate Code procedures for making “day-to-day medical treatment decisions . . . on an on-going basis” in a nursing facility.

---

1 The likelihood that a “patient representative” would be outvoted is increased by the possibility that a surrogate committee could be stacked by a health care institution to include additional members in support of the position of the health care institution. See Tentative Recommendation, Section 4722 (c) (“This section . . . is not intended to restrict participation by other appropriate persons.”).

2 “In most cases, the conservator will be the Public Guardian, which may be a non-solution if the Public Guardian’s policy is not to exercise the duty to decide as set down in Drabick.” Tentative Recommendation, p. 17 n.56.
Tentative Recommendation, p. 21 (quoting from the legislative findings accompanying Cal. Health & Safety Code § 1418.8, the statute authorizing medical decisions to be made by “interdisciplinary teams” for incapacitated nursing facility residents).

The Tentative Recommendation uses the alleged inadequacy of current procedures as a justification for the surrogate committee proposed in section 4722. We suggest that, in this respect, the Tentative Recommendation is an overreaction to problems that should be addressed through the amendment of currently-existing procedures, rather than through the creation of a new, constitutionally-suspect surrogate committee. For example, the Tentative Recommendation could be modified so that it mandated the Public Guardian’s offices to consider the refusal of life-sustaining treatment in appropriate circumstances, and so that it amended the Probate Code to authorize an order for the refusal of treatment under petitions brought under Prob. Code § 3200. Indeed, the Commission already is considering such an amendment to Prob. Code §§ 3200-11. See Commission Memorandum 98-42 (May 27, 1998). There simply is no need to commission the type of ad hoc surrogate committee proposed by the Tentative Recommendation, when existing procedures instead could be improved and streamlined.

IV. A Request to Forego Resuscitative Measures Should Not Require a Physician’s Signature.

The signature of a physician should not be required on a Request to Forego Resuscitative Measures. See Tentative Recommendation, section 4780(b). Because, as set forth by the cases cited earlier in this letter, an individual’s health care decisions generally cannot be overruled by a health care provider, the validity of a Request to Forego Resuscitative Measures should not be dependent upon a physician’s signature.4

3 We note that the Executive Committee of the State Bar’s Estate Planning, Trust and Probate Law Section voted in favor of Court authorization of medical procedures for incapacitated persons without surrogates, and against the surrogate committee proposed by the Tentative Recommendation. See Letter from Leah Granof, Estate Planning, Trust and Probate Law Section of the State Bar, to Stan Ulrich, California Law Revision Commission, attached to Memorandum 98-42 of the California Law Revision Commission.

4 We recognize that current law requires the signature of “a physician and surgeon” on a Request to Forego Resuscitative Measures. See Cal. Prob. Code § 4753(b).
V. A Health Care Provider or Health Care Institution Should Comply With a Patient’s Decision If the Patient’s Transfer Cannot Be Arranged, Even Though the Provider of Institution Otherwise Would Have the Right to Decline to Comply.

Section 4736 of the Tentative Recommendation states that, if a health care provider or health care institution properly declines to comply with a health care decision, the provider or institution must provide continuing care until a transfer of the patient can be arranged. The Comment states that “[t]his section does not resolve the problem that may occur where a transfer cannot be accomplished and the continuing care required . . . is a form of care the health care provider or institution has a right to decline.” There is no reason for the Tentative Recommendation to evade this issue. The Tentative Recommendation should be amended so that, when a transfer cannot be arranged, the provider or institution must comply with the patient’s decision.

VI. Conclusion.

We appreciate the Commission’s work on this important topic. Please feel free to call at any time with any questions or suggestions.

Sincerely,

Eric M. Carlson, Esq.
Director, Nursing Home Advocacy Project
August 20, 1998

Stan Ulrich
C.L.R.C.
4000 Middlefield Road, D-2
Palo Alto, CA 94306

Re: Disposition of Principal's Remains

Dear Stan:

This letter addresses the proposed addition of Sections (3.3) to Part 3 of the Advance Health Care Directive forms, being an amendment to Cal. Prob. Code Section 4701. This is referred to in Leah V. Granof's August 17, 1998 letter to you.

I. The Law. I believe the applicable law is set forth in Health and Safety Code Section 7100.0. The lead sentence of Section 7100.1(a) is the most important:

"(a) A decedent, prior to death, may direct, in writing, the disposition of his or her remains and specify funeral goods and services to be provided"

Thus, any "writing" is sufficient: e.g.;

(i) in a will: See 7100.1(c);
(ii) in a letter;
(iii) in a written lease;
(iv) in any scrap of paper;
(v) in a healthcare directive.

So, the principal’s directions, in writing, in a healthcare directive, disposing of his remains is valid.

II. Proposed Section (3.3). I am opposed to Proposed Section (3.3) for these reasons:

A. It is quite common for an individual to change his/her wishes regarding the disposition of remains. This change could be, and in many cases would be, contrary to, or inconsistent with, those in a prior Advance Health Care Directive form.
B. More common: what about the oral wishes given to the principal’s spouse as the principal is dying. On death of principal, the spouse finds the principal’s Advance Health Care Directive form which contains the principal’s wishes in (3.3) that are directly contrary to the principal’s oral wishes.

C. Most principal’s execute an Advance Health Care Directive form only once and do not examine it periodically to determine if it still clearly expresses the principal’s wishes. So, the disposition of the principal’s remains can be frozen in an Advance Health Care Directive form that is 5, or 10, or 20, etc. years old; and may be contrary to the principal’s current wishes.

D. Disposition of ashes is a somewhat minor matter. However, the principal cannot have his/her ashes lawfully scattered wherever he/she wishes. See Health and Safety Code Section 7054.7. The implication of proposed (3.3)(b) is that the principal can lawfully direct the disposition of his/her ashes. That cannot be done!

E. What “Other”: Proposed (3.3)(c) is puzzling what “other” disposition of the principal’s body? Proposed (3.3)(a) and (b) cover burial, cremation and ashes. What is contemplated by “other”? Perhaps delivering the body to some religious sect for burning?

Best Wishes,

Harley J. Spitler
HJS:dp

cc: Leah V. Granof
    Fay Blix
    David English
    Sandy Rae
    James Deeringer
August 20, 1998

California Law Revision Commission
4000 Middlefield Road, Suite D1
Palo Alto, California 94303-4739

Re:  Comments on Proposed Legislation Concerning Health Care Decisions for
Patients Without Surrogates

Dear Law Revision Commission Members:

The Long Term Care Subcommittee of the Los Angeles County Bar Association
Bioethics Committee undertook last year to draft a legislative proposal outlining a process by
which decisions concerning the withholding or withdrawal of life-sustaining medical treatment
could be made on behalf of patients in skilled nursing facilities who lack both decision-making
capacity and surrogate decision-makers. As the LRC is aware (see Staff Note re proposed § 4721
in Staff Draft Tentative Recommendation (Statutory Material), dated April 15, 1998, at B-44),
the court of appeal in Rains v. Belshe, 32 Cal. App. 4th 157 (1995), expressly stated that
California Health & Safety Code section 1418.8, which sets forth procedures for making certain
"medical intervention" decisions for nursing home residents who lack decision-making capacity
and also have no surrogates, applies only to "relatively nonintrusive and routine, ongoing medical
intervention . . . ." Id. at 186. Thus, it does not apply to decisions to withhold or withdraw life-
sustaining treatment, and there remains a significant gap in the law. This is a particular problem
for nursing homes, which are far more likely than hospitals to have patients who lack both
decision-making capacity and available surrogate decision-makers, and for whom major end-of-
life decisions nevertheless must be made.

Several months ago, when we were nearly finished our draft proposal, we learned that the
Law Revision Commission ("LRC") had formulated a tentative recommendation for repeal of
Health & Safety Code section 1418.8 and adoption of new provisions of the Probate Code
dealing in part with this issue (although the new Probate Code provisions would cover, inter alia,
all health care decisions for patients without surrogates, not only those concerning withholding
or withdrawal of life-sustaining treatment). We obtained a copy of the LRC's Tentative

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Recommendation, and found that many of the provisions covering decisions for patients without surrogates were virtually identical to those we had drafted. However, because the LRC's proposed legislation does not focus on skilled nursing facilities, the members of the Long Term Care Subcommittee believe it is crucial that certain additions be made in order to address issues unique to the nursing home context. In addition, the Long Term Care Subcommittee presented its draft proposal, along with information about the LRC's proposed legislation, at a meeting of the full Los Angeles County Bar Association Bioethics Committee on May 13, and received some comments which bioethics committee members wished to communicate to the LRC. We therefore submit the following as part of the public comment process, for your consideration and possible incorporation into the LRC's proposed legislation.

1. Section 4720(c): In order to communicate that providers must make reasonable efforts to locate any available surrogate, we propose that § 4720(c) should read as follows:¹

   After a diligent search, no surrogate can be selected under Chapter 3 (commencing with Section 4710) or the surrogate is not reasonably available.

2. Section 4721:

   a. Sections 4720 through 4736 are intended (at least in part) to replace Health & Safety Code § 1418.8. That statute makes clear that providers who follow the procedures set forth therein have met the legal requirements for obtaining informed consent, without which a healthcare provider cannot treat any patient (except in certain emergencies not relevant here). Unlike H&S § 1418.8, however, § 4721 makes no reference whatever to informed consent. In order to clarify that by following the procedures set forth in Section 4722 through 4726, providers will be deemed to meet the informed consent requirement, the first sentence of § 4721 should read as follows:

      A patient's primary physician may obtain approval informed consent for a proposed health care decision by referring the matter to a surrogate committee before the health care decision is implemented.

   b. Some members of the Bioethics Committee were concerned that in the nursing home context, the patient's attending physician (who is required to visit the patient only once every 30 days) may not be aware of the need for

¹ Underlined text represents proposed additions to the draft legislation. Proposed deletions have a line through the text to be deleted.
an important medical decision as soon as some other persons, and may not make a sufficiently timely request for establishment of a surrogate committee. Therefore, we believe the statute should provide expressly that other interested persons may request the establishment of a surrogate committee (which, of course, must include the patient's primary physician) to consider giving consent to a health care decision. A second sentence should be added to §4721 which reads:

Interested persons other than the primary physician, including but not limited to other members of the patient's health care team, social workers familiar with the patient, or representatives of the Office of the Long Term Care Ombudsman familiar with the patient, may request that a surrogate committee be established to consent to a proposed health care decision.

3. Section 4722 (b):

a. The first phrase of 4722(b) should read: "The surrogate committee shall include the following individuals: . . ." (This was probably an inadvertent omission.)

b. 4722(b)(2) and (3):

i. Skilled nursing facilities differ from acute care hospitals in that the patients are not generally there for a short time just to be treated; they live there. Most of the care they receive on a daily basis is given by nursing assistants, not RNs or even LVNs. In many nursing homes, there is only one RN, the Director of Nursing, who does not have the opportunity to get to know individual residents nearly as well as the nursing assistants who provide care to the residents every day. Since the purpose of the surrogate committee is to ascertain either what the patient would want or, failing that, what is in the patient's best interest, it is important to have on the committee at least one person who actually provides care to the patient on a regular basis. (As noted above, in a nursing home the primary physician probably does not fulfill this role either.) Therefore, in a skilled nursing facility the surrogate committee must include a nursing assistant who cares for the patient, and also should include either an RN or an LVN who is responsible for the patient's care and familiar with the patient's condition.

ii. In addition, nursing homes are very heavily regulated, both by the State of California Department of Health Services
and by the federal Health Care Financing Administration, and are subject to severe sanctions -- including possible loss of license and termination from the federal Medicare and joint federal-state Medi-Cal programs -- for violating applicable statutes and regulations. DHS has indicated that failure to follow proper procedures prior to withholding or withdrawal of life-sustaining treatment could result not only in the above-referenced penalties, but also in reporting for elder abuse pursuant to the provisions of the Welfare & Institutions Code and possible criminal prosecution. See California Association of Health Facilities Guidelines Bulletin 89-05 at 3 setting forth the DHS Guidelines (stating that missing or inconsistent documentation regarding withdrawal or withholding of life sustaining procedures may constitute "a reportable incident of elder or dependent adult abuse pursuant to Welfare and Institutions Code Section 15630, et. seq., a criminal act reportable to the appropriate authorities, and/or grounds for issuance of a deficiency or citation"). Thus, nursing homes must be particularly circumspect in making such decisions. For this reason, we propose that in nursing homes the surrogate committee also include a second physician, which may be the facility's medical director if he/she is not also the patient's primary physician, and member of the facility staff who provides social services to the patient.

iii. In order to facilitate prompt organization of the committee when necessary in a skilled nursing facility, we proposed that the facility administrator be designated to convene the committee and serve as a non-voting member.

c. Section 4722(b)(5) and (b)(6)

i. The proposed legislation does not define the phrase "critical health care decisions," which appears in § 4722, subsections (b)(5) and (b)(6). We believe these subsections should specify that "critical health care decisions" include decisions to withhold or withdraw life-sustaining treatment.

ii. Subsection (b)(5) refers to "a member of the community who is not employed by or regularly associated with the primary physician, the health care institution or employees of the healthcare institution." We believe that in order to avoid any possible
suggestion of undue influence, a community member who serves on a surrogate committee should not receive any compensation for that service, regardless of whether he or she actually is an "employee," and the statute should so specify. In addition, some members of the Bioethics Committee were concerned that one person from outside the facility might not be enough, that such a person might be reluctant to disagree with health care professionals who are familiar with the patient.

Section 4722(b) therefore should read as follows:

(b) The surrogate committee shall include the following individuals:
(1) The patient's primary physician.
(2) A registered professional nurse, or in the case of a skilled nursing facility, a registered professional nurse or licensed vocational nurse, with responsibility for the patient and with knowledge of the patient's condition.
(3) Other appropriate health care institution staff in disciplines as determined by the patient's needs. In skilled nursing facilities, the surrogate committee shall include a nursing assistant who regularly provides care to the patient, a staff member who provides social services to the patient, and a second physician, who may be the facility Medical Director if he or she is not also the patient's primary physician. The skilled nursing facility administrator shall be responsible for convening the surrogate committee and shall serve as a non-voting member.
(4) One or more patient representatives, who may be a family member or friend of the patient who is unable to take full responsibility for the patient's health care decisions, but has agreed to serve on the surrogate committee.
(5) In cases in involving critical health care decisions, which include but are not limited to decisions to withhold or withdraw life-sustaining treatment, a member of the community who is not employed by or regularly associated with the primary physician, the health care institution, or employees of the health care institution, and who receives no remuneration for service on the surrogate committee.
(6) In cases involving critical health care decisions, which include but are not limited to decisions to withhold or withdraw life-sustaining treatment, a member of the health care institution's ethics committee or an outside ethics consultant.

4. Section 4723(a)(3): This subsection provides that the surrogate committee "shall interview the patient." However, this may be impossible in many instances (especially since we are concerned here with patients who lack capacity to make their own health care decisions), because the patient simply is incapable of
communicating at even the most basic level. The statute should not mandate the impossible. Therefore, subsection 4723(a)(3) should read as follows:

(3) A discussion of the desires of the patient, if known. To determine the desires of the patient, the surrogate committee shall interview the patient if the patient is capable of communicating, review the patient's medical records, and consult with family members or friends, if any have been identified.

5. Section 4724:

a. The second sentence of Section 4724 states that "decisions relating to refusal or withdrawal of life-sustaining treatment may not be approved if any member of the surrogate committee is opposed." (Emphasis added.) This suggests that some members could abstain, and the decision still could be approved if a majority of the committee members voted in favor of it and no one voted against it. We believe this is acceptable, and should be made explicit.

b. As noted above, skilled nursing homes may be exposed to severe sanctions imposed by regulatory agencies as well as possible criminal penalties if they have not documented adequately their decision-making processes with respect to decisions to withhold or withdraw life-sustaining treatment.

Therefore, Section 4724 should read as follows:

The surrogate committee shall attempt to reach consensus on proposed health care decisions, but may approve consent to proposed health care decisions other than decisions to withhold or withdraw life-sustaining treatment by majority vote. Surrogate committee members may abstain from voting to withhold or withdraw life-sustaining treatment, and such abstentions will not be considered opposition. However, the surrogate committee may not consent to proposed health care decisions relating to refusal or withdrawal of life-sustaining treatment may not be approved if any member of the surrogate committee is opposed, or if less than a majority of the total committee is in favor. Therefore, if the members of the surrogate committee who choose to vote cannot reach a unanimous decision to withhold or withdraw life-sustaining treatment, or if the voting members in favor do not constitute a majority of the total surrogate committee, then life-sustaining treatment will be initiated or continued. The findings and
determinations of the surrogate committee pursuant to Section 4723 shall be documented fully in the patient's medical record.

The foregoing comments and recommendations were discussed and approved by the full Los Angeles County Bar Association Bioethics Committee at its meeting on August 12, 1998. However, these comments and recommendations have not been submitted to or considered by the Board of the Los Angeles County Bar Association, and thus they do not represent the views of the Los Angeles County Bar Association as a whole.

If the LRC has any questions regarding these proposals, please feel free to contact the Subcommittee through Chris Wilson at the above address and telephone number. Thank you very much for your consideration of our comments on this important proposed legislation.

Very truly yours,

Christine J. Wilson, R.N., Esq., Chair

Terri D. Keville, Esq., Comments Draftsperson

Linda Faber-Czingula, R.N., Secretary
Long Term Care Subcommittee of the
Los Angeles County Bar Association
Bioethics Committee
Law Revision Commission

California Law Revision Commission
4000 Middlefield Road, Room D-1
Palo Alto, CA 94303-4739

Re: Health Care Decisions for Incapacitated Adults
Tentative Recommendation

TO: Members, Law Revision Commission

On behalf of California Advocates for Nursing Home Reform, I submit the following comments:

Section 4712: Selection of statutory surrogate and Section 4715 Reassessment of surrogate selection

These two sections allow the patient's primary physician to select a surrogate and to replace a surrogate under certain circumstances. The proposed statute allows the physician to reject a designated surrogate and to replace him/her with one of the physician's choosing. When no surrogate has been designated, Section 4712 also allows the physician to select the surrogate based on a number of subjective factors. Section 4712, in effect, permits physicians to substitute their judgment for that of the patients.

These provisions create an inherent conflict between the physician's interests and the patient's best interests and are contrary to California law. California courts have repeatedly found that the patients' right to dictate their own medical treatment is generally paramount to any state or personal interest. *Bartling v. Superior Court* (1984) 163 Cal.App.3d 186, 209 Cal.Rptr. 220; *Bouvia v. Superior Court* (1986) 179 Cal.App.3d 1127, 225 Cal.Rptr. 297; *Thor v. Superior Court* (1993) 5 Cal. 4th, 725, 21 Cal.Rptr. 2d 357.

Our organization opposes these recommendations and would hope that the Commission would refrain from delegating to physicians what are and should remain the rights of patients and their families.

Chapter 4. Health Care Decisions for Patients Without Surrogates: §§ 4720-4726

We have a number of concerns with this chapter, not the least of which is that is relies substantially (and erroneously) on Health & Safety Code § 1418.8 (the Epple bill) and would repeal §1418.8.
A. Scope

Currently, Health & Safety Code Section 1418.8 applies only to patients of skilled nursing and intermediate care facilities and allows such patients to receive certain medical interventions after a physician has determined the patient lacks capacity to give informed consent and after an interdisciplinary review team has determined the treatment is medically appropriate.

The Law Revision Recommendation would repeal Section 1418.8, create a surrogate committee to determine all medical decisions (including withdrawal of life-sustaining treatments) and extend the coverage to acute care facilities. There is nothing in the legislative history or judicial history of Section 1418.8 to indicate that such an expansion of the scope of Section 1418.8 would be appropriate or constitutional. In fact, in finding that the procedures provided by Section 1418.8 did not violate the constitutional rights of nursing home residents, the court took care to note that the scope of medical interventions anticipated by Section 1418.8 was limited.

In addition, section 1418.8, by its own terms applies only to the relatively noninvasive and routine, ongoing medical intervention which may be afforded by physicians in nursing homes; it does not purport to grant blanket authority for more severe medical interventions such as medically necessary, one-time procedures which would be carried out at a hospital or other acute care facility, as to which compliance with Probate Code section 3200 et seq. would still be required, except in emergency situations.


Clearly the court never anticipated that decisions regarding the withholding of life sustaining treatment or other major medical decisions would be delegated to a "surrogate" committee. Unfortunately, the Tentative Recommendation *does* purport to grant blanket authority - not only for more severe medical interventions - but for withholding and withdrawal of treatment as well.

Our organization opposes this recommendation and recommends that the Committee consider amending Probate Code Section 3200 to address withdrawing life sustaining treatment and withholding of treatment.

B. Repeal of 1418.8

The Tentative Recommendation would repeal Health & Safety Code Section 1418.8 and eliminate important protections for California's nursing home residents. In addition to eliminating the due process protections under Section 1418.8(j), the Recommendation would eliminate Section 1418.8(l), which requires documentation of the determinations of incapacity and medical interventions and the basis of those determinations and the right of the patient's representative to review those determinations.

The comments regarding Section 1418.8(l) on page 95 indicate that this section is superseded by Probate Code Sections 4676 (right to health care information) and 4732 (duty of primary physician to record relevant information).
The Right to Health Care Information in Section 4676 is limited to persons "then authorized to make health care decisions for a patient. Current Section 1418.8 has no such limitation. A "patient's representative" can include a number of persons - who may or may not have the right to make health care decisions. Indeed, as Section 1418.8 per se deals with those who have no health care surrogate, the statute clearly anticipated access to the medical records by patients' representatives who do not have the right to make health care decisions.

Section 1418.8 (l) is also very specific as to the documentation required by providers when making determinations regarding capacity, determinations regarding medical interventions and periodic evaluations. Section 4732 (Primary physician's duty to record relevant information) is not an adequate substitute for this documentation, as the only relevant information required to be recorded is the determination of capacity.

We appreciate the opportunity to submit comments on this important issue. Please contact me if you have any questions.

Sincerely,

[Signature]

Patricia L. McGinnis
Executive Director
August 27, 1998

Via Facsimile and U.S. Mail
California Law Revision Commission
4000 Middlefield Road, Room D-1
Palo Alto, CA 94303-4739

Re: Tentative Recommendation for Health Care Decisions for Incapacitated Adults

Dear Law Revision Commission:

The Executive Committee of the Probate, Trusts and Estates Section of the Beverly Hills Bar Association has reviewed your tentative recommendation regarding health care decisions for incapacitated adults and we commend the Law Revisions Commission in its efforts to provide comprehensive rules dealing with health care issues and decision making for incapacitated adults.

We realize that this is a very difficult and highly personal area of the law that is riddled with sensitive issues. Practically speaking, many of the health care decisions required to be made on a daily basis may not be readily resolvable, but we appreciate the goal of the proposed legislation to establish an orderly decision-making process to resolve these difficult health care decisions.

Our formal comments to the tentative recommendation are as follows:

1. We particularly like the statutory surrogates rules: these rules provide guidelines for the health care provider in choosing a decision maker while giving the health care provider the necessary flexibility in making his or her decision. The notice of the selection of the health care decision maker to family members is also appreciated.

2. For patients where no surrogate is available, the surrogate committee is a very good idea. We agree with the Law Revision Commission that the surrogate committee should be able to act by majority vote, except with respect to the withdrawal of life-sustaining treatment. We agree that this decision is so monumental that unanimous consent should be required.

3. The recognition of the validity of out of state advance directives and health care powers of attorney is long overdue.

4. While we have no specific objections to the tentative recommendation, we do have general concerns with the proposed legislation regarding how it will work in practical terms on a daily basis. With the practice of health care becoming more impersonal, the doctor-patient relationship is not as it used to be. If the physician does not have an ongoing relationship with patient and is not familiar with the patient’s desires with respect to health care decisions and/or health care agents and is not familiar with the patient’s family and personal relationships, to what extent can the physician realistically be able to choose the appropriate health care decision maker? How will the proposed law work where there are multiple physicians handling the patient’s care? Will the primary care physician’s decision control?
5. The proposed registry system with the Secretary of State's office is a good one, but as with the will registry, the system is voluntary. To the extent that the registry is voluntary, we are unsure of the usefulness of this system. A voluntary system that is not widely utilized will have limited usefulness. Perhaps some thought should be given to the consequences of making the system mandatory with respect to health care powers. If everyone was required to register their health care powers, it would serve as a legitimate database and valuable information source for lay persons, health care providers and attorneys. On the other hand, there may be some serious obstacles in establishing a mandatory registry system (i.e., budget limitations, internal structure of the Secretary of State, enforcement of compliance, etc.).

As always, we appreciate the opportunity to comment on any legislation proposed by the California Law Revision Commission and will follow the status of this proposed legislation with interest.

Sincerely,

[Signature]

Jeannette Hahm
Chair of the Probate, Trusts and Estates Section
of the Beverly Hills Bar Association

cc: Bert Z. Tigerman
    Susan Jabkowksi
    Marc L. Sallus
    Geraldine Wyle
    Joelle Drucker
    Phyllis Cardoza
August 26, 1998

Stanley Ulrich  
Assistant Executive Secretary  
California Law Revision Commission  
4000 Littlefield Road, Room D-1  
Palo Alto, CA 94303-4739

Dear Mr. Ulrich,


The only further commentary I wish to add to my letter is to draw your attention to the last sentence in the third paragraph. I would like to delete the words "withdrawal of" and substitute the word "forgoing."

Thank you for your consideration and please do not hesitate to contact me if you have any questions or comments.

Sincerely,

Lawrence J. Schneiderman, M.D.

LJS:sm
National Senior Citizens Law Center (NSCLC) is a non-profit organization engaged in policy advocacy on behalf of senior citizens and individuals with disabilities and providing legal representation on impact issues for these client groups. For 25 years we have worked to improve conditions in nursing homes and other long-term care facilities and to protect the rights of residents of those facilities. NSCLC publishes the Nursing Home Law Letter, a quarterly publication about nursing home matters. NSCLC was lead counsel in the Valdivia case which required California to comply with the federal Nursing Home Reform Act.

NSCLC submits the following comments on the June 1998 Tentative Recommendation on Health Care Decisions for Incapacitated Adults. Our comments are limited primarily to issues relating to Chapter 4, "Health Care Decisions for Patients Without Surrogates" in the context of nursing homes and residential care facilities (RCF). We express no opinion, approval or disapproval of any provision not specifically referred to in this letter. Nor do we express any opinion on the advisability or legality of the use of surrogate committees. Rather, our comments are predicated on the assumption that the Commission will include such a provision in its final recommendation.

**Locating a Designated Representative or Surrogate**
Section 4720 (b) and (c): In order to ensure that reasonable attempts are made to locate a designated decision-maker or surrogate under Chapter 3, add the words "After a diligent search" at the opening of each subsection.

**Reducing Institutional Dominance of Surrogate Committees**
Section 4722. One of the principal problems with surrogate committees as proposed is the close relationship between most of the committee members and the management of the nursing facility or RCF. Institutions may have conflicts between the institutional interest and that of the resident in some situations. Decisions which seem routinely medical may have underlying motives that are not in the interest of the patient. For example, tube feeding may be sought by a nursing home as a convenience for an understaffed facility unwilling to provide the necessary assistance to a resident who can swallow but needs to be fed.
The per diem reimbursement system under Medicare, Medi-Cal and most private pay systems already offers financial incentives for minimizing the services delivered in the nursing home. The conflicts may be intensified in the case of nursing homes by changes in the reimbursement system. Under Section 4432 of the Balanced Budget Act of 1997, the Medicare program is converting to a prospective payment system. The California Department of Health Services is currently considering developing a new method of reimbursing nursing homes. It is possible that nursing homes could be reimbursed under a system that provides financial rewards to the institution for reducing the period or amount of treatment in a nursing home.

Section 4722 loads the committee with persons affiliated with the institution. In addition, it is common in nursing homes (and sometimes in RCFs) that one physician may act as primary physician for a large number of residents through the recommendation or intervention of the management of the facility. The physician in this case may be disposed to defer to the wishes of management. Since it is the institution that selects the community member, the community member is likely to have ties to management.

Although it is often wise to have a variety of persons who treat the resident contributing to the deliberations of the surrogate committee, there is no reason why the committee voting process should be dominated by members affiliated with the institution. Therefore, we recommend that it be mandatory that the committee consist of, and be limited to, (1) the primary physician, (2) a member of the health care institution staff engaged in providing services to the resident and who has knowledge of the resident's condition (including a nurse's aide), (3) a patient representative as defined in par. (b) (4) (if available after a diligent search) and (4) a community representative as designated below.

The appointment of a community representative should not be made by the institution, as the person so chosen will almost always have strong ties to the institution and not provide an independent judgment. Rather, the statute should provide that the community member be designated by the local affiliate of the State Long-Term Care Ombudsman Program. These programs operate largely through volunteers, many of whom visit the facility regularly and who may already be familiar with the resident involved in the surrogate decision. In addition, no payment should be made to the community representative by the institution for service on the surrogate committee or for any other reason.

As written, Sec. 4722 is unclear as to who, if anyone, is required to serve on the surrogate committee. Subsection (b) states that "[t]hat the surrogate shall include the following individuals:" (emphasis added). However, subsection (c) suggests that perhaps not everyone listed must be on the committee if inclusion would "unnecessarily interfere in the administration of health care." As a practical matter, there may not always be a patient representative available or willing to serve. In addition, few nursing homes and virtually no RCFs have ethics committees, and few will undertake the expense of payment of an outside ethics consultant, so that rarely will an ethics consultant will rarely be available in the context of the nursing home or RCF. For this reason, the language should be clarified to require participation of the community.
representative in all cases, and of the patient representative where one is available.

If no patient representative is available, a second community representative should be required. If the committee consists solely of health care professionals and a single lay person, the lay person may often defer to the professionals. Having at least two lay persons independent of the institution will reinforce the value of independent outside judgment.

**Recording the Bases for Decisions**

Section 4723. There is no provision which requires the bases for the determinations concerning the criteria set forth in this section to be recorded in the patient's records, a requirement currently in § 1418.8 (l). Section 4732 requires only that the determination of incapacity be recorded, but does not require recording of the bases of the determinations concerning the criteria. One of the best protections against arbitrary decisions is a requirement that the reasons for an action be explained and recorded. Recording also provides a basis for review of the decision where necessary or appropriate, including regular institutional quality reviews.

**Mandate Communication with the Patient**

Section 4723. The requirement of communication with the patient in subdivision (3) should be retained. Even residents with limited capacity, cognitive impairments or communication barriers may be able to make their wishes known in some useful way. It is far better to err on the side of communication to ensure that the views of the patient are known, notwithstanding the minor inconvenience where the committee must try to communicate with someone it perceives as unable to understand or respond.

**Requirements for Reaching a Decision**

Section 4724. Under this section as written, majority decisions by institution-affiliated committee members could be made in which both the community member and patient representative abstain, or one abstains and the other opposes the decision. On issues of life sustaining treatment, under 4724 as written, if both community and patient representative abstain, a decision to terminate or forego treatment could still be made.

In all cases involving critical health care decisions, the affirmative concurrence in the decision of either the community member or the patient representative should be required. In a case involving refusal or withdrawal of life-sustaining treatment, the affirmative concurrence of both the community member and the patient representative should be required, that is, life saving treatment should be undertaken or continued unless both affirmatively concur in a decision against life saving treatment. The life and death nature of the decision should not permit treatment to be denied by the expedient of abstention.

**Request to Forego Resuscitative Measures.**

Section 4780 (a)(1) appears to require the concurrence of a physician on a request to forego resuscitative measures. Because a competent individual’s health care decision generally
cannot be overruled by a health care provider, the validity of a request to forego resuscitative measures should not be dependent upon a physician’s concurrence.

Thank you for your consideration of these comments.

Sincerely,

[Signature]

Herbert Semmel
August 31, 1998

VIA FACSIMILE

California Law Revision Commission
4000 Middlefield Road, Room D-1
Palo Alto, California 94303-4739

Re: Tentative Recommendation #L-4000
   Relating to Health Care Decisions for
   Incapacitated Adults

Dear Law Revision Commission Members:

I have been following the evolution of the Law Revision Commission’s recommendations regarding Health Care Decisions for Incapacitated Adults and have, in general, been supportive of those efforts.

However, the formalization of Surrogate Health Care Decisionmakers, as currently proposed in Section 4712 creates serious concerns.

My first concern has to do with the designation of the “primary physician” as the person who selects the surrogate. In this regard I concur completely with the comments previously submitted by Eric Carlson, and will therefore not spend any more time on that aspect of the matter.

My other concern has to do with the concept of Statutory Surrogacy itself. By formalizing the concept of surrogacy and creating a hierarchy of persons entitled to function in that capacity I believe we are creating a serious problem for persons living in non traditional relationships. This is true whether they are “same sex” or heterosexual couples and regardless of the age of the individuals. In such circumstances, to place the domestic partner as sixth in the hierarchy does a disservice to the commitment of the relationship and may well create contentious and adversarial situations where non need otherwise exist.
On a number of occasions I have been involved representing parties where it was clear from all of the indicia of the relationship that the domestic partner was the one who should have health care decision making capacity. However, when a medical crisis arose, the health care providers turned to blood relations who often did not approve of the relationship (a scenario especially true in same-sex relationships). Under such circumstances the blood relations use the medical crisis as a means of “getting even” with the domestic partner by not only stripping them of their decision making capacity, but also prohibiting them from visiting the ill partner or otherwise being involved. Obviously, the answer is for all persons to have written Advanced Directives, but we know this is a pipe dream.

In California, where non-traditional relationships abound, I think we work a serious disservice to our population by formalizing the hierarchy contained in Section 4712. If we intend to create statutory surrogacy, then I would amend Section 4712 by:

(a) Eliminating the physician as the appointing person and simply establish a hierarchy as a matter of law;

(b) Amend Section 4712 (a) (1) by adding subsection (6) to it so that the spouse or domestic partner are given top and equal priority.

Thank you for your consideration.

Sincerely,

By:  

Stuart D. Zimring

SDZ:vv
August 31, 1998

California Law Revision Commission
4000 Middlefield Rd., Rm D-1
Palo Alto, CA 94303-4739

RE: Review of Health Care Decision for Incapacitated Adults

Dear Commission Members,

I was given your half inch thick tentative recommendations to review by Faye Elix after an August meeting of the South California Chapter of the National Academy of Elder Law Attorneys. I was the co-chair of the Health Care Decision Making Special Interest Group of the National Academy of Elder Law Attorneys this last year. Our Special Interest Group discussed an earlier recommendaiton and memorandum circulated last spring. I have been following the progress of this revision for a while.

I have a few comments after first commending you for the effort to make health care decision making by surrogates more available to the majority of our populace who do not have written medical decision making planning. Whereas I believe that the probate codes have dealt with the folks with no wills or trusts well by the intestacy provisions and the new Probate Code Section 13100 limit of $100,000, medical decision making with no documents have been left to the doctors', nursing homes' and hospitals' good (or bad) sense. Doctors and hospitals have better sense than nursing homes in my experience. Unfortunately, many of the people in nursing homes are beyond being able to do written documents.

I have listed my concerns in the priority of their urgency and needed revision.

1. Code Section 4695, "Revocation of advance health care directive 4695, a) a patient having capacity may revoke the designation of an agent only by a signed writing or by
personally informing the supervising healthcare provider; b) A patient having capacity may revoke all or part of an advanced health care directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke". (at page 54)

My Comments:

I am deeply concerned by this provision. The provision does not limit itself to physicians so the Section 4732 duty of physician to "record relevant information" doesn't necessarily have any control. I have three times been in situations in which a social worker (not a doctor) didn't like the decision of an agent and refused to allow it to be followed it based on a claim that the patient had made something akin to an "oral revocation: communicating an intent to revoke". All three times were after surgery while a patient was sedated and "recovering". Each decision related to either ventilators or feeding tubes. Each required that the agent demand an ethics committee meeting to get them resolved. Fortunately, I believe each was finally resolved. But in none of the cases did the person have "capacity" except to be afraid. The social workers refused to explain much of anything to the agent.

I believe that if a patient is determined to "revoke", not only should there be a duty to communicate it as stated in Section 4696 but when no physician makes the determination of "capacity" that there also be a mandatory bio-ethics meeting with the agent to explain why the person was determined to have capacity and what was done to fully inform the patient of the pros and cons of the "revocation". I also believe their 4732 duty to "record relevant information" should be modified to include non-doctors and medical caregivers. If 4732 is not modified to deal with the problems of 4795, you have created a loophole for the majority of medical caregivers.

Under the proposed Code 4796, the burden of proof is put on the person who seeks to establish that the principal did not have capacity. That is fine after the information is available about what happened. It is also fine if the physician made the determination and recorded why. In each of my three problem cases the care provider simply told the agent the sick person he "understood". There was nothing in writing. The bio-ethics meeting took a great deal of effort
by the surrogate to arrange. Either put the burden of proof
on a non-physician person who decides that the person no
longer agrees with a previous decision or and make them do a
written statement of what happened. Then let the burden
switch.

Section 4633 Defines “Reasonably Available” (at page 36)

4633, “Reasonably available” means readily able to be
contacted without undue effort and will and able to act in a
timely manner considering the urgency of the patient’s health
care needs”.

My Comments:

“Undue effort” needs to be defined. I have seen one too
many nursing homes not even bother to call an agent in the
middle of the night or during the day and just decide on
their own what they want to do in a crucial but not life and
death situation. It at least needs to be stated that the
medical provider call all known phone numbers of the agent and
the alternate agents before acting on their own except in a
matter so urgent no time may be reasonably taken to do this.

I believe this is an essential change to stop nursing
home cheating. Just last weekend a week I had a situation in
which the nursing home took the patient to the hospital with a
fever, did not call the agent and acknowledged they did not
call the agent. The patient died the next day of the
infection and no one called the agent then either. No
permission was asked, no notice of change of status was given
and no notice of death was given. This happens all the time.
Make it clear what the health provider is to do by defining
undue effort with making those phone calls and making a record
of them. Make the institution or the physician’s staff
responsible for recording their efforts to contact the agent.

Section 4680 Formalities for Executing a Power of Attorney for
Healthcare (at page 49)

My Comments:

The new rules require only one witness for a person not
in a nursing home. How will this document be accepted in
other states?
I recognize that you are trying to make the execution of this document easier. Many people move across state borders and expect a California document to be accepted if they have a heart attack in Branson, Missouri. I don't know the answer to this question. But it needs to be considered.

4. Section 4712 Selection of Statutory Surrogate (at page 65)

My Comments:

4712(a), "Subject to Section 4710, if no surrogate has been designated under Section 4711 or if the designated surrogate is not reasonably available, the primary physician may select a surrogate to make health care decisions for the patient from the following adults with a relationship to the patient:

1. The spouse, unless legally separated
2. Children
3. Parents
4. Brothers and sisters
5. Grandchildren
6. An individual in a long-term relationship of indefinite duration with the patient, etc."

My Comments:

Fundamentally this is a much needed and beneficial provision. But once again I believe the use of "not reasonably available" must be referenced to a definition that is more explicit of what people must do. The code section needs to refer to Section 4633. If the contact efforts are actually made, then this needs to be recorded as evidence that a reasonable effort was made. Then the burden should switch to an agent to prove no reasonable effort was made. Give the medical people a carrot to protect them in this code section. If they have recorded their efforts to contact these people (and it is correct), then they will be held harmless for going to a surrogate to decide. But we need to encourage everyone to try to contact the known agents first and only then chose a surrogate.

Beyond that the method of selecting a surrogate is flexible enough to allow a long time live-in "domestic
partner" the ability to speak for their partner.

Code Section 4712 interacts with 4715. This challenge provision allowing a higher priority surrogate the ability to request a re-evaluation of the choice of surrogate leaves the physician dangling. To protect the discretion of the primary physician, that physician needs to be required, when his or her decision is challenged under Section 4715, to provide the challenger a statement in writing explaining why he has made his decision. Referencing Section 4715(b) to Section 4712(c) should help the physician know what the writing needs to track. Thus, all that needs to be done at the end of 4712(c) is to add the following words, "as described in Section 4712(c)(1) to (6) and provides this person with higher priority to reason for this decision in writing."

5. Section 4722 Composition of Surrogate Committee (at page 68)

My Comments:

I have been asked by many out-of-town medical agents to represent them in bio-ethics meeting. I’ve never been allowed by the facility to do this.

It seems to be that the family should be able to nominate the sick person’s attorney or other people to be part of this surrogate committee. Often I know more about my client’s medical wishes that do distant family members. Beyond that, I am often on the spot. Why not add to Section 4722(b)(4), "one or more patient representatives, who may be a family member, or a friend of the patient or other nominee of a family member, who is unable to take full responsibility for the patient’s health care decision, but has agreed to serve on the surrogate committee. A nomination may be made orally or in writing". That allows the patient’s attorney to act if say the family is all in New Jersey, or allows the family to give a friend of a sick person their backing by nominating him or her.

Final Comments:

I think you for your work in this matter. The revisions are needed.
I've listed my concerns in order of their priority. I hope they have been of some help.

Sincerely,

[Signature]

ELIZABETHANNE MILLER ANGEVINE

EMA: jlm
cc: Faye Blix
August 29, 1998

Mr. Stan Ulrich  
Assistant Executive Secretary  
California Law Revision Commission  
4000 Middlefield Road, B-1  
Palo Alto, CA 94303-4739

Sent Via Facsimile (650) 494-1827 and U.S. Mail.

Re: Tentative Recommendation, #L-4000,  
    Health Care Decisions for Incapacitated Adults, June 1998

Dear Mr. Ulrich:

I am a member of the Advance Directives Committee of the State Bar chaired by Leah Granof. I am concerned about a surrogate's and a surrogate committee's power to authorize anatomical gifts. Personally, I have granted the agent in my own Power of Attorney for Health Care the authority to make anatomical gifts; however, my experience as an estate planning attorney is that there are many people who strongly oppose giving their agent authority to make anatomical gifts. Some of my clients who are of the Buddhist or Hindu faith oppose anatomical gifts for religious reasons. Other clients of mine seem to have a gut level aversion to the thought of their organs being taken from their body at death and therefore oppose anatomical gifts. Perhaps surrogates should not be given authority to make anatomical gifts. If such a prohibition were in the statute, those who want to make anatomical gifts could still do so by completing a DMV donor card or providing for anatomical gifts in a Power of Attorney for Health Care.

Since a surrogate committee would be made up mainly of health care professionals, members of the committee could have an interest in “harvesting” the patients’ organs. This interest in harvesting organs could cause patients to be taken off life support too early. Due to this conflict of interest, I believe that surrogate committees should be denied the power to authorize anatomical gifts from a “friendless” patient.

Sincerely,

Bruce Hudson Towne

BHT/dl  
cc: Leah Granof  

59
September 3, 1998

Stan Ulrich, Esq.
California Law Revision Commission
4000 Middlefield Road, Room D-1
Palo Alto, CA 94303-4739

Re: CMA Comments Concerning Proposed Health Care Decisions Law

Dear Stan:

The California Medical Association very much appreciates having the opportunity to offer its comments concerning the proposed Health Care Decisions Law. At the outset, CMA would like to commend both you and the Commission for your outstanding work in promulgating this important law. If enacted, it will rectify the gaps, inconsistencies, and confusion that exist under California's current patchwork of laws.

In particular, CMA supports the concept of a Surrogate Committee that would be empowered to make medical decisions for mentally incapacitated patients who do not have surrogate decisionmakers. Medical decisionmaking for such patients has long been extremely problematic, and CMA applauds the Commission for having developed a workable solution to this previously-intractable dilemma. In addition, while continuing to question the need for, and value of, a statutory surrogate law, CMA can support such a law with the proposed provision enabling a primary physician to select the most appropriate surrogate in certain circumstances. In these specific areas, and with regard to the proposed law as a whole, CMA believes that the Commission has made an significant contribution in the area of health care decisionmaking.

CMA has only a few specific concerns relating to the proposed law. First, on page 101, in section 2355, the proposed law will specifically give a conservator the right to withhold or withdraw life sustaining treatment for a conservatee who lacks the ability to make medical decisions. CMA is extremely pleased that this section will clearly spell out the scope of a conservator's power with regard to life-sustaining treatment decisions, and, in addition, clarify that the powers and responsibilities created by this section are conferred equally on private and public conservators. CMA also supports the amendment that will require a conservator to consider a conservatee's wishes, if any, when making health care decisions. However, CMA recommends that section 2355 be further amended to include a reference (preferably in the Code itself but, at the very least, in the Comment section) to the evidentiary standard that shall apply.
In several states, controversy has arisen in the last few years concerning whether or not a surrogate, including a conservator, may make a decision to withhold or withdraw life-sustaining treatment only if the conservatee has previously indicated his or her wishes by clear and convincing evidence. CMA fears that such a heightened evidentiary standard will inevitably necessitate frequent judicial involvement. Furthermore, in many cases, a conservatee may not have made such a pre-incapacity statement of wishes; therefore, a court might conclude that a conservator is precluded from making an appropriate decision for a conservatee concerning the forgoing of life-sustaining treatment. Indeed, a case is currently pending in California, In Re the Matter of Robert Wendland, Conservatee, in which a trial court ruled that a conservator (even under current section 2355) could not make a decision to forgo life-sustaining treatment until it could be proved by clear and convincing evidence that the conservatee “would, under the circumstances, want to die.” It would be extremely unfortunate if the amendment to section 2355, requiring a conservator to consider the wishes, if known, of a conservatee, were interpreted to allow courts to impose such a heightened evidentiary standard. Therefore, CMA strongly recommends that the Commission clarify that such a standard would not be applicable under the amended section.

Second, on page 65, section 4712(b)(1), the proposed law states that, where there are multiple possible surrogates at the same priority level, the primary physician shall select the individual who reasonably appears after a good faith inquiry to be best qualified. As CMA has suggested at previous Commission hearings, a good faith liability standard is necessary to ensure that physicians will be willing to exercise their power to make such a surrogate selection. A more demanding evidentiary standard, e.g., a “reasonableness” standard, merely invites litigation. The threat of such potential litigation and possible liability will cause physicians to seek judicial approval for surrogate selection in many cases. This would be wholly unworkable and would delay the provision of needed care to patients. As it stands, section 4712(b)(1) appears to combine both standards. Accordingly, CMA believes that the word “reasonable” on line 34 should be deleted. This would clarify that the good faith standard alone applies and would make this subsection consistent with later immunity provisions.

Third, on page 44, proposed section 4665 preserves the validity of previously-executed advance health care directives, but does not preserve the validity of unexecuted printed forms that were valid at the time they were printed. The current laws governing durable powers of attorney for health care have always maintained the validity of such printed forms, recognizing that many hospitals have considerable inventories of these forms and should not be required to suffer the expense of disposing of existing forms and purchasing new ones. We therefore urge the Commission to include a provision which will clearly preserve the validity and usability of forms which were valid at the time they were printed.
Fourth, on page 73, in proposed section 4736(b), the law would require a health care provider or institution that declines to comply with an individual health care instruction or health care decision “to provide continuing care to the patient until a transfer can be accomplished.” CMA is concerned that this provision can be read to override proposed section 4735, which states that a health care provider or institution may decline to comply with an instruction or decision that requires medically ineffective health care or health care contrary to generally accepted health care standards. That is, section 4736(b) could be interpreted to require the provision of medically ineffective care if the patient cannot be transferred to another facility. Certainly, such patients would not be abandoned. They would, of course, be provided with full palliative care and emotional support. However, CMA believes that demands for excessively invasive, aggressive or inappropriate care need not always be followed, even if a patient cannot be transferred. CMA therefore recommends that a cross-reference be included in subsection (b), such as “Subject to section 4735 above,” or some other statement which will address this situation.

Finally, on page 33, proposed section 4617, CMA recommends that the reference to “orders not to resuscitate” in subsection (b) be deleted and, instead, that the reference be included in subsection (c) as follows: “Directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.” The reference to CPR appears more appropriately to belong in subsection (c). CMA recommends that the same modification be made on page 104, proposed section 3200(b)(2) and (3).

Again, CMA supports the Commission’s effort to achieve consistency in the law and to address existing uncertainties, flaws and omissions. CMA looks forward to continuing to participate with you in the ongoing development of the proposed law.

Sincerely,

Alice P. Mead
CMA Legal Counsel

cc: Jack Lewin, MD
    Mike Goldman
    Roger Purdy
    Aura Bland
    Trish Beall
CALIFORNIA MEDICAL ASSOCIATION

MEMORANDUM

TO: CMA Executive Committee
FROM: Vicki Michel
SUBJ: Request for Authorization to Proceed as Amicus Curiae in In re The Matter of Robert Wendland, Conservatee

DATE: May 28, 1998

The attorney for Rose Wendland requests CMA’s amicus assistance at the appellate court level in this case involving a decision to forgo life-sustaining treatment made by a conservator for a severely brain-damaged conservatee.

SHORT SUMMARY OF THE CASE

Robert Wendland, now age 45, had a motor vehicle accident in September 1993, which left him in a coma until January 1995. Since awakening he has made limited progress and, although he can follow a few simple verbal cues, he does not recognize people or communicate. He is definitely not in a persistent vegetative state or terminally ill. Robert’s wife Rose decided, in July 1995, that his feeding tube should be withdrawn, based on her understanding of his wishes which, according to her, had been clearly expressed to her and other family members. Rose’s decision was supported by Robert’s physicians and the hospital ethics committee. However, Robert’s estranged mother and sister found out about Rose’s intention and got a temporary restraining order, which led Rose to go to court to be appointed Robert’s conservator with the authority to withdraw life-sustaining treatment.

The legal battle has continued since that time with a resolution at the trial court level in March of this year. The trial court judge, while deciding that Rose Wendland is the appropriate conservator for her husband and also the appropriate decisionmaker, and that her decision to withdraw treatment was made as required under Probate Code §2355 in good faith and with the advice of physicians, still did not permit the withdrawal of treatment because he said Rose must also prove by clear and convincing evidence that Robert “would, under the circumstances, want to die.”

Attorneys for Rose Wendland and Robert Wendland are appealing this decision.

IMPACT OF THIS DECISION ON PHYSICIANS IF IT WERE UPHOLDEN

When a court appoints a conservator of the person under the Probate Code and explicitly gives that conservator the power to make medical treatment decisions for his or her conservatee, physicians should be able to follow the directions from the conservator, relying on the legal authority that the court gave that person. This decision, if upheld, would require that in cases where the decision involved foregoing life-sustaining treatment, the conservator meet an additional burden of proving, by clear and convincing evidence, that the conservatee wanted treatment withdrawn in the circumstances that exist. This would burden physicians with the responsibility of making what is
Vicki Michel to CMA Executive Committee
August 28, 1998
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a legal, not a medical, determination before following the conservator’s direction or if physicians, as is likely to be the case, were unwilling to make that determination, every such case would have to go to court. Going to court, of course, would burden everyone and also be contrary to what just about every state legislature and court has said is appropriate.

DISCUSSION

The California Supreme Court has never decided a case concerning a surrogate decisionmaker’s decision to forgo life-sustaining treatment for a person without capacity to decide for him or herself. The mother and sister in this case apparently have the resources to take this case all the way up so the potential for establishing a legal rule that would be extremely burdensome for families and physicians exists here. Concern in this regard is warranted because the key appellate case, Drabick, that deals with a conservator decision to forgo life-sustaining treatment for his conservatee who was in a persistent vegetative state contains contradictory statements about the scope of permissible decisionmaking under the relevant statute, Probate Code §2355. That statute says “...the conservator has the exclusive authority to give consent for such medical treatment to be performed on the conservatee as the conservator in good faith based on medical advice determines to be necessary ...” (emphasis added). It is generally understood that the authority to consent to treatment must include the authority to refuse treatment to have any meaning and the court in Drabick says this explicitly.

The Drabick court also says “There is no necessity or authority for adopting a rule to the effect that the conservatee’s desire to have medical treatment withdrawn must be proved by clear and convincing evidence or another standard. Acknowledging that the patient’s expressed preferences are relevant, it is enough for the conservator, who must act in the conservatee’s best interests, to consider them in good faith.”

Unfortunately, however, the Drabick court also said, “The medical advice that will support a conservator’s decision to forgo life-sustaining treatment must include the prognosis that there is no reasonable possibility of return to cognitive and sapient life.” (emphasis added). In other words, the court’s interpretation of Probate Code §2355 as it applies to decisions to forgo life-sustaining treatment seems limited to only a particular prognosis. This leaves the opening for the judge in the Wendland case to create an additional evidentiary standard of clear and convincing evidence that the conservator must meet when the prognosis is different.

But Probate Code §2355 does not distinguish between different prognoses and it makes no sense that it should. Once the court has chosen an appropriate decisionmaker, the guidance of the statute’s language should be sufficient to set the standard of decisionmaking and physicians should be able to follow the decision of the conservator without worrying about an additional standard of proof.
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CMA POLICY

CMA has always supported statutory mechanisms for surrogate decisionmaking concerning medical treatment whether through a conservatorship or a durable power of attorney for health care. CMA was an active participant in the California Consortium for Patient Self-Determination which created the state adopted materials that health institutions must give patients concerning their legal rights and including the rights of surrogate decisionmakers. CMA’s Council on Ethical Affairs unanimously agreed that CMA should support Rose and Robert Wendland with an amicus brief because of the case’s importance to physicians.

OPTIONS RE AMICUS PARTICIPATION

1. Submit an amicus brief supporting the Wendlands’ argument that conservators should be governed in medical decisionmaking by Probate Code §2335 without any additional requirements for particular decisions to forgo life-sustaining treatment.¹

2. Do nothing.

RECOMMENDATION RE AMICUS PARTICIPATION

Option 1: The issue posed by this case is important to physicians, who should not have to be faced with several different standards for conservator’s decisions about medical treatment. The parties in the case will have to argue that Robert Wendland’s earlier statements do constitute clear and convincing evidence of his wishes whereas CMA can focus on the inappropriateness of the ‘clear and convincing’ standard.

VM/pm
cc: Jack Lewin
    Pete Sybinsky
    Mike Goldman
    Ginnie Yee (for distribution)

¹Preparation of an AC brief in this case would take approximately 40 hours ($5,000) and would be done inhouse. This calculation is based on CMA’s average in-house cost for attorney time of approximately $125.00 per hour. It must be emphasized, however, that this number is very imprecise from CMA’s standpoint. This is because we don’t pay our attorneys by the hour, and we typically use our work on AC briefs for other purposes.
MEMORANDUM

Date: September 1, 1998

To: Stan Ulrich
California Law Revision Commission
Fax: (650) 494-1827

From: Maureen Sullivan, Legal Counsel
Lois Richardson, Legal Counsel
California Healthcare Association

Subject: Comments on Tentative Recommendation for Health Care Decisions for Incapacitated Adults

Via Facsimile and followed by U.S. mail

Attached please find comments submitted by the California Healthcare Association regarding the tentative recommendation for Health Care Decisions for Incapacitated Adults. We have extensively reviewed the tentative recommendation and are impressed with the quality of the proposed legal revisions. However, we have some concerns that are expressed within the comments and hope that the Commission will consider them when further developing its recommendation.

The California Healthcare Association represents acute care hospitals and physician groups. In addition, many of our members also have skilled nursing, hospice and home health within their facilities. Therefore, the proposed recommendations will have a significant impact on our membership and the patients they serve.

In addition, CHA publishes annually the Consent Manual. This publication is used by our membership and is often requested by non-members as well. The tentative recommendations for the proposed legislation will result in enormous change to the provisions within the Consent Manual and the education seminars that accompany each year’s new Consent Manual.

Given the aforementioned, I am sure you can understand our deep interest in the tentative recommendation. We look forward to working with you as you continue to refine and modify the recommendation and encourage you to call either Maureen Sullivan at (916)552-7689 or Lois Richardson (916) 552-7611 if we can be of assistance.
1. Page 33, line 33 revise to read: © *Meaningful* directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care.

2. Page 33, add to section 4617: (d) determination of visitors permitted to see the patient

3. Page 34, line 21: Revise to read: “Health care provider”, for purposes of this division,...

4. Page 35, line 20: Revise to read: “Patient, for purposes of this division,...

5. Page 36, lines 1-6: suggest adding to the language defining primary physician “physician who has continuous knowledge of patient”. Reasoning is that it is the physician with continuous knowledge and interaction with a patient and/or family members who is in the best position to assist in the decision making. Primary care physician may not be the best choice in situations involving cancer when the specialist/oncologist is often the physician with the continuous knowledge. In addition, the advent of the “hospitalist” as the in-hospital physician may place this physician in the inappropriate position of primary physician due to the environment. One of the criticisms of “hospitalists” is that their role and function interferes with continuity of care and communication because they function exclusively within the hospital/in-patient environment.

6. Page 36, line 5: Revise to read: “…is not reasonably available, or declines to be primary physician…”

7. Page 37, lines 20-24: definition of supervising health care provider is vague and could create confusion among non-physician providers, particularly in non-acute settings. Consequently there could be differing opinions or no one willing to facilitate decision making. One alternative is to add “following physician’s orders” to the definition of supervising health care provider to clarify role and responsibilities.

8. Page 40, lines 22-25: generally accepted health care standards may be overlybroad in its interpretation in a situation where there could be a legal challenge to a physician’s decision. Suggest adding or substituting “accepted standard of care” as the requirement for physician decisions. Language is congruent with standard used in other situations where physician decisions or treatment are challenged.
9. Page 41, Section 4657: Clarify and make express within the section that presumption of capacity is a rebuttable presumption.

10. Page 44, lines 16-33: Due to the extensive revisions to the CHA Consent Manual and corresponding consent seminars, there exists some concern that the January 1, 2000 date will provide insufficient time to educate members, revise documents and incorporate the substantive changes to the consent procedure. Presuming the legislation is signed into law at the end of the legislative session for 1999, merely four months will remain until the effective date for the new provisions. We suggest extending the date for compliance to July 1, 2000.

11. Page 46, Section 4673: For purposes of notarizing an advance health care directive, can the notary be an employee of the skilled nursing facility? Whether it is permissible or not, it needs to be expressly stated.

12. Page 49, Section 4675: Add to list, Knox Keene health care service plan


14. Page 54, lines 8-11: For evidentiary purposes, suggest requiring, where it is possible, a writing when a principal/patient is revoking the designation of an agent. This may make the process more complicated; however, the agent’s role and responsibility are significant. Given the agent’s importance, the revocation should be express and well documented to insure against abuse or misunderstanding resulting in inappropriate action.

15. In addition, the requirement of supervising health care provider is too inflexible given the lack of clarity in determining who that person is.

16. Page 56 line 33: The agent, under law, is not permitted to make all health care decisions for the principal. The agent may not authorize abortion, sterilization, electroconvulsive shock therapy, etc. The limitations need to be included in the form as well as how the agent’s power can be revoked.

17. Page 57 line 16: change “individuals” to adults.

18. Page 57, line 23: Explain in form how the advance health care directive can be revoked or replaced.

19. Page 58, section (1.2): Include exceptions to health care decisions that agent is permitted to make, particularly considering the limitations articulated in section 4681.
20. Page 59, section (2.2): Is there any legal liability for a physician following this directive? What are the possibilities that consenting to and providing relief from pain that may hasten, and, in fact, does hasten death, may be construed as a criminal act or physician assisted suicide? Perhaps reference to the tripartite legislation and its policy would clarify what is acceptable.


22. Page 60, Part 4: designation of primary physician in a document may be problematic within managed care environment when consumers must often change plans due to employer contracts or are assigned another physician within the same managed care organization.

23. Page 65, lines 14-44 and Page 66, lines 1-12: Concern with the proposed priority scheme exists because often the need for a surrogate arises when there is a decision to be made and insufficient time to explore many options. It is likely under conditions where there is a sense of urgency, that the priority scheme will be misused because time constraints and staff concerns will discourage health care providers from thoroughly exploring the priorities to reach the most appropriate person as a surrogate. In addition, the priority scheme, even when physician discretion is permitted, is often the source of discord when the person requiring a surrogate is in a homosexual or domestic partner relationship. Suggest using the priority scheme as a fall-back position and permit a physician or other health care provider to select a surrogate based on the factors listed on lines 33-44 on page 65 and lines 1-5 on page 66. Use those factors as the foundation and only when a potential surrogate does not meet those conditions, use the priority scheme.

24. Page 65, line 24, change "individual" to "adult"

25. Page 67, lines 1-5: Again, suggest the revocation of a surrogate be done expressly and with a writing for the same reasons set forth for requiring same for revocation of agent.

26. Page 68, lines 34-36: does this person or persons function on a voluntary basis or can they be compensated for serving. If compensation is permissible, does the person then revert to employee status?

27. Page 70, lines 18-21: Would the communication by the health care provider to a patient regarding a health care decision made by another be a valid communication when the patient lacks capacity. In many cases, a surrogate is making the decision because the patient cannot or lacks capacity. It appears incongruous to require communication under the circumstances. However, documentation is critical.

28. Page 72, section 4734: include an additional exception where a physician or health care provider may not decline comply for reasons relating to cost of care and/or reimbursement.
29. Page 72, lines 37-41: While it is generally understood within the medical community that when treatment is considered to be futile, the treating physician can choose not to provide that treatment, the language in this section appears subject to varied interpretation with the use of the standard of “ineffective care” regarding the standards physicians must use to deny treatment. Suggest incorporating the medical futility standard or, at minimum, defining standard as the generally accepted standard of care for this situation. Alternatively, define what ineffective care is.

30. Page 73, lines 8-18: Under the circumstances articulated in this section, particularly where the situation is one of medical futility, it is unlikely that another provider or institution will accept the transfer of the patient. Requiring the transfer of a patient under these conditions is onerous, unduly burdensome and likely to be unsuccessful, thereby subjecting the institution and/or provider to potential liability. Suggest incorporating language that addresses the patient’s ability to be transferred. In addition, suggest authorizing judicial intervention in these circumstances, on a case by case basis.

31. Page 74, line 2: revise to read “including, but not limited to any of the following conduct”

32. Page 74, section 4740: add (d) Declining to comply with a directive in accordance with section 4736.
Health Care Decisions for Adults
Without Decisionmaking Capacity

[December] 1998

California Law Revision Commission
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SUMMARY OF RECOMMENDATION

This recommendation proposes a new Health Care Decisions Law to consolidate the Natural Death Act and the statutes governing the durable power of attorney for health care, and provide comprehensive rules relating to health care decisionmaking for incapacitated adults. The proposed law, drawing heavily from the Uniform Health-Care Decisions Act (1993), includes new rules governing individual health care instructions, and provides a new optional statutory form of an advance health care directive.

The proposed law would add procedures governing surrogate health care decisionmakers (“family consent”) where an individual has not appointed an agent and no conservator of the person has been appointed, and procedures for making health care decisions for patients who do not have any surrogate willing to serve.

Conforming changes in the procedure for obtaining court authorization for medical treatment would make clear that courts in proper cases have the same authority as other surrogates to make health care decisions, including withholding or withdrawal of life-sustaining treatment. Similarly, the statute governing decisionmaking by conservators for patients who have been adjudicated to lack the capacity to make health care decisions are conformed to the standards governing other health care surrogates.

This recommendation was prepared pursuant to Resolution Chapter 91 of the Statutes of 1998.
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HEALTH CARE DECISIONS FOR ADULTS WITHOUT DECISIONMAKING CAPACITY

Staff Note. This preliminary part will need to be revised to reflect changes made in response to comments received on the tentative recommendation, as discussed in Memorandum 98-63 and in the Staff Notes following sections in the draft statute.

California has been a pioneer in the area of health care decisionmaking for incapacitated persons, with the enactment of the 1976 Natural Death Act\(^1\) and the 1983 Durable Power of Attorney for Health Care.\(^2\) Legislation in other states over the last 15 years, enactment of the federal Patient Self-Determination Act in 1990,\(^3\) and promulgation of a new Uniform Health-Care Decisions Act in 1993,\(^4\) suggest the need to review existing California law and consider revising and supplementing it.

California law does not adequately address several important areas:

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

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

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

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

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

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

NEED FOR REVISED LAW

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

During the last decade, states have enacted three different kinds of documents to deal with health care of incompetent patients. The legislation’s main impetus and central focus have been to provide a procedure to approve life support termination in appropriate cases, although it also addresses other health care concerns. The earliest of the statutes was a natural death act, which authorizes a directive, popularly called a living will, to physicians. The second was a general durable power of attorney, sometimes in the form of a specially crafted health care durable power of attorney, which essentially empowers an appointed agent to make appropriate decisions for an incompetent patient. The agent is bound by directions contained in the appointing power. Finally, some states have enacted family consent laws empowering others, typically family, to decide health care matters absent a directive or power of attorney to guide them. At the end of 1990, Congress gave these laws new importance by mandating their observance.

The statutes differ; provisions of one form conflict with provisions of another form. Most contradictions raise problems, some nettlesome, others destructive of important interests. After more than a decade of experience with such forms, it is time to review the present state of the laws and to coordinate and debug them. In the author’s view, a single statute incorporating the best of each of the three types of law is now in order.

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

BACKGROUND AND OVERVIEW

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


In the Natural Death Act, the Legislature made the explicit finding that “an adult person has the fundamental right to control the decisions relating to the rendering of his or her own medical care, including the decision to have life-sustaining treatment withheld or withdrawn in instances of a terminal
The proposed law reaffirms this fundamental right along the lines of the Uniform Health-Care Decisions Act, which acknowledges the right of a competent individual to decide all aspects of his or her own health care in all circumstances, including the right to decline health care or to direct that health care be discontinued, even if death ensues. An individual’s instructions may extend to any and all health-care decisions that might arise and, unless limited by the principal, an agent has authority to make all health-care decisions which the individual could have made. The Act recognizes and validates an individual’s authority to define the scope of an instruction or agency as broadly or as narrowly as the individual chooses.7

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

1. Power of Attorney

California has a detailed statute governing durable powers of attorney for health care and providing a special statutory form durable power of attorney for health care.8 The DPAHC requires appointment of an attorney-in-fact (“agent” in the statutory form durable power of attorney for health care) to carry out the principal’s wishes as expressed in the power of attorney or otherwise made known to the attorney-in-fact, but the attorney-in-fact also has authority to act in the best interest of the principal where the principal’s desires are unknown.9 The power of attorney for health care rules are generally carried forward in the proposed law.

7. UHCDA Prefatory Note.
8. Prob. Code § 4600 et seq. This statute and its predecessor in the Civil Code were enacted on Commission recommendation. See:


In the Commission’s study resulting in the comprehensive Power of Attorney Law, substantive review of health care decisionmaking issues was deferred for consideration as the second part of the study. This enabled legislative enactment of the comprehensive restructuring of the power of attorney statutes to proceed without further delay and was also necessary in light of other legislative priorities.

2. Natural Death Act, Living Will

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

3. Statutory Surrogacy

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

4. Court-Appointed Conservator

California law provides a highly developed Guardianship-Conservatorship Law. The Lanterman-Petris-Short Act provides a special type of conservatorship for the gravely disabled. These provisions are not the focus of this recommendation.

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


12. Welf. & Inst. § 5350 et seq.

13. Communications to the Commission suggest that the procedure for court-authorized medical treatment and related conservatorship provisions should be reviewed for consistency with the scope of the proposed Health Care Decisions Law. As noted below, this recommendation proposes revisions in Probate Code Sections 3200-3211, and in Section 2355 (medical treatment of conservatee adjudicated to lack
5. Other Judicial Intervention

A special procedure for court-authorized medical treatment is available for adults without conservators.¹⁴

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

POWER OF ATTORNEY FOR HEALTH CARE

The proposed Health Care Decisions Law continues and recasts the existing law governing the durable power of attorney for health care, including the statutory form durable power of attorney for health care.¹⁷ For the well-advised or careful individual who is making sensible arrangements for the time when he or she may be incapacitated, the power of attorney for health care¹⁸ is clearly the best approach. Expressing desires about health care and naming one or more agents¹⁹ subject to appropriate standards is the best way to accomplish “incapacity planning” and seek to effectuate a person’s intent with regard to health care decisions, especially with regard to life-sustaining treatment.

In the new terminology — not so new in practice, but new to the Probate Code — a power of attorney for health care is one type of “advance health care direc-

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¹⁶. Id. at 335.

¹⁷. For the central provisions governing the durable power of attorney for health care, see Prob. Code §§ 4600-4752. For the statutory form durable power of attorney for health care, see Prob. Code §§ 4770-4779.

¹⁸. For convenience, the proposed law uses the term “power of attorney for health care” instead of “durable power of attorney for health care.” The reference to durability was more important in earlier years, when the idea of an agency surviving the incapacity of the principal was still a novel concept. It should now be clear and, in any event, in the realm of health care decisionmaking, it is common sense that almost all powers of attorney for health care will operate only after the principal becomes incapable of making health care decisions. The substance of the law is clear in the proposed law, notwithstanding the omission of the term “durable.”

¹⁹. The proposed law uses the more “user-friendly” term “agent” in place of “attorney-in-fact” used in the existing durable power of attorney for health care statute. However, the terms are interchangeable, as provided in existing law (Prob. Code § 4014(a)) and in the proposed law (proposed Prob. Code § 4607(a)).
The proposed law restructures the power of attorney for health care provisions based on a mix of principles from the existing Power of Attorney Law and the Uniform Health-Care Decisions Act. Where rules apply only to powers of attorney for health care, the proposed law uses that terminology. Where rules apply to all written advance health care directives, the language will vary, but the general substance of the law continues, except as noted.

Execution Formalities

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

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

Witnessing can be useful, however, even if it is not required. The proposed law follows the UHCDA in recommending but not requiring witnesses. Witness requirements can operate as more of an intent-defeating technicality than a protection against possible fraud. The drafters of the UHCDA viewed technical execu-

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20. The comment to UHCDA Section 1(1) notes that the term “appears in the federal Patient Self-Determination Act enacted as sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990 and has gained widespread usage among health-care professionals.”
22. See former Civ. Code § 2436.5, as enacted by 1983 Cal. Stat. ch. 1204, § 10. See also Prob. Code § 4654 (transitional provision concerning former seven-year powers). The proposed law does not provide any special rules for these earlier powers. See infra text accompanying note 85.
23. URTIA § 2. The 1989 revision of URTIA continued this requirement.
24. UHCDA § 2(b).
25. Prob. Code §§ 4121-4122, 4700-4701. To be valid, the statutory form power of attorney for health care must be witnessed; it is not validated by notarization. Prob. Code § 4771 & Comment.
26. This is not to say that more formal requirements are not important in powers of attorney for property, where the possibility of fraud is more significant. The execution formalities in the Power of Attorney Law
tion formalities as unnecessarily inhibiting while at the same time doing “little, if anything, to prevent fraud or enhance reliability.”\textsuperscript{27} The genuineness of advance health care directives is bolstered by placing reliance on the health care providers. Recordkeeping plays a critical role. Health care providers are required to enter the advance directive in the patient’s health care records. Medical ethics also reinforce the duty to determine and effectuate genuine intent. The proposed law also provides penalties for violation of statutory duties.\textsuperscript{28}

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

**Statutorily Required Warnings**

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

The existing warning provisions are too confusing and rigid. While there has been an attempt to educate potential users through concise and simple statements, the net effect of the existing scheme may have been to inhibit usage. Some form of introductory explanation is still needed, however, and the optional statutory form drawn from the UHCDA in the proposed law fulfills this purpose. But the proposed law no longer attempts to instruct lawyers on how to advise their clients. The Commission expects that those who prepare printed forms will copy the language of the optional form or use a reasonable equivalent without the need to mandate specific language.

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\textsuperscript{28} See infra text accompanying notes 66-69.

\textsuperscript{29} See Prob. Code §§ 4121-4122, 4701.

\textsuperscript{30} See Prob. Code §§ 4703 (requirements for printed form), 4704 (warnings in power of attorney for health care not on printed form), 4771 (statutory form), 4772 (warning or lawyer’s certificate), 4774 (requirements for statutory form). For a number of complicated, technical rules governing earlier printed form requirements, see Prob. Code §§ 4651, 4775.

\textsuperscript{31} Prob. Code § 4653. A similar rule applies under the Section 7192.5 in the NDA.
Revocation

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

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

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

INDIVIDUAL HEALTH CARE INSTRUCTIONS

California does not authorize what the UHCDA calls an “individual instruction,” other than through the mechanism of the Natural Death Act which applies only to patients in a terminal or permanent unconscious condition. Health care instructions may, of course, be given in the context of appointing and instructing an attorney-in-fact under a durable power of attorney for health care. The Commission is informed that, in practice, individuals will execute a durable power of attorney for health care without appointing an attorney-in-fact so that they can use that vehicle to effectively state their health care instructions. It is also possible to appoint an attorney-in-fact, but limit the agent’s authority while expressing broad health care instructions. These approaches may succeed in getting formal health care instructions into the patient’s record, but existing law is not well-adapted for this purpose.

32. Prob. Code § 4727(a), (b), (d).
33. UHCDA § 3.
34. Prob. Code § 4727(e). The designation is revived if the principal and the former spouse are remarried.
Health care providers’ duties under the existing durable power of attorney for health care focus on the agent’s decisions, not the principal’s instructions.

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

STATUTORY SURROGATES — FAMILY CONSENT

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

Existing California Law

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

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

A patient should be denied the opportunity to weigh the risks only where it is evident he cannot evaluate the data, as for example, where there is an emergency or the patient is a child or incompetent. For this reason the law provides that in an emergency consent is implied …, and if the patient is a minor or incompetent, the authority to consent is transferred to the patient’s legal guardian or closest available relative …. In all cases other than the foregoing, the decision whether or not to undertake treatment is vested in the party most directly affected: the patient.

But this language is not a holding of the case.

35. See supra note 10.
36. Health & Safety Code § 1418.8(c).
37. 8 Cal. 3d 229, 243-44, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) (citations omitted).
38. The “closest available relative” statement cites three cases, none of which involve incapacitated adults. Consent on behalf of an incapacitated adult was not an issue in the case, since the patient did not lack capacity, but was claiming that he had not given informed consent. Still, Cobbs is cited frequently in later cases involving consent or withdrawal of consent to medical treatment.
The leading case of *Barber v. Superior Court*[^39] contains a thorough discussion of the problems:

Given the general standards for determining when there is a duty to provide medical treatment of debatable value, the question still remains as to who should make these vital decisions. Clearly, the medical diagnoses and prognoses must be determined by the treating and consulting physicians under the generally accepted standards of medical practice in the community and, whenever possible, the patient himself should then be the ultimate decision-maker.

When the patient, however, is incapable of deciding for himself, because of his medical condition or for other reasons, there is no clear authority on the issue of who and under what procedure is to make the final decision.

It seems clear, in the instant case, that if the family had insisted on continued treatment, petitioners would have acceded to that request. The family’s decision to the contrary was, as noted, ignored by the superior court as being a legal nullity.

In support of that conclusion the People argue that only duly appointed legal guardians have the authority to act on behalf of another. While guardianship proceedings might be used in this context, we are not aware of any authority requiring such procedure. In the case at bench, petitioners consulted with and relied on the decisions of the immediate family, which included the patient’s wife and several of his children. No formal guardianship proceedings were instituted.

... The authorities are in agreement that any surrogate, court appointed or otherwise, ought to be guided in his or her decisions first by his knowledge of the patient’s own desires and feelings, to the extent that they were expressed before the patient became incompetent....

If it is not possible to ascertain the choice the patient would have made, the surrogate ought to be guided in his decision by the patient’s best interests. Under this standard, such factors as the relief of suffering, the preservation or restoration of functioning and the quality as well as the extent of life sustained may be considered. Finally, since most people are concerned about the well-being of their loved ones, the surrogate may take into account the impact of the decision on those people closest to the patient....

There was evidence that Mr. Herbert had, prior to his incapacitation, expressed to his wife his feeling that he would not want to be kept alive by machines or “become another Karen Ann Quinlan.” The family made its decision together (the directive to the hospital was signed by the wife and eight of his children) after consultation with the doctors.

Under the circumstances of this case, the wife was the proper person to act as a surrogate for the patient with the authority to decide issues regarding further treatment, and would have so qualified had judicial approval been sought. There is no evidence that there was any disagreement among the wife and children. Nor was there any evidence that they were motivated in their decision by anything other than love and concern for the dignity of their husband and father.

Furthermore, in the absence of legislative guidance, we find no legal requirement that prior judicial approval is necessary before any decision to withdraw treatment can be made.

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

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

Current Practice: LACMA-LACBA Pamphlet

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

The process suggested in these Guidelines has been developed in light of the following principles established by the California courts and drawn from the Joint Committee’s Guidelines for Forgoing Life-Sustaining Treatment for Adult Patients:

(a) Competent adult patients have the right to refuse treatment, including life-sustaining treatment, whether or not they are terminally ill.

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

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

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

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

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

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

Current Practice: Patient Information Pamphlet

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

What if I’m too sick to decide?

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

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

41. See also American Medical Ass’n, Code of Medical Ethics § 2.20, at 40 (1997-98) (“[W]hen there is no person closely associated with the patient, but there are persons who both care about the patient and have sufficient relevant knowledge of the patient, such persons may be appropriate surrogates.”); California Healthcare Ass’n, Consent Manual: A Reference for Consent and Related Health Care Law 2-18 (23d ed. 1996) (“In some circumstances, it may be necessary or desirable to rely upon the consent given by the incompetent patient’s ‘closest available relative.’ The validity of such consent cannot be stated with certainty, but the California Supreme Court has indicated that in some cases it is appropriate for a relative to give consent.” [citing Cobbs v. Grant]; President’s Comm’n etc., Deciding To Forego Life-Sustaining Treatment 126-27 (1983) (“When a patient lacks the capacity to make a decision, a surrogate decisionmaker should be designated. Ordinarily this will be the patient’s next of kin, although it may be a close friend or another relative if the responsible health care professional judges that this other person is in fact the best advocate for the patient’s interests.”)).
Alternative Approaches to Statutory Surrogate Priorities

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

Priority schemes among relatives and friends seem natural. Intestate succession law43 provides a ready analogy — thus, the spouse, children, parents, siblings, and so forth, seem to be a natural order. The same order is established in the preference for appointment as conservator.44 But the analogy between health care, life-sustaining treatment, and personal autonomy on one hand and succession to property on the other is weak. A health care decision cannot be parceled out like property in an intestate’s estate. The consequences of a serious health care decision are different in kind from decisions about distributing property.

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

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

The UHCDA scheme lists the familiar top four classes of surrogates (spouse, children, parents, siblings), but is less restrictive than many state statutes in several respects:46 (1) Class members may act as surrogate and need to assume authority to do so. It is not clear whether a class member must affirmatively decline to act or may be disregarded if he or she fails to assume authority, but unlike some state statutes, an abstaining class member does not prevent action. (2) Determinations

43. Prob. Code § 6400 et seq.
44. Prob. Code § 1812.
46. UHCDA § 5.
within classes can be made by majority vote under the UHCDA. This is not likely
to be a common approach to making decisions where there are disagreements, but
could be useful to validate a decision of a majority where there are other class
members whose views are unknown or in doubt. (3) Orally designated surrogates
are first on the UHCDA priority list, as an attempt to deal with the fact that a strict
statutory priority list does not necessarily reflect reality. The “orally designated
surrogate was added to the Act not because its use is recommended but because it
is how decision makers are often designated in clinical practice.”

(4) The authorization for adults who have “exhibited special care and concern” is relatively new.

Under the common law, the status of friends as surrogates is, in Professor Meisel’s
words, “highly uncertain.” In a special procedure applicable to “medical inter-
ventions” in nursing homes, California law requires consultation with friends of
nursing home patients and authorizes a friend to be appointed as the patient’s rep-
resentative, but the health care decision is made by an “interdisciplinary team.”

**Statutory Surrogates Under Proposed Law**

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

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

> Although the intent of such priority lists is a good one — to eliminate possible
> confusion about who has the legal authority to make decisions for incompetent
> patients — the result of surrogate-designation pursuant to statute is not only
> mechanical but can be contrary or even inimical to the patient’s wishes or best
> interests. This would occur, for example, if the patient were estranged from his
> spouse or parents. However, it is not clear that the result would be much different

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file with California Law Revision Commission).

48. 2 A. Meisel, The Right to Die §14.4, at 51 (2d ed. Supp. #1 1997). *But cf.* Conservatorship of
patient and a diagnosis establishing that further treatment offers no reasonable hope of returning the
patient to cognitive life, the decision whether to continue noncurative treatment is an ethical one for the physicians
and family members or other persons who are making health care decisions for the patient.”)

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

in the absence of a statute because the ordinary custom of physicians sanctioned by judicial decision, is to look to incompetent patients’ close family members to make decisions for them. In the absence of a statute, the physician might ignore a spouse known to be estranged from the patient in favor of another close family member as surrogate, but because there is nothing in most statutes to permit a physician to ignore the statutory order of priority, the result could be worse under a statute than in its absence.

In recognition of the problems as well as the benefits of a priority scheme, the proposed law sets out a default list of statutory surrogates: (1) The spouse, unless legally separated, (2) children, (3) parents, (4) brothers and sisters, (5) grandchildren, (6) an individual in a long-term relationship of indefinite duration with the patient in which the individual has demonstrated an actual commitment to the patient similar to the commitment of a spouse and in which the individual and the patient consider themselves to be responsible for each other’s well-being (including a person known as a domestic partner), and (7) close friends.

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

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

(1) Whether the proposed surrogate reasonably appears to be best able to make decisions in accordance with the statutory standard (patient’s instructions, if known, or best interest, taking into account personal values).
(2) The degree of regular contact with the patient before and during the patient’s illness.
(3) Demonstrated care and concern for the patient.
(4) Familiarity with the patient’s personal values.
(5) Availability to visit the patient.
(6) Availability to engage in face-to-face contact with health care providers for the purpose of fully participating in the health care decisionmaking process.

In addition, the process of applying these standards and making the determination must be documented in the patient’s medical record.

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

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

The Commission also considered a family consensus approach, such as that provided under Colorado law. In this procedure, the class of potential surrogates, composed of close family members and friends, is given the responsibility and duty to select a surrogate from among their number. It is difficult to judge how well this type of procedure would work in practice. The concern is that it might result in too much confusion and administrative burden, without improving the prospects for effective decisionmaking or resolving disputes.

The proposed law adopts a presumptive “pecking order” like the UHCDA, but places the responsibility on the primary physician to select the best-situated person based on standards set out in the statute. This avoids the rigidity of the UHCDA approach and the indefiniteness and administrative burden of the consensus approach. Notice of the selection should be given to other family members. Potential surrogates with serious objections to the selection of the surrogate or the decisions being made by the surrogate would still have the right to bring a judicial challenge or seek appointment as a conservator.

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

DECISIONMAKING WHERE NO SURROGATE IS AVAILABLE

Providing statutory surrogate rules where a patient has not executed an advance directive or designated a surrogate, and for whom a conservator of the person has not been appointed, does not answer all of the problems. The statutory surrogate rules will not apply to a significant group of incapacitated adults for whom there

52. UHCDA § 5.
54. See infra text accompanying notes 73-77.
are no potential surrogates because they have no close relatives or friends familiar
with their health care treatment desires or values, or because potential surrogates
are unwilling or unable to make decisions.

Existing law addresses this problem with respect to “medical interventions” for
patients in the nursing home context, 55 but there is no general surrogacy rule
applicable in these circumstances. The UHxDA does not address this problem.

The alternative of appointing a conservator of the person in each of these cases is
not an adequate solution to the problem, as recognized by the Legislature when it
enacted the nursing home medical intervention procedure. 56 While it is possible to
seek court approval for medical “treatment” under Probate Code Section 3200 et
seq. (authorization of medical treatment for adult without conservator), this proce-
dure does not authorize orders for withdrawal of treatment or refusal of consent. 57

The proposed law adopt a procedure based on nursing home medical interven-
tion procedure. Under this proposal, health care decisions for the “friendless”
icapacitated adult could be made by a “surrogate committee.” The committee
would be made up of the following persons, as appropriate under the
circumstances:

(1) The patient’s primary physician.
(2) A registered professional nurse with responsibility for the patient.
(3) Other appropriate health care institution staff in disciplines as determined by
the patient’s needs.
(4) One or more patient representatives, who may be a family member or friend
of the patient who is unable to take full responsibility for the patient’s health care
decisions, but has agreed to serve on the surrogacy committee.
(5) In cases involving major health care decisions, a member of the community
who is not employed by or regularly associated with the primary physician, the
health care institution, or employees of the health care institution.
(6) In cases involving major health care decisions, a member of the health care
institution’s ethics committee or an outside ethics consultant.

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

(1) The primary physician’s assessment of the patient’s condition.
(2) The reason for the proposed health care decision.

2d 185 (1995) (upholding the constitutionality of the procedure for patients in nursing homes who lack
capacity to make health care decisions, “even though they do not have a next of kin, an appointed
conservator, or another authorized decision maker to act as their surrogate”).

56. In most cases, the conservator will be the Public Guardian, which may be a non-solution if the Public
Guardian’s policy is not to exercise the duty to decide as set down in Drabick.

57. Probate Code Section 3208 refers to “authorizing the recommended course of medical treatment of
the patient” and “the existing or continuing medical condition.”
(3) The desires of the patient, if known. To determine the desires of the patient, the surrogate committee must interview the patient, review the patient’s medical records, and consult with family members or friends, if any have been identified.

(4) The type of health care to be used in the patient’s care, including its probable frequency and duration.

(5) The probable impact on the patient’s condition, with and without the use of the proposed health care.

(6) Reasonable alternative health care decisions considered or utilized, and reasons for their discontinuance or inappropriateness.

The surrogate committee is required to periodically evaluate the results of approved health care decisions at least quarterly or whenever there is a significant change in the patient’s medical condition.

The proposed law intends the surrogate committee to try to operate on a consensus basis. If consensus cannot be reached, the committee is authorized to approve proposed health care decisions by majority vote. There is an important exception: proposed health care decisions relating to withdrawal of life-sustaining treatment cannot be approved if any member of the surrogate committee is opposed. If a surrogate committee becomes hopelessly deadlocked, resort to judicial proceedings may be necessary.

STANDARDS FOR SURROGATE DECISIONMAKING

The existing power of attorney for health care law requires the attorney-in-fact to “act consistent with the desires of the principal as expressed in the durable power of attorney or otherwise made known to the attorney-in-fact at any time or, if the principal’s desires are unknown, to act in the best interests of the principal.”58

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

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

The proposed law, like the UHCDA, applies these standards generally throughout the statute. Thus, the same fundamental standard will apply to all surrogate health care decisionmakers: agents under powers of attorney, surrogates designated by the patient, family and friends who can act as surrogates under general principles codified in the statutory surrogate rules, surrogate committees acting for the “friendless” patient, private conservators and Public Guardians acting for conser-

vatees without the capacity to make health care decisions,\(^{59}\) and courts deciding cases under the court-authorized health care procedure.\(^{60}\)

**DUTIES OF HEALTH CARE PROVIDERS AND OTHERS**

The proposed law sets out a number of specific duties of health care providers, drawn from the UHCDA,\(^{61}\) that are more detailed than existing law. Since a fundamental feature of the uniform act is reliance on health care professionals to make necessary determinations and to comply with advance directives and health care decisions made by surrogates, the proposed law requires communication with the patient, entry in the patient’s medical records of the existence of an advance directive (including a copy) or a surrogate designation, and of any revocation or modification. The recordkeeping duties are extremely important since in the clinical setting, the patient’s records provide the best means to make advance directives and surrogate designations effective.

The proposed law requires the health care provider and institution to comply with the patient’s advance directive and with health care decisions made by the patient’s surrogate decisionmaker, to the same extent as if the patient made the decision while having capacity.\(^{62}\) However, a health care provider may lawfully decline to comply for reasons of conscience or institutional policy. This rule, drawn from the UHCDA,\(^{63}\) is consistent with the Natural Death Act and case law.\(^{64}\) If the health care provider declines to comply, however, there is a duty to transfer the patient to another health care institution.

Another important limitation on the health care provider’s duty to comply is recognized in the proposed law. The health care provider or institution may decline to provide medically ineffective care or care that is contrary to generally accepted health care standards.\(^{65}\) But as in other cases where compliance can be declined, the health care provider and institution have a duty to continue care until a transfer can be accomplished. The proposed law does not go beyond the statement of these basic rules — it does not attempt to resolve the issue that may arise where a transfer is not practicable and the duty to provide continuing care conflicts with the right to decline to provide ineffective treatment.

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59. See *infra* text accompanying notes 81-84.
60. See *infra* text accompanying notes 78-80.
61. UHCDA § 7.
62. These duties are not specified, although they are implicit, in the existing law on durable powers of attorney for health care. See Prob. Code § 4720. A duty to comply with a directive or transfer the patient is provided in the Natural Death Act. See Health & Safety Code § 7187.5. (2d sentence).
63. UHCDA §
65. This is drawn from UHCDA Section 7(f).
LIABILITIES OF HEALTH CARE PROVIDERS AND OTHERS

The existing law governing durable powers of attorney for health care provides protection from criminal prosecution, civil liability, and professional disciplinary action for health care providers who in good faith rely on the decision of an attorney-in-fact in circumstances where in good faith the health care provider believes the decision is consistent with the desires and best interests of the principal.\textsuperscript{66} Similarly, the Natural Death Act protects health care providers who comply with a declaration in good faith and in accordance with reasonable medical standards.\textsuperscript{67}

The proposed law combines and generalizes these rules based on the UHCDA.\textsuperscript{68} Health care providers and institutions are protected for actions taken under the law if they act in good faith and in accordance with generally accepted health care standards applicable to them. Specifically listed are compliance with a health care decision by a person apparently having authority to make the decision, declining to comply where a person does not appear to have authority, and complying with an advance directive assumed to be validly executed and not revoked.

The proposed law provides new statutory penalties, based on the UHCDA,\textsuperscript{69} for intentional violation of the law in the amount of $2500 or actual damages, whichever is greater, plus attorney’s fees. Any person who intentionally forges, conceals, or destroys an advance directive or revocation without consent, or who coerces or fraudulently induces a person to give, revoke, or refrain from give an advance directive is similarly liable in the amount of $10,000. The statutory penalties are in addition to any other remedies that may exist in tort or contract, and to criminal penalties and professional discipline.

JUDICIAL REVIEW

California law does not favor judicial involvement in health care decisions. The Power of Attorney Law provides as a general rule that a power of attorney is exercisable free of judicial intervention.\textsuperscript{70} The Natural Death Act declares that “in the absence of a controversy, a court normally is not the proper forum in which to make decisions regarding life-sustaining treatment.”\textsuperscript{71} In connection with incapacitated patients in nursing homes, the Legislature has found:\textsuperscript{72}

\begin{itemize}
  \item \textsuperscript{66} Prob. Code § 4750.
  \item \textsuperscript{67} Health & Safety Code § 7190.5.
  \item \textsuperscript{68} UHCDA § 9(a).
  \item \textsuperscript{69} UHCDA § 10.
  \item \textsuperscript{70} Prob. Code § 4900.
  \item \textsuperscript{71} Health & Safety Code § 7185.5(e).
  \item \textsuperscript{72} 1992 Cal. Stat. ch. 1303, § 1(b).
\end{itemize}
The current system is not adequate to deal with the legal, ethical, and practical issues that are involved in making health care decisions for incapacitated skilled nursing facility or intermediate care facility residents who lack surrogate decisionmakers. Existing Probate Code procedures, including public conservatorship, are inconsistently interpreted and applied, cumbersome, and sometimes unavailable for use in situations in which day-to-day medical treatment decisions must be made on an on-going basis.

Appellate decisions also caution against overinvolvement of courts in the intensely personal realm of health care decisionmaking. However, there may be occasions where a dispute must be resolved and an appropriately tailored procedure is needed.

The UHCDA takes a similar approach, but provides less detail than existing law:73

[T]he Act provides a procedure for the resolution of disputes. While the Act is in general to be effectuated without litigation, situations will arise where resort to the courts may be necessary. For that reason, the Act authorizes the court to enjoin or direct a health-care decision or order other equitable relief and specifies who is entitled to bring a petition.

The proposed law contains a procedure drawn largely from the Power of Attorney Law.74 Under this procedure, any of the following persons may file a petition in the superior court: the patient, the patient’s spouse (unless legally separated), a relative of the patient, the patient’s agent or surrogate, the conservator of the person of the patient, a court investigator, the public guardian of the county where the patient resides, the supervising health care provider or health care institution, and any other interested person or friend of the patient. As under existing law, there is no right to a jury trial.75

The grounds for a petition are broad, but not unlimited, and include determining (1) whether the patient has capacity to make health care decisions, (2) whether an advance health care directive is in effect, and (3) whether the acts or proposed acts of an agent or surrogate are consistent with the patient’s desires as expressed in an advance health care directive or otherwise made known to the court or, where the patient’s desires are unknown or unclear, whether the acts or proposed acts of the agent or surrogate are in the patient’s best interest. When capacity is to be determined in judicial proceedings, the provisions of the Due Process in Capacity Determinations Act76 are applicable. The standard for reviewing the agent’s or sur-

73. UHCDA Prefatory Note.
74. See Prob. Code §§ 4900-4947. Because of the placement of the Health Care Decisions Law beginning at Section 4600, the judicial proceedings provisions (Part 5) applicable to non-health care powers of attorney are moved to form a new Part 4 (commencing with Section 4500). The law applicable to non-health care powers remains the same; only the special provisions concerning health care powers of attorney have been removed.
rogate’s actions is consistent with the general standard applicable under the proposed Health Care Decisions Law, as already discussed.\(^\text{77}\)

COURT-AUTHORIZED MEDICAL TREATMENT

The court-authorized medical treatment procedure was enacted on Commission recommendation in 1979.\(^\text{78}\) The original intent of this procedure, as described in the Commission’s Comment preceding Probate Code Section 3200, was as follows:

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

The authority of the court, or a surrogate appointed by the court, to authorize medical treatment under the Section 3200 procedure is not as broad as a conservator with full powers, an agent under a power of attorney for health care, or a statutory surrogate under the proposed Health Care Decisions Law. Where the conservatee has been adjudicated to lack the capacity to give informed consent to medical treatment, a conservator under Section 2355 can authorize removal of life-sustaining treatment (i.e., refuse consent to further treatment), if the decision is made in good faith and is based on appropriate medical advice.\(^\text{79}\)

The Section 3200 procedure has not been interpreted by the appellate courts to permit withholding or withdrawing life support. The statutory language is clearly directed toward care needed to maintain health that does not fall into the category of emergency care. The statute permits an order authorizing the “recommended course of medical treatment” and “designating a person to give consent to the

\(^\text{77}\) See \textit{supra} text accompanying note 58.


Some additional amendments have been made to the original procedure, mainly as a result of the Due Process in Competency Determinations Act (DPCDA) (1995 Cal. Stat. ch. 842, §§ 9-11), which revised the procedural rules in Sections 3201, 3204, and 3208 related to determinations of capacity to make health care decisions (“give informed consent”).

recommended course of medical treatment” if all of the following are determined
from the evidence:

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

The reference to the probability that the condition will become life-endangering is
not designed to address the situation of the patient in a persistent vegetative state
whose continued existence is not seriously threatened. Since the Section 3200 pro-
cedure is not designed to deal with end-of-life decisionmaking, there is no statu-
tory procedure available for making decisions in the best interest of a patient in a
persistent vegetative state, short of appointment of a conservator with full powers
under Section 2355. Appointment of a conservator is usually not a feasible alter-
native because of the expense and the lack of a person willing to serve as the con-
servator of the person.

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

CONSERVATOR’S RESPONSIBILITY TO MAKE HEALTH CARE DECISIONS

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

81. See supra note 11.
based on a determination of the conservatee’s best interest, taking into account the
conservatee’s personal values known to the conservator.

The proposed revision is consistent with *Conservatorship of Drabick*: 82

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

Use of the terms “health care” and “health care decision” from the proposed
Health Care Decisions Law make clear that the scope of health care decisions that
can be made by a conservator under this section is the same as provided in the
Health Care Decisions Law.

The importance of the existing statutory language concerning the exclusive
authority of the conservator and the duty this places on the conservator was also
emphasized in *Drabick*: 83

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

The intent of the rule in the proposed law is to protect and further the patient’s
interest in making a health care decision in accordance with the patient’s expressed
desires, where known, and if not, to make a decision in the patient’s best interest,
taking personal values into account. The necessary determinations are to be made
by the conservator, whether private or public, in accordance with the statutory
standard. Court control or intervention in this process is neither required by
statute, nor desired by the courts. 84

**TECHNICAL MATTERS**

**Location of Proposed Law**

The proposed Health Care Decisions Law would be located in the Probate Code
following the Power of Attorney Law. There is no ideal location for a statute that

83. Id. at 211-12.
*Drabick*, 200 Cal. App. 3d at 198-200.
applies both to incapacity planning options (e.g., the power of attorney for health care) and to standards governing health care decisionmaking for incapacitated adults. But considering the alternatives, the Probate Code appears to be the best location because of associated statutes governing conservatorship of the person, court-authorized medical treatment, and powers of attorney. In addition, estate planning and elder law practitioners are familiar with the Probate Code.

**Severance from Power of Attorney Law**

Drafting health care decisionmaking rules as a separate statute should eliminate or minimize these exceptions and overlays in the Power of Attorney Law (PAL), thereby improving the organization and usability of both the PAL as it relates to property and financial matters and the law relating to health care powers.  

**Application to Out-of-State Advance Directives**

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

**Application to Pre-existing Instruments**

The proposed law would apply to all advance directives, as broadly defined in the new law, beginning on January 1, 2000. It is unlikely that circumstances could arise where the new law would invalidate older powers of attorney or declarations under the Natural Death Act, but the proposed law makes clear that it does not affect the validity of an older instrument that was valid under prior law. The new law would not revive instruments that are invalid under existing law. However,

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

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

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

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

88. For example, some durable powers of attorney for health care executed between January 1, 1984, and December 31, 1991, were subject to a seven-year term (which could be extended if the term expired
where a surrogate is required to take into account the wishes of a patient, it may be appropriate to consider and evaluate expressions of the patient’s health care wishes stated in a now obsolete form.

OTHER PROCEDURES

DNR Orders

The proposed law continues the existing special procedures governing requests to forgo resuscitative measure (DNR orders) with a few technical revisions for consistency with definitions under the Health Care Decisions Law. The Commission did not undertake a substantive review of the recently enacted DNR rules.

Secretary of State’s Registry

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

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

when the principal was incapacitated). See Prob. Code § 4654. Practically speaking, it is virtually certain that this class of powers will have expired by January 1, 2000.


HEALTH CARE DECISIONS FOR ADULTS WITHOUT DECISION-MAKING CAPACITY

Structural Outline

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HEALTH CARE DECISIONS FOR ADULTS
WITHOUT DECISION-MAKING CAPACITY

Staff Note. Dr. Ronald B. Miller suggests changing the title of the recommendation from
"Health Care Decisions for Incapacitated Adults," presumably because "incapacitated" is not
necessarily clear in isolation. (Exhibit p. 1.) The staff agrees and suggests the modification above.
We have not modified the division heading (see below).

Division 4.7 (added). Health care decisions

SEC. ___. Division 4.7 (commencing with Section 4600) is added to the
Probate Code, to read:

DIVISION 4.7. HEALTH CARE DECISIONS

Staff Note. Harley Spitler suggests calling this division the "Health Care Decisions Law."
(Exhibit p. 13.) We have not been consistent, but more often than not, named Commission
"Laws" — such as the Attachment Law, Enforcement of Judgments Law, Wage Garnishment
Law, and Power of Attorney Law — do not add the word "Law" to the enacted heading.
However, the "Trust Law" and the "Eminent Domain Law" take the other approach. We routinely
put "Act" in the major headings where uniform acts are located. Does the Commission have a
preference?

PART 1. DEFINITIONS AND GENERAL

CHAPTER 1. SHORT TITLE AND DEFINITIONS

§ 4600. Short title

4600. This division may be cited as the Health Care Decisions Law.

Comment. Section 4600 is new and provides a convenient means of referring to this division.
The Health Care Decisions Law is essentially self-contained, but other agency statutes may be
applied as provided in Section 4662. See also Sections 20 et seq. (general definitions applicable in
Probate Code depending on context), 4755 (application of general procedural rules). For the
scope of this division, see Section 4651.

Many provisions in Parts 1, 2, and 3 are the same as or drawn from the Uniform Health-Care
Decisions Act (1993). Some general provisions included in the Uniform Health-Care Decisions
Act (1993) are generalized elsewhere in this code. See Sections 2(b) (construction of provisions
drawn from uniform acts) (cf. UHCDCA § 15), 11 (severability) (cf. UHCDCA § 17). In Comments
to sections in this title, a reference to the "Uniform Health-Care Decisions Act (1993)" or the
"uniform act" (in context) means the official text of the uniform act approved by the National
Conference of Commissioners on Uniform State Laws.

§ 4603. Application of definitions

4603. Unless the provision or context otherwise requires, the definitions in this
chapter govern the construction of this division.

Comment. Section 4603 serves the same purpose as former Section 4600 and is comparable to
Section 4010 (Power of Attorney Law).
Some definitions included in the Uniform Health-Care Decisions Act (1993) are generalized elsewhere in this code. See Sections 56 (“person” defined) (cf. uniform act Section 1(10)), 74 (“state” defined) (cf. uniform act Section 1(15)).

§ 4605. Advance health care directive; advance directive

4605. “Advance health care directive” or “advance directive” means either an individual health care instruction or a power of attorney for health care.

Comment. Section 4605 is new. The first sentence is the same as Section 1(1) of the Uniform Health-Care Decisions Act (1993), except that the term “advance directive” is defined for convenience. “Advance directive” is commonly used in practice as a shorthand. Statutory language also may use the shorter term. See, e.g., Section 4698. A declaration or directive under the repealed Natural Death Act (former Health & Safety Code § 7185 et seq.) is a type of advance directive. See Section 4623 Comment.

See also Sections 4623 (“individual health care instruction” defined), 4629 (“power of attorney for health care” defined).

Background from Uniform Act. The term “advance health-care directive” appears in the federal Patient Self-Determination Act enacted as Sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990 and has gained widespread usage among health-care professionals.

[Adapted from Unif. Health-Care Decisions Act § 1(1) comment (1993).]

§ 4607. Agent

4607. (a) “Agent” means an individual designated in a power of attorney for health care to make a health care decision for the principal, regardless of whether the person is known as an agent or attorney-in-fact, or by some other term.

(b) “Agent” includes a successor or alternate agent.

Comment. Section 4607 is consistent with the definition of attorney-in-fact in the Power of Attorney Law. See Section 4014. The first part of subdivision (a) is the same as Section 1(2) of the Uniform Health-Care Decisions Act (1993). For limitations on who may act as a health care agent, see Section 4660.

See also Sections 4629 (“power of attorney for health care” defined), 4632 (“principal” defined).

Background from Uniform Act. The definition of “agent” is not limited to a single individual. The Act permits the appointment of co-agents and alternate agents.

[Adapted from Unif. Health-Care Decisions Act § 1(2) comment (1993).]

§ 4609. Capacity

4609. “Capacity” means a patient’s ability to understand the nature and consequences of proposed health care, including its significant benefits, risks, and alternatives, and to make and communicate a health care decision.

Comment. Section 4609 is a new provision drawn from former Health and Safety Code Section 1418.8(b) and Section 1(3) of the Uniform Health-Care Decisions Act (1993).

For provisions in this division relating to capacity, see Sections 4651 (authority of person having capacity not affected), 4657 (presumption of capacity), 4658 (determination of capacity and other medical conditions), 4659 (patient’s objections), 4682 (when agent’s authority effective), 4670 (authority to give individual health care instruction), 4671 (authority to execute power of attorney for health care), 4683 (scope of agent’s authority), 4695 (revocation of power of attorney for health care), 4710 (authority of surrogate to make health care decisions), 4720 (health care decisions for patient without surrogates), 4732 (duty of primary physician to record
relevant information), 4733 (obligations of health care provider), 4766 (petition as to durable power of attorney for health care).

See also Sections 4615 ("health care" defined), 4617 ("health care decision" defined).

**Staff Note.** Harley Spitler would delete the word “significant” in the second line as "troublesome." (Exhibit p. 13.) The staff prefers to keep the adjective, which is used in the UHCDCA. It is not, however, used in the Eppe bill. See Health & Safety Code § 1418.8(b) ("unable to understand the nature and consequences of the proposed medical intervention, including its risks and benefits, or is unable to express a preference regarding the intervention").

§ 4611. Community care facility


**Comment.** Section 4611 continues former Section 4603 without substantive change.

For provisions in this division using this term, see Sections 4660 (limitations on who may act as agent), 4673 (witnessing requirements in skilled nursing facility).

§ 4613. Conservator

4613. “Conservator” means a court-appointed conservator or guardian having authority to make a health care decision for a patient.

**Comment.** Section 4613 is a new provision and serves the same purpose as Section 1(4) of the Uniform Health-Care Decisions Act (1993) (definition of “guardian”). See also Section 1490 ("guardian" means conservator of adult or married minor).

For provisions in this division concerning conservators, see Sections 4617 (“health care decision” defined), 4631 (“primary physician” defined), 4641 (“surrogate” defined), 4660 (limitations on who may act as agent), 4672 (nomination of conservator in written advance health care directive), 4696 (duty to communicate revocation), 4710 (authority of surrogate to make health care decisions), 4732 (duty of primary physician to record relevant information), 4753 (limitations on right to petition), 4765 (petitioners), 4770 (temporary health care order).

See also Section 4617 (“health care decision” defined), 4625 (“patient” defined).

§ 4615. Health care

4615. “Health care” means any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a patient’s physical or mental condition.

**Comment.** Section 4615 continues the first part of former Section 4609 without substantive change and is the same in substance as Section 1(5) of the Uniform Health-Care Decisions Act (1993).

See also Section 4625 (“patient” defined).

**Background from Uniform Act.** The definition of “health care” is to be given the broadest possible construction. It includes the types of care referred to in the definition of “health-care decision” [Prob. Code § 4617], and to care, including custodial care, provided at a “health-care institution” [Prob. Code § 4619]. It also includes non-medical remedial treatment.

[Adapted from Unif. Health-Care Decisions Act § 1(5) comment (1993).]

§ 4617. Health care decision

4617. “Health care decision” means a decision made by a patient or the patient’s agent, conservator, or surrogate, regarding the patient’s health care, including the following:

(a) Selection and discharge of health care providers and institutions.
(b) Approval or disapproval of diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate.

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

Comment. Section 4617 supersedes former Section 4612 and is the same in substance as Section 1(6) of the Uniform Health-Care Decisions Act (1993). Adoption of the uniform act formulation is not intended to limit the scope of health care decisions applicable under former law. Thus, like former law, this section encompasses 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.

See also Sections 4607 (“agent” defined), 4613 (“conservator” defined), 4615 (“health care” defined), 4625 (“patient” defined), 4641 (“surrogate” defined).

Staff Note

(1) Harley Spitler would expand subdivision (c) to include the items listed in the third sentence of the Comment. (Exhibit p. 13.) The Commission had decided earlier to stick closer to the UHCDCA language and the compromise was to include this language in the Comment. Does the Commission wish to provide the additional language suggested by Mr. Spitler?

(2) The California Healthcare Association suggests adding “meaningful” to modify “directions” in subdivision (c). (Exhibit p. 67, ¶ 1.) The question whether a direction (or really a health care decision) is meaningful will be determined by applying the appropriate substantive rules. If this subdivision needs a qualifier, then presumably the others would, as well. The staff thinks this addition is unnecessary and would cause confusion.

The CHA also suggests adding a subdivision (d): “Determination of visitors permitted to see the patient.” (Exhibit p. 67, ¶ 2.) The staff would prefer not to put this in the definition of “health care decision.” It would be better to address the issue directly by providing that the person with the authority to make health care decisions can also determine visitation. This would be consistent with the concept that the surrogate decisionmaker has the powers (subject to some exceptions) that the patient would have if the patient had capacity. Accordingly, it would be appropriate to include this authority in Section 4683 (scope of agent’s authority), but the staff is uncertain whether a statutory surrogate or a surrogate committee should be given this explicit authority.

(3) The California Medical Association recommends removing “orders not to resuscitate” from subdivision (b) and adding “including cardiopulmonary resuscitation” at the end of subdivision (c). (Exhibit p. 62.) The staff agrees with CMA that this subject is better located in subdivision (c), and we would make this change. As a technical question, is CPR coextensive with resuscitation?

§ 4619. Health care institution

4619. “Health care institution” means an institution, facility, or agency licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business.

Comment. Section 4619 is a new provision and is the same as Section 1(7) of the Uniform Health-Care Decisions Act (1993).

For provisions in this division using this term, see Sections 4654 (compliance with generally accepted health care standards), 4660 (limitation on who may act as agent or surrogate), 4675 (restriction on requiring or prohibiting advance directive), 4696 (duty to communicate revocation), 4701 (optional form of advance health care directive), 4711 (patient’s designation of surrogate), 4722 (composition of surrogate committee), 4733 (obligations of health care institution), 4734 (right to decline for reasons of conscience or institutional policy), 4735 (health care institution’s right to decline ineffective care), 4736 (obligations of declining health care
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institutions), 4740 (immunities of health care provider or institution), 4742 (statutory damages), 4765 (petitioners), 4785 (application of request to forgo resuscitative measures).

See also Section 4615 (“health care” defined).

Background from Uniform Act. The term “health-care institution” includes a hospital, nursing home, residential-care facility, home health agency, or hospice.

[Adapted from Unif. Health-Care Decisions Act § 1(7) comment (1993).]

§ 4621. Health care provider

4621. “Health care provider” means an individual licensed, certified, or otherwise authorized or permitted by the law of this state to provide health care in the ordinary course of business or practice of a profession.

Comment. Section 4621 continues former Section 4615 without substantive change and is the same as Section 1(8) of the Uniform Health-Care Decisions Act (1993). This section also continues former Health and Safety Code Section 7186(c) (Natural Death Act) without substantive change.

For provisions in this division using this term, see Sections 4617 (“health care decision” defined), 4639 (“supervising health care provider” defined), 4654 (compliance with generally accepted health care standards), 4660 (limitations on who may act as agent), 4673 (witnessing requirements in skilled nursing facility), 4674 (validity of written advance directive executed in another jurisdiction), 4675 (restriction on requiring or prohibiting advance directive), 4685 (agent’s priority), 4696 (duty to communicate revocation), 4701 (optional form of advance health care directive), 4712 (selection of statutory surrogate), 4733 (obligations of health care provider), 4734 (health care provider’s right to decline for reasons of conscience), 4735 (health care provider’s right to decline ineffective care), 4736 (obligations of declining health care provider), 4740 (immunities of health care provider), 4742 (statutory damages).

See also Section 4615 (“health care” defined).

Staff Note

(1) The California Healthcare Association suggests adding “for purposes of this division” in this definition. (Exhibit p. 67, ¶ 3.) This is unnecessary since Section 4603 controls the scope of the definitions.

(2) Harley Spitler suggests eliminating “of this state.” (Exhibit p. 14.) This restriction to licensees under California law is drawn from existing law. The UHCDA language is not restricted, but it is not clear whether it means to include out-of-state licensees who are not permitted to practice medicine in California. It does not seem appropriate to the staff that this section should override other statutes governing who can practice in California.

§ 4623. Individual health care instruction; individual instruction

4623. “Individual health care instruction” or “individual instruction” means a patient’s written or oral direction concerning a health care decision for herself or himself.

Comment. Section 4623 is a new provision and is the same in substance as Section 1(9) of the Uniform Health-Care Decisions Act (1993). The term “individual health care instruction” is included to provide more clarity. A declaration or directive under the repealed Natural Death Act (former Health & Safety Code § 7185 et seq.) is an individual health care instruction.

For provisions in this division using this term, see Sections 4605 (“advance health care directive” defined), 4625 (“patient” defined), 4658 (determination of capacity and other medical conditions), 4670 (individual health care instruction recognized), 4671 (power of attorney for health care may include individual instruction), 4684 (standard governing agent’s health care decisions), 4713 (standard governing surrogate’s health care decisions), 4720 (application of
chapter governing health care decisions for patients without surrogates), 4732 (duty of primary
physician to record relevant information), 4733 (obligations of health care provider or institution),
4734 (health care provider’s or institution’s right to decline), 4735 (right to decline to provide
ineffective care), 4736 (obligations of declining health care provider or institution).
See also Section 4617 (“health care decision” defined), 4625 (“patient” defined).

**Background from Uniform Act.** The term “individual instruction” includes any type of
written or oral direction concerning health-care treatment. The direction may range from a written
document which is intended to be effective at a future time if certain specified conditions arise
and for which a form is provided in Section 4 [Prob. Code §§ 4701], to the written consent
required before surgery is performed, to oral directions concerning care recorded in the health-
care record. The instruction may relate to a particular health-care decision or to health care in
general.

[Adapted from Unif. Health-Care Decisions Act § 1(9) comment (1993).]

§ 4625. Patient

4625. “Patient” means an adult whose health care is under consideration, and
includes a principal under a power of attorney for health care and an adult who has
given an individual health care instruction or designated a surrogate.

**Comment.** Section 4625 is a new provision added for drafting convenience. “Adult” includes
an emancipated minor. See Fam. Code §§ 7002 (emancipation), 7050 (emancipated minor
considered as adult for consent to medical, dental, or psychiatric care). For provisions governing
surrogates, see Section 4710 et seq.

See also Sections 4615 (“health care” defined), 4623 (“individual health care instruction”
defined), 4629 (“power of attorney for health care” defined), 4632 (“principal” defined), 4641
(“surrogate” defined). Compare Section 3200 (“patient” defined for purposes of court-authorized
medical treatment procedure).

**Staff Note.** The California Healthcare Association suggests adding “for purposes of this
division” in this definition. (Exhibit p. 67, ¶ 4.) This is unnecessary since Section 4603 controls
the scope of the definitions.

§ 4627. Physician

4627. “Physician” means a physician and surgeon licensed by the Medical Board
of California or the Osteopathic Medical Board of California.

**Comment.** Section 4627 continues and generalizes former Health and Safety Code Section
7186(g) (Natural Death Act) and is the same in substance as Section 1(11) of the Uniform Health-
Care Decisions Act (1993).

§ 4629. Power of attorney for health care

4629. “Power of attorney for health care” means a written instrument
designating an agent to make health care decisions for the principal.

**Comment.** Section 4629 supersedes former Section 4606 (defining “durable power of attorney
for health care”) and is the same in substance as Section 1(12) of the Uniform Health-Care
Decisions Act (1993). The writing requirement continues part of Section 4022 (defining “power
of attorney” generally) as it applied to powers of attorney for health care under former law, and is
consistent with part of the second sentence of Section 2(b) of the Uniform Health-Care Decisions

See also Sections 4607 (“agent” defined), 4617 (“health care decision” defined).
§ 4631. Primary physician

4631. “Primary physician” means a physician designated by a patient or the patient’s agent, conservator, or surrogate, to have primary responsibility for the patient’s health care or, in the absence of a designation or if the designated physician is not reasonably available or declines to act as primary physician, a physician who undertakes the responsibility.

Comment. Section 4631 supersedes former Health and Safety Code Section 7186(a) (“attending physician” defined) and is the same in substance as Section 1(13) of the Uniform Health-Care Decisions Act (1993), with the addition of the reference to the ability to decline to act as primary physician.

For provisions in this division using this term, see Sections 4639 (“supervising health care provider” defined), 4658 (determination of capacity and other medical conditions), 4701 (optional form of advance health care directive), 4710 (authority of surrogate to make health care decisions), 4712 (selection of statutory surrogate), 4715 (reassessment of surrogate selection), 4720 (application of rules on patients without surrogates), 4721 (referral to interdisciplinary team), 4722 (composition of surrogate committee), 4723 (standards of review by surrogate committee), 4732 (duty of primary physician to record relevant information).

See also Sections 4607 (agent” defined), 4613 (“conservator” defined), 4615 (“health care” defined), 4627 (“physician” defined), 4633 (“reasonably available” defined), 4641 (“surrogate” defined).

Background from Uniform Act. The Act employs the term “primary physician” instead of “attending physician.” The term “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.

[Adapted from Unif. Health-Care Decisions Act § 1(13) comment (1993).]

* Staff Note. The California Healthcare Association suggests addition of a requirement that the primary physician have “continuous knowledge of the patient.” (Exhibit p. 67, ¶ 5.) The purpose is to identify the physician who is in the best position to assist in decisionmaking, rather than the “hospitalist” who technically may be the primary physician, but who does not have significant knowledge of the patient. The staff thinks this is an important point, but we are worried about the interpretation of “continuous.” There may also be situations where there needs to be a primary physician, and where a physician can act professionally and ethically under the statute without meeting a traditional family physician standard that is no longer realistic. Perhaps it would be better to return to the “attending” physician concept, or add a requirement that the primary physician have treated the patient and have knowledge of the patient’s condition. The uniform act replaced “attending physician” because of a perceived defect in that term, as explained in the background comment above. However, in that process, it appears that the concept of actual contact between physician and patient has been lost, presumably inadvertently. On the other hand, we can imagine situations where the patient has placed confidence in and communicated with a particular physician who is not the specialist or surgeon who is the “treating” or “attending” physician. But we don’t want to provide so many qualifications on the primary physician so that the statute always falls back on a more distant physician (the supervising health care provider). On balance, the staff would prefer to leave this aspect of the statute as it stands, and rely on other substantive rules and medical ethics.

The CHA also suggests that the definition incorporate the notion that a physician may decline to be the primary physician. (Exhibit p. 67, ¶ 6.) This makes sense to the staff and has been added to Section 4631.
§ 4632. Principal

4632. “Principal” means an adult who executes a power of attorney for health care.

Comment. Section 4632 is the same in substance as Section 4026 in the Power of Attorney Law. “Adult” includes an emancipated minor. See Fam. Code §§ 7002 (emancipation), 7050 (emancipated minor considered as adult for consent to medical, dental, or psychiatric care).

See also Section 4629 “(power of attorney for health care” defined).

§ 4633. Reasonably available

4633. “Reasonably available” means readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the patient’s health care needs.

Comment. Section 4633 is the same as Section 1(14) of the Uniform Health-Care Decisions Act (1993).

For provisions in this division the use this term, see Sections 4631 (“primary physician” defined), 4639 (“supervising health care provider” defined), 4685 (agent’s priority), 4701 (optional form of advance health care directive), 4710 (authority of surrogate to make health care decisions), 4712 (selection of statutory surrogate), 4715 (reassessment of surrogate selection), 4720 (application of rules on patients without surrogates).

See also Section 4615 (“health care” defined), 4625 (“patient” defined).

Background from Uniform Act. The term “reasonably available” is used in the Act to accommodate the reality that individuals will sometimes not be timely available. The term is incorporated into the definition of “supervising health-care provider” [Prob. Code § 4639]. It appears in the optional statutory form (Section 4) [Prob. Code § 4701] to indicate when an alternate agent may act. In Section 5 [Prob. Code § 4712] it is used to determine when a surrogate will be authorized to make health-care decisions for an individual, and if so, which class of individuals has authority to act.

[Adapted from Unif. Health-Care Decisions Act § 1(14) comment (1993).]

Staff Note. Elizabethanne Miller Angevine would like “undue effort” to be defined. (Exhibit p. 55.) Specifically, she suggests that the health care provider should “call all known phone numbers of the agent and the alternate agents before acting on their own” except in an emergency. She argues that this is necessary to prevent “nursing home cheating.” Should this clarification be added to Section 4633?

§ 4635. Residential care facility for the elderly

4635. “Residential care facility for the elderly” means a “residential care facility for the elderly” as defined in Section 1569.2 of the Health and Safety Code.

Comment. Section 4635 continues former Section 4618 without substantive change.

For provisions in this division using this term, see Sections 4660 (limitations on who may act as agent), 4673 (witnessing requirements in skilled nursing facility), 4701 (optional form of advance health care directive).

§ 4637. Skilled nursing facility

4637. “Skilled nursing facility” means a “skilled nursing facility” as defined in Section 1250 of the Health and Safety Code.

Comment. Section 4637 is a new provision that incorporates the relevant definition from the Health and Safety Code.
For provisions in this division using this term, see Sections 4673 (witnessing requirements in skilled nursing facility), 4701 (optional form of advance health care directive).

§ 4639. Supervising health care provider

4639. “Supervising health care provider” means the primary physician or, if there is no primary physician or the primary physician is not reasonably available, the health care provider who has undertaken primary responsibility for a patient’s health care.

Comment. Section 4639 is a new provision and is the same in substance as Section 1(16) of the Uniform Health-Care Decisions Act (1993).

For provisions in this division using this term, see Sections 4660 (limitations on who may act as agent or surrogate), 4695 (revocation of power of attorney for health care), 4696 (duty to communicate revocation), 4701 (optional form of advance health care directive), 4711 (patient’s designation of surrogate), 4714 (disqualification of surrogate), 4730 (duty of health care provider to communicate), 4731 (duty of supervising health care provider to record relevant information), 4765 (petitioners).

See also Sections 4607 (“agent” defined), 4615 (“health care” defined), 4621 (“health care provider” defined), 4625 (“patient” defined), 4631 (“primary physician” defined), 4633 (“reasonably available” defined).

Background from Uniform Act. The definition of “supervising health-care provider” accommodates the circumstance that frequently arises where care or supervision by a physician may not be readily available. The individual’s primary physician is to assume the role, however, if reasonably available.

[Adapted from Unif. Health-Care Decisions Act § 1(16) comment (1993).]

Staff Note. The California Healthcare Association finds this definition “vague” and believes it “could create confusion among non-physician providers, particularly in non-acute settings.” (Exhibit p. 67, ¶ 7.) The CHA suggests adding “following physician’s orders” to the definition “to clarify role and responsibilities.” The staff agrees that this section doesn’t contain much meat. It can be understood only when plugged into the sections where it is used, which is one reason the Comment lists the sections where the term is used. It also functions as a fallback rule for situations where there is no primary physician so that someone is always available to receive a notice or communication, make a decision, or perform a duty. The CHA suggestion appears to be based on the assumption that the “supervising health care provider” may not be a physician and might act contrary to physician’s orders. “Health care provider” is defined in Section 4621 as an individual licensed to provide health care, which would include physicians and presumably other licensed health care providers. This is not the same as a “health care institution.” See Section 4619. In these definitional sections, we have hewed close to the uniform act, following the Commission’s early decision.

§ 4641. Surrogate

4641. “Surrogate” means an adult, other than a patient’s agent or conservator, authorized under this division to make a health care decision for the patient.

Comment. Section 4641 is a new provision and is the same in substance as Section 1(17) of the Uniform Health-Care Decisions Act (1993), except that this section refers to “conservator” instead of “guardian” and to “adult” instead of “individual.” “Adult” includes an emancipated minor. See Fam. Code §§ 7002 (emancipation). For provisions governing surrogates, see Section 4710 et seq.

For provisions in this division using this term, see Sections 4617 (health care decision), 4625 (patient), 4631 (primary physician), 4653 (mercy killing, assisted suicide, euthanasia not approved), 4657 (presumption of capacity), 4658 (determination of capacity and other medical
conditions), 4659 (patient’s objections), 4660 (limitation on who may act as agent or surrogate), 4661 (use of copies), 4696 (duty to communicate revocation), 4710-4715 (health care surrogates), 4720 (application of rules on patients without surrogates), 4725 (general surrogate rules applicable to surrogate committee), 4731 (duty of supervising health care provider to record relevant information), 4732 (duty of primary physician to record relevant information), 4741 (immunities of agent and surrogate), 4750 (judicial intervention disfavored), 4762 (jurisdiction over agent or surrogate), 4763 (venue), 4765 (petitioners), 4766 (purposes of petition), 4769 (notice of hearing), 4771 (award of attorney’s fees). See also 4780 (“request to forgo resuscitative measures”), 4783 (forms for requests to forgo resuscitative measures).

See also Sections 4607 (“agent” defined), 4617 (“health care decision” defined), 4625 (“patient” defined).

**Background from Uniform Act.** The definition of “surrogate” refers to the individual having present authority under Section 5 [Prob. Code § 4710 et seq.] to make a health-care decision for a patient. It does not include an individual who might have such authority under a given set of circumstances which have not occurred.

[Adapted from Unif. Health-Care Decisions Act § 1(17) comment (1993).]

**CHAPTER 2. GENERAL PROVISIONS**

§ 4650. Legislative findings

4650. The Legislature finds the following:

(a) An adult has the fundamental right to control the decisions relating to his or her own health care, including the decision to have life-sustaining treatment withheld or withdrawn.

(b) Modern medical technology has made possible the artificial prolongation of human life beyond natural limits. In the interest of protecting individual autonomy, this prolongation of the process of dying for a person for whom continued health care 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.

(c) In recognition of the dignity and privacy a person has a right to expect, the law recognizes that an adult has the right to instruct his or her physician to continue, withhold, or withdraw life-sustaining treatment, in the event that the person is unable to make those decisions.

(d) In the absence of controversy, a court is normally not the proper forum in which to make health care decisions, including decisions regarding life-sustaining treatment.

**Comment.** Section 4650 preserves and continues the substance of the legislative findings set out in former Health and Safety Code Section 7185.5 (Natural Death Act). These findings, in an earlier form, have been relied upon by the courts. Conservatorship of Drabick, 200 Cal. App. 3d 185, 206, 245 Cal. Rptr. 840, 853 (1988); Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1137, 225 Cal. Rptr. 297, 302 (1986); Bartling v. Superior Court, 163 Cal. App. 3d 186, 194-95, 209 Cal. Rptr. 220, 224-25 (1984); Barber v. Superior Court, 147 Cal. App. 3d 1006, 1015-16, 195 Cal. Rptr. 484, 489-90 (1983). The earlier legislative findings were limited to persons with a terminal condition or permanent unconscious condition. This restriction is not continued here in recognition of the broader scope of this division and the development of case law since enactment of the original Natural Death Act in 1976. References to “medical care” in former law have been changed to “health care” for consistency with the language of this division. See Section 4615.
(“health care” defined). This is not intended as a substantive change. “Adult” includes an emancipated minor. See Fam. Code §§ 7002 (emancipation), 7050 (emancipated minor considered as adult for consent to medical, dental, or psychiatric care). “Continue” has been added to subdivision (c) for consistency with the scope of this division. See, e.g., Sections 4615 (“health care” defined), 4617 (“health care decision” defined), 4701 (optional form of advance directive).

Parts of former Health and Safety Code Section 7185.5 that are more appropriately stated as substantive provisions are not continued here. See also Section 4750 (judicial intervention disfavored).

§ 4651. Scope of division

4651. (a) Except as otherwise provided, this division applies to health care decisions for adults who lack capacity to make health care decisions for themselves.

(b) This division does not affect any of the following:

(1) The right of an individual to make health care decisions while having the capacity to do so.

(2) The law governing health care in an emergency.

(3) The law governing health care for unemancipated minors.

Comment. Subdivision (a) of Section 4651 is a new provision

Subdivision (b)(1) is the same in substance as Section 11(a) of the Uniform Health-Care Decisions Act (1993) and replaces former Health and Safety Code Section 7189.5(a) (Natural Death Act).

Subdivision (b)(2) continues the substance of former Section 4652(b).

Subdivision (b)(3) is new. This division applies to emancipated minors to the same extent as adults. See Fam. Code §§ 7002 (emancipation), 7050 (emancipated minor considered as adult for consent to medical, dental, or psychiatric care).

See also Sections 4605 (“advance health care directive” defined), 4615 (“health care” defined), 4617 (“health care decision” defined), 4687 (other authority of person named as agent not affected).

§ 4652. Unauthorized acts

4652. This division does not authorize consent to any of the following on behalf of a patient:

(a) Commitment to or placement in a mental health treatment facility.

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

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

(d) Sterilization.

(e) Abortion.

Comment. Section 4652 continues former Section 4722 without substantive change and revises language for consistency with the broader scope of this division. A power of attorney may not vary the limitations of this section. See also Section 4653 (mercy killing, assisted suicide, euthanasia not approved).

Staff Note. Harley Spitler disagrees with the limitations in subdivisions (a)-(d). (Exhibit p. 14.) The staff agrees as a matter of logic and policy that these limitations should not be absolute.
We are not ready to conclude, however, that this section imposes an unconstitutional interference
with fundamental liberty interests. It should also be noted that these limitations were not devised
by the Commission in its work on the durable power of attorney for health care. However, for
political reasons, the staff has not recommended removal of these restrictions. The Commission
has discussed the issues earlier in this study, as well as the option of making several or all of these
treatments or procedures available if specifically listed in the advance directive. Barring a
consensus on the matter, we would be reluctant to remove one or more subdivisions or the entire
section now, after the tentative recommendation has been circulated.

§ 4653. Mercy killing, assisted suicide, euthanasia not approved

4653. Nothing in this division shall be construed to condone, authorize, or
approve mercy killing, assisted suicide, or euthanasia. This division is not intended
to permit any affirmative or deliberate act or omission to end life other than the
withholding or withdrawal of health care pursuant to an advance health care
directive, by a surrogate, or as otherwise provided, so as to permit the natural
process of dying.

Comment. Section 4653 continues the first sentence of former Section 4723 without
substantive change, and is consistent with Section 13(c) of the Uniform Health-Care Decisions
Act (1993). This section also continues the substance of former Health and Safety Code Section
7191.5(g) (Natural Death Act). Language has been revised to conform to the broader scope of this
division. This section provides a rule governing the interpretation of this division. It is not
intended as a general statement beyond the scope of this division nor is it intended to affect any
other authority that may exist.

See Sections 4670 et seq. (advance health care directives), 4710 et seq. (health care surrogates),
4725 (surrogate rules applicable to surrogate committee). See also Sections 4605 (“advance
health care directive” defined), 4615 (“health care” defined), 4641 (“surrogate” defined).

Staff Note. Dr. Ronald B. Miller comments on this section, based on discussions at the April
meeting. (Exhibit p. 1.) The section has been revised to address some of these issues, but is also
intended to continue some language of existing law that is thought to be important.

§ 4654. Compliance with generally accepted health care standards

4654. This division does not authorize or require a health care provider or health
care institution to provide health care contrary to generally accepted health care
standards applicable to the health care provider or health care institution.

Comment. Section 4654 is the same as Section 13(d) of the Uniform Health-Care Decisions
Act (1993). For a special application of this general rule, see Section 4735 (right to decline to
provide ineffective care). This section continues the substance of former Health & Safety Code
Section 7191.5(f) (Natural Death Act) and subsumes the specific duty under former Health and
Safety Code Section 7189.5(b) concerning providing comfort care and alleviation of pain.

See also Sections 4615 (“health care” defined), 4619 (“health care institution” defined), 4621
(“health care provider” defined).

Staff Note

(1) The California Healthcare Association suggests adding or substituting “accepted standard of
care” for “generally accepted health care standards.” (Exhibit p. 67, ¶ 8.) The CHA argues that
this is “congruent with standard used in other situations where physician decisions or treatment
are challenged.” The standard in Section 4654 is from the uniform act. We are not sure why CHA
finds this language problematic. The two statements are quite close, and much closer to each
other than to the Natural Death Act standard that it replaces: “reasonable medical standards.”
With regard to the professional negligence standard, there are many different formulations. See, e.g., 6 B. Witkin, Summary of California Law Torts, § 774, at 113 et seq. (9th ed. 1988 & Supp. 1998). The staff does not find the suggested statement to be superior to the language of the draft section.

(2) Dr. Ronald B. Miller discusses the issue raised earlier by Dr. Robert Orr concerning a Jehovah’s Witness wallet card requesting no transfusion. (Exhibit p. 2; Memorandum 98-28, 1st Supplement, Exhibit.) This type of expression of the patient’s treatment decisions is an advance directive clearly within the terms of Sections 4605 (advance directive), 4623 (individual instruction), 4670 (authority to give individual health care instruction), and related provisions. The staff is reluctant to attempt to catalog special classes of individual instructions either in the statute or the Comments and would prefer to rely on the general language.

§ 4655. Impermissible constructions

4655. (a) This division does not create a presumption concerning the intention of a patient who has not made or who has revoked an advance health care directive.

(b) In making health care decisions under this division, a patient’s attempted suicide shall not be construed to indicate a desire of the patient that health care be restricted or inhibited.

Comment. Subdivision (a) of Section 4655 is the same in substance as Section 13(a) of the Uniform Health-Care Decisions Act (1993).

Subdivision (b) continues the second sentence of former Section 4723 without substantive change and with wording changes to reflect the broader scope of this division.

See also Sections 4605 (“advance health care directive” defined), 4615 (“health care” defined), 4617 (“health care decision” defined), 4625 (“patient” defined).

§ 4656. Effect on death benefits

4656. Death resulting from withholding or withdrawing health care in accordance with this division does not for any purpose constitute a suicide or homicide or legally impair or invalidate a policy of insurance or an annuity providing a death benefit, notwithstanding any term of the policy or annuity to the contrary.

Comment. Section 4656 continues and generalizes former Health and Safety Code Section 7191.5(a)-(b) (Natural Death Act), and is the same in substance as Section 13(b) of the Uniform Health-Care Decisions Act (1993).

See also Section 4615 (“health care” defined).

§ 4657. Presumption of capacity

4657. A patient is presumed to have capacity to make a health care decision, to give or revoke an advance health care directive, and to designate or disqualify a surrogate. This presumption is a presumption affecting the burden of proof.

Comment. Section 4657 is the same in substance as Section 11(b) of the Uniform Health-Care Decisions Act (1993). The presumption of capacity with regard to revocation continues the substance of former Section 4727(c), and is consistent with former Health and Safety Code Section 7189.5(a) (Natural Death Act). See also Section 4766(a) (petition to review capacity determinations). The burden of proof is on the person who seeks to establish that the principal did not have capacity.

See also Sections 4605 (“advance health care directive” defined), 4609 (“capacity” defined), 4617 (“health care decision” defined), 4625 (“patient” defined), 4641 (“surrogate” defined).
Background from Uniform Act. Section 11 reinforces the principle of patient autonomy by providing a rebuttable presumption that an individual has capacity for all decisions relating to health care referred to in the Act.

[Adapted from Unif. Health-Care Decisions Act § 11 comment (1993).]

Staff Note

(1) The California Healthcare Association suggests that the statute make clear the presumption is rebuttable. (Exhibit p. 68, ¶ 9.) The staff agrees and has added the second sentence, which is the same as the existing language in Section 4727(c).

(2) Dr. Ronald B. Miller raises a concern over the interplay between this section and the delineation of capacity in the Due Process in Competency Determinations Act, Prob. Code §§ 811-812. (Exhibit p. 2.) The staff concludes that the presumption in this section, and other provisions relating to capacity in the tentative recommendation would prevail in the event of a conflict, since DPCDA contains a number of exceptions. Section 812 starts with “Except as otherwise provided by law….” Section 813 is limited to judicial determinations of capacity. And Section 811(e) would read, as amended in the proposed conforming revision infra:

(e) This part applies only to the evidence that is presented to, and the findings that are made by, a court determining the capacity of a person to do a certain act or make a decision, including, but not limited to, making medical decisions. Nothing in this part shall affect the decisionmaking process set forth in Section 1418.8 of the Health and Safety Code, nor provided in Chapter 4 (commencing with Section 4720) of Part 2 of Division 4.7. This part does not increase or decrease the burdens of documentation on, or potential liability of, physicians and surgeons who, outside the judicial context, determine the capacity of patients to make a medical decision.

§ 4658. Determination of capacity and other medical conditions

4658. Unless otherwise specified in a written advance health care directive, for the purposes of this division, a determination that a patient lacks or has recovered capacity, or that another condition exists that affects an individual health care instruction or the authority of an agent or surrogate, shall be made by the primary physician.

Comment. Section 4658 is drawn from Section 2(d) (advance directives) and part of Section 5(a) (surrogates) of the Uniform Health-Care Decisions Act (1993). This section makes clear that capacity determinations need not be made by the courts. For provisions governing judicial determinations of capacity, see Sections 810-813 (Due Process in Capacity Determinations Act). See also Section 4766 (petitions concerning advance directives). For the primary physician’s duty to record capacity determinations, see Section 4732. See also Section 4766(a) (petition to review capacity determinations).

See also Sections 4605 (“advance health care directive” defined), 4607 (“agent” defined), 4609 (“capacity” defined), 4623 (“individual health care instruction” defined), 4625 (“patient” defined), 4631 (“primary physician” defined), 4641 (“surrogate” defined).

Background from Uniform Act. Section 2(d) provides that unless otherwise specified in a written advance health-care directive, a determination that a principal has lost or recovered capacity to make health-care decisions must be made by the primary physician. For example, a principal might specify that the determination of capacity is to be made by the agent in consultation with the primary physician. Or a principal, such as a member of the Christian Science faith who relies on a religious method of healing and who has no primary physician, might specify that capacity be determined by other means. In the event that multiple decision makers are specified and they cannot agree, it may be necessary to seek court instruction as authorized by Section 14 [see Prob. Code § 4766].
Section 2(d) also provides that unless otherwise specified in a written advance health-care directive, the existence of other conditions which affect an individual instruction or the authority of an agent must be determined by the primary physician. For example, an individual might specify that an agent may withdraw or withhold treatment that keeps the individual alive only if the individual has an incurable and irreversible condition that will result in the individual’s death within a relatively short time. In that event, unless otherwise specified in the advance health-care directive, the determination that the individual has that condition must be made by the primary physician.

[Adapted from Unif. Health-Care Decisions Act § 2(d) comment (1993).]

§ 4659. Patient’s objections

4659. Nothing in this division authorizes consent to health care, or consent to the withholding or withdrawal of health care necessary to keep a patient alive, if the patient having capacity objects to the health care or to the withholding or withdrawal of the health care. In this situation, the case is governed by the law that would apply if there were no advance health care directive or surrogate decisionmaker.

Comment. Section 4659 is drawn from former Section 4724, which applied only to powers of attorney for health care. The scope of this section is broader, however, since it applies to powers of attorney for health care, other written advance health care directives, oral advance directives, and statutory surrogates. The reference to the patient’s capacity has been added for consistency with the statutory scheme. See Section 4657 (presumption of capacity) & Comment. This section supersedes part of former Health and Safety Code Section 7188(a).

See also Sections 4605 (“advance health care directive” defined), 4609 (“capacity” defined), 4615 (“health care” defined), 4617 (“health care decision” defined), 4625 (“patient” defined), 4641 (“surrogate” defined).

Staff Note. Dr. Ronald B. Miller asks whether this section should address the issue of what happens if the patient without capacity makes an objection. (Exhibit p. 2-3.) This section is an expanded version of existing Section 4724, which applies only to objections to consent by an attorney-in-fact under a durable power of attorney for health care. In effect, the oral objection from the principal would revoke the agent’s authority, notwithstanding failure to comply with any applicable procedure for revoking the power of attorney. Existing law does not say whether the principal must have capacity. Perhaps Dr. Miller is thinking of Health and Safety Code Section 7188(a) in the Natural Death Act, which provides for revocation of a declaration “at any time and in any manner, without regard to the declarant’s mental or physical condition.” This rule was no doubt born of an abundance of caution, at a time (1976) when a consensus was still being formed about the propriety and extent of the right to withdraw or withhold life support. The same can be said for Probate Code Section 4724 (1982), although it is not as obviously overprotective.

The staff wonders whether Section 4659 can be deleted. The proposed law consistently validates the patient’s expression of health care desires. That is the fundamental principle at stake. Unlike existing law, the proposed law explicitly recognizes oral and written individual health care instructions, making the rule in the first sentence redundant. The second sentence makes sense in the limited scope of existing Section 4724, but is confusing in light of the broader scope of the proposed law.

§ 4660. Limitations on who may act as agent or surrogate

4660. (a) Except as provided in subdivision (b), none of the following persons may make health care decisions as an agent under a power of attorney for health care or a surrogate under this division:
(1) The supervising health care provider or an employee of the health care institution where the patient is receiving care.

(2) An operator or employee of a community care facility or residential care facility where the patient is receiving care.

(b) The prohibition in subdivision (a) does not apply to the following persons:

(1) An employee who is related to the patient by blood, marriage, or adoption.

(2) An employee who is employed by the same health care institution, community care facility, or residential care facility for the elderly as the patient.

(c) A conservator under the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code) may not be designated as an agent or surrogate to make health care decisions by the conservatee, unless all of the following are satisfied:

(1) The advance health care directive is otherwise valid.

(2) The conservatee is represented by legal counsel.

(3) The lawyer representing the conservatee signs a certificate stating in substance:

“I am a lawyer authorized to practice law in the state where this advance health care directive was executed, and the principal or patient was my client at the time this advance directive was executed. I have advised my client concerning his or her rights in connection with this advance directive and the applicable law and the consequences of signing or not signing this advance directive, and my client, after being so advised, has executed this advance directive.”

(d) This section does not apply to participation in or decisionmaking by a surrogate committee pursuant to Chapter 4 (commencing with Section 4720) of Part 2.

Comment. Subdivisions (a)-(c) of Section 4660 restate former Section 4702 without substantive change, and extend its principles to cover surrogates. The terms “supervising health care provider” and “health care institution” have been substituted for “treating health care provider” as appropriate, for consistency with the terms used in this division. See Section 4639 (“supervising health care provider” defined).

Subdivisions (a) and (b) serve the same purpose as Section 2(b) (fourth sentence) and Section 5(i) of the Uniform Health-Care Decisions Act (1993). Subdivision (a) does not preclude a person from appointing, for example, a friend who is a physician as the agent under the person’s power of attorney for health care, but if the physician becomes the person’s “supervising health care provider,” the physician is precluded from acting as the agent under the power of attorney. See also Section 4673 (witnessing requirements in skilled nursing facilities).

Subdivision (b) provides a special exception to subdivision (a). This will, for example, permit a nurse to serve as agent for the nurse’s spouse when the spouse is being treated at the hospital where the nurse is employed.

Subdivision (c) prescribes conditions that must be satisfied if a conservator is to be designated as the agent or surrogate for a conservatee under the Lanterman-Petris-Short Act. This subdivision has no application where a person other than the conservator is so designated.

Subdivision (d) makes clear that the rules governing surrogate committees under Sections 4720-4725 prevail over this section.
§ 4661. Use of copies

4661. A copy of a written advance health care directive, revocation of an advance directive, or designation or disqualification of a surrogate has the same effect as the original.

Comment. Section 4661 provides a special rule permitting the use of copies under this division. It is the same as Section 12 of the Uniform Health-Care Decisions Act (1993). The rule under this section for powers of attorney for health care differs from the rule under the Power of Attorney Law. See Section 4307 (certified copy of power of attorney). See also Sections 4605 (“advance health care directive” defined), 4641 (“surrogate” defined). Background from Uniform Act. The need to rely on an advance health-care directive may arise at times when the original is inaccessible. For example, an individual may be receiving care from several health-care providers or may be receiving care at a location distant from that where the original is kept. To facilitate prompt and informed decision making, this section provides that a copy of a valid written advance health-care directive, revocation of an advance health-care directive, or designation or disqualification of a surrogate has the same effect as the original. [Adapted from Unif. Health-Care Decisions Act § 12 comment (1993).]

§ 4662. Relation to general agency law

4662. Where this division does not provide a rule, the law of agency may be applied.

Comment. Section 4662 is analogous to Section 4051 in the Power of Attorney Law. Under this section, reference may be made to relevant agency principles set forth in case law and statutes. See, e.g., Civ. Code §§ 2019 et seq., 2295 et seq.; Prob. Code § 4000 et seq. (Power of Attorney Law).

Staff Note. Harley Spitler would change “may” to “shall.” (Exhibit p. 14.) The staff thinks this is too strong a statement. Unlike the Power of Attorney Law, this division applies to matters other than attorneys-in-fact under powers of attorney. We doubt that there is much useful agency law that could or should be applied to matters covered by this division. Section 4662 could be omitted without any loss and we would prefer that approach (leaving it to lawyers and the courts to decide when agency law should be applied) to mandating general agency rules. As far as other statutory rules are concerned, it requires a great deal of imagination to think of a case where they would be helpful. We have not spent the time to research the common law of agency.

CHAPTER 3. TRANSITIONAL PROVISIONS

§ 4665. Application to existing advance directives and pending proceedings

4665. Except as otherwise provided by statute:

(a) On and after January 1, 2000, this division applies to all advance health care directives, including but not limited to durable powers of attorney for health care and declarations under the former Natural Death Act (former Chapter 3.9 (commencing with Section 7185) of Part 1 of Division 7 of the Health and Safety
Code), regardless of whether they were given or executed before, on, or after January 1, 2000.

(b) This division applies to all proceedings concerning advance health care directives commenced on or after January 1, 2000.

(c) This division applies to all proceedings concerning written advance health care directives commenced before January 1, 2000, unless the court determines that application of a particular provision of this division would substantially interfere with the effective conduct of the proceedings or the rights of the parties and other interested persons, in which case the particular provision of this division does not apply and prior law applies.

(d) Nothing in this division affects the validity of an advance health care directive executed before January 1, 2000, that was valid under prior law.

Comment. Section 4665 serves the same purpose as Section 4054 in the Power of Attorney Law, but covers all advance health care directives, including powers of attorney, written or oral individual health care instructions, and surrogate designations.

Subdivision (a) provides the general rule that this division applies to all advance health care directives, regardless of when a written advance directive was executed or an oral individual instruction was made. As provided in subdivision (d), however, nothing in this division invalidates any advance directive that was validly executed under prior law.

Subdivision (b) is a specific application of the general rule in subdivision (a). See Section 4750 et seq. (judicial proceedings). Subdivision (c) provides discretion to the court to resolve problems arising in proceedings commenced before the operative date.

See also Sections 4605 (“advance health care directive” defined), 4629 (“power of attorney for health care” defined).

Staff Note

(1) Several commentators have difficulty with this section. In comments directed to the April draft, Dr. Ronald B. Miller sees a contradiction between subdivision (a) and subdivision (d). (Exhibit p. 3.) Harley Spitler also thinks there is an inconsistency. (Exhibit pp. 14-15.) The doubt seems to arise because of the failure to limit subdivision (d) to the issue of validity of the advance directive under prior law. Subdivision (a) applies this division to existing directives, but would not invalidate them. In actuality, since the proposed law is less formal in terms of execution requirements, the staff cannot think of a case where this division could invalidate an advance directive executed under the prior law. We have added a sentence in the Comment to help clarify the matter.

(2) Deferred operative date. The California Healthcare Association requests that the operative date be deferred for six months until July 1, 2000, to provide additional time to update their advisory materials and provide training. (Exhibit p. 68, ¶ 10.) The staff is not opposed to this proposal. It was common during the preparation of various installments of the Probate Code in the 1980’s and other major revisions, such as the Enforcement of Judgments Law, for the Commission to recommend deferred operative dates, although one of the main reasons was to permit the Judicial Council to revise forms. However, toward the end of the Probate Code revision process, practitioners had come to the conclusion that they would prefer to have the new law operative on January 1 rather than deal with the confusion of having two sets of provisions in the current code volumes. Legal publishers prefer the January 1 operative date, too. We are sympathetic to the CHA concern, but on balance, the staff would prefer to keep the January 1 date. We would like to hear the opinions of other groups.

(3) Printed forms under prior law. The California Medical Association would like to see a savings clause for printed forms that are in inventory, as has been done several times in the past.
when the durable power of attorney for health care statute was amended. (Exhibit p. 61.) CMA does not think hospitals should be required to suffer the expense of disposing of existing forms and purchasing new ones.

This is a difficult issue, as can be seen from a reading of existing Probate Code Sections 4651 and 4775 (which, mercifully, are not set out here). But at least in the past the changes in the form were relatively minor or incremental. The form looked essentially the same, but with some important changes, such as when the seven-year limit on duration of the power was eliminated, or when the warning statements were revised. The differences in appearance and content between the existing statutory form and the proposed statutory form are dramatic. Substantively, the warning statement in the existing form would not state the law. The older form would be too limited, since it is directed toward appointment of an agent and instructing the agent about health care desires. The new statutory form is a broader advance directive and treats the giving of individual health care instructions as a separate and independent part of the form. The new form does not assume that an agent will be appointed, whereas the old form does. Accordingly, while we are sympathetic to the problem, the staff is reluctant to do anything that would encourage continued use of the old forms. There is nothing in the law that would prevent their use — the proposed Health Care Decisions Law is more open to different forms than existing law. The proposed law does not contain the detailed restrictions on the content of printed forms in existing law. See, e.g., Prob. Code § 4774.

But there is still a need to make clear that a power of attorney executed on an old form is not invalid to protect the individual executing the form, regardless of whether they got the form from a hospital, a stationery store, their lawyer, a nonprofit organization, or just happened to get around to executing a form they had had in their possession for years. Accordingly, the staff recommends adding the following: “(e) Nothing in this division affects the validity of a durable power of attorney executed on a printed form that was valid under prior law, regardless of whether execution occurred before, on, or after January 1, 2000.”

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**PART 2. UNIFORM HEALTH CARE DECISIONS ACT**

**CHAPTER 1. ADVANCE HEALTH CARE DIRECTIVES**

**Article 1. General Provisions**

§ 4670. Authority to give individual health care instruction

4670. An adult having capacity may give an individual health care instruction. The individual instruction may be oral or written. The individual instruction may be limited to take effect only if a specified condition arises.

**Comment.** Section 4670 is drawn from Section 2(a) of the Uniform Health-Care Decisions Act (1993). This section supersedes part of former Health and Safety Code Section 7186.5 (Natural Death Act). “Adult” includes an emancipated minor. See Fam. Code §§ 7002 (emancipation), 7050 (emancipated minor considered as adult for consent to medical, dental, or psychiatric care).

See also Sections 4615 (“health care” defined), 4623 (“individual health care instruction” defined).

**Background from Uniform Act.** The individual instruction authorized in Section 2(a) may but need not be limited to take effect in specified circumstances, such as if the individual is dying. An individual instruction may be either written or oral.

[Adapted from Unif. Health-Care Decisions Act § 2(a) comment (1993).]
§ 4671. Authority to execute power of attorney for health care

4671. (a) An adult having capacity may execute a power of attorney for health care, as provided in Article 2 (commencing with Section 4680). The power of attorney for health care may authorize the agent to make health care decisions and may also include individual health care instructions.

(b) The principal in a power of attorney for health care may grant authority to make decisions relating to the personal care of the principal, including, but not limited to, determining where the principal will live, providing meals, hiring household employees, providing transportation, handling mail, and arranging recreation and entertainment.

Comment. Subdivision (a) of Section 4671 is drawn from the first and third sentences of Section 2(b) of the Uniform Health-Care Decisions Act (1993). The first sentence supersedes Section 4120 (who may execute power of attorney) to the extent it applied to powers of attorney for health care. “Adult” includes an emancipated minor. See Fam. Code §§ 7002 (emancipation), 7050 (emancipated minor considered as adult for consent to medical, dental, or psychiatric care).

Subdivision (b), relating to personal care authority, is parallel to Section 4123(c) (personal care authority permissible in non-health care power of attorney). For powers of attorney generally, see the Power of Attorney Law, Section 4000 et seq. Personal care powers are not automatic. Under subdivision (b), the agent does not have personal care powers except to the extent that they are granted by the principal.

See also Sections 4607 (“agent” defined), 4617 (“health care decision” defined), 4623 (“individual health care instruction” defined), 4629 (“power of attorney for health care” defined).

Background from Uniform Act. Section 2(b) authorizes a power of attorney for health care to include instructions regarding the principal’s health care. This provision has been included in order to validate the practice of designating an agent and giving individual instructions in one document instead of two. The authority of an agent falls within the discretion of the principal as expressed in the instrument creating the power and may extend to any health-care decision the principal could have made while having capacity.

Section 2(b) excludes the oral designation of an agent. Section 5(b) [Prob. Code § 4711] authorizes an individual to orally designate a surrogate by personally informing the supervising health-care provider. A power of attorney for health care, however, must be in writing and signed by the principal, although it need not be witnessed or acknowledged [except in certain circumstances].

[Adapted from Unif. Health-Care Decisions Act § 2(b) comment (1993).]

§ 4672. Nomination of conservator in written advance directive

4672. (a) A written advance health care directive may include the individual’s nomination of a conservator of the person or estate or both, or a guardian of the person or estate or both, for consideration by the court if protective proceedings for the individual’s person or estate are thereafter commenced.

(b) If the protective proceedings are conservatorship proceedings in this state, the nomination has the effect provided in Section 1810 and the court shall give effect to the most recent writing executed in accordance with Section 1810, whether or not the writing is a written advance health care directive.

Comment. Section 4672 continues Section 4126 without substantive change, insofar as that section applied to powers of attorney for health care, and expands the scope of the rule to apply to other written advance health care directives. Subdivision (a) is the same in substance as Section 2(g) of the Uniform Health-Care Decisions Act (1993).
See also Sections 4605 ("advance health care directive" defined), 4613 ("conservator" defined).

§ 4673. Witnessing required in skilled nursing facility

4673. (a) If an individual is a patient in a skilled nursing facility when the advance health care directive is executed, the advance directive shall be acknowledged before a notary public or signed by at least two witnesses as provided in this section.

(b) If the advance health care directive is signed by witnesses, the following requirements shall be satisfied:

(1) The witnesses shall be adults.

(2) Each witness shall witness either the signing of the advance health care directive by the patient or the patient’s acknowledgment of the signature or the advance directive.

(3) None of the following persons may act as a witness:

(A) The agent, with regard to a power of attorney for health care.

(B) The patient’s health care provider or an employee of the patient’s health care provider.

(C) The operator or an employee of a community care facility.

(D) The operator or an employee of a residential care facility for the elderly.

(4) Each witness shall make the following declaration in substance:

“I declare under penalty of perjury under the laws of California that the individual who signed or acknowledged this document is personally known to me, or that the identity of the individual was proven to me by convincing evidence, that the individual signed or acknowledged this advance health care directive in my presence, that the individual appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not the individual’s health care provider, an employee of the individual’s 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, nor an employee of an operator of a residential care facility for the elderly.”

(c) An advance health care directive governed by this section is not effective unless a patient advocate or ombudsman, as may be designated by the Department of Aging for this purpose pursuant to any other applicable provision of law, signs the advance directive as a witness, either as one of two witnesses or in addition to notarization. The patient advocate or ombudsman shall declare that he or she is serving as a witness as required by this subdivision. It is the intent of this subdivision to recognize that some patients in skilled nursing facilities are insulated from a voluntary decisionmaking role, by virtue of the custodial nature of their care, so as to require special assurance that they are capable of willfully and voluntarily executing an advance directive.
(d) For the purposes of the declaration of witnesses, “convincing evidence”
means the absence of any information, evidence, or other circumstances that
would lead a reasonable person to believe the individual executing the advance
health care directive, whether by signing or acknowledging his or her signature, is
not the individual he or she claims to be, and any one of the following:

(1) Reasonable reliance on the presentation of any one of the following, if the
document is current or has been issued within five years:
(A) An identification card or driver’s license issued by the California
Department of Motor Vehicles.
(B) A passport issued by the Department of State of the United States.
(2) Reasonable reliance on the presentation of any one of the following, if the
document is current or has been issued within five years and contains a photograph
and description of the person named on it, is signed by the person, bears a serial or
other identifying number, and, in the event that the document is a passport, has
been stamped by the United States Immigration and Naturalization Service:
(A) A passport issued by a foreign government.
(B) A driver’s license issued by a state other than California or by a Canadian or
Mexican public agency authorized to issue drivers’ licenses.
(C) An identification card issued by a state other than California.
(D) An identification card issued by any branch of the armed forces of the
United States.
(e) A witness who is a patient advocate or ombudsman may rely on the
representations of the administrators or staff of the skilled nursing facility, or of
family members, as convincing evidence of the identity of the patient if the patient
advocate or ombudsman believes that the representations provide a reasonable
basis for determining the identity of the patient.

Comment. Subdivisions (a)-(c) of Section 4673 continue Sections 4121 and 4122 without
substantive change, to the extent they applied to powers of attorney for health care, and continues
former Section 4701 without substantive change, to the extent it applied to powers of attorney
governed by this section. This section expands the witnessing and notarization rules under former
law to cover all written advance directives executed in nursing homes, not just powers of
attorney.

Subdivisions (d) and (e) continue the substance of relevant parts of former Section 4751
(convincing evidence of identity of principal) and apply to all written advance directives covered
by this section, not just powers of attorney for health care as under former law.

See also Sections 4605 (“advance health care directive” defined), 4611 (“community care
facility” defined), 4621 (“health care provider” defined), 4625 (“patient” defined), 4635
(“residential care facility for the elderly” defined), 4637 (“skilled nursing facility” defined).

Staff Note. The California Healthcare Association suggests making clear whether a
notarization can be done by an employee of the skilled nursing facility. (Exhibit p. 68, ¶ 11.)
Existing law does not address this issue. The staff assumes that the restriction would not apply to
a notary, who has responsibilities as a notary independent of employment by the institution. We
wonder whether there is any problem under existing law. As it stands, we believe the law is clear
enough and we shouldn’t need to make an issue of it in the statute. However, if the decision is to
restrict notaries acting if they are also employees of the institution, then that would have to be
made explicit.
§ 4674. Validity of written advance directive executed in another jurisdiction

4674. (a) A written advance health care directive or similar instrument executed in another state or jurisdiction in compliance with the laws of that state or jurisdiction or of this state, is valid and enforceable in this state to the same extent as a written advance directive validly executed in this state.

(b) In the absence of knowledge to the contrary, a physician or other health care provider may presume that a written advance health care directive or similar instrument, whether executed in another state or jurisdiction or in this state, is valid.

Comment. Subdivision (a) of Section 4674 continues former Section 4653 without substantive change, and extends its principles to apply to all written advance health care directives, which include both powers of attorney for health care and written individual instructions. This subdivision also continues and generalizes former Health and Safety Code Section 7192.5 (Natural Death Act). This subdivision is consistent with Section 2(h) of the Uniform Health-Care Decisions Act (1993), as applied to instruments.

Subdivision (b) continues former Section 4752 without substantive change, and broadens the former rule for consistency with the scope of this division. This subdivision also continues and generalizes former Health and Safety Code Section 7192 (Natural Death Act).

See also Section 4605 ("advance health care directive" defined), 4621 ("health care provider" defined), 4627 ("physician" defined). For the rule applicable under the Power of Attorney Law, see Section 4053.

Background from Uniform Act. Section 2(h) validates advance health-care directives which conform to the Act, regardless of when or where executed or communicated. This includes an advance health-care directive which would be valid under the Act but which was made prior to the date of its enactment and failed to comply with the execution requirements then in effect. It also includes an advance health-care directive which was made in another jurisdiction but which does not comply with that jurisdiction’s execution or other requirements.

[Adapted from Unif. Health-Care Decisions Act § 2(h) comment (1993).]

§ 4675. Restriction on requiring or prohibiting advance directive

4675. A health care provider, health care service plan, health care institution, disability insurer, self-insured employee welfare plan, or nonprofit hospital plan or a similar insurance plan may not require or prohibit the execution or revocation of an advance health care directive as a condition for providing health care, admission to a facility, or furnishing insurance.

Comment. Section 4675 continues and generalizes former Section 4725, and contains the substance of Section 7(h) of the Uniform Health-Care Decisions Act (1993). The former provision applied only to powers of attorney for health care. This section supersedes former Health and Safety Code Sections 7191(e)-(f) and 7191.5(c) (Natural Death Act) This section is intended to eliminate the possibility that duress might be used by a health care provider, insurer, plan, or other entity to cause the patient to execute or revoke an advance directive. The reference to a “health care service plan” is drawn from Health and Safety Code Section 1345(f) in the Knox-Keene Health Care Service Plan Act of 1975.

See also Sections 4605 (“advance health care directive” defined), 4615 (“health care” defined), 4619 (“health care institution” defined), 4621 (“health care provider” defined).

Background from Uniform Act. Section 7(h), forbidding a health-care provider or institution to condition provision of health care on execution, non-execution, or revocation of an advance health-care directive, tracks the provisions of the federal Patient Self-Determination Act. 42 U.S.C. §§ 1395cc(f)(1)(C) (Medicare), 1396a(w)(1)(C) (Medicaid).
§ 4676. Right to health care information

4676. Unless otherwise specified in an advance health care directive, a person then authorized to make health care decisions for a patient has the same rights as the patient to request, receive, examine, copy, and consent to the disclosure of medical or any other health care information.

Comment. Section 4676 is drawn from Section 8 of the Uniform Health-Care Decisions Act (1993). This section continues former Section 4721 without substantive change, but is broader in scope since it covers all persons authorized to make health care decisions for a patient, not just agents. A power of attorney may limit the right of the agent, for example, by precluding examination of specified medical records or by providing that the examination of medical records is authorized only if the principal lacks the capacity to give informed consent. The right of the agent is subject to any limitations on the right of the patient to reach medical records. See Health & Safety Code §§ 1795.14 (denial of right to inspect mental health records), 1795.20 (providing summary of record rather than allowing access to entire record).

See also Sections 4605 (“advance health care directive” defined), 4617 (“health care decision” defined), 4625 (“patient” defined).

Background from Uniform Act. An agent, conservator, [guardian,] or surrogate stands in the shoes of the patient when making health-care decisions. To assure fully informed decisionmaking, this section provides that a person who is then authorized to make health-care decisions for a patient has the same right of access to health-care information as does the patient unless otherwise specified in the patient’s advance health-care directive.

[Adapted from Unif. Health-Care Decisions Act § 8 comment (1993).]

Article 2. Powers of Attorney for Health Care

§ 4680. Formalities for executing a power of attorney for health care

4680. A power of attorney for health care is legally sufficient if all of the following requirements are satisfied:

(a) The power of attorney contains the date of its execution.
(b) The power of attorney is signed either (1) by the principal or (2) in the principal’s name by another adult in the principal’s presence and at the principal’s direction.
(c) The power of attorney satisfies applicable witnessing requirements of Section 4673.

Comment. Section 4680 continues Section 4121, insofar as it applied to powers of attorney for health care, without substantive change, except that (1) “adult” has been substituted for “person” in subdivision (b), and (2) the witnessing requirements in subdivision (c) are restricted to the special circumstances provided in Section 4673. “Adult” includes an emancipated minor. See Fam. Code §§ 7002 (emancipation), 7050 (emancipated minor considered as adult for consent to medical, dental, or psychiatric care).

A power of attorney must be in writing. See Section 4629 (“power of attorney for health care” defined). This section provides the general execution formalities for a power of attorney under

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this division. A power of attorney that complies with this section is legally sufficient as a grant of
authority to an agent.

See also Section 4632 ("principal" defined).

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Staff Note. Elizabethanne Miller Angevine asks how this document will be accepted in other
states if there is only one witness for a person not in a nursing home. (Exhibit p. 55.) There is no
witnessing requirement in such cases, but the form encourages witnessing. The staff recalls that
there was a state requiring notarization and recording. We have not made a survey of execution
requirements, but we believe the general trend is away from formalistic execution requirements.
The greatest effect of such requirements is to invalidate implementation of a person’s intent on a
technicality, without a compensating beneficial effect, such as the prevention of fraud. As for Ms.
Angevine’s emigrant to Branson, Missouri, the staff’s desktop reference says that there are no
listed formalities of execution in Missouri.

§ 4681. Limitations expressed in power of attorney for health care

4681. (a) Except as provided in subdivision (b), the principal may limit the
application of any provision of this division by an express statement in the power
of attorney for health care or by providing an inconsistent rule in the power of
attorney.

(b) A power of attorney for health care may not limit either the application of a
statute specifically providing that it is not subject to limitation in the power of
attorney or a statute concerning any of the following:

(1) Statements required to be included in a power of attorney.
(2) Operative dates of statutory enactments or amendments.
(3) Formalities for execution of a power of attorney for health care.
(4) Qualifications of witnesses.
(5) Qualifications of agents.
(6) Protection of third persons from liability.

Comment. Section 4681 continues Section 4101, insofar as it applied to powers of attorney for
health care, without substantive change. This section makes clear that many of the statutory rules
provided in this division are subject to express or implicit limitations in the power of attorney. If a
statutory rule is not subject to control by the power of attorney, this is stated explicitly, either in a
particular section or as to a group of sections.

See also Sections 4607 ("agent" defined), 4629 ("power of attorney for health care” defined),
4632 ("principal” defined).

§ 4682. When agent’s authority effective

4682. Unless otherwise provided in a power of attorney for health care, the
authority of an agent becomes effective only on a determination that the principal
lacks capacity, and ceases to be effective on a determination that the principal has
recovered capacity.

Comment. Section 4682 is drawn from Section 2(c) of the Uniform Health-Care Decisions Act
(1993) and continues the substance of the last part of former Section 4720(a). See Sections 4657
(presumption of capacity), 4658 (determination of capacity and other medical conditions) &
Comment. As under former law, the default rule is that the agent is not authorized to make health
care decisions if the principal has the capacity to make health care decisions. The power of
attorney may, however, give the agent authority to make health care decisions for the principal
even though the principal does have capacity, but the power of attorney is always subject to
Section 4659 (if principal objects, agent not authorized to consent to health care or to the withholding or withdrawal of health care necessary to keep the principal alive).

See also Sections 4607 (“agent” defined), 4609 (“capacity” defined), 4629 (“power of attorney for health care” defined), 4632 (“principal” defined).

**Background from Uniform Act.** Section 2(c) provides that the authority of the agent to make health-care decisions ordinarily does not become effective until the principal is determined to lack capacity and ceases to be effective should the principal recover capacity. A principal may provide, however, that the authority of the agent becomes effective immediately or upon the happening of some event other than the loss of capacity but may do so only by an express provision in the power of attorney. For example, a mother who does not want to make her own health-care decisions but prefers that her daughter make them for her may specify that the daughter as agent is to have authority to make health-care decisions immediately. The mother in that circumstance retains the right to later revoke the power of attorney as provided in Section 3 [Prob. Code § 4696].

[Adapted from Unif. Health-Care Decisions Act § 2(c) comment (1993).]

§ 4683. Scope of agent’s authority

4683. Subject to any limitations in the power of attorney for health care:

(a) An agent designated in the power of attorney may make health care decisions for the principal to the same extent the principal could make health care decisions if the principal had the capacity to do so.

(b) The agent may also make decisions that may be effective after the principal’s death, including the following:

(1) Making a disposition under the Uniform Anatomical Gift Act (Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7 of the Health and Safety Code).

(2) Authorizing an autopsy under Section 7113 of the Health and Safety Code.

(3) Directing the disposition of remains under Section 7100 of the Health and Safety Code.

**Comment.** Section 4683 continues former Section 4720(b) without substantive change. Subdivision (a) is consistent with the last part of the first sentence of Section 2(b) of the Uniform Health-Care Decisions Act (1993). Technical revisions have made to conform to the language of this division. See Section 4658 (determination of capacity and other medical conditions). The agent’s authority is subject to Section 4652 which precludes consent to certain specified types of treatment. See also Section 4653 (impermissible acts and constructions). The principal is free to provide any limitations on types of treatment in the durable power of attorney that are desired. See also Section 4750 et seq. (judicial proceedings).

The description of certain post-death decisions in subdivision (b) is not intended to limit the authority to make such decisions under the governing statutes in the Health and Safety Code.

See also Sections 4607 (“agent” defined), 4609 (“capacity” defined), 4615 (“health care” defined), 4617 (“health care decision” defined), 4629 (“power of attorney for health care” defined), 4633 (“reasonably available” defined).

**Staff Note**

(1) The State Bar Advance Directive Committee notes that subdivision (b) gives the agent authority that is not reflected in the statutory form in Section 4701. (Exhibit p. 21.) The Committee believes these options should be implemented in the form, and a draft has been drawn by Fay Blix, one of the Committee members. This is discussed further following Section 4701 infra. (For a dissenting view of a Committee member, see the discussion in Memorandum 98-63.)
(2) The California Healthcare Association suggests that this section be amended to “conform to new provisions and regulations for organ procurement (Federal Register, Vol. 63, No. 119, Monday, June 22, 1998, page 338856).” (Exhibit p. 68, ¶ 13.)

The staff is not familiar with these regulations, but we can research them, if needed. Generally, however, we try to word state law in a way that avoids conflict with federal law. We write state law to govern things that are within the scope of state authority, and these subjects have been to the best of our knowledge. Note also that this section mainly refers to authority in other laws. Unless federal law now controls the ability of agents designated under state law, this section should be safe. Another reason we tend not to draft state law as a function of federal law is that the Supremacy Clause tends to take care of the matter when there is a conflict. Obviously we do not want to mislead principals in crafting their powers of attorney for health care, so the question will need to be investigated.

§ 4684. Standard governing agent’s health care decisions

4684. An agent shall make a health care decision in accordance with the principal’s individual health care instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the agent’s determination of the principal’s best interest. In determining the principal’s best interest, the agent shall consider the principal’s personal values to the extent known to the agent.

Comment. Section 4684 continues the substance of former Section 4720(c) and is the same as Section 2(e) of the Uniform Health-Care Decisions Act (1993). Although the new wording of this fundamental rule is different, Section 4684 continues the principle of former law that, in exercising authority, the agent has the duty to act consistent with the principal’s desires if known or, if the principal’s desires are unknown, to act in the best interest of the principal. The agent’s authority is subject to Section 4652, which precludes consent to certain specified types of treatment. See also Section 4653 (mercy killing, assisted suicide, euthanasia not approved). The principal is free to provide any limitations on types of treatment in the power of attorney that are desired. See also Section 4750 et seq. (judicial proceedings). This fundamental standard is also applicable to decisions made by surrogate committees. See Section 4713.

See also Sections 4607 (“agent” defined), 4623 (“individual health care instruction” defined), 4632 (“principal” defined).

Background from Uniform Act. Section 2(e) requires the agent to follow the principal’s individual instructions and other expressed wishes to the extent known to the agent. To the extent such instructions or other wishes are unknown, the agent must act in the principal’s best interest. In determining the principal’s best interest, the agent is to consider the principal’s personal values to the extent known to the agent. The Act does not prescribe a detailed list of factors for determining the principal’s best interest but instead grants the agent discretion to ascertain and weigh the factors likely to be of importance to the principal.

[Adapted from Unif. Health-Care Decisions Act § 2(e) comment (1993).]

§ 4685. Agent’s priority

4685. Unless the power of attorney for health care provides otherwise, the agent designated in the power of attorney who is known to the health care provider to be reasonably available and willing to make health care decisions has priority over any other person in making health care decisions for the principal.

Comment. Section 4685 continues without substantive change the first part of former Section 4720(a) and part of former Section 4652(a) relating to availability, willingness, and ability of agents. This section gives the agent priority over others, including a conservator or statutory...
surrogate, to make health care decisions if the agent is known to the health care provider to be
available and willing to act. See Section 4710 (statutory surrogate’s authority dependent on
appointment and availability of agent). The power of attorney may vary this priority, as
recognized in the introductory clause, and the rule of this section is subject to a contrary court
order. See Section 4766. In part, this section serves the same purpose as Section 6(b) of the

See also Sections 4607 (“agent” defined), 4617 (“health care decision” defined), 4621 (“health
care provider” defined), 4629 (“power of attorney for health care” defined), 4632 (“principal”
defined), 4633 (“reasonably available” defined).

§ 4686. Duration

4686. Unless the power of attorney for health care provides a time of
termination, the authority of the agent is exercisable notwithstanding any lapse of
time since execution of the power of attorney.

Comment. Section 4686 continues Section 4127, insofar as it applied to powers of attorney for
health care, without substantive change. This rule is the same in substance as the second sentence
of the official text of Section 2 of the Uniform Durable Power of Attorney Act (1987), Uniform
Probate Code Section 5-502 (1991). See Section 2(b) (construction of provisions drawn from
uniform acts).

See also Sections 4607 (“agent” defined), 4629 (“power of attorney for health care” defined).

§ 4687. Other authority of person named as agent not affected

4687. Nothing in this division affects any right the person designated as an agent
under a power of attorney for health care may have, apart from the power of
attorney, to make or participate in making health care decisions for the principal.

Comment. Section 4687 continues former Section 4720(d) without substantive change, and
supersedes part of former Section 4652(a). An agent may, without liability, decline to act under
the power of attorney. For example, the agent may not be willing to follow the desires of the
principal as stated in the power of attorney because of changed circumstances. This section makes
clear that, in such a case, the person may make or participate in making health care decisions for
the principal without being bound by the stated desires of the principal to the extent that the
person designated as the agent has the right under the applicable law apart from the power of
attorney. See Section 4722(b)(4) (patient representative on surrogate committee).

See also Sections 4607 (“agent” defined), 4617 (“health care decision” defined), 4629 (“power
of attorney for health care” defined), 4632 (“principal” defined).

§ 4688. Application to acts and transactions under power of attorney

4688. (a) If a power of attorney for health care provides that the law of this state
governs the power of attorney or otherwise indicates that the law of this state
governs the power of attorney, this division governs the power of attorney and
applies to an agent’s activities in this state or outside this state where any of the
following conditions is satisfied:

(1) The principal or agent was domiciled in this state when the principal
executed the power of attorney for health care.

(2) The authority conferred on the agent relates to activities in this state.

(3) The activities of the agent occurred or were intended to occur in this state.

(4) The principal executed the power of attorney for health care in this state.
(5) There is otherwise a reasonable relationship between this state and the
principal’s health care.

(b) If subdivision (a) does not apply to the power of attorney for health care, this
division governs the power of attorney and applies to the agent’s activities in this
state where either of the following conditions is satisfied:

(1) The principal was domiciled in this state when the principal executed the
power of attorney for health care.

(2) The principal executed the power of attorney for health care in this state.

(c) A power of attorney for health care described in this section remains subject
to this division despite a change in domicile of the principal or the agent.

Comment. Section 4688 is drawn from Section 4052 in the Power of Attorney Law. Nothing in
this section limits the jurisdiction exercisable under Code of Civil Procedure Section 410.10.
See also Sections 4607 (“agent” defined), 4629 (“power of attorney for health care” defined),
4632 (“principal” defined).

Article 3. Revocation of Advance Directives

§ 4695. Revocation of advance health care directive

4695. (a) A patient having capacity may revoke the designation of an agent only
by a signed writing or by personally informing the supervising health care
provider.

(b) A patient having capacity may revoke all or part of an advance health care
directive, other than the designation of an agent, at any time and in any manner
that communicates an intent to revoke.

Comment. Section 4695 is drawn from Section 3(a)-(b) of the Uniform Health-Care Decisions
Act (1993). This section replaces former Section 4727(a) (revocation rules applicable to durable
power of attorney for health care) and former Health and Safety Code Section 7188(a) (revocation
under former Natural Death Act). This section also supersedes Sections 4150 and 4151 in the
Power of Attorney Law to the extent they applied to powers of attorney for health care. The
principal may revoke the designation or authority only if, at the time of revocation, the principal
has sufficient capacity to make a power of attorney for health care. The burden of proof is on the
person who seeks to establish that the principal did not have capacity to revoke the designation or
authority. See Section 4657 (presumption of capacity). “Personally informing,” as used in
subdivision (a), includes both oral and written communications.

See also Sections 4605 (“advance health care directive” defined), 4625 (“patient” defined),
4629 (“power of attorney for health care” defined), 4639 (“supervising health care provider”
defined).

Background from Uniform Act. Section 3(b) provides that an individual may revoke any
portion of an advance health-care directive at any time and in any manner that communicates an
intent to revoke. However, a more restrictive standard applies to the revocation of the portion of a
power of attorney for health care relating to the designation of an agent. Section 3(a) provides that
an individual may revoke the designation of an agent only by a signed writing or by personally
informing the supervising health-care provider. This higher standard is justified by the risk of a
false revocation of an agent’s designation or of a misinterpretation or miscommunication of a
principal’s statement communicated through a third party. For example, without this higher
standard, an individual motivated by a desire to gain control over a patient might be able to
assume authority to act as agent by falsely informing a health-care provider that the principal no
longer wishes the previously designated agent to act but instead wishes to appoint the individual.
The section does not specifically address amendment of an advance health-care directive because such reference is not necessary. Section 3(b) specifically authorizes partial revocation, and Section 3(e) [Prob. Code § 4698] recognizes that an advance health-care directive may be modified by a later directive.

[Adapted from Unif. Health-Care Decisions Act § 3(a)-(b), (e) comment (1993).]

**Staff Note**

1. Dr. Ronald B. Miller discusses the question of whether a revoked advance directive in the patient’s file should be destroyed and removed from the patient’s record. (Exhibit p. 3.) He thinks it should be marked as revoked, and maybe that action witnessed, and the revoked material retained in the patient’s record. The tentative recommendation does not deal with this issue. Dr. Miller’s remarks make sense, but the staff is not sure we need to codify what appears to be sound practice. We don’t see anything in the statute that stands in the way of the suggested practice. For the duty to record revocations, see Section 4731.

2. The California Healthcare Association would prefer “for evidentiary purposes” to require revocations to be in writing. (Exhibit p. 68, ¶¶ 14-15.) “Given the agent’s importance, the revocation should be express and well documented to insure against abuse or misunderstanding resulting in inappropriate action.” CHA is also concerned that the identity of the supervising health care provider is unclear, further complicating the rule in Section 4695. The Commission has discussed this section on a number of occasions. The problem with requiring a writing is that it would defeat the principal’s intention. Existing law permits an oral revocation of authority. See Prob. Code §§ 4153(a)(2) (oral revocation of authority under general Power of Attorney Law), 4724 (principal’s objections under durable power of attorney for health care). As a practical matter, if a patient has capacity, it is difficult to imagine that a health care provider would proceed in the face of the patient’s contrary directions or statement of revocation. But perhaps CHA is concerned about the possibility that the health care provider may claim a revocation or removal of an agent that the provider disagrees with.

3. Elizabethanne Miller Angevine is deeply concerned about this provision. (Exhibit p. 54.) The problem is that a revocation under subdivision (b) can be communicated to anyone, not just the physician. She relates some experiences where social workers purported to determine the patient’s capacity, with the effect that the authority of the agent was put on hold. Ms. Angevine would require convening an ethics committee when a physician has not made the capacity determination, and would also expand the duty to record revocations under Section 4732 to persons other than health care providers.

The staff is sympathetic to the problem, but we are not sure how to solve it. The proposed law does not suggest or permit social workers to make effective capacity determinations, so there is no basis for invoking ethics committees. We are also reluctant to attempt to impose record-keeping duties on others. It is appropriate to require health care providers to record relevant facts in the patient’s record, but they have access to the records and the social worker and others should not be subject to a duty that they can’t fulfill.

The proposed law, drawn from the UHCDA scheme, attempts to broadly effectuate the patient’s intentions and to protect the record of critical decisions and factors. Thus, the patient has great freedom to revoke a power of attorney for health care or a health care instruction and the duty to create the record is imposed on health care providers. However, as provided in Section 4696, a number of other fiduciaries are subject to a duty to promptly communicate a revocation to the health care provider with record-keeping responsibility. It is permissible to impose a duty on agents, conservators, and surrogates, because they are fiduciaries directly involved in the process. We do not see social workers and other individuals as having the requisite relation upon which to base the duty. Of course, the duty could simply be imposed by adding “any other person” to Section 4696, but we doubt it would be very effective. Nor would it solve the problem of the social worker who claims to determine capacity and is permitted to stymie an agent.
§ 4696. Duty to communicate revocation

4696. A health care provider, agent, conservator, or surrogate who is informed of a revocation of an advance health care directive shall promptly communicate the fact of the revocation to the supervising health care provider and to any health care institution where the patient is receiving care.

Comment. Section 4696 is the same as Section 3(c) of the Uniform Health-Care Decisions Act (1993).

See also Sections 4605 (“advance health care directive” defined), 4607 (“agent” defined), 4613 (“conservator” defined), 4619 (“health care institution” defined), 4621 (“health care provider” defined), 4625 (“patient” defined), 4639 (“supervising health care provider” defined), 4641 (“surrogate” defined).

Background from Uniform Act. Section 3(c) requires any health-care provider, agent, guardian or surrogate who is informed of a revocation to promptly communicate that fact to the supervising health-care provider and to any health-care institution at which the patient is receiving care. The communication triggers the Section 7(b) [Prob. Code § 4731] obligation of the supervising health-care provider to record the revocation in the patient’s health-care record and reduces the risk that a health-care provider or agent, guardian or surrogate will rely on a health-care directive that is no longer valid.

[Adapted from Unif. Health-Care Decisions Act § 3(c) comment (1993).]

+/− Staff Note

(1) Dr. Ronald B. Miller suggests that the revocation should also be communicated “to any provider or institution known or thought likely to have a copy of the now revoked directive, and to a provider or institution thought likely to provide health care to the patient in the future.” (Exhibit p. 3.) This seems like a good idea, but the staff finds the standard somewhat vague and we can envision a conscientious agent or surrogate not knowing where to start in performing the statutory duty. Of course, if the agent knows of other institutions where the advance directive has been recorded in the patient’s records, it would be best to notify them of the revocation. We could add some gloss in the Comment, but it is unlikely to be very effective. Does the Commission wish to expand the scope of this section?

(2) For a discussion of expanding the duty to notify of a revocation, see Elizabethanne Miller Angevine’s comments in paragraph (3) of the Staff Note following Section 4695.

§ 4697. Effect of dissolution or annulment

4697. (a) If after executing a power of attorney for health care the principal’s marriage to the agent is dissolved or annulled, the principal’s designation of the former spouse as an agent to make health care decisions for the principal is revoked.

(b) If the agent’s authority is revoked solely by subdivision (a), it is revived by the principal’s remarriage to the agent.

Comment. Section 4697 continues former Section 4727(e) without substantive change. Subdivision (a) is comparable to Section 3(d) of the Uniform Health-Care Decisions Act (1993), but does not revoke the designation of an agent on legal separation. For special rules applicable to a federal “absentee” (as defined in Section 1403), see Section 3722.

This section is subject to limitation by the power of attorney. See Section 4681 (limitations expressed in power of attorney for health care). See also Sections 4607 (“agent” defined), 4617 (“health care decision” defined), 4629 (“power of attorney for health care” defined), 4632 (“principal” defined).
(1) Harley Spitler suggests adoption of the UHCDA rule. (Exhibit p. 15.) This question has been thoroughly discussed on several occasions and the staff does not wish to revisit the issue. See, e.g., Minutes, March 1998, at 16; Minutes, April 1998, at 10.

(2) Dr. Ronald B. Miller is concerned that this section may imply the principal couldn’t revive the power of attorney in effect by appointing the former spouse as agent. (Exhibit p. 3.) We do not read this section as any sort of limitation on renaming the former spouse. The rule only applies where the power of attorney is executed before the marriage is dissolved or annulled. While it is probably an unlikely situation, we could make the point clear in the Comment.

§ 4698. Effect of later advance directive on earlier advance directive

4698. An advance health care directive that conflicts with an earlier advance directive revokes the earlier advance directive to the extent of the conflict.

Comment. Section 4698 is the same as Section 3(e) of the Uniform Health-Care Decisions Act (1993) and supersedes former Section 4727(d). This section is also consistent with former Health and Safety Code Section 7193 (Natural Death Act).

See also Section 4605 (“advance health care directive” defined).

Background from Uniform Act. Section 3(e) establishes a rule of construction permitting multiple advance health-care directives to be construed together in order to determine the individual’s intent, with the later advance health-care directive superseding the former to the extent of any inconsistency.

[Adapted from Unif. Health-Care Decisions Act § 3(e) comment (1993).]
CHAPTER 2. ADVANCE HEALTH CARE DIRECTIVE FORMS

§ 4700. Authorization for statutory form of advance directive

4700. The form provided in Section 4701 may, but need not, be used to create an advance health care directive. The other sections of this division govern the effect of the form or any other writing used to create an advance health care directive. An individual may complete or modify all or any part of the form in Section 4701.

Comment. Section 4700 is drawn from the introductory paragraph of Section 4 of the Uniform Health-Care Decisions Act (1993). This section supersedes former Section 4779 (use of other forms).

See also Section 4605 ("advance health care directive" defined).

§ 4701. Optional form of advance directive

4701. The statutory advance health care directive form is as follows:

ADVANCE HEALTH CARE DIRECTIVE

(California Probate Code Section 4701)

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a co-worker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
(b) select or discharge health care providers and institutions;
(c) approve or disapprove diagnostic tests, surgical procedures, programs of
medication, and orders not to resuscitate; and
(d) direct the provision, withholding, or withdrawal of artificial nutrition
and hydration and all other forms of health care.

Part 2 of this form lets you give specific instructions about any aspect of your
health care. Choices are provided for you to express your wishes regarding the
provision, withholding, or withdrawal of treatment to keep you alive, as well as
the provision of pain relief. Space is also provided for you to add to the choices
you have made or for you to write out any additional wishes.

Part 3 of this form lets you express an intention to donate your bodily organs and
tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility
for your health care.

After completing this form, sign and date the form at the end. It is recommended
but not required that you request two other adults to sign as witnesses. Give a copy
of the signed and completed form to your physician, to any other health care
providers you may have, to any health care institution at which you are receiving
care, and to any health care agents you have named. You should talk to the person
you have named as agent to make sure that he or she understands your wishes and
is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this
form at any time.

* * * * * * * * * * * * * * * * *

PART 1
POWER OF ATTORNEY FOR HEALTH CARE

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to
make health care decisions for me:

(name of individual you choose as agent)

(address)    (city)    (state)    (zip code)

(home phone)    (work phone)
OPTIONAL: If I revoke my agent’s authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

(name of individual you choose as first alternate agent)

(address)  (city)  (state)  (zip code)

(home phone)  (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

(name of individual you choose as second alternate agent)

(address)  (city)  (state)  (zip code)

(home phone)  (work phone)

(1.2) AGENT’S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

(Add additional sheets if needed.)

(1.3) WHEN AGENT’S AUTHORITY BECOMES EFFECTIVE: My agent’s authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box [ ], my agent’s authority to make health care decisions for me takes effect immediately.

(1.4) AGENT’S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what
my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

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.

Staff Note. Harley Spitler suggests deletion of the above paragraph. (Exhibit p. 16.) He believes the first sentence is wrong and will confuse principals. He believes the instructions below should always be completed. The staff would prefer to keep the uniform act, although we respect Mr. Spitler’s point of view. His suggestion would leave the issue in doubt where an agent has been appointed but the boxes in Part 2 are not checked. Granting full authority to an agent should be permissible without more, just as it is in property powers and under the existing durable power of attorney for health care.

(2.1) 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 (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) 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.

(2.2) 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:

(Add additional sheets if needed.)
(1) Dr. Ronald B. Miller suggests adding “to be effective in pain relief” following “even if” in
the second line of Part 2.2. (Exhibit p. 4.) He is concerned that “a person might misinterpret the
section to suggest that he or she were requesting euthanasia of the health care provider.” Should
this change be made?

(2) The California Healthcare Association asks whether there is liability for a physician
following this directive. (Exhibit p. 69, ¶ 20.) CHA asks: “What are the possibilities that
consenting to and providing relief from pain that may hasten, and, in fact does hasten death, may
be [construed] as a criminal act or physician assisted suicide?” This is a major issue. It cannot be
resolved here. Perhaps the change suggested by Dr. Miller would help provide some guidance,
but ultimately, where the question is a close one, it will have to be resolved on a case-by-case
basis. We trust this is an issue constantly under review by medical ethicists and that experts can
clearly see the difference between palliative care and active euthanasia. See, e.g., AMA Council
on Ethical and Judicial Affairs, Code of Medical Ethics 2.20 (Withholding or Withdrawing Life-
Sustaining Medical Treatment), at 40, 2.21 (Euthanasia), at 55 (1996-97 ed.).

(2.3) 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.)

(2) Staff Note. Dr. Ronald B. Miller asks whether a “do not resuscitate” (DNR) instruction can be
entered in paragraph 2.3. (Exhibit p. 4.) There is nothing preventing it.

PART 3
DONATION OF ORGANS AT DEATH
(OPTIONAL)

(3.1) Upon my death (mark applicable box):

☐ (a) I give any needed organs, tissues, or parts, OR

☐ (b) I give the following organs, tissues, or parts only.

☐ (c) My gift is for the following purposes (strike any of the following you do not want):

(1) Transplant
(2) Therapy
(3) Research
(4) Education
Staff Note

(1) The State Bar Advance Directive Committee proposed addition of form material at this point, to implement the agent’s authority under Section 4683 and some other revisions to Part 3. (See Exhibit pp. 21-22, 24.) Harley Spitler disagrees with the Committee’s proposal. (Exhibit pp. 32-33.) He notes that a person may change his or her mind, but that argument applies equally to the rest of the advance directive form. He notes that disposition of remains may be accomplished in a number of ways, and of course one of them would be an advance directive, so we see no inconsistency here. As for the statutory limitations on disposition of ashes (or bodies), they would apply regardless of what the principal states in the power or in any other scrap of paper, so the staff does not see this as a legitimate criticism of the Committee’s proposal. We are not sure what to say about oral wishes that may be contrary to earlier written expressions, but that is a problem now; it is not created by this proposal.

The staff is generally in favor of this proposal. It makes the form consistent with the statutory authority. Since users of the form will probably not be familiar with the statute, it presents the issues that otherwise might not be considered, with the result that the agent would have the authority without the principal having made any statement on the matter. As it stands, the draft is inconsistent, since the form implements the organ donation authority under Section 4683(b)(1), but not the autopsy and disposition of remains under subdivisions (b)(2)-(3). The authority continues existing law. The existing statutory form in item 7 of Section 4771 provides that the agent has the power and authority to make all three forms of decisions, quoting the statutory language, and instructs that the principal must state limitations in paragraph 4 (“Statement of Desires, Special Provisions, and Limitations”). The two best options would be to adopt the approach of the existing form and replace the material in Part 3, above, with a similar statement and instruction or to implement the statutory authority as suggested by the Committee. (We would also take the Committee’s suggestion concerning revision of the Explanation concerning Part 3. See Exhibit p. 22.)

(2) The California Healthcare Association suggests adding an option of donating the entire body. (Exhibit p. 69, ¶ 21.) The first option (any needed organs, tissues, or parts) would seem to cover the matter.

PART 4

PRIMARY PHYSICIAN

(OPTIONAL)

(4.1) I designate the following physician as my primary physician:

(name of physician)

(address) (city) (state) (zip code)

(phone)
OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

______________________________
(name of physician)

______________________________
(address) (city) (state) (zip code)

______________________________
(phone)

--- Staff Note ---

(1) Dr. Ronald B. Miller suggests adding space for a third or fourth alternate. (Exhibit p. 4.) It is difficult to know the right number. This form is the same as the UHCDA form in this respect. If someone wants to add more, they are free to do so, but the staff does not want to make the form longer for everyone in this regard. A group, such as CMA, that would issue its own versions of the statutory form could add extra lines if desired.

(2) The California Healthcare Association notes that “designation of primary physician in a document may be problematic within managed care environment when consumers must often change plans … or are assigned another physician.” (Exhibit p. 69, ¶ 22.) The staff agrees with this assessment. This part is in the form because the form is essentially the same as the UHCDA form. The staff would probably not have suggested adding this option if we had started from the existing California statutory durable power of attorney for health care, rather than from the UHCDA.

--- PART 5 ---

(5.1) EFFECT OF COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURES: Sign and date the form here:

______________________________
(date) (sign your name)

______________________________
(address) (print your name)

______________________________
(city) (state)

(Optional) SIGNATURES OF WITNESSES:

First witness Second witness
Staff Note. Dr. Ronald B. Miller would require witnessing “because of the importance” of the advance directive. (Exhibit p. 4.) This issue was fully considered by the Commission in its early deliberations on this topic, and the Commission decided to follow the UHCDA approach which encourages but does not require witnesses.

PART 6
SPECIAL WITNESS REQUIREMENT

(6.1) The following statement is required only if you are a patient in a skilled nursing facility — a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

Statement of Patient Advocate or Ombudsman

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4673 of the Probate Code.

(date) (sign your name)

(address) (print your name)

(city) (state)

Comment. Section 4701 provides the contents of the optional statutory form for the Advance Health Care Directive. Parts 1-5 of this form are drawn from Section 4 of the Uniform Health-
Care Decisions Act (1993). This form supersedes the Statutory Form Durable Power of Attorney for Health Care in former Section 4771 and the related rules in former Sections 4772-4774, 4776-4778. Part 6 of this form continues a portion of the former statutory form applicable to patients in skilled nursing facilities.

**Background from Uniform Act.** The optional form set forth in this section incorporates the Section 2 [Prob. Code § 4670 et seq.] requirements applicable to advance health-care directives. There are four parts to the form. An individual may complete all or any parts of the form. Any part of the form left blank is not to be given effect. For example, an individual may complete the instructions for health care part of the form alone. Or an individual may complete the power of attorney for health care part of the form alone. Or an individual may complete both the instructions and power of attorney for health care parts of the form. An individual may also, but need not, complete the parts of the form pertaining to donation of bodily organs and tissue and the designation of a primary physician.

Part 1, the power of attorney for health care, appears first on the form in order to ensure to the extent possible that it will come to the attention of a casual reader. This reflects the reality that the appointment of an agent is a more comprehensive approach to the making of health-care decisions than is the giving of an individual instruction, which cannot possibly anticipate all future circumstances which might arise.

Part [1.1] of the power of attorney for health care form requires only the designation of a single agent, but with opportunity given to designate a single first alternate and a single second alternate, if the individual chooses. No provision is made in the form for the designation of co-agents in order not to encourage the practice. Designation of co-agents is discouraged because of the difficulties likely to be encountered if the co-agents are not all readily available or do not agree. If co-agents are appointed, the instrument should specify that either is authorized to act if the other is not reasonably available. It should also specify a method for resolving disagreements.

Part [1.2] of the power of attorney for health care form grants the agent authority to make all health-care decisions for the individual subject to any limitations which the individual may state in the form. Reference is made to artificial nutrition and hydration and other forms of treatment to keep an individual alive in order to ensure that the individual is aware that those are forms of health care that the agent would have the authority to withdraw or withhold absent specific limitation.

Part [1.3] of the power of attorney for health care form provides that the agent’s authority becomes effective upon a determination that the individual lacks capacity, but as authorized by Section 2(c) [Prob. Code § 4682] a box is provided for the individual to indicate that the authority of the agent takes effect immediately.

Part [1.4] of the power of attorney for health care form directs the agent to make health-care decisions in accordance with the power of attorney, any instructions given by the individual in Part 2 of the form, and the individual’s other wishes to the extent known to the agent. To the extent the individual’s wishes in the matter are not known, the agent is to make health-care decisions based on what the agent determines to be in the individual’s best interest. In determining the individual’s best interest, the agent is to consider the individual’s personal values to the extent known to the agent. Section 2(e) imposes this standard, whether or not it is included in the form, but its inclusion in the form will bring it to the attention of the individual granting the power, to the agent, to any guardian or surrogate, and to the individual’s health-care providers.

Part [1.5] of the power of attorney for health care form nominates the agent, if available, able, and willing to act, otherwise the alternate agents in order of priority stated, as guardians of the person for the individual. This provision is included in the form for two reasons. First, if an appointment of a guardian becomes necessary the agent is the one whom the individual would most likely want to serve in that role. Second, the nomination of the agent as guardian will reduce the possibility that someone other than the agent will be appointed as guardian who could use the position to thwart the agent’s authority.

Because the variety of treatment decisions to which health-care instructions may relate is virtually unlimited, Part 2 of the form does not attempt to be comprehensive, but is directed at the
types of treatment for which an individual is most likely to have special wishes. Part [2.1] of the form, entitled “End-of-Life Decisions,” provides two alternative choices for the expression of wishes concerning the provision, withholding, or withdrawal of treatment. Under the first choice, the individual’s life is not to be prolonged if the individual has an incurable and irreversible condition that will result in death within a relatively short time, if the individual becomes unconscious and, to a reasonable degree of medical certainty, will not regain consciousness, or if the likely risks and burdens of treatment would outweigh the expected benefits. Under the second choice, the individual’s life is to be prolonged within the limits of generally accepted health-care standards.... Part [2.2] of the form provides space for an individual to specify any circumstance when the individual would prefer not to receive pain relief. Because the choices provided in Parts [2.1-2.2] do not cover all possible situations, Part [2.3] of the form provides space for the individual to write out his or her own instructions or to supplement the instructions given in the previous subparts of the form. Should the space be insufficient, the individual is free to add additional pages.

The health-care instructions given in Part 2 of the form are binding on the agent, any guardian, any surrogate, and, subject to exceptions specified in Section 7(e)-(f) [Prob. Code §§ 4734-4735], on the individual’s health-care providers. Pursuant to Section 7(d) [Prob. Code § 4733], a health-care provider must also comply with a reasonable interpretation of those instructions made by an authorized agent, guardian, or surrogate.

Part 3 of the form provides the individual an opportunity to express an intention to donate bodily organs and tissues at death. The options provided are derived from a suggested form in the Comment to Section 2 of the Uniform Anatomical Gift Act (1987). [See Health & Safety Code § 7150 et seq.]

Part 4 of the form provides space for the individual to designate a primary physician should the individual choose to do so. Space is also provided for the designation of an alternate primary physician should the first designated physician not be available, able, or willing to act.

[Part 5.1] of the form conforms with the provisions of Section 12 [Prob. Code § 4661] by providing that a copy of the form has the same effect as the original.

The Act does not require witnessing, [except as provided in Prob. Code § 4673,] but to encourage the practice [Part 5.2 of] the form provides space for the signatures of two witnesses.

The form does not require formal acceptance by an agent. Formal acceptance by an agent has been omitted not because it is an undesirable practice but because it would add another stage to executing an advance health-care directive, thereby further reducing the number of individuals who will follow through and create directives. However, practitioners who wish to adapt this form for use by their clients are strongly encouraged to add a formal acceptance. Designated agents have no duty to act until they accept the office either expressly or through their conduct. Consequently, requiring formal acceptance reduces the risk that a designated agent will decline to act when the need arises. Formal acceptance also makes it more likely that the agent will become familiar with the principal’s personal values and views on health care. While the form does not require formal acceptance, the explanation to the form does encourage principals to talk to the person they have named as agent to make certain that the designated agent understands their wishes and is willing to take the responsibility.

[Adapted from Unif. Health-Care Decisions Act § 4 comment (1993).]

--- Staff Note ---

(1) Harley Spitler suggests amplifying the meaning of “relatively short time” in the Uniform Health-Care Decisions Act comment relating to Part 2. (Exhibit p. 16.) While the staff doesn’t disagree with his interpretation of what that phrase may mean, we prefer not to editorialize within the uniform act comments where we are not compelled to make a change due to differences in the statutory language. However, if the Commission thinks some additional clarification is desirable, we could add Mr. Spitler’s suggested language, or some variation of it, in the Commission Comment.
(2) Dr. Ronald B. Miller suggests adding spaces for agents to sign their acceptance. (Exhibit p. 4.) This could be added by others, but we would not require it in the statutory form. The meaning and effect of an agent’s acceptance is not covered in this statute. There is, perhaps, a general belief that an agent becomes bound by signing a power of attorney, but the staff does not think this is an enforceable relation with regard to health care powers. Compare Section 4230 (duty to act under property power of attorney, express agreement to act).

Dr. Miller also suggests adding a place for indicating that the advance directive has been revoked. Again, the staff does not want to overcomplicate the statutory form, and we are not convinced this would be a useful addition.

(3) The California Healthcare Association suggests that the form indicate the limitations on the agent’s authority under Section 4652. (Exhibit p. 68, ¶ 16.) This could be added, but the staff does not think it is necessary. There is a real benefit to keeping the form simple. We doubt that many principals are interested in granting authority for shock therapy or abortion, for example.

CHA suggests explaining how a power of attorney can be revoked. (Exhibit p. 68, ¶¶ 16, 18.) Again, we prefer the simpler statement that the power can be revoked without going into the details. Since the agent’s appointment can be revoked by a writing or by informing the supervising health care provider (who is usually the primary physician), it is not too counter-intuitive. And the other parts of an advance directive can be revoked in any manner that communicates an intent to revoke. See Section 4695(b). There is nothing to explain.

CHA suggests that part 2.1 should explain the limitations on the principal’s power to control provided in Section 4681. (Exhibit p. 68, ¶ 19.) The staff prefers not to explain these rules since they are generally irrelevant to what people will do in this part of the form.

It should be noted that the existing statutory form does not attempt to explain these various technicalities and we have concluded that the existing form is overly technical. The optional statutory form under the tentative recommendation is intended to be even simpler and easier to understand than the existing form, so our general approach will be to resist addition of detail that does not clarify or illuminate a central function of the form.

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CHAPTER 3. HEALTH CARE SURROGATES

§ 4710. Authority of surrogate to make health care decisions

4710. A surrogate who is designated or selected under this chapter may make health care decisions for a patient if all of the following conditions are satisfied:

(a) The patient has been determined by the primary physician to lack capacity.

(b) No agent has been designated under a power of attorney for health care and no conservator of the person has been appointed with authority to make health care decisions, or the agent or conservator is not reasonably available.

Comment. Section 4710 is drawn from Section 5(a) of the Uniform Health-Care Decisions Act (1993). Section 4658 provides for capacity determinations by the primary physician under this division. Both the patient and the surrogate must be adults. See Sections 4625 (“patient” defined), 4641 (“surrogate” defined). “Adult” includes an emancipated minor. See Fam. Code §§ 7002 (emancipation), 7050 (emancipated minor considered as adult for consent to medical, dental, or psychiatric care).

See also Sections 4609 (“capacity” defined), 4613 (“conservator” defined), 4615 (“health care” defined), 4617 (“health care decision” defined), 4625 (“patient” defined), 4629 (“power of attorney for health care” defined), 4631 (“primary physician” defined), 4633 (“reasonably available” defined), 4641 (“surrogate” defined).

Background from Uniform Act. Section 5(a) authorizes a surrogate to make a health-care decision for a patient who is an adult or emancipated minor if the patient lacks capacity to make health-care decisions and if no agent or guardian has been appointed or the agent or guardian is
not reasonably available. Health-care decision making for unemancipated minors is not covered by this section. The subject of consent for treatment of minors is a complex one which in many states is covered by a variety of statutes and is therefore left to other state law.

[Adapted from Unif. Health-Care Decisions Act § 5(a) comment (1993).]

§ 4711. Patient’s designation of surrogate

4711. A patient may designate an individual as a surrogate to make health care decisions by personally informing the supervising health care provider. An oral designation of a surrogate is effective only during the course of treatment or illness or during the stay in the health care institution when the designation is made.

Comment. The first sentence of Section 4711 is drawn from Section 5(b) of the Uniform Health-Care Decisions Act (1993). Both the patient and the surrogate must be adults. See Sections 4625 (“patient” defined), 4641 (“surrogate” defined). “Personally informing,” as used in this section, includes both oral and written communications. The second sentence is intended to guard against the possibility of giving effect to obsolete oral statements entered in the patient’s record.

See also Sections 4617 (“health care decision” defined), 4619 (“health care institution” defined), 4625 (“patient” defined), 4633 (“reasonably available” defined), 4639 (“supervising health care provider” defined), 4641 (“surrogate” defined).

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

See Section 3(a) [Prob. Code § 4695(a)].

[Adapted from Unif. Health-Care Decisions Act § 5(b) comments (1993).]

§ 4712. Selection of statutory surrogate

4712. (a) Subject to Section 4710, if no surrogate has been designated under Section 4711 or if the designated surrogate is not reasonably available, the primary physician may select a surrogate to make health care decisions for the patient from among the following adults with a relationship to the patient:

(1) The spouse, unless legally separated.
(2) Children.
(3) Parents.
(4) Brothers and sisters.
(5) Grandchildren.
(6) An adult in a long-term relationship of indefinite duration with the patient in which the individual has demonstrated an actual commitment to the patient similar to the commitment of a spouse and in which the individual and the patient consider themselves to be responsible for each other’s well-being. This individual may be known as a domestic partner.
(7) Close friends.
(b) The primary physician shall select the surrogate, with the assistance of other health care providers or institutional committees, in the order of priority set forth in subdivision (a), subject to the following conditions:

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

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

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

(1) Whether the proposed surrogate reasonably appears to be best able to make decisions in accordance with Section 4713.

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

(3) Demonstrated care and concern for the patient.

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

(5) Availability to visit the patient.

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

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

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


See also Sections 4617 (“health care decision” defined), 4625 (“patient” defined), 4633 (“reasonably available” defined), 4639 (“supervising health care provider” defined), 4641 (“surrogate” defined).

Background from Uniform Act. Section 5(d) requires a surrogate who assumes authority to act to immediately so notify the members of the patient’s family who in given circumstances would be eligible to act as surrogate. Notice to the specified family members will enable them to follow health-care developments with respect to their now incapacitated relative. It will also alert them to take appropriate action, including the appointment of a guardian or the commencement of judicial proceedings under Section 14 [Prob. Code § 4750 et seq., should the need arise.

[Adapted from Unif. Health-Care Decisions Act § 5(d) comment (1993).]
Basic policy issues concerning this section are discussed in Memorandum 98-63.

1. The California Medical Association would delete “reasonably” in subdivisions (b)(1) and (c)(1). (Exhibit p. 61.) As we have discussed at prior meetings, CMA believes a good faith standard is necessary but that the “more demanding evidentiary standard, e.g., a ‘reasonableness’ standard, merely invites litigation.” This issue is discussed in connection with other comments in the memorandum.

Dr. Ronald B. Miller seconds the remarks concerning the “reasonably” standard. (Exhibit p. 4.)

2. Harley Spitler suggests excluding from subdivision (a)(1) a spouse “living separate and apart from the patient with no intention of resuming the marital relationship with the patient.” (Exhibit pp. 16-17.) He argues that the “legal” separation standard does not reflect the real world. The staff is sympathetic to Mr. Spitler’s point, but in the context of the proposal as circulated in the tentative recommendation, the categories in subdivision (a) are not as rigid as first appears. The selection of the surrogate is subject to application of the substantive standards in subdivisions (b) and(c). These standards are better-designed to achieve the desired result than the standard proposed by Mr. Spitler. However, if the Commission decides on a straight hierarchy of surrogates, then it would be appropriate to consider the qualification proposed by Mr. Spitler.

3. Mr. Spitler proposes to replace subdivision (a)(7) with the second tier category from UHCDMA Section 5(c): “An adult who has exhibited special care and concern for the patient, who is familiar with the patient’s personal values, and who is reasonably available to act as surrogate.” (Exhibit p. 17.) An earlier draft had used this language, but the Commission decided it overlapped too much with subdivision (a)(6). Furthermore, since the hierarchy is not intended to operate automatically, the “close friends” category would be subject to the standards in subdivision (c).

§ 4713. Standard governing surrogate’s health care decisions

4713. A surrogate shall make a health care decision in accordance with the patient’s individual health care instructions, if any, and other wishes to the extent known to the surrogate. Otherwise, the surrogate shall make the decision in accordance with the surrogate’s determination of the patient’s best interest. In determining the patient’s best interest, the surrogate shall consider the patient’s personal values to the extent known to the surrogate.

Comment. Section 4713 is drawn from Section 5(f) of the Uniform Health-Care Decisions Act (1993). This standard is consistent with the health care decisionmaking standard applicable to agents. See Section 4684. See also Sections 4617 (“health care decision” defined), 4623 (“individual health care instruction” defined), 4625 (“patient” defined), 4641 (“surrogate” defined).

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

[Adapted from Unif. Health-Care Decisions Act § 5(f) comment (1993).]
should come into play only when an evaluation of the patient’s best interest needs to be made by the surrogate.

§ 4714. Disqualification of surrogate

4714. A patient having capacity at any time may disqualify another person, including a member of the patient’s family, from acting as the patient’s surrogate by a signed writing or by personally informing the supervising health care provider of the disqualification.

Comment. Section 4714 is drawn from Section 5(h) of the Uniform Health-Care Decisions Act (1993). See Section 4731 (duty to record surrogate’s disqualification). “Personally informing,” as used in this section, includes both oral and written communications.

See also Sections 4625 (“patient” defined), 4639 (“supervising health care provider” defined), 4641 (“surrogate” defined).

Background from Uniform Act. Section 5(h) permits an individual to disqualify any family member or other individual from acting as the individual’s surrogate, including disqualification of a surrogate who was orally designated.

[Adapted from Unif. Health-Care Decisions Act § 5(h) comment (1993).]

Staff Note

(1) Dr. Ronald B. Miller asks whether the patient can disqualify even if lacking capacity. (Exhibit p. 4.) The answer should be “no” and the staff has added “having capacity” in the first line to make it clear.

(2) The California Healthcare Association suggests more formal procedures, as under Section 4695. (Exhibit p. 69, ¶ 25.) See the Staff Note under Section 4695.

§ 4715. Reassessment of surrogate selection

4715. (a) If a surrogate selected pursuant to Section 4712 is not reasonably available, the surrogate may be replaced.

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

Comment. Section 4715 is drawn from West Virginia law. See W. Va. Code § 16-30B-7 (1997). A surrogate is replaced in the circumstances described in this section by applying the rules in Section 4712. The determination of whether a surrogate has become unavailable or whether a higher priority potential surrogate has become reasonably available is made by the primary physician under Section 4712 and this section. Accordingly, a person who believes it is appropriate to reassess the surrogate selection would need to communicate with the primary physician.

See also Sections 4631 (“primary physician” defined), 4633 (“reasonably available” defined), 4641 (“surrogate” defined).
CHAPTER 4. HEALTH CARE DECISIONS FOR
PATIENTS WITHOUT SURROGATES

Staff Note. Basic policy issues concerning this chapter are discussed in Memorandum 98-63.

§ 4720. Application of chapter

4720. This chapter applies where a health care decision needs to be made for a patient and all of the following conditions are satisfied:

(a) The patient has been determined by the primary physician to lack capacity.
(b) No agent has been designated under a power of attorney for health care and no conservator of the person has been appointed with authority to make health care decisions, or the agent or conservator is not reasonably available.
(c) No surrogate can be selected under Chapter 3 (commencing with Section 4710) or the surrogate is not reasonably available.
(d) No dispositive individual health care instruction is in the patient’s record.

Comment. Section 4720 is new. The procedure in this chapter is in part drawn from and supersedes former Health and Safety Code Section 1418.8 applicable to medical interventions in long-term care facilities. This chapter does not apply to emergency health care. See Section 4651(b)(2).

See also Sections 4607 (“agent” defined), 4609 (“capacity” defined), 4613 (“conservator” defined), 4617 (“health care decision” defined), 4623 (“individual health care instruction” defined), 4625 (“patient” defined), 4631 (“primary physician” defined), 4633 (“reasonably available” defined), 4641 (“surrogate” defined).

Staff Note.

(1) Dr. Ronald B. Miller asks whether “reasonably available” should be further defined. (Exhibit p. 4.) The staff thinks the definition in Section 4633 is sufficient.

(2) The Long Term Care Subcommittee of the Los Angeles County Bar Association Bioethics Committee suggests adding “after a diligent search” to the beginning of subdivision (c), in order to “communicate that providers must make reasonable efforts to locate any available surrogate.” (Exhibit p. 35.) We take the Subcommittee’s point, but would prefer to put the standard in Section 4712. This matter is discussed further in Memorandum 98-63.

(3) Similarly, the National Senior Citizens Law Center suggests adding “after a diligent search” in both subdivisions (b) and (c). (Exhibit p. 47.)

§ 4721. Referral to surrogate committee

4721. A patient’s primary physician may obtain approval for a proposed health care decision by referring the matter to a surrogate committee before the health care decision is implemented.

Comment. Section 4721 is new. It supersedes former Health and Safety Code Section 1418.8(d) applicable to medical interventions in long-term care facilities. The procedure for making health care decisions on behalf of incapacitated adults with no other surrogate decisionmakers is optional and it does not displace any other means for making such decisions. See also Sections 4617 (“health care decision” defined), 4625 (“patient” defined), 4631 (“primary physician” defined), 4633 (“reasonably available” defined), 4641 (“surrogate” defined).
§ 4722. Composition of surrogate committee

(a) A surrogate committee may be established by the health care institution. If a surrogate committee has not been established by the patient’s health care institution, or if the patient is not in a health care institution, the surrogate committee may be established by the county health officer or as otherwise determined by the county board of supervisors.

(b) The surrogate committee shall include the following individuals:

(1) The patient’s primary physician.

(2) A registered professional nurse with responsibility for the patient and with knowledge of the patient’s condition.

(3) Other appropriate health care institution staff in disciplines as determined by the patient’s needs.

(4) One or more patient representatives, who may be a family member or friend of the patient who is unable to take full responsibility for the patient’s health care decisions, but has agreed to serve on the surrogate committee.

(5) In cases involving critical health care decisions, a member of the community who is not employed by or regularly associated with the primary physician, the health care institution, or employees of the health care institution.

(6) In cases involving critical health care decisions, a member of the health care institution’s ethics committee or an outside ethics consultant.

(c) This section provides general guidelines for the composition of the surrogate committee and is not intended to restrict participation by other appropriate persons or unnecessarily interfere in the administration of health care.

Comment. Section 4722 is new. Subdivision (a) provides for establishment of surrogate committees.

Subdivision (b) is drawn in part from provisions of former Health and Safety Code Section 1418.8(e)-(f) applicable to medical interventions in long-term care facilities. Subdivision (b)(4) makes clear that a person who may be qualified to serve as a surrogate under Chapter 3 (commencing with Section 4710) may still participate in health care decisionmaking as a patient representative.

See also Sections 4615 (“health care” defined), 4617 (“health care decision” defined), 4619 (“health care institution” defined), 4625 (“patient” defined), 4631 (“primary physician” defined).

§ 4723. Standards of review by surrogate committee

(a) The surrogate committee’s review of proposed health care shall include all of the following:

(1) A review of the primary physician’s assessment of the patient’s condition.

(2) The reason for the proposed health care decision.

(3) A discussion of the desires of the patient, if known. To determine the desires of the patient, the surrogate committee shall interview the patient, if the patient is capable of communicating, review the patient’s medical records, and consult with family members or friends, if any have been identified.

(4) The type of health care to be used in the patient’s care, including its probable frequency and duration.
(5) The probable impact on the patient’s condition, with and without the use of the proposed health care.

(6) Reasonable alternative health care decisions considered or utilized, and reasons for their discontinuance or inappropriateness.

(b) The surrogate committee shall periodically evaluate the results of an approved health care decision at least quarterly or upon a significant change in the patient’s medical condition.

Comment. Section 4723 is new and is patterned after provisions of former Health and Safety Code Section 1418.8(e) applicable to medical interventions in long-term care facilities. Subdivision (b) continues and generalizes former Health and Safety Code Section 1418.8(g).

See also Sections 4617 (“health care decision” defined), 4625 (“patient” defined), 4631 (“primary physician” defined), 4722 (composition of surrogate committee).

**Staff Note**

(1) Dr. Ronald B. Miller asks what “type of health care” means in subdivision (a)(4). (Exhibit p. 5.) The staff assumes it means the prescribed treatment, whether curative or palliative or life support. The phrase comes from “type of medical intervention” in the Epple bill, Health and Safety Code Section 1418.8(e)(4).

(2) Dr. Lawrence J. Schneiderman suggests revising subdivision (b) to read: “The ethics committee shall review the decisions and provide follow-up reviews on a reasonable basis in accordance with the patient’s medical condition.” (Exhibit, p. 9.) This looks like a plausible alternative, but the language in the proposed law has the advantage of being the same as the Epple bill standard. Now, if there is a problem revealed by the experience with that language, we would like to know what it is, but we are reluctant to replace what we think is a more concrete standard with the suggested language. We are also uncomfortable with using the “ethics committee” as the “surrogate committee.” Comments made by health care professionals at an earlier Commission meeting led us to conclude that ethics committees do not generally want to get into making treatment decisions. While the Commission wanted the procedure to be flexible enough to permit the ethics committee to act as the surrogate committee, if desired, the decision was made that this should not be mandated. The name of the committee is not too important, but the statute should use a different term so that the different role is clear.

(3) The Long Term Care Subcommittee of the Los Angeles County Bar Association Bioethics Committee notes that the interview in subdivision (a)(3) may be impossible in many instances, particularly since the situation involves patients who lack capacity, and they are concerned that the statute should not “mandate the impossible.” (Exhibit pp. 38-39.) (A similar issue was raised with regard to Section 4730.). The staff has implemented the Subcommittee’s suggestion to add “if the patient is capable of communicating.”

(4) The National Senior Citizens Law Center would retain the requirement of communication with the patient. (Exhibit p. 49.) “Even residents with limited capacity, cognitive impairments or communication barriers may be able to make their wishes known in some useful way.” It isn’t clear whether the Center would object to the standard proposed by the Long Term Care Subcommittee in paragraph (3) above.

§ 4724. Decisionmaking by surrogate committee

4724. The surrogate committee shall attempt to reach consensus on proposed health care decisions, but may approve proposed health care decisions by majority vote. However, proposed health care decisions relating to refusal or withdrawal of
life-sustaining treatment may not be approved if any member of the surrogate committee is opposed.

Comment. Section 4724 is new. The principle of decisionmaking by a majority is consistent with the rule applicable to statutory surrogates under Section 5(e) of the Uniform Health-Care Decisions Act (1993). With respect to medical interventions in long-term care facilities, this section supersedes part of the second sentence of former Health and Safety Code Section 1418.8(e) relating to “a team approach to assessment and care planning.” For the standard governing surrogate decisionmaking generally, see Section 4713.

See also Sections 4617 (“health care decision” defined), 4722 (composition of surrogate committee). For provisions concerning judicial proceedings, see Sections 4765(d) (petitioners), 4766 (purposes of petition).

Staff Note

(1) Dr. Ronald B. Miller discusses the concern about whether a single member of the committee could block action where unanimity is required. (Exhibit p. 5.)

(2) The Long Term Care Subcommittee of the Los Angeles County Bar Association Bioethics Committee proposes a redraft of this section to clarify the effect of abstaining surrogate committee members and the duty to keep records of the surrogate committee’s decisionmaking. (Exhibit p. 39.) The staff thinks these are good changes and would adopt the substance of the Subcommittee’s proposal if the Commission decides to proceed with the surrogate committee proposal.

(3) The National Senior Citizens Law Center is concerned about domination of a surrogate committee by institution-affiliated committee members and would require affirmative concurrence by either the community member or patient representative and, in the case of refusal or withdrawal of life-sustaining treatment, the concurrence of both. (Exhibit p. 49.) “The life and death nature of the decision should not permit treatment to be denied by the expedient of abstention.”

§ 4725. General surrogate rules applicable to surrogate committee

4725. Provisions applicable to health care decisionmaking, duties, and immunities of surrogates apply to a surrogate committee and its members.

Comment. Section 4725 is new. For provisions applicable to health care surrogates generally, see Chapter 3 (commencing with Section 4710), Section 4741 (immunities of surrogate). See also Section 4653 (mercy killing, assisted suicide, euthanasia not approved). For a list of sections applicable to surrogates, see Section 4641 Comment. For the standard governing surrogate decisionmaking generally, see Section 4713.

See also Sections 4617 (“health care decision” defined), 4641 (“surrogate” defined), 4722 (composition of surrogate committee).

§ 4726. Review of emergency care

4726. In a case subject to this chapter where emergency care is administered without approval by a surrogate committee, if the emergency results in the application of physical or chemical restraints, the surrogate committee shall meet within one week of the emergency for an evaluation of the health care decision.

Comment. Section 4726 generalizes former Health and Safety Code Section 1418.8(h).
CHAPTER 5. DUTIES OF HEALTH CARE PROVIDERS

§ 4730. Supervising health care provider’s duty to communicate

4730. Before implementing a health care decision made for a patient, a supervising health care provider, if possible, shall promptly communicate to the patient the decision made and the identity of the person making the decision.

Comment. Section 4730 is drawn from Section 7(a) of the Uniform Health-Care Decisions Act (1993). The duty to communicate the identity of the decisionmaker also applies to a surrogate committee. See Section 4725 (general surrogate rules applicable to surrogate committee).

See also Sections 4617 (“health care decision” defined), 4625 (“patient” defined), 4639 (“supervising health care provider” defined).

Background from Uniform Act. Section 7(a) further reinforces the Act’s respect for patient autonomy by requiring a supervising health-care provider, if possible, to promptly communicate to a patient, prior to implementation, a health-care decision made for the patient and the identity of the person making the decision.

[Adapted from Unif. Health-Care Decisions Act § 7(a) comment (1993).]

Staff Note. The California Healthcare Association ponders whether the mandated attempt at communication with a patient who lacks capacity makes sense. (Exhibit p. 70, ¶ 27.) Of course, it would be merely a formality in many cases, but the section does not require communication where it is not possible. The purpose of the section is explained in the UHCDA background comment.

§ 4731. Supervising health care provider’s duty to record relevant information

4731. (a) 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. If a copy is furnished, the supervising health care provider shall arrange for its maintenance in the patient’s health care record.

(b) A supervising health care provider who knows of a revocation of a power of attorney for health care or a disqualification of a surrogate shall make a reasonable effort to notify the agent or surrogate of the revocation or disqualification.

Comment. Subdivision (a) of Section 4731 is drawn from Section 7(b) of the Uniform Health-Care Decisions Act (1993). With respect to recording notice of revocation of a power of attorney for health care, this section continues the substance of part of former Section 4727(b). The recordkeeping duty continues part of former Health and Safety Code Section 7186.5(c) (Natural Death Act).

Subdivision (b) continues the substance of part of former Section 4727(b) and applies the same duty to surrogate disqualification.

See also Sections 4605 (“advance health care directive” defined), 4625 (“patient” defined), 4629 (“power of attorney for health care” defined), 4639 (“supervising health care provider” defined), 4641 (“surrogate” defined).

Background from Uniform Act. The recording requirement in Section 7(b) reduces the risk that a health-care provider or institution, or agent, guardian or surrogate, will rely on an outdated individual instruction or the decision of an individual whose authority has been revoked.

[Adapted from Unif. Health-Care Decisions Act § 7(b) comment (1993).]
§ 4732. Primary physician’s duty to record relevant information

4732. A primary physician who makes or is informed of a determination that a patient lacks or has recovered capacity, or that another condition exists affecting an individual health care instruction or the authority of an agent, conservator of the person, or surrogate, shall promptly record the determination in the patient’s health care record and communicate the determination to the patient, if possible, and to a person then authorized to make health care decisions for the patient.

Comment. Section 4732 is drawn from Section 7(c) of the Uniform Health-Care Decisions Act (1993). This duty also applies to a surrogate committee. See Section 4725 (general surrogate rules applicable to surrogate committee). This duty generally continues recordkeeping duties in former Health and Safety Code Sections 7186.5(c) and 7189 (Natural Death Act).

See also Sections 4607 (“agent” defined), 4609 (“capacity” defined), 4613 (“conservator” defined), 4617 (“health care decision” defined), 4623 (“individual health care instruction” defined), 4625 (“patient” defined), 4631 (“primary physician” defined).

Background from Uniform Act. Section 7(c) imposes recording and communication requirements relating to determinations that may trigger the authority of an agent, guardian or surrogate to make health-care decisions on an individual’s behalf. The determinations covered by these requirements are those specified in Sections 2(c)-(d) and 5(a) [Prob. Code §§ 4658, 4682 & 4710 respectively].

[Adapted from Unif. Health-Care Decisions Act § 7(c) comment (1993).]

§ 4733. Duty of health care provider or institution to comply with health care instructions and decisions

4733. Except as provided in Sections 4734 and 4735, a health care provider or health care institution providing care to a patient shall do the following:

(a) Comply with an individual health care instruction of the patient and with a reasonable interpretation of that instruction made by a person then authorized to make health care decisions for the patient.

(b) Comply with a health care decision for the patient made by a person then authorized to make health care decisions for the patient to the same extent as if the decision had been made by the patient while having capacity.

Comment. Section 4733 is drawn from Section 7(d) of the Uniform Health-Care Decisions Act (1993). This section generalizes a duty to comply provided in former Health and Safety Code Section 7187.5 (2d sentence) (Natural Death Act).

See also Sections 4609 (“capacity” defined), 4617 (“health care decision” defined), 4619 (“health care institution” defined), 4621 (“health care provider” defined), 4623 (“individual health care instruction” defined), 4625 (“patient” defined).

Background from Uniform Act. Section 7(d) requires health-care providers and institutions to comply with a patient’s individual instruction and with a reasonable interpretation of that instruction made by a person then authorized to make health-care decisions for the patient. A health-care provider or institution must also comply with a health-care decision made by a person then authorized to make health-care decisions for the patient to the same extent as if the decision had been made by the patient while having capacity. These requirements help to protect the patient’s rights to autonomy and self-determination and validate and seek to effectuate the substitute decision making authorized by the Act.

[Adapted from Unif. Health-Care Decisions Act § 7(d) comment (1993).]
§ 4734. Right to decline for reasons of conscience or institutional policy

4734. (a) A health care provider may decline to comply with an individual health care instruction or health care decision for reasons of conscience.

(b) A health care institution may decline to comply with an individual health care instruction or health care decision if the instruction or decision is contrary to a policy of the institution that 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.

Comment. Section 4734 is drawn from Section 7(e) of the Uniform Health-Care Decisions Act (1993).

See also Sections 4615 (“health care” defined), 4619 (“health care institution” defined), 4621 (“health care provider” defined), 4623 (“individual health care instruction” defined), 4625 (“patient” defined).

Background from Uniform Act. Not all instructions or decisions must be honored, however. Section 7(e) [Prob. Code § 4734(a)] authorizes a health-care provider to decline to comply with an individual instruction or health-care decision for reasons of conscience. Section 7(e) also allows a health-care institution to decline to comply with a health-care instruction or 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 an individual then authorized to make health-care decisions for the patient.

[Adapted from Unif. Health-Care Decisions Act § 7(e) comment (1993).]

Staff Note. The California Healthcare Association suggests including an exception “where a physician or health care provider may not decline [to] comply for reasons relating to cost of care and/or reimbursement.” (Exhibit p. 69, ¶ 28.) This makes sense, of course, but perhaps fits best as a statement in the Comment. The section applies only where there is a conscience objection. Subdivision (a) covers the physician’s conscientious objection. Subdivision (b) covers the hospital’s institutional objection expressly based on conscience. A reluctance to comply with a health care decision based on cost could not come within the terms of this section.

Basic policy issues concerning “futile care” and the duty to provide “continuing care” are discussed in Memorandum 98-63.

§ 4735. Right to decline to provide ineffective care

4735. A health care provider or health care institution may decline to comply with an individual health care 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.

Comment. Section 4735 is drawn from Section 7(f) of the Uniform Health-Care Decisions Act (1993). This section is a special application of the general rule in Section 4654.

See also Sections 4615 (“health care” defined), 4619 (“health care institution” defined), 4621 (“health care provider” defined), 4623 (“individual health care instruction” defined), 4625 (“patient” defined).

Background from Uniform Act. Section 7(f) [Prob. Code § 4734(b)] further authorizes a health-care provider or institution to decline to comply with an instruction or decision that requires the provision of care which would be medically ineffective or contrary to generally accepted health-care standards applicable to the provider or institution. “Medically ineffective health care,” as used in this section, means treatment which would not offer the patient any significant benefit.

[Adapted from Unif. Health-Care Decisions Act § 7(f) comment (1993).]
 Staff Note

(1) The State Bar Advance Directive Committee would make the definitional statement in the last sentence of the UHCDA background comment into a statutory definition in a new Section 4624. (Exhibit p. 23.) This is not a bad idea, except that the term is used only in this section. If further clarification is needed, then the better approach would be to include the guts of the definition in Section 4735, replacing “medically ineffective health care” with “treatment that would not offer the patient any significant benefit.” Is the second phrase better than the first? If so, we should use it. Or should we attempt to put both phrasings into the section?

(2) The California Healthcare Association suggests replacing “ineffective care” with the concept of “futile care” or, alternatively, defining ineffective care based on the generally accepted standard of care in the situation. (Exhibit p. 70, ¶ 29.) These issues are discussed in Memorandum 98-63.

§ 4736. Duty of declining health care provider or institution

4736. A health care provider or health care institution that declines to comply with an individual health care instruction or health care decision shall do all of the following:

(a) Promptly so inform the patient, if possible, and any person then authorized to make health care decisions for the patient.
(b) Provide continuing care to the patient until a transfer can be accomplished.
(c) 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.

Comment. Section 4736 is drawn from Section 7(g) of the Uniform Health-Care Decisions Act (1993). This section applies to situations where the health care provider or institution declines to comply under Section 4734 or 4735. This section continues the duty to transfer provided in former Health and Safety Code Sections 7187.5 (2d sentence) and 7190 (Natural Death Act). Nothing in this section requires administration of ineffective care. See Sections 4654, 4735. This section does not resolve the problem that may occur where a transfer cannot be accomplished and the continuing care required by subdivision (b) is a form of care the health care provider or institution has a right to decline under Section 4734 or 4735. See also Sections 4617 (“health care decision” defined), 4619 (“health care institution” defined), 4621 (“health care provider” defined), 4623 (“individual health care instruction” defined), 4625 (“patient” defined).

Background from Uniform Act. Section 7(g) requires a health-care provider or institution that declines to comply with an individual instruction or health-care decision to promptly communicate the refusal to the patient, if possible, and to any person then authorized to make health-care decisions for the patient. The provider or institution also must provide continuing care to the patient until a transfer can be effected. In addition, unless the patient or person then authorized to make health-care decisions for the patient refuses assistance, the health-care provider or institution must 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.

[Adapted from Unif. Health-Care Decisions Act § 7(g) comment (1993).]

 Staff Note. Basic policy issues concerning “futile care” and the duty to provide “continuing care” are discussed in Memorandum 98-63.
CHAPTER 6. IMMUNITIES AND LIABILITIES

§ 4740. Immunities of health care provider and institution

4740. A health care provider or health care institution acting in good faith and in accordance with generally accepted health care standards applicable to the health care provider or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for any actions in compliance with this division, including, but not limited to, any of the following conduct:

(a) Complying with a health care decision of a person apparently having authority to make a health care decision for a patient, including a decision to withhold or withdraw health care.

(b) Declining to comply with a health care decision of a person based on a belief that the person then lacked authority.

(c) Complying with an advance health care directive and assuming that the directive was valid when made and has not been revoked or terminated.

Comment. Section 4740 is drawn from Section 9(a) of the Uniform Health-Care Decisions Act (1993) and supersedes former Sections 4727(f) and 4750 (durable power of attorney for health care). This section also supersedes former Health and Safety Code Sections 1418.8(k) (medical interventions in nursing homes) and 7190.5 (Natural Death Act). The major categories of actions listed in subdivisions (a)-(c) are given as examples and not by way of limitation on the general rule stated in the introductory paragraph. Hence, the protections of this section apply to selection of a surrogate under Section 4712. This immunity also applies where health care decisions are approved by a surrogate committee. See Section 4725 (general surrogate rules applicable to surrogate committee).

The good faith standard of former law is continued in this section. Like former law, this section protects the health care provider who acts in good faith reliance on a health care decision made by an agent pursuant to this division. The reference to acting in accordance with generally accepted health care standards makes clear that a health care provider is not protected from liability for malpractice. The specific qualifications built into the rules provided in former Section 4750(a) are superseded by the good faith rule in this section and by the affirmative requirements of other provisions. See, e.g., Sections 4683(a) (scope of agent’s authority) (compare to second part of introductory language of former Section 4750(a)), 4684 (standard governing agent’s health care decisions) (compare to former Section 4750(a)(1)-(2)). See also Section 4733 (duty of health care provider or institution to comply with health care instructions and decisions), 4734 (health care provider’s or institution’s right to refuse), 4736 (duty of declining health care provider or institution).

See also Sections 4605 (“advance health care directive” defined), 4617 (“health care decision” defined), 4619 (“health care institution” defined), 4621 (“health care provider” defined), 4625 (“patient” defined).

Background from Uniform Act. Section 9 [Prob. Code §§ 4740-4741] grants broad protection from liability for actions taken in good faith. Section 9(a) permits a health-care provider or institution to comply with a health-care decision made by a person appearing to have authority to make health-care decisions for a patient; to decline to comply with a health-care decision made by a person believed to be without authority; and to assume the validity of and to comply with an advance health-care directive. Absent bad faith or actions taken that are not in accord with generally accepted health-care standards, a health-care provider or institution has no duty to investigate a claim of authority or the validity of an advance health-care directive.

[Adapted from Unif. Health-Care Decisions Act § 9(a) comment (1993).]
Staff Note. The California Healthcare Association would like the lead-in to say “including, but not limited to, any of the following conduct.” (Exhibit p. 70, ¶ 31.) Of course, that is what “including” means, but our practice is to add the “but” phrase in sensitive situations when someone thinks it is really important, and we have done so here. We are duty-bound to note, however, that this raises the possibility that someone may interpret other “bare including” lead-ins as having a more restrictive meaning. See, e.g., Sections 4609, 4617, 4650, 4683, 4714, 4723, 4765, 4770 (bare “including”). But see Sections 4665, 4671, 4760 (“including but not …”).

CHA would also add a subdivision (d): “Declining to comply with a directive in accordance with Section 4736.” Should this be added?

§ 4741. Immunities of agent and surrogate

4741. A person acting as agent or surrogate under this part is not subject to civil or criminal liability or to discipline for unprofessional conduct for health care decisions made in good faith.

Comment. Section 4741 is drawn from Section 9(b) of the Uniform Health-Care Decisions Act (1993). This immunity also applies where health care decisions are approved by a surrogate committee. See Section 4725 (general surrogate rules applicable to surrogate committee).

See also Sections 4607 (“agent” defined), 4617 (“health care decision” defined), 4641 (“surrogate” defined).

Background from Uniform Act. Section 9(b) protects agents and surrogates acting in good faith from liability for making a health-care decision for a patient. Also protected from liability are individuals who mistakenly but in good faith believe they have the authority to make a health-care decision for a patient. For example, an individual who has been designated as agent in a power of attorney for health care might assume authority unaware that the power has been revoked. Or a family member might assume authority to act as surrogate unaware that a family member having a higher priority was reasonably available and authorized to act.

[Adapted from Unif. Health-Care Decisions Act § 9(b) comment (1993).]

§ 4742. Statutory damages

4742. (a) A health care provider or health care institution that intentionally violates this part is subject to liability to the aggrieved individual for damages of $2,500 or actual damages resulting from the violation, whichever is greater, plus reasonable attorney’s fees.

(b) A person 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 $10,000 or actual damages resulting from the action, whichever is greater, plus reasonable attorney’s fees.

(c) The damages provided in this section are cumulative and not exclusive of any other remedies provided by law.

Comment. Subdivisions (a) and (b) of Section 4742 are drawn from Section 10 of the Uniform Health-Care Decisions Act (1993) and supersede former Health and Safety Code Section 7191(a)-(b) (Natural Death Act).

Subdivision (c) continues the rule of former Health and Safety Code Section 7191(g) (Natural Death Act) and is consistent with the uniform act. See Unif. Health-Care Decisions Act § 10 comment (1993).
See also Sections 4605 (“advance health care directive” defined), 4619 (“health care institution” defined), 4621 (“health care provider” defined).

Background from Uniform Act. Conduct which intentionally violates the Act and which interferes with an individual’s autonomy to make health-care decisions, either personally or through others as provided under the Act, is subject to civil damages rather than criminal penalties out of a recognition that prosecutions are unlikely to occur. The legislature of an enacting state will have to determine the amount of damages which needs to be authorized in order to encourage the level of potential private enforcement actions necessary to effect compliance with the obligations and responsibilities imposed by the Act. The damages provided by this section do not supersede but are in addition to remedies available under other law.

[Adapted from Unif. Health-Care Decisions Act § 10 comment (1993).]

§ 4743. Criminal penalties

4743. Any person who alters or forges a written advance health care directive of another, or willfully conceals or withholds personal knowledge of a revocation of an advance directive, with the intent to cause a withholding or withdrawal of health care necessary to keep the patient alive contrary to the desires of the patient, and thereby directly causes health care necessary to keep the patient alive to be withheld or withdrawn and the death of the patient thereby to be hastened, is subject to prosecution for unlawful homicide as provided in Chapter 1 (commencing with Section 187) of Title 4 of Part 1 of the Penal Code.

Comment. Section 4743 continues former Section 4726 without substantive change and supersedes former Health and Safety Code Section 7191(c)-(d) (Natural Death Act). References to “principal” have been changed to “patient” to reflect the broader scope of this division, and some surplus language has been omitted.

See also Sections 4605 (“advance health care directive” defined), 4615 (“health care” defined), 4625 (“patient” defined).
CHAPTER 1. GENERAL PROVISIONS

§ 4750. Judicial intervention disfavored

4750. Subject to this division:
(a) An advance health care directive is effective and exercisable free of judicial intervention.
(b) A health care decision made by an agent for a principal is effective without judicial approval.
(c) A health care decision made by a surrogate for a patient is effective without judicial approval.
(d) A health care decision made pursuant to Chapter 4 (commencing with Section 4720) is effective without judicial approval.

Comment. This section makes clear that judicial involvement in health care decisionmaking is disfavored. See Section 4650(d) (legislative findings). Subdivision (a) of Section 4750 continues former Section 4900 to the extent it applied to powers of attorney for health care.

Subdivision (b) is drawn from Section 2(f) of the Uniform Health-Care Decisions Act (1993).
Subdivision (c) is drawn from Sections 2(f) and 5(g) of the Uniform Health-Care Decisions Act (1993).
Subdivision (d) is patterned after subdivisions (b) and (c) and is analogous to former Health and Safety Code Section 1418.8(i) (medical interventions for resident of long-term care facility).

See also Sections 4605 (“advance health care directive” defined), 4607 (“agent” defined), 4617 (“health care decision” defined), 4625 (“patient” defined), 4632 (“principal” defined), 4641 (“surrogate” defined).

§ 4751. Cumulative remedies

4751. The remedies provided in this part are cumulative and not exclusive of any other remedies provided by law.

Comment. Section 4751 continues former Section 4901 to the extent it applied to powers of attorney for health care.

§ 4752. Effect of provision in advance directive attempting to limit right to petition

4752. Except as provided in Section 4753, this part is not subject to limitation in an advance health care directive.

Comment. Section 4752 continues former Section 4902 to the extent it applied to powers of attorney for health care.
See also Sections 4605 (“advance health care directive” defined), 4681 (general rule on limitations provided in power of attorney).
§ 4753. Limitations on right to petition

4753. (a) Subject to subdivision (b), an advance health care directive may expressly eliminate the authority of a person listed in Section 4765 to petition the court for any one or more of the purposes enumerated in Section 4766, if both of the following requirements are satisfied:

(1) The advance directive is executed by an individual having the advice of a lawyer authorized to practice law in the state where the advance directive is executed.

(2) The individual’s lawyer signs a certificate stating in substance:

“I am a lawyer authorized to practice law in the state where this advance health care directive was executed, and [insert name] was my client at the time this advance directive was executed. I have advised my client concerning his or her rights in connection with this advance directive and the applicable law and the consequences of signing or not signing this advance directive, and my client, after being so advised, has executed this advance directive.”

(b) An advance health care directive may not limit the authority of the following persons to petition under this part:

(1) The conservator of the person, with respect to a petition relating to an advance directive, for a purpose specified in subdivision (b) or (d) of Section 4766.

(2) The agent, with respect to a petition relating to a power of attorney for health care, for a purpose specified in subdivision (b) or (c) of Section 4766.

Comment. Section 4753 continues former Section 4903 to the extent it applied to powers of attorney for health care. Subdivision (a) makes clear that a power of attorney may limit the applicability of this part only if it is executed with the advice and approval of the principal’s counsel. This limitation is designed to ensure that the execution of a power of attorney that restricts the remedies of this part is accomplished knowingly by the principal. The inclusion of a provision in the power of attorney making this part inapplicable does not affect the right to resort to any judicial remedies that may otherwise be available.

Subdivision (b) specifies the purposes for which a conservator of the person or an agent may petition the court under this part with respect to a power of attorney for health care. The rights provided in these paragraphs cannot be limited by a provision in an advance directive, but the advance directive may restrict or eliminate the right of any other persons to petition the court under this part if the individual executing the advance directive has the advice of legal counsel and the other requirements of subdivision (a) are met. See Section 4681 (effect of provision in power of attorney attempting to limit right to petition).

Under subdivision (b)(1), despite a contrary provision in the advance directive, the conservator of the person may obtain a determination of whether an advance directive is in effect or has terminated (Section 4766(b)) or whether the authority of an agent or surrogate is terminated (Section 4766(d)). See also Section 4766 Comment.

Under subdivision (b)(2), despite a contrary provision in the power of attorney, the agent may obtain a determination of whether the power of attorney for health care is in effect or has terminated (Section 4766(b)), or an order passing on the acts or proposed acts of the agent under the power of attorney (Section 4766(c)).

See also Sections 4605 (“advance health care directive” defined), 4607 (“agent” defined), 4613 (“conservator” defined), 4629 (“power of attorney for health care” defined).
§ 4754. Jury trial

4754. There is no right to a jury trial in proceedings under this division.

Comment. Section 4754 continues former Section 4904 to the extent it applied to powers of attorney for health care. This section is consistent with the rule applicable to other fiduciaries. See Sections 1452 (guardianships and conservatorships), 4504 (powers of attorney generally), 7200 (decedents’ estates), 17006 (trusts).

§ 4755. Application of general procedural rules

4755. Except as otherwise provided in this division, the general provisions in Division 3 (commencing with Section 1000) apply to proceedings under this division.

Comment. Section 4755 continues former Section 4905 to the extent it applied to powers of attorney for health care. Like Section 4505, this section provides a cross-reference to the general procedural rules that apply to this division. See, e.g., Sections 1003 (guardian ad litem), 1021 (verification required), 1041 (clerk to set matters for hearing), 1046 (hearing and orders), 1203 (order shortening time for notice), 1215-1216 (service), 1260 (proof of service).

CHAPTER 2. JURISDICTION AND VENUE

§ 4760. Jurisdiction and authority of court or judge

4760. (a) The superior court has jurisdiction in proceedings under this division.

(b) The court in proceedings under this division is a court of general jurisdiction and the court, or a judge of the court, has the same power and authority with respect to the proceedings as otherwise provided by law for a superior court, or a judge of the superior court, including, but not limited to, the matters authorized by Section 128 of the Code of Civil Procedure.

Comment. Section 4760 continues former Section 4920 to the extent it applied to powers of attorney for health care. Like Section 4520, this section is comparable to Section 7050 governing the jurisdiction and authority of the court in proceedings concerning administration of decedents’ estates. See Section 7050 Comment.

§ 4761. Basis of jurisdiction

4761. The court may exercise jurisdiction in proceedings under this division on any basis permitted by Section 410.10 of the Code of Civil Procedure.

Comment. Section 4761 continues former Section 4921 to the extent it applied to powers of attorney for health care. Like Section 4521, this section is comparable to Section 7054 (jurisdiction under Trust Law). This section recognizes that the court, in proceedings relating to powers of attorney under this division, may exercise jurisdiction on any basis that is not inconsistent with the California or United States Constitutions, as provided in Code of Civil Procedure Section 410.10. See generally Judicial Council Comment to Code Civ. Proc. § 410.10; Prob. Code § 17004 Comment (basis of jurisdiction under Trust Law).

§ 4762. Jurisdiction over agent or surrogate

4762. Without limiting Section 4761, a person who acts as an agent under a power of attorney for health care or as a surrogate under this division is subject to personal jurisdiction in this state with respect to matters relating to acts and
transactions of the agent or surrogate performed in this state or affecting a patient in this state.

Comment. Section 4762 continues former Section 4922 to the extent it applied to powers of attorney for health care, and extends its principles to cover surrogates. Like Section 4522, this section is comparable to Sections 3902(b) (jurisdiction over custodian under Uniform Transfers to Minors Act) and 17003(a) (jurisdiction over trustee). This section is intended to facilitate exercise of the court’s power under this part when the court’s jurisdiction is properly invoked. As recognized by the introductory clause, constitutional limitations on assertion of jurisdiction apply to the exercise of jurisdiction under this section. Consequently, appropriate notice must be given to an agent or surrogate as a condition of personal jurisdiction. Cf. Mullane v. Central Hanover Bank & Trust Co., 339 U.S. 306 (1950).

See also Sections 4607 (“agent” defined), 4625 (“patient” defined), 4629 (“power of attorney for health care” defined), 4641 (“surrogate” defined).

§ 4763. Venue

4763. The proper county for commencement of a proceeding under this division shall be determined in the following order of priority:
(a) The county in which the patient resides.
(b) The county in which the agent or surrogate resides.
(c) Any other county that is in the patient’s best interest.

Comment. Section 4763 continues former Section 4923 to the extent it applied to powers of attorney for health care.

See also Sections 4607 (“agent” defined), 4625 (“patient” defined), 4641 (“surrogate” defined).

CHAPTER 3. PETITIONS, ORDERS, APPEALS

§ 4765. Petitioners

4765. Subject to Section 4753, a petition may be filed under this part by any of the following persons:
(a) The patient.
(b) The patient’s spouse, unless legally separated.
(c) A relative of the patient.
(d) The agent or surrogate, including a member of a surrogate committee.
(e) The conservator of the person of the patient.
(f) The court investigator, described in Section 1454, of the county where the patient resides.
(g) The public guardian of the county where the patient resides.
(h) The supervising health care provider or health care institution involved with the patient’s care.
(i) Any other interested person or friend of the patient.

Comment. Section 4765 continues former Section 4940 to the extent it applied to powers of attorney for health care, with some omissions and clarifications appropriate for the scope of this division. The purposes for which a person may file a petition under this part are limited by other rules. See Sections 4752 (effect of provision in advance directive attempting to limit right to petition), 4753 (limitations on right to petition), 4766 (petition with respect to advance directive). See also Section 4751 (other remedies not affected).
§ 4766. Purposes of petition

4766. A petition may be filed under this part for any one or more of the following purposes:
(a) Determining whether or not the patient has capacity to make health care decisions.
(b) Determining whether an advance health care directive is in effect or has terminated.
(c) Determining whether the acts or proposed acts of an agent or surrogate are consistent with the patient’s desires as expressed in an advance health care directive or otherwise made known to the court or, where the patient’s desires are unknown or unclear, whether the acts or proposed acts of the agent or surrogate are in the patient’s best interest.
(d) Declaring that the authority of an agent or surrogate is terminated, upon a determination by the court that the agent or surrogate has made a health care decision for the patient that authorized anything illegal or upon a determination by the court of both of the following:
   (1) The agent or surrogate has violated, has failed to perform, or is unfit to perform, the duty under an advance health care directive to act consistent with the patient’s desires or, where the patient’s desires are unknown or unclear, is acting (by action or inaction) in a manner that is clearly contrary to the patient’s best interest.
   (2) At the time of the determination by the court, the patient lacks the capacity to execute or to revoke an advance health care directive or disqualify a surrogate.

Comment. Section 4766 continues the substance of former Section 4942 to the extent it applied to powers of attorney for health care, and adds language relating to advance directives and surrogates for consistency with the scope of this division.
A determination of capacity under subdivision (a) is subject to the Due Process in Competency Determinations Act. See Sections 810-813.
Under subdivision (c), the patient’s desires as expressed in the power of attorney for health care, individual health care instructions, or otherwise made known to the court provide the standard for judging the acts of the agent or surrogate. See Section 4713 (standard governing surrogate’s health care decisions). Where it is not possible to use a standard based on the patient’s desires because they are not stated in an advance directive or otherwise known or are unclear, subdivision (c) provides that the “patient’s best interest” standard be used.
Subdivision (d) permits the court to terminate health care decisionmaking authority where an agent or surrogate is not complying with the duty to carry out the patient’s desires or act in the patient’s best interest. See Section 4713 (standard governing surrogate’s health care decisions). Subdivision (d) permits termination of authority under an advance health care directive not only where an agent, for example, is acting illegally or failing to perform the duties under a power of attorney or is acting contrary to the known desires of the principal, but also where the desires of the principal are unknown or unclear and the agent is acting in a manner that is clearly contrary to the patient’s best interest. The patient’s desires may become unclear as a result of developments...
in medical treatment techniques that have occurred since the patient’s desires were expressed, such developments having changed the nature or consequences of the treatment.

This section also applies to surrogate committees under Sections 4720-4726. Thus, under subdivision (d), the action (or nonaction) of a surrogate committee may be reviewed by the court. For the decisionmaking standards applicable to surrogate committees, see Section 4723. See also Section 4725 (general surrogate rules applicable to surrogate committee).

An advance health care directive may limit the authority to petition under this part. See Sections 4752 (effect of provision in advance directive attempting to limit right to petition), 4753 (limitations on right to petition).

See also Sections 4605 (“advance health care directive” defined), 4607 (“agent” defined), 4609 (“capacity” defined), 4613 (“conservator” defined), 4629 (“power of attorney for health care” defined), 4632 (“principal” defined), 4641 (“surrogate” defined).

§ 4767. Commencement of proceeding

4767. A proceeding under this part is commenced by filing a petition stating facts showing that the petition is authorized under this part, the grounds of the petition, and, if known to the petitioner, the terms of any advance health care directive in question.

Comment. Section 4767 continues former Section 4943 to the extent it applied to powers of attorney for health care.

See also Section 4605 (“advance health care directive” defined).

§ 4768. Dismissal of petition

4768. The court may dismiss a petition if it appears that the proceeding is not reasonably necessary for the protection of the interests of the patient and shall stay or dismiss the proceeding in whole or in part when required by Section 410.30 of the Code of Civil Procedure.

Comment. Section 4768 is similar to Section 4944 in the Power of Attorney Law. Under this section, the court has authority to stay or dismiss a proceeding in this state if, in the interest of substantial justice, the proceeding should be heard in a forum outside this state. See Code Civ. Proc. § 410.30.

See also Section 4625 (“patient” defined).

§ 4769. Notice of hearing

4769. (a) Subject to subdivision (b), at least 15 days before the time set for hearing, the petitioner shall serve notice of the time and place of the hearing, together with a copy of the petition, on the following:

(1) The agent or surrogate, if not the petitioner.

(2) The patient, if not the petitioner.

(b) In the case of a petition to compel a third person to honor the authority of an agent or surrogate, notice of the time and place of the hearing, together with a copy of the petition, shall be served on the third person in the manner provided in Chapter 4 (commencing with Section 413.10) of Title 5 of Part 2 of the Code of Civil Procedure.

Comment. Section 4769 continues former Section 4945 to the extent it applied to powers of attorney for health care and extends it principles to apply to surrogates. Subdivision (b) is generalized from former Section 4945(b) applicable to property powers of attorney.
§ 4770. Temporary health care order

4770. The court in its discretion, on a showing of good cause, may issue a temporary order prescribing the health care of the patient until the disposition of the petition filed under Section 4766. If a power of attorney for health care is in effect and a conservator (including a temporary conservator) of the person is appointed for the principal, the court that appoints the conservator in its discretion, on a showing of good cause, may issue a temporary order prescribing the health care of the principal, the order to continue in effect for the period ordered by the court but in no case longer than the period necessary to permit the filing and determination of a petition filed under Section 4766.

Comment. Section 4770 continues former Section 4946 to the extent it applied to powers of attorney for health care. This section is intended to make clear that the court has authority to provide, for example, for the continuance of treatment necessary to keep the patient alive pending the court’s action on the petition. See also Section 1046 (court authority to make appropriate orders).

See also Sections 4605 (“advance health care directive” defined), 4613 (“conservator” defined), 4615 (“health care” defined), 4625 (“patient” defined), 4632 (“principal” defined).

§ 4771. Award of attorney’s fees

4771. In a proceeding under this part commenced by the filing of a petition by a person other than the agent or surrogate, the court may in its discretion award reasonable attorney’s fees to one of the following:

(a) The agent or surrogate, if the court determines that the proceeding was commenced without any reasonable cause.

(b) The person commencing the proceeding, if the court determines that the agent or surrogate has clearly violated the duties under the advance health care directive.

Comment. Section 4771 continues part of former Section 4947 to the extent it applied to powers of attorney for health care.

See also Sections 4605 (“advance health care directive” defined), 4607 (“agent” defined), 4632 (“principal” defined), 4641 (“surrogate” defined).
PART 4. REQUEST TO FORGO RESUSCITATIVE MEASURES

§ 4780. Request to forgo resuscitative measures

4780. (a) As used in this part:
(1) “Request to forgo resuscitative measures” means a written document, signed by (A) an individual, or a legally recognized surrogate health care decisionmaker, and (B) a physician, that directs a health care provider to forgo resuscitative measures for the individual.
(2) “Request to forgo resuscitative measures” includes a prehospital “do not resuscitate” form as developed by the Emergency Medical Services Authority or other substantially similar form.
(b) A request to forgo resuscitative measures may also be evidenced by a medallion engraved with the words “do not resuscitate” or the letters “DNR,” a patient identification number, and a 24-hour toll-free telephone number, issued by a person pursuant to an agreement with the Emergency Medical Services Authority.

Comment. Section 4780 continues former Section 4753(b) without substantive change. The phrase “for the individual” has been added at the end of subdivision (a)(1) for clarity. The former reference to “physician and surgeon” has been changed to “physician” for clarity. See Section 4627 (“physician” defined). For rules governing “legally recognized surrogate health care decisionmakers,” see Part 2 (commencing with Section 4670) (Uniform Health Care Decisions Act).

See also Section 4781 (“health care provider” defined), 4625 (“patient” defined).

Staff Note

(1) Responding to an earlier staff note, Dr. Ronald B. Miller suggests treating DNR orders as advance directives, that is, including them within the coverage of Part 2, the Uniform Health Care Decisions Act. (Exhibit p. 6.) We have retained the DNR statute as a separate part because it is a relatively recent enactment and has been a separate type of document, directed to EMS personnel from the start. While it may not be ideal to have this special rule that overlaps advance directive law in some ways, but has its own unique and inconsistent provisions, the job of attempting to integrate it into the general statute does not seem worth it. The staff would probably not have recommended dealing with this statute in connection with this project except that from the start it has been inserted into the power of attorney for health care statute and so cannot be avoided. It may be appropriate for a separate future study to consider changes in this material.

(2) Bet Tzedek argues that the signature of a physician should not be required on the request under subdivision (a). (Exhibit p. 30.) This is consistent with their view that physicians should not have any part in making or approving health care decisions by patients. The staff agrees that this limitation seems outmoded, particularly in view of the less formal execution requirements for an advance directive under the HCDL. The only reason this rule is in the proposed law, of course, is that it is existing law and is a relatively recent enactment. Like the registry system, we have had this special and limited procedure before us because it was inserted into the durable power of attorney for health care provisions in the Power of Attorney Law, which are repealed in conjunction with the HCDL. Something must be done with the DNR procedure and thus far, we
have been taking the approach of keeping it close to the advance directive statutes generally, since
it is related subject matter.

The National Senior Citizens Law Center shares Bet Tzedek’s viewpoint on this issue. (Exhibit
pp. 49-50.)

§ 4781. Health care provider

4781. As used in this part, “health care provider” includes, but is not limited to, the following:
(a) Persons described in Section 4621.
(b) Emergency response employees, including, but not limited to, firefighters, law enforcement officers, emergency medical technicians I and II, paramedics, and employees and volunteer members of legally organized and recognized volunteer organizations, who are trained in accordance with standards adopted as regulations by the Emergency Medical Services Authority pursuant to Sections 1797.170, 1797.171, 1797.172, 1797.182, and 1797.183 of the Health and Safety Code to respond to medical emergencies in the course of performing their volunteer or employee duties with the organization.

Comment. Section 4781 continues former Section 4753(g) without substantive change.

§ 4782. Immunity for honoring request to forgo resuscitative measures

4782. A health care provider who honors a request to forgo resuscitative measures is not subject to criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction, as a result of his or her reliance on the request, if the health care provider (1) believes in good faith that the action or decision is consistent with this part, and (2) has no knowledge that the action or decision would be inconsistent with a health care decision that the individual signing the request would have made on his or her own behalf under like circumstances.

Comment. Section 4782 continues former Section 4753(a) without substantive change.

See also Sections 4617 (“health care decision” defined), 4780 (“request to forgo resuscitative measures” defined), 4781 (“health care provider” defined).

§ 4783. Forms for requests to forgo resuscitative measures

4783. (a) Forms for requests to forgo resuscitative measures printed after January 1, 1995, shall contain the following:

“By signing this form, the surrogate acknowledges that this request to forgo resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.”

(b) A substantially similar printed form is valid and enforceable if all of the following conditions are met:
(1) The form is signed by the individual, or the individual’s legally recognized surrogate health care decisionmaker, and a physician.
(2) The form directs health care providers to forgo resuscitative measures.
(3) The form contains all other information required by this section.

Comment. Section 4783 continues former Section 4753(c)-(d) without substantive change. For rules governing “legally recognized surrogate health care decisionmakers,” see Part 2 (commencing with Section 4670) (Uniform Health Care Decisions Act).

See also Sections 4627 (“physician” defined), 4780 (“request to forgo resuscitative measures” defined), 4781 (“health care provider” defined).

§ 4784. Presumption of validity

4784. In the absence of knowledge to the contrary, a health care provider may presume that a request to forgo resuscitative measures is valid and unrevoked.

Comment. Section 4784 continues former Section 4753(e) without change.

See also Sections 4780 (“request to forgo resuscitative measures” defined), 4781 (“health care provider” defined).

§ 4785. Application of part

4785. This part applies regardless of whether the individual executing a request to forgo resuscitative measures is within or outside a hospital or other health care institution.

Comment. Section 4785 continues former Section 4753(f) without substantive change.

See also Section 4619 (“health care institution” defined), 4780 (“request to forgo resuscitative measures” defined).

§ 4786. Relation to other law

4786. This part does not repeal or narrow laws relating to health care decisionmaking.

Comment. Section 4786 restates former Section 4753(h) without substantive change. The references to the Durable Power of Attorney for Health Care and the Natural Death Act have been omitted as unnecessary. The reference to “current” laws had been eliminated as obsolete.

PART 5. ADVANCE HEALTH CARE DIRECTIVE REGISTRY

§ 4800. Registry system established by Secretary of State

4800. (a) The Secretary of State shall establish a registry system through which a person who has executed a written advance health care directive may register in a central information center information regarding the advance directive, making that information available upon request to any health care provider, the public guardian, or other person authorized by the registrant.

(b) Information that may be received and released is limited to the registrant’s name, social security or driver’s license or other individual identifying number established by law, if any, address, date and place of birth, the intended place of deposit or safekeeping of the written advance health care directive, and the name and telephone number of the agent and any alternative agent.
(c) The Secretary of State, at the request of the registrant, may transmit the information received regarding the written advance health care directive to the registry system of another jurisdiction as identified by the registrant.

(d) The Secretary of State may charge a fee to each registrant in an amount such that, when all fees charged to registrants are aggregated, the aggregated fees do not exceed the actual cost of establishing and maintaining the registry.

Comment. Section 4800 continues former Section 4800 without substantive change as applied to powers of attorney for health care, and generalizes the former provision to apply to all written advance health care directives. Hence, in addition to powers of attorney for health care, this section as revised permits registration of individual health care instructions.

See Section 4605 (“advance health care directive” defined), 4607 (“agent” defined), 4621 (“health care provider” defined).

§ 4801. Identity and fees

4801. The Secretary of State shall establish procedures to verify the identities of health care providers, the public guardian, and other authorized persons requesting information pursuant to Section 4800. No fee shall be charged to any health care provider, the public guardian, or other authorized person requesting information pursuant to Section 4800.

Comment. Section 4801 continues former Section 4801 without change.

See also Section 4621 (“health care provider” defined).

§ 4802. Notice

4802. The Secretary of State shall establish procedures to advise each registrant of the following:

(a) A health care provider may not honor a written advance health care directive until it receives a copy from the registrant.
(b) Each registrant must notify the registry upon revocation of the advance directive.

c) Each registrant must reregister upon execution of a subsequent advance directive.

**Comment.** Section 4802 continues former Section 4802 without substantive change as applied to powers of attorney for health care, and generalizes it to apply to all written advance health care directives. Hence, in addition to powers of attorney for health care, this section as revised permits registration of individual health care instructions.

See also Section 4605 ("advance health care directive" defined), 4621 ("health care provider" defined).

**Staff Note.** Dr. Ronald B. Miller raises some issues concerning the interpretation of subdivision (a) and suggests some revisions. (Exhibit p. 7.) However, at this point, the staff does not think it is attempting to perfect this rarely-used procedure.

§ 4803. Effect of failure to register

4803. Failure to register with the Secretary of State does not affect the validity of any advance health care directive.

**Comment.** Section 4803 continues former Section 4804 without substantive change as applied to powers of attorney for health care, and generalizes it to apply to all written advance health care directives instead of the more limited class of durable powers of attorney for health care.

See also Section 4605 ("advance health care directive" defined).

§ 4804. Effect of registration on revocation and validity

4804. Registration with the Secretary of State does not affect the ability of the registrant to revoke the registrant’s advance health care directive or a later executed advance directive, nor does registration raise any presumption of validity or superiority among any competing advance directives or revocations.

**Comment.** Section 4804 continues former Section 4805 without substantive change as applied to powers of attorney for health care, and generalizes it to apply to all written advance health care directives. Hence, in addition to powers of attorney for health care, this section as revised permits registration of individual health care instructions.

See also Section 4605 ("advance health care directive" defined).

§ 4805. Effect on health care provider

4805. Nothing in this chapter shall be construed to require a health care provider to request from the registry information about whether a patient has executed an advance health care directive. Nothing in this chapter shall be construed to affect the duty of a health care provider to provide information to a patient regarding advance health care directives pursuant to any provision of federal law.

**Comment.** Section 4805 continues former Section 4806 without substantive change as applied to powers of attorney for health care, and generalizes it to apply to all written advance health care directives. Hence, in addition to powers of attorney for health care, this section as revised permits registration of individual health care instructions.

See also Section 4605 ("advance health care directive" defined), 4621 ("health care provider" defined), 4625 ("patient" defined).
CONFORMING REVISIONS AND REPEALS

Note. For convenience of reference, the text of some repealed sections is included in this document. To improve readability, repealed sections reproduced below are not shown in strikeout. The section heading indicates the disposition of each amended or repealed section.

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HEALTH AND SAFETY CODE

Health & Safety Code § 1418.8 (repealed). Consent for incapacitated patient in skilled
nursing facility or intermediate care facility

SEC. ____. Section 1418.8 of the Health and Safety Code is repealed.

1418.8. (a) If the attending physician and surgeon of a resident in a skilled
nursing facility or intermediate care facility prescribes or orders a medical
intervention that requires informed consent be obtained prior to administration of
the medical intervention, but is unable to obtain informed consent because the
physician and surgeon determines that the resident lacks capacity to make
decisions concerning his or her health care and that there is no person with legal
authority to make those decisions on behalf of the resident, the physician and
surgeon shall inform the skilled nursing facility or intermediate care facility.

(b) For purposes of subdivision (a), a resident lacks capacity to make a decision
regarding his or her health care if the resident is unable to understand the nature
and consequences of the proposed medical intervention, including its risks and
benefits, or is unable to express a preference regarding the intervention. To make
the determination regarding capacity, the physician shall interview the patient,
review the patient’s medical records, and consult with skilled nursing or
intermediate care facility staff, as appropriate, and family members and friends of
the resident, if any have been identified.

(c) For purposes of subdivision (a), a person with legal authority to make
medical treatment decisions on behalf of a patient is a person designated under a
valid Durable Power of Attorney for Health Care, a guardian, a conservator, or
next of kin. To determine the existence of a person with legal authority, the
physician shall interview the patient, review the medical records of the patient and
consult with skilled nursing or intermediate care facility staff, as appropriate, and
family members and friends of the resident, if any have been identified.

(d) The attending physician and the skilled nursing facility or intermediate care
facility may initiate a medical intervention that requires informed consent pursuant
to subdivision (e) in accordance with acceptable standards of practice.

(e) Where a resident of a skilled nursing facility or intermediate care facility has
been prescribed a medical intervention by a physician and surgeon that requires
informed consent and the physician has determined that the resident lacks capacity
to make health care decisions and there is no person with legal authority to make
those decisions on behalf of the resident, the facility shall, except as provided in
subdivision (h), conduct an interdisciplinary team review of the prescribed medical
intervention prior to the administration of the medical intervention. The
interdisciplinary team shall oversee the care of the resident utilizing a team
approach to assessment and care planning and shall include the resident’s
attending physician, a registered professional nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident’s needs, and, where practicable, a patient representative, in accordance with applicable federal and state requirements. The review shall include all of the following:

1. A review of the physician’s assessment of the resident’s condition.
2. The reason for the proposed use of the medical intervention.
3. A discussion of the desires of the patient, where known. To determine the desires of the resident, the interdisciplinary team shall interview the patient, review the patient’s medical records and consult with family members or friends, if any have been identified.
4. The type of medical intervention to be used in the resident’s care, including its probable frequency and duration.
5. The probable impact on the resident’s condition, with and without the use of the medical intervention.
6. Reasonable alternative medical interventions considered or utilized and reasons for their discontinuance or inappropriateness.
7. A patient representative may include a family member or friend of the resident who is unable to take full responsibility for the health care decisions of the resident, but has agreed to serve on the interdisciplinary team, or other person authorized by state or federal law.
8. The interdisciplinary team shall periodically evaluate the use of the prescribed medical intervention at least quarterly or upon a significant change in the resident’s medical condition.
9. In case of an emergency, after obtaining a physician and surgeon’s order as necessary, a skilled nursing or intermediate care facility may administer a medical intervention which requires informed consent prior to the facility convening an interdisciplinary team review. If the emergency results in the application of physical or chemical restraints, the interdisciplinary team shall meet within one week of the emergency for an evaluation of the medical intervention.
10. Physician and surgeons and skilled nursing facilities and intermediate care facilities shall not be required to obtain a court order pursuant to Section 3201 of the Probate Code prior to administering a medical intervention which requires informed consent if the requirements of this section are met.
11. Nothing in this section shall in any way affect the right of a resident of a skilled nursing facility or intermediate care facility for whom medical intervention has been prescribed, ordered, or administered pursuant to this section to seek appropriate judicial relief to review the decision to provide the medical intervention.
12. No physician or other health care provider, whose action under this section is in accordance with reasonable medical standards, is subject to administrative sanction if the physician or health care provider believes in good faith that the
action is consistent with this section and the desires of the resident, or if unknown, the best interests of the resident.

(1) The determinations required to be made pursuant to subdivisions (a), (e), and (g), and the basis for those determinations shall be documented in the patient’s medical record and shall be made available to the patient’s representative for review.

Comment. Former Section 1418.8 is superseded by the procedure for making health care decisions for patients without surrogates provided by Probate Code Sections 4720-4725. The new procedure is not limited to incapacitated persons in skilled nursing facilities or intermediate care facilities. Parts of the new procedure were drawn from this section. See Prob. Code §§ 4720-4725 Comments. The terminology varies, however. For example, the term “medical intervention” is superseded by “health care decision” as defined in Probate Code Section 4617.

The conditions for using the procedure in subdivision (a) are continued in substance by Probate Code Section 4720. Provisions relating to capacity and capacity determinations in subdivision (b) are superseded by Probate Code Sections 4609 (“capacity” defined), 4657 (presumption of capacity), and 4658 (determination of capacity and other medical conditions).

Subdivision (c) is superseded by Probate Code Section 4720 (application of surrogate committee chapter). See also Prob. Code § 4712 (selection of statutory surrogate).

Subdivision (d) is superseded by Probate Code Section 4721 (referral to surrogate committee by primary physician). See also Prob. Code § 4654 (compliance with generally accepted health care standards).

The first sentence of subdivision (e) is superseded by Probate Code Sections 4720 (conditions for application of chapter) and 4721 (referral to surrogate committee). The interdisciplinary team is superseded by a surrogate committee. As to emergency care, see Prob. Code § 4651(b)(2). The second sentence is superseded by Probate Code Sections 4722 (composition of surrogate committee) and 4724 (decisionmaking by surrogate committee). The standards of review in the third sentence are continued and generalized in Probate Code Section 4723(a).

The part of subdivision (f) relating to family and friends is continued and generalized in Probate Code Section 4722(b)(4). The reference to persons authorized by state or federal law is omitted as surplus, but such persons would be permissible under Probate Code Section 4722, which provides some flexibility in composition of the surrogate committee.

Subdivision (g) is continued and generalized in Probate Code Section 4723(b) (periodic review).

Subdivision (h) is continued and generalized in Probate Code Section 4726 (review of emergency care).

Subdivision (i) is superseded by Probate Code Section 4750(d) (judicial intervention disfavored), which continues the same policy.

Subdivision (j) is superseded by Probate Code Section 4765 (permissible petitioners).

The first part of subdivision (k) is superseded by Probate Code Section 4740 (immunities of health care provider and institution). The last part is superseded by Probate Code Sections 4713 (standard governing surrogate’s health care decisions), 4723(a)(3) (standards of review by surrogate committee), and 4725 (general surrogate rules applicable to surrogate committee).

Subdivision (l) is superseded by Probate Code Sections 4676 (right to health care information) and 4732 (duty of primary physician to record relevant information).

Health & Safety Code § 1599.73. Statement of patients’ right to confidential treatment

SEC. ____. Section 1599.73 of the Health and Safety Code is amended to read:

1599.73. (a) Every contract of admission shall state that residents have a right to confidential treatment of medical information.
(b) The contract shall provide a means by which the resident may authorize the disclosure of information to specific persons, by attachment of a separate sheet that conforms to the specifications of Section 56 of the Civil Code. After admission, the facility shall encourage competent residents having capacity to make health care decisions to execute a durable power of attorney for health care, an advance health care directive in the event that he or she becomes unable to give consent for disclosure. The facility shall make available upon request to the long-term care ombudsman a list of newly admitted patients.

Comment. Section 1599.73 is amended to reflect the replacement of the durable power of attorney for health care under the Power of Attorney Law with advance health care directives under the Health Care Decisions Law.

Health & Safety Code §§ 7185-7194.5 (repealed). Natural Death Act

SEC. ____. Chapter 3.9 (commencing with Section 7185) of Part 1 of Division 7 of the Health and Safety Code is repealed.

§ 7185 (repealed). Short title

Comment. Former Section 7185 is not continued. The Natural Death Act is superseded by the provisions of Division 4.7 (commencing with Section 4600) of the Probate Code relating to advance health care directives. The new law is not limited to decisions concerning life-sustaining treatment of persons in a terminal or permanent unconscious condition.

§ 7185.5 (repealed). Legislative findings and declarations

Comment. The substance of subdivisions (a)-(e) of former Section 7185 is continued in Probate Code Section 4650 (legislative findings), except that the references to “terminal condition or permanent unconscious decision” have been omitted to reflect relevant case law and the scope of the Uniform Health Care Decisions Act (Prob. Code § 4670 et seq.). See also Section 4750 (judicial intervention disfavored).

Subdivision (f) is omitted as surplus. See former Section 7185 Comment.

§ 7186 (repealed). Definitions

Comment. Subdivision (a) of former Section 7186 is continued in Probate Code Section 4631 (“primary physician” defined) without substantive change. Subdivision (b) is superseded by Probate Code Section 4605 (“advance health care directive” defined). Subdivision (c) is continued in Probate Code Section 4621 without substantive change. Subdivisions (d) and (e) are not continued. See former Section 7185 Comment.

Subdivision (f) is unnecessary in view of Probate Code Section 56 (“person” defined). Subdivision (g) is continued in Probate Code Section 4627 without change. Subdivision (h) is superseded by Probate Code Sections 4670 (who may give individual instruction). Subdivision (i) is unnecessary in view of Probate Code Section 74 (“state” defined). Subdivision (j) is not continued. See former Section 7185 Comment.

§ 7186.5 (repealed). Declaration governing life-sustaining treatment

Comment. The first sentence of former Section 7186.5(a) is superseded by Probate Code Section 4670 (who may give individual instruction). The second sentence concerning general witnessing requirements is not continued; an individual health care instruction is not generally required to be witnessed. The third sentence concerning special witnessing requirements in skilled nursing facilities is continued in Probate Code Section 4673 without substantive change.
The declaration form in subdivision (b) is superseded by the optional form of an advance health care directive in Probate Code Section 4701 and related substantive rules. For transitional provisions relating to declarations executed under the repealed Natural Death Act, see Prob. Code § 4665(a).

The substance of the record-keeping duty in subdivision (c) is continued in Probate Code Section 4731. The language concerning a health care provider who is unwilling to comply is superseded by Probate Code Sections 4734 (right to decline for reasons of conscience or institutional policy), 4735 (right to decline to provide ineffective care), and 4736 (obligation of declining health care provider or institution).

§ 7187 (repealed). Skilled nursing facility or long-term health care facility

Comment. Former Section 7187 is continued in Probate Code Section 4673(c) without substantive change. See also Prob. Code Section 4637 (“skilled nursing facility” defined).

§ 7187.5 (repealed). When declaration becomes operative

Comment. The first sentence of former Section 7187.5 is not continued. See former Section 7185 Comment. As to the determination of preconditions to operation of the declaration (advance health care directive), see Probate Code Sections 4651(b)(1) (authority of individual with capacity not affected), 4657 (presumption of capacity), 4658 (determination of capacity and other conditions).

The duty to comply with the declaration in the second sentence is superseded by Probate Code Section 4733(a). The duty to transfer is superseded by Probate Code Section 4736.

§ 7188 (repealed). Revocation

Comment. Subdivision (a) of former Section 7188 is superseded by Probate Code Sections 4659 (patient’s objections) and 4695 (revocation of advance directive).

The duty to record the revocation provided in subdivision (b) is continued in Probate Code Section 4731(a) without substantive change.

§ 7189 (repealed). Determination of terminal or permanent unconscious condition

Comment. Former Section 7189 is superseded by Probate Code Sections 4658 (authority to determine capacity and other conditions) and 4732 (duty to record relevant information).

§ 7189.5 (repealed). Patient’s right to make decisions concerning life-sustaining treatment

Comment. Subdivision (a) of former Section 7189.5 is replaced by Probate Code Section 4651(b)(1). See also Prob. Code §§ 4657 (presumption of capacity), 4659 (patient’s objections).

Subdivision (b) is replaced by the general rules in Probate Code Sections 4654 (compliance with generally accepted health care standards), 4733 (obligation to comply with reasonable interpretation of health care instructions and decisions). See also Prob. Code § 4736(b) (continuing care until transfer can be accomplished).

Subdivision (c) is not continued. But cf. Prob. Code § 4652(e) (Health Care Decisions Law does not authorize consent to abortion).

§ 7190 (repealed). Duties of health care provider unwilling to comply with chapter

Comment. Former Section 7190 is continued in Probate Code Section 4736 without substantive change.

§ 7190.5 (repealed). Liability and professional discipline

Comment. Former Section 7190.5 is superseded by Probate Code Section 4740.
§ 7191 (repealed). Specified conduct as misdemeanor; prosecution of specified conduct as unlawful homicide

Comment. Subdivisions (a) and (b) of former Section 7191 are superseded by Probate Code Section 4742, which provides statutory damages instead of criminal penalties.
Subdivisions (c) and (d) are replaced by Probate Code Section 4743.
Subdivisions (e) and (f) are superseded by the prohibition in Probate Code Section 4675.
The rule in subdivision (g) is continued in Probate Code Section 4742(c).

§ 7191.5 (repealed). Effect of death on life insurance or annuity; declaration as condition for insurance or receipt of health care services; effect of chapter on patient’s right to decide

Comment. Subdivision (a) of former Section 7191.5 is generalized in Probate Code Section 4656.
Subdivision (b) is replaced by Probate Code Section 4656.
Subdivision (c) is continued in Probate Code Section 4675 without substantive change.
Subdivision (d) is continued and generalized in Probate Code Section 4655(a).
Subdivision (e) is superseded by Probate Code Section 4651(b)(1) (authority not affected). See also Prob. Code § 4657 (presumption of capacity)
Subdivision (f) is continued in Probate Code Section 4654 without substantive change.
Subdivision (g) is continued in Probate Code Section 4653 without substantive change.
Subdivision (h) is superseded by Probate Code Sections 4651(b) (other authority not affected) and 4751 (cumulative remedies).

§ 7192 (repealed). Presumption of validity of declaration

Comment. Former Section 7192 is continued and generalized in Probate Code Section 4674(b).

§ 7192.5 (repealed). Validity of declarations executed in another state

Comment. Former Section 7192.5 is continued in Probate Code Section 4674(a) without substantive change.

§ 7193 (repealed). Effect of Durable Power of Attorney for Health Care

Comment. Former Section 7193 is superseded by Probate Code Section 4698 (effect of later advance directive on earlier advance directive).

§ 7193.5 (repealed). Instruments to be given effect

Comment. Former Section 7193.5 is superseded by Probate Code Sections 4665 (application to existing advance directives), 4674 (validity of written advance directive executed in another jurisdiction). See also Prob. Code § 4605 ("advance health care directive" defined).

§ 7194 (repealed). Severability clause

Comment. Former Section 7194 is superseded by Probate Code Section 11.

§ 7194.5 (repealed). Conformity with Uniform Rights of the Terminally Ill Act

Comment. Former Section 7194.5 is superseded by Probate Code Section 2(b) (construction of provisions drawn from uniform acts).
Health & Safety Code § 24179.5. Application of chapter to withholding or withdrawal of life-sustaining procedures

SEC. ____. Section 24179.5 of the Health and Safety Code is amended to read:

24179.5. Notwithstanding any other provision of this chapter, this chapter shall not apply to an adult person in a terminal condition who executes a directive directing the withholding or withdrawal of life-sustaining procedures pursuant to Section 7188. To the extent of any conflict, the provisions of Chapter 3.9 (commencing with Section 7185) of Part 1, of Division 7 shall prevail Division 4.7 (commencing with Section 4600) of the Probate Code prevails over the provisions of this chapter.

Comment. Section 24179.5 is amended to reflect the replacement of the Natural Death Act in former Section 7185 et seq. with the Health Care Decisions Law, Probate Code Section 4600 et seq.

PROBATE CODE

Prob. Code § 811 (amended). Deficits in mental functions

SEC. ____. Section 811 of the Probate Code is amended to read:

811. (a) A determination that a person is of unsound mind or lacks the capacity to make a decision or do a certain act, including, but not limited to, the incapacity to contract, to make a conveyance, to marry, to make medical decisions, to vote, or to execute wills or trusts, shall be supported by evidence of a deficit in at least one of the following mental functions, subject to subdivision (b):

1. Alertness and attention, including, but not limited to, the following:
   (A) Level of arousal or consciousness.
   (B) Orientation to time, place, person, and situation.
   (C) Ability to attend and concentrate.

2. Information processing, including, but not limited to, the following:
   (A) Short- and long-term memory, including immediate recall.
   (B) Ability to understand or communicate with others, either verbally or otherwise.
   (C) Recognition of familiar objects and familiar persons.
   (D) Ability to understand and appreciate quantities.
   (E) Ability to reason using abstract concepts.
   (F) Ability to plan, organize, and carry out actions in one’s own rational self-interest.
   (G) Ability to reason logically.

3. Thought processes. Deficits in these functions may be demonstrated by the presence of the following:
   (A) Severely disorganized thinking.
   (B) Hallucinations.
   (C) Delusions.
   (D) Uncontrollable, repetitive, or intrusive thoughts.
(4) Ability to modulate mood and affect. Deficits in this ability may be
demonstrated by the presence of a pervasive and persistent or recurrent state of
euphoria, anger, anxiety, fear, panic, depression, hopelessness or despair,
helplessness, apathy or indifference, which is inappropriate in degree to the
individual’s circumstances.

(b) A deficit in the mental functions listed above may be considered only if the
deficit, by itself or in combination with one or more other mental function deficits,
significantly impairs the person’s ability to understand and appreciate the
consequences of his or her actions with regard to the type of act or decision in
question.

(c) In determining whether a person suffers from a deficit in mental function so
substantial that the person lacks the capacity to do a certain act, the court may take
into consideration the frequency, severity, and duration of periods of impairment.

(d) The mere diagnosis of a mental or physical disorder shall not be sufficient in
and of itself to support a determination that a person is of unsound mind or lacks
the capacity to do a certain act.

(e) This part applies only to the evidence that is presented to, and the findings
that are made by, a court determining the capacity of a person to do a certain act or
make a decision, including, but not limited to, making medical decisions. Nothing
in this part shall affect the decisionmaking process set forth in Section
1418.8 of the Health and Safety Code, nor provided in Chapter 4 (commencing
with Section 4720) of Part 2 of Division 4.7. This part does not increase or
decrease the burdens of documentation on, or potential liability of, physicians and
surgeons who, outside the judicial context, determine the capacity of patients to
make a medical decision.

Comment. Section 811 is amended to reflect the replacement of Health and Safety Code
Section 1418.8 with Probate Code Sections 4720-4726 in the Uniform Health Care Decisions Act.


SEC. ___. Section 1302 of the Probate Code is amended to read:

1302. With respect to a power of attorney, the grant or refusal to grant the
following orders is appealable governed by the Power of Attorney Law, Division
4.5 (commencing with Section 4000), an appeal may be taken from any of the
following:

(a) Any final order under Section 4941, except an order pursuant to
subdivision (c) of Section 4941.

(b) Any final order under Section 4942, except an order pursuant to subdivision
(c) of Section 4942.

(c) An order dismissing the petition or denying a motion to dismiss under
Section 4944.

Comment. Section 1302 is amended to reflect the renumbering of former Sections 4900-4947
and to refer to powers of attorney governed by the Power of Attorney Law. Appeals relating to
powers of attorney governed by the Health Care Decisions Law are governed by Section 1302.5.
The introductory clause is also revised to correct erroneous language.
Prob. Code § 1302.5 (added). Grounds for appeal under Health Care Decisions Law

SEC. ____. Section 1302.5 is added to the Probate Code, to read:

1302.5. With respect to an advance health care directive governed by the Health Care Decisions Law, Division 4.7 (commencing with Section 4600), an appeal may be taken from any of the following:

(a) Any final order under Section 4541, except an order pursuant to subdivision (c) of Section 4541.

(b) An order dismissing the petition or denying a motion to dismiss under Section 4544.

Comment. Section 1302.5 is added to reflect enactment of the Health Care Decisions Law (Section 4600 et seq.) and the removal of health care powers of attorney from the Power of Attorney Law (Section 4000 et seq.).

Prob. Code § 2105 (amended). Joint guardians or conservators

SEC. ____. Section 2105 of the Probate Code is amended to read:

2105. (a) The court, in its discretion, may appoint for a ward or conservatee:

(1) Two or more joint guardians or conservators of the person.

(2) Two or more joint guardians or conservators of the estate.

(3) Two or more joint guardians or conservators of the person and estate.

(b) When joint guardians or conservators are appointed, each shall qualify in the same manner as a sole guardian or conservator.

(c) Subject to subdivisions (d) and (e):

(1) Where there are two guardians or conservators, both must concur to exercise a power.

(2) Where there are more than two guardians or conservators, a majority must concur to exercise a power.

(d) If one of the joint guardians or conservators dies or is removed or resigns, the powers and duties continue in the remaining joint guardians or conservators until further appointment is made by the court.

(e) Where joint guardians or conservators have been appointed and one or more are (1) absent from the state and unable to act, (2) otherwise unable to act, or (3) legally disqualified from serving, the court may, by order made with or without notice, authorize the remaining joint guardians or conservators to act as to all matters embraced within its order.

(f) If a custodial parent has been diagnosed as having a terminal condition, as evidenced by a declaration executed by a licensed physician, the court, in its discretion, may appoint the custodial parent and a person nominated by the custodial parent as joint guardians of the person of the minor. However, this appointment shall not be made over the objection of a noncustodial parent without a finding that the noncustodial parent’s custody would be detrimental to the minor, as provided in Section 3041 of the Family Code. It is the intent of the Legislature in enacting the amendments to this subdivision adopted during the 1995-96 Regular Session for a parent with a terminal condition to be able to make
arrangements for the joint care, custody, and control of his or her minor children so as to minimize the emotional stress of, and disruption for, the minor children whenever the parent is incapacitated or upon the parent’s death, and to avoid the need to provide a temporary guardian or place the minor children in foster care, pending appointment of a guardian, as might otherwise be required.

“Terminal condition,” for purposes of this subdivision, means an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, within reasonable medical judgment, result in death.

Nothing in this section shall be construed to broaden or narrow the definition of the term “terminal condition,” as defined in subdivision (j) of Section 7186 of the Health and Safety Code.

Comment. The last paragraph of Section 2105 is deleted because the definition to which it referred is repealed. See former Health & Safety Code § 7186 Comment.

Staff Note. Harley Spitler makes some suggestions concerning the definition of “terminal condition.” (Exhibit p. 17.) However, we are only amending this section to delete the cross-reference to the Natural Death Act which is to be repealed. We have not undertaken a substantive review of this or related sections.

Prob. Code § 2355 (amended). Health care where conservatee lacks capacity

SEC. ____. Section 2355 of the Probate Code is amended to read:

2355. (a) If the conservatee has been adjudicated to lack the capacity to give informed consent for medical treatment make health care decisions, the conservator has the exclusive authority to give consent for such medical treatment to be performed on make health care decisions for the conservatee as that the conservator in good faith based on medical advice determines to be necessary and the. The conservator shall make health care decisions for the conservatee in accordance with the conservatee’s individual health care instructions, if any, and other wishes to the extent known to the conservator. Otherwise, the conservator shall make the decision in accordance with the conservator’s determination of the conservatee’s best interest. In determining the conservatee’s best interest, the conservator shall consider the conservatee’s personal values to the extent known to the conservator. The conservator may require the conservatee to receive such medical treatment the health care, whether or not the conservatee objects. In any such this case, the consent health care decision of the conservator alone is sufficient and no person is liable because the medical treatment is performed upon health care is administered to the conservatee without the conservatee’s consent. For the purposes of this subdivision, “health care” and “health care decision” have the meanings provided in Sections 4615 and 4617, respectively.

(b) If prior to the establishment of the conservatorship the conservatee was an adherent of a religion whose tenets and practices call for reliance on prayer alone for healing, the treatment required by the conservator under the provisions of this section shall be by an accredited practitioner of that religion.
Comment. Subdivision (a) of Section 2105 is amended to add the second sentence providing a standard for making health care decisions. This standard is the same in substance as the standard applicable to other surrogate health care decisionmakers under the Health Care Decisions Law of Division 4.7 (commencing with Section 4600). See Sections 4684 (standard governing agent’s health care decisions under power of attorney for health care), 4713 (standard governing statutory surrogate’s health care decisions), 4725 (application of statutory surrogate rules to surrogate committee). Under this standard, the surrogate has both the right and fiduciary duty (“shall make health care decisions”) to make a decision based on the individual circumstances of the conservatee. As amended, subdivision (a) is consistent with Conservatorship of Drabick, 220 Cal. App. 3d 185, 245 Cal. Rptr. 840 (1988):

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

Id. at 205. Use of the terms “health care” and “health care decision” from the Health Care Decisions Law make clear that the scope of health care decisions that can be made by a conservator under this section is the same as provided in the Health Care Decisions Law.

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

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

Id. at 211-12. The intent of the rule in subdivision (a) is to protect and further the patient’s interest in making a health care decision in accordance with the patient’s expressed desires, where known, and if not, to make a decision in the patient’s best interest, taking personal values into account. The necessary determinations are to be made by the conservator, whether private or public, in accordance with the statutory standard. Court control or intervention in this process is neither required by statute, nor desired by the courts. See, e.g., Conservatorship of Morrison, 206 Cal. App. 3d 304, 312, 253 Cal. Rptr. 530 (1988). Drabick, 200 Cal. App. 3d at 198-200. See also Sections 4650(d) (legislative findings), 4750 (judicial intervention disfavored).

Staff Note. The California Medical Association is “extremely pleased” with the clarification of the scope of the authority concerning life-sustaining treatments. (Exhibit pp. 60-61.) CMA would also like to see amendments to clarify the applicable evidentiary standard, particularly in view of the Wendland case. (For a summary and overview of Wendland, see the CMA memo in Exhibit pp. 63-65.) The staff agrees with CMA that a clear and convincing standard should not be imposed.

Prob. Code § 2356 (amended). Limitations on application of chapter

SEC. ____. Section 2356 of the Probate Code is amended to read:

2356. (a) No ward or conservatee may be placed in a mental health treatment facility under this division against the will of the ward or conservatee. Involuntary civil placement of a ward or conservatee in a mental health treatment facility may be obtained only pursuant to Chapter 2 (commencing with Section 5150) or Chapter 3 (commencing with Section 5350) of Part 1 of Division 5 of the Welfare
and Institutions Code. Nothing in this subdivision precludes the placing of a ward
in a state hospital under Section 6000 of the Welfare and Institutions Code upon
application of the guardian as provided in that section. The Director of Mental
Health shall adopt and issue regulations defining “mental health treatment facility”
for the purposes of this subdivision.

(b) No experimental drug as defined in Section 111515 of the Health and Safety
Code may be prescribed for or administered to a ward or conservatee under this
division. Such an experimental drug may be prescribed for or administered to a
ward or conservatee only as provided in Article 4 (commencing with Section
111515) of Chapter 6 of Part 5 of Division 104 of the Health and Safety Code.

(c) No convulsive treatment as defined in Section 5325 of the Welfare and
Institutions Code may be performed on a ward or conservatee under this division.
Convulsive treatment may be performed on a ward or conservatee only as
provided in Article 7 (commencing with Section 5325) of Chapter 2 of Part 1 of
Division 5 of the Welfare and Institutions Code.

(d) No minor may be sterilized under this division.

(e) This chapter is subject to any of the following instruments if a valid and
effective: advance health care directive under the Health Care Decisions Law,
Division 4.7 (commencing with Section 4600).

(1) A directive of the conservatee under Chapter 3.9 (commencing with Section

(2) A power of attorney for health care, whether or not a durable power of
attorney.

Staff Note. Harley Spitler argues that subdivision (e) means an agent can consent to
convulsive treatment or sterilization. (Exhibit p. 67.) Draft Section 4652 provides the contrary
rule, although Mr. Spitler is on record as opposing that limitation under current law and under the
tentative recommendation. Subdivision (e) is not an exception from subdivisions (a)-(d); it is a
limitation on the authority of conservators generally: “This chapter is subject to ....” The
proposed amendment is technical.
Heading amended

SEC. ____. The heading for Part 7 (commencing with Section 3200) of Division 4 of the Probate Code is amended to read:

PART 7. AUTHORIZATION OF MEDICAL TREATMENT
CAPACITY DETERMINATIONS AND HEALTH CARE
DECISIONS FOR ADULT WITHOUT CONSERVATOR

Comment. The part heading is amended to reflect the expanded scope of this part. See 1995 Cal. Stat. ch. 842, § 9 (adding determination of capacity to consent to specified medical treatment as independent ground for petition under Section 3201).


The provisions of this part afford an alternative to establishing a conservatorship of the person where there is no ongoing need for a conservatorship. The procedural rules of this part provide an expeditious means of obtaining authorization for medical treatment while safeguarding basic rights of the patient: The patient has a right to counsel. Section 3205. The hearing is held after notice to the patient, the patient’s attorney, and such other persons as the court orders. Section 3206. The court may determine the issue on medical declarations alone if the attorney for the petitioner and the attorney for the patient so stipulate. Section 3207. The court may not order medical treatment under this part if the patient has capacity to give informed consent to the treatment but refuses to do so. Section 3208.5.

Prob. Code § 3200 (amended). Definitions

SEC. ____. Section 3200 of the Probate Code is amended to read:

3200. As used in this part, “patient” part:
(a) “Health care” means any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a patient’s physical or mental condition.
(b) “Health care decision” means a decision regarding the patient’s health care, including the following:
(1) Selection and discharge of health care providers and institutions.
(2) Approval or disapproval of diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate.
(3) Directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care.
(c) “Health care institution” means an institution, facility, or agency licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business.

(d) “Patient” means an adult who does not have a conservator of the person and who is in need of medical treatment for whom health care decision needs to be made.

Comment. Section 3200 is amended to adopt definitions that are consistent with the Health Care Decisions Law. See Section 4500 et seq. The definition of “health care decision” in subdivision (b) makes clear, as used in other provisions in this part, that court-authorized health care decisions include end-of-life decisions. See Section 3208(c). This is consistent with the scope of the Health Care Decisions Law.

Staff Note

Harley Spitler strongly favors using the definitions from the Health Care Decisions Law. (Exhibit p. 12.) He also favors merging the Section 3200 procedure into the proposed HCDL. (Exhibit p. 18.) This is in response to an inquiry included in the tentative recommendation:

Note. The following material includes a draft of one alternative approach to expand the scope of the Section 3200 procedure to cover all health care decisions, including end-of-life decisions. This drafting approach leaves the procedure in its current location. An alternative would be to merge the procedure into the judicial proceedings portion of the proposed Health Care Decisions Law. See proposed Prob. Code §§ 4750-4771 supra.

The Commission solicits comments on the preferable drafting approach. Amending the Section 3200 series would maintain greater continuity with existing law, whereas merging the procedure into the Health Care Decisions Law would result in a more efficient statute and eliminate overlapping and inconsistent procedural rules.

Mr. Spitler’s is the only comment we received on this point. The staff has not completed a draft that would merge the Section 3200 procedure into the proposed HCDL. The staff can see advantages to both approaches, as explained in earlier material and summarized in the above note. On balance, although it is a close call, we favor leaving the procedure at Section 3200.

(2) Mr. Spitler also objects to the short-hand “end-of-life decisions” which is used in the Comment to include decisions to withhold or withdraw life sustaining treatment. (Exhibit p. 18.)

(3) The California Medical Association recommends removing “orders not to resuscitate” from subdivision (b)(2) and adding “including cardiopulmonary resuscitation” at the end of subdivision (b)(3), as recommended for Section 4617. (Exhibit p. 62.) The staff agrees.


SEC. ____. Section 3201 of the Probate Code is amended to read:

3201. (a) A petition may be filed to determine that a patient has the capacity to give informed consent to a specified medical treatment for make a health care decision concerning an existing or continuing medical condition.

(b) A petition may be filed to determine that a patient lacks the capacity to give informed consent to a make a health care decision concerning specified medical treatment for an existing or continuing medical condition, and further for an order authorizing a designated person to give consent to such treatment make a health care decision on behalf of the patient.
(c) One proceeding may be brought under this part under both subdivisions (a) and (b).

(d) In determining whether a person’s mental functioning is so severely impaired that the person lacks the capacity to give informed consent to any form of medical treatment, the court may take into consideration the frequency, severity and duration of periods of impairment.

(e) Nothing in this part shall supersede the right that any person may have under existing law to make medical decisions on behalf of a patient, or affect the decisionmaking process of a long-term health care facility, as defined in subdivision (b) of Section 1418.8 of the Health and Safety Code.

(f) This chapter is permissive and cumulative for the relief to which it applies.

(g) Nothing in this part shall be construed to supersede or impair the right of any individual to choose treatment by spiritual means in lieu of medical treatment, nor shall any person choosing treatment by spiritual means, in accordance with the tenets and practices of that individual’s established religious tradition, be required to submit to medical testing of any kind pursuant to a determination of competency.

Comment. Subdivisions (a) and (b) of Section 3201 are amended to use the terminology of Section 3200 and make the language internally consistent. See Section 3200 Comment. Other technical, nonsubstantive changes are also made.

Subdivision (d) is continued in Section 3208(b) without substantive change. See Section 3208 Comment.

Subdivision (e) is continued in Section 3210(c) without substantive change. Subdivision (f) is continued in Section 3210(a) without substantive change. See Section 3210 Comment.

Subdivision (g) is continued in Section 3212 without substantive change. See Section 3212 Comment.

Prob. Code § 3202 (unchanged). Jurisdiction and venue

3202. The petition may be filed in the superior court of any of the following counties:

(a) The county in which the patient resides.

(b) The county in which the patient is temporarily living.

(c) Such other county as may be in the best interests of the patient.


SEC. ____. Section 3203 of the Probate Code is amended to read:

3203. A petition may be filed by any of the following:

(a) The patient.

(b) The patient’s spouse of the patient.

(c) A relative or friend of the patient or other interested person, including the patient’s agent under a power of attorney for health care.

(d) The patient’s physician.

(e) A person acting on behalf of the medical facility health care institution in which the patient is located if the patient is in a medical facility health care institution.
(f) The public guardian or such other county officer as is designated by the board of supervisors of the county in which the patient is located or resides or is temporarily living.

Comment. Section 3203 is amended to use the terminology of Section 3200. See Section 3200 Comment. Other technical, nonsubstantive changes are also made. Subdivision (c) is amended to make clear that an agent under a power of attorney for health care is an interested person. See Section 4607 (“agent” defined under Health Care Decisions Law).

Staff Note. Harley Spitler suggests the addition of the language added in subdivision (c). (Exhibit p. 12.) The staff agrees with this clarification.

**Prob. Code § 3204 (amended). Contents of petition**

SEC. ____. Section 3204 of the Probate Code is amended to read:

3204. The petition shall state, or set forth by a medical declaration attached thereto to the petition, all of the following so far as is known to the petitioner at the time the petition is filed:

(a) The **nature condition** of the **medical condition** of the patient which **patient’s health** that requires treatment.

(b) The **recommended course of medical treatment** which **health care** that is considered to be medically appropriate.

(c) The threat to the **health of the patient** patient’s condition if authorization for the recommended course of treatment health care is delayed or denied by the court.

(d) The predictable or probable outcome of the recommended course of treatment health care.

(e) The medically available alternatives, if any, to the course of treatment recommended health care.

(f) The efforts made to obtain an informed consent from the patient.

(g) If the petition is filed by a person on behalf of a medical facility health care institution, the name of the person to be designated to give consent to the recommended course of treatment health care on behalf of the patient.

(h) The deficit or deficits in the patient’s mental functions listed in subdivision (a) of Section 811 which are impaired, and identifying an identification of a link between the deficit or deficits and the patient’s inability to respond knowingly and intelligently to queries about the recommended medical treatment health care or inability to participate in a treatment decision about the recommended medical treatment health care by means of a rational thought process.

(i) The names and addresses, so far as they are known to the petitioner, of the persons specified in subdivision (b) of Section 1821.

Comment. Section 3204 is amended to use the terminology of Section 3200. See Section 3200 Comment. Other technical, nonsubstantive changes are also made. The reference to “informed” consent is omitted as unnecessary. See Section 3208.5 Comment.

Staff Note. Harley Spitler would state specifically that the “medical” declaration in subdivision (a) should be made by the patient’s physician, and would replace the reference throughout this statute with that language. (Exhibit pp. 12, 18.) This may be unobjectionable, but the staff wonders why “medical declaration” was chosen when the Commission devised this
procedure 20 years ago. We assume it means the same thing; that only a “medical” doctor could make a “medical” declaration. We are inclined to keep the existing language, but do not feel strongly about it.

Mr. Spitler would omit “knowingly and intelligently” and “by means of a rational thought process” in subdivision (h). The staff is not inclined to change this language which is the result of recent legislation connected with the Due Process in Capacity Determinations Act.

Prob. Code § 3205 (unchanged). Appointment of legal counsel

3205. Upon the filing of the petition, the court shall determine the name of the attorney the patient has retained to represent the patient in the proceeding under this part or the name of the attorney the patient plans to retain for that purpose. If the patient has not retained an attorney and does not plan to retain one, the court shall appoint the public defender or private counsel under Section 1471 to consult with and represent the patient at the hearing on the petition and, if such appointment is made, Section 1472 applies.

Prob. Code § 3206 (amended). Notice of hearing

SEC. ____. Section 3206 of the Probate Code is amended to read:

3206. (a) Not less than 15 days before the hearing, notice of the time and place of the hearing and a copy of the petition shall be personally served on the patient and the patient’s attorney, and the agent under the patient’s power of attorney for health care, if any.

(b) Not less than 15 days before the hearing, notice of the time and place of the hearing and a copy of the petition shall be mailed to the following persons:

(1) The patient’s spouse, if any, of the proposed conservatee at the address stated in the petition.

(2) The patient’s relatives named in the petition at their addresses stated in the petition.

(c) For good cause, the court may shorten or waive notice of the hearing as provided by this section. In determining the period of notice to be required, the court shall take into account both of the following:

(1) The existing medical facts and circumstances set forth in the petition or in a medical affidavit declaration attached to the petition or in a medical affidavit declaration presented to the court.

(2) The desirability, where the condition of the patient permits, of giving adequate notice to all interested persons.

Comment. Subdivision (b) of Section 3206 is amended to correct the reference to a “proposed conservatee.” See Section 3200(d) (“patient” defined).

Subdivision (c) is amended to replace the references to “affidavit,” in conformity with Section 3204.

Staff Note. Harley Spitler suggests requiring service on the patient’s agent. (Exhibit pp. 13, 18.) This seems like an appropriate addition and has been implemented.
Prob. Code § 3207 (amended). Submission for determination on medical affidavits

SEC. ____. Section 3207 of the Probate Code is amended to read:

3207. Notwithstanding Section 3206, the matter presented by the petition may be submitted for the determination of the court upon proper and sufficient medical affidavits or declarations if the attorney for the petitioner and the attorney for the patient so stipulate and further stipulate that there remains no issue of fact to be determined.

Comment. Section 3207 is amended to eliminate the reference to “affidavits,” in conformity with Section 3204.

Prob. Code § 3208 (amended). Order authorizing treatment

SEC. ____. Section 3208 of the Probate Code is amended to read:

3208. (a) The court may make an order authorizing the recommended course of medical treatment of health care for the patient and designating a person to give consent to the recommended course of medical treatment health care on behalf of the patient if the court determines from the evidence all of the following:

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

   (b) In determining whether the patient’s mental functioning is so severely impaired that the patient lacks the capacity to make any health care decision, the court may take into consideration the frequency, severity, and duration of periods of impairment.

   (c) The court may make an order authorizing withdrawal or withholding of artificial nutrition and hydration and all other forms of health care and designating a person to give or withhold consent to the recommended health care on behalf of the patient if the court determines from the evidence all of the following:

      (1) The recommended health care is in accordance with the patient’s best interest, taking into consideration the patient’s personal values to the extent known to the petitioner.
      (2) The patient is unable to consent to the recommended health care.

   (d) Instead of designating a person to make health care decisions on behalf of the patient under this section, the court may refer the matter to a surrogate committee under Chapter 4 (commencing with Section 4720) of Part 2 of Division 4.7. If there is no appropriate surrogate committee in existence, the court may order creation of a surrogate committee to act under Chapter 4 (commencing with Section 4720) of Part 2 of Division 4.7.
(b) If the patient has the capacity to give informed consent to the recommended
course of medical treatment, the court shall so find in its order.

(c) If the court finds that the patient has the capacity to give informed consent to
the recommended course of medical treatment, but that the patient refuses consent,
the court shall not make an order authorizing the course of recommended medical
treatment or designating a person to give consent to such treatment. If an order has
been made authorizing the recommended course of medical treatment and
designating a person to give consent to that treatment, the order shall be revoked if
the court determines that the patient has recovered the capacity to give informed
consent to the recommended course of medical treatment. Until revoked or
modified, the order is effective authorization for the course of medical treatment.

(d) In a proceeding under this part, where the court has determined that the
patient has the capacity to give informed consent, the court shall, if requested,
determine whether the patient has accepted or refused the recommended course of
treatment, and whether a patient’s consent to the recommended course of treatment
is an informed consent.

Comment. Subdivision (a) of Section 3208 is amended to use the terminology of Section 3200.
See Section 3200 Comment. Other technical, nonsubstantive changes are also made. The
reference to “informed” consent has been omitted as surplus. See Section 3805 Comment.
New subdivision (b) continues former subdivision (d) of Section 3201 without substantive
change.

A new subdivision (c) is added to permit withholding or withdrawal of health care, including
artificial nutrition and hydration. This amendment extends the authority of the court to authorize
health care decisions to the same extent as surrogates and subject to the same standards as
provided in the Health Care Decisions Law. See, e.g., Sections 4684 (standard governing agent’s
health care decisions under power of attorney for health care), 4713 (standard governing
surrogate’s health care decisions).

New subdivision (d) provides a mechanism for the court to use the surrogate committee
procedure in the Health Care Decisions Law. See Sections 4720-4726. In such a case, the
surrogate committee would be governed by the Health Care Decisions Law, except as limited by
the court’s order. Nothing in this section is intended to encourage court control or involvement in
the surrogate committee process, but in appropriate cases, such as where continuing health care
decisions will need to be made, the surrogate committee may offer the best approach.

Former subdivisions (b)-(d) are continued in Section 3208.5 without substantive change. See
Section 3208.5 Comment.

Staff Note. Harley Spitler suggests adding “to the petitioner” at the end of subdivision (c)(1).
(Exhibit p. 13.) This has been implemented.

Prob. Code § 3208.5 (added). Effect of order determining that patient has capacity

SEC. ____. Section 3208.5 is added to the Probate Code, to read:

3208.5. In a proceeding under this part:
(a) Where the patient has the capacity to consent to the recommended health
care, the court shall so find in its order.
(b) Where the court has determined that the patient has the capacity to consent to
the recommended health care, the court shall, if requested, determine whether the
patient has accepted or refused the recommended health care, and whether the
patient’s consent to the recommended health care is an informed consent.

(c) Where the court finds that the patient has the capacity to consent to the
recommended health care, but that the patient refuses consent, the court shall not
make an order authorizing the recommended health care or designating a person to
give consent to the recommended health care. If an order has been made
authorizing the recommended health care and designating a person to give consent
to the recommended health care, the order shall be revoked if the court determines
that the patient has recovered the capacity to consent to the recommended health
care. Until revoked or modified, the order is effective authorization for the
recommended health care.

Comment. Section 3208.5 continues former subdivisions (b)-(d) of Section 3208 without
substantive change. The subdivisions have been placed in a different order. Terminology has been
conformed to the definitions in Section 3200. Thus, for example, “health care” replaces “medical
treatment” appearing in the former provision. Except in subdivision (b), references to “informed”
consent have been omitted as surplus and for consistency with other provisions in this part and in
the Health Care Decisions Law (Section 4600 et seq.). To be effective, the patient’s consent must
satisfy the law of informed consent.


3209. The court in which the petition is filed has continuing jurisdiction to
revoke or modify an order made under this part upon a petition filed, noticed, and
heard in the same manner as an original petition filed under this part.


SEC. ____. Section 3210 of the Probate Code is amended to read:

3210. (a) This part is supplemental and alternative to other procedures or
methods for obtaining medical consent to health care or making health care
decisions, and is permissive and cumulative for the relief to which it applies.

(b) Nothing in this part limits the providing of medical treatment health care in
an emergency case in which the medical treatment health care is required because
(1) such treatment the health care is required for the alleviation of severe pain or
(2) the patient has a medical condition which that, if not immediately diagnosed
and treated, will lead to serious disability or death.

(c) Nothing in this part supersedes the right that any person may have under
existing law to make health care decisions on behalf of a patient, or affects the
decisionmaking process of a health care institution.

Comment. Subdivisions (a) and (b) of Section 3210 are amended to use the terminology of
Section 3200. See Section 3200 Comment. Other technical, nonsubstantive changes are also
made. The second clause added to subdivision (a) continues former subdivision (f) of Section
3201 without substantive change. The erroneous reference to “this chapter” in the former
provision is corrected.

Subdivision (c) continues former subdivision (e) of Section 3201, with revisions reflecting the
replacement of Health and Safety Code Section 1418.8 with Probate Code Sections 4720-4726
(surrogate committee). Subdivision (c) thus applies to all health care institutions, as defined in
Section 3200(c), not just long-term health care facilities, as defined in former Health and Safety Code Section 1418.8(b). Other technical, nonsubstantive changes are also made.

**Prob. Code § 3211 (amended). Limitations on part**

SEC. ____. Section 3211 of the Probate Code is amended to read:

3211. (a) No person may be placed in a mental health treatment facility under the provisions of this part.

(b) No experimental drug as defined in Section 111515 of the Health and Safety Code may be prescribed for or administered to any person under this part.

(c) No convulsive treatment as defined in Section 5325 of the Welfare and Institutions Code may be performed on any person under this part.

(d) No person may be sterilized under this part.

(e) The provisions of this part are subject to any of the following instruments if a valid and effective: advance health care directive under the Health Care Decisions Law, Division 4.7 (commencing with Section 4600).

(1) A 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).

(2) A power of attorney for health care, whether or not a durable power of attorney.

**Comment.** Subdivision (e) of Section 3211 is amended to use the inclusive term “advance health care directive” used in the Health Care Decisions Law. This continues the substance of former law, since declarations under the former Natural Death Act and powers of attorney for health care are types of advance directives. See Section 4605 & Comment. Also covered by this language are “individual health care instructions.” See Section 4623 & Comment.

**Prob. Code § 3212 (added). Choice of treatment by spiritual means**

SEC. ____. Section 3212 is added to the Probate Code, to read:

3212. Nothing in this part shall be construed to supersede or impair the right of any individual to choose treatment by spiritual means in lieu of medical treatment, nor shall any individual choosing treatment by spiritual means, in accordance with the tenets and practices of that individual’s established religious tradition, be required to submit to medical testing of any kind pursuant to a determination of capacity.

**Comment.** Section 3212 continues former subdivision (g) of Section 3201 without substantive change. The former reference to “competency” has been changed to “capacity” to conform to the terminology of this part and related statutes. See, e.g., Section 3201 (capacity determination).

**Prob. Code § 3722 (technical amendment). Effect of dissolution, annulment, or legal separation on power of attorney involving federal absentees**

SEC. ____. Section 3722 of the Probate Code is amended to read:

3722. If after the absentee executes a power of attorney, the principal’s spouse who is the attorney-in-fact commences a proceeding for dissolution, annulment, or legal separation, or a legal separation is ordered, the attorney-in-fact’s authority is revoked. This section is in addition to the provisions of Section 4154 and 4697.
Comment. Section 3722 is amended to refer to a corresponding section concerning advance health care directives.

See also Sections 1403 ("absentee" defined), 4014 ("attorney-in-fact" defined), 4022 ("power of attorney" defined).

Prob. Code § 4050 (amended). Types of powers of attorney governed by this division

SEC. ____. Section 4050 of the Probate Code is amended to read:
4050. (a) This division applies to the following:
(1) Durable powers of attorney, other than powers of attorney for health care governed by Division 4.7 (commencing with Section 4600).
(2) Statutory form powers of attorney under Part 3 (commencing with Section 4400).
(3) Durable powers of attorney for health care under Part 4 (commencing with Section 4600).
(4) Any other power of attorney that incorporates or refers to this division or the provisions of this division.
(b) This division does not apply to the following:
(1) A power of attorney to the extent that the authority of the attorney-in-fact is coupled with an interest in the subject of the power of attorney.
(2) Reciprocal or interinsurance exchanges and their contracts, subscribers, attorneys-in-fact, agents, and representatives.
(3) A proxy given by an attorney-in-fact to another person to exercise voting rights.
(c) This division is not intended to affect the validity of any instrument or arrangement that is not described in subdivision (a).

Comment. Section 4050 is amended to reflect the revision of the law relating to powers of attorney for health care. See Section 4600 et seq. (Health Care Decisions Law). Division 4.5 no longer governs powers of attorney for health care.

Comment (1994 Revised). Section 4050 describes the types of instruments that are subject to the Power of Attorney Law. If a section in this division refers to a "power of attorney," it generally refers to a durable power of attorney, but may, under certain circumstances, also apply to a nondurable power of attorney. For example, a statutory form power of attorney may be durable or nondurable. See Sections 4401, 4404. A nondurable power may incorporate provisions of this division, thereby becoming subject to its provisions as provided in Section 4050(a)(4).

Subdivision (b) makes clear that certain specialized types of power of attorney are not subject to the Power of Attorney Law. This list is not intended to be exclusive. See subdivision (c). Subdivision (b)(1) recognizes the special rule applicable to a power coupled with an interest in the subject of a power of attorney provided in Civil Code Section 2356(a). Subdivision (b)(2) continues the substance of the limitation in former Civil Code Section 2420(b) and broadens it to apply to the entire Power of Attorney Law. See Ins. Code § 1280 et seq. For the rules applicable to proxy voting in business corporations, see Corp. Code § 705. For other statutes dealing with proxies, see Corp. Code §§ 178, 702, 5069, 5613, 7613, 9417, 12405, 13242; Fin. Code §§ 5701, 5702, 5710, 6005. See also Civ. Code § 2356(e) (proxy under general agency rules).

Subdivision (c) makes clear that this division does not affect the validity of other agencies and powers of attorney. The Power of Attorney Law thus does not apply to other specialized agencies, such as real estate agents under Civil Code Sections 2373-2382. As a corollary, an instrument denominated a power of attorney that does not satisfy the execution requirements for a power of attorney under this division may be valid under general agency law or other principles.
See also Sections 4014 (“attorney-in-fact” defined), 4018 (“durable power of attorney” defined), 4022 (“power of attorney” defined).

**Prob. Code § 4100 (amended). Application of part**

SEC. ____. Section 4100 of the Probate Code is amended to read:

4100. This part applies to all powers of attorney under this division, subject to any special rules applicable to statutory form powers of attorney under Part 3 (commencing with Section 4400) or durable powers of attorney for health care under Part 4 (commencing with Section 4600).

**Comment.** Section 4100 is amended to delete a reference to powers of attorney for health care, which are governed by Division 4.7 (commencing with Section 4600) (Health Care Decisions Law). See also Section 4050 (types of powers of attorney governed by this division).

**Prob. Code § 4121 (amended). Formalities for executing a power of attorney**

SEC. ____. Section 4121 of the Probate Code is amended to read:

4121. A power of attorney is legally sufficient if all of the following requirements are satisfied:

(a) The power of attorney contains the date of its execution.

(b) The power of attorney is signed either (1) by the principal or (2) in the principal’s name by another adult in the principal’s presence and at the principal’s direction.

(c) The power of attorney is either (1) acknowledged before a notary public or (2) signed by at least two witnesses who satisfy the requirements of Section 4122.

**Comment.** Subdivision (b) of Section 4121 is amended to make clear that the person signing at the principal’s direction must be an adult. This is consistent with the language of Section 4680 (formalities for executing power of attorney for health care).

**Prob. Code § 4122 (amended). Requirements for witnesses**

SEC. ____. Section 4122 of the Probate Code is amended to read:

4122. If the power of attorney is signed by witnesses, as provided in Section 4121, the following requirements shall be satisfied:

(a) The witnesses shall be adults.

(b) The attorney-in-fact may not act as a witness.

(c) Each witness signing the power of attorney shall witness either the signing of the instrument by the principal or the principal’s acknowledgment of the signature or the power of attorney.

(d) In the case of a durable power of attorney for health care, the additional requirements of Section 4701.

**Comment.** Section 4122 is amended to delete a reference to powers of attorney for health care, which are governed by Division 4.7 (commencing with Section 4600) (Health Care Decisions Law).

This section is not subject to limitation in the power of attorney. See Section 4101. See also Sections 4014 (“attorney-in-fact” defined), 4022 (“power of attorney” defined), 4026 (“principal” defined).
Prob. Code § 4123 (amended). Permissible purposes

SEC. ____. Section 4123 of the Probate Code is amended to read:

4123. (a) In a power of attorney, a principal may grant authority to an attorney-in-fact to act on the principal’s behalf with respect to all lawful subjects and purposes or with respect to one or more express subjects or purposes. The attorney-in-fact may be granted authority with regard to the principal’s property, personal care, health care, or any other matter.

(b) With regard to property matters, a power of attorney may grant authority to make decisions concerning all or part of the principal’s real and personal property, whether owned by the principal at the time of the execution of the power of attorney or thereafter acquired or whether located in this state or elsewhere, without the need for a description of each item or parcel of property.

(c) With regard to personal care, a power of attorney may grant authority to make decisions relating to the personal care of the principal, including, but not limited to, determining where the principal will live, providing meals, hiring household employees, providing transportation, handling mail, and arranging recreation and entertainment.

(d) With regard to health care, a power of attorney may grant authority to make health care decisions, both before and after the death of the principal, as provided in Part 4 (commencing with Section 4600).

Comment. Section 4123 is amended to delete subdivision (d), which referred to powers of attorney for health care that are now governed by Division 4.7 (commencing with Section 4600) (Health Care Decisions Law). See Section 4050 (types of powers of attorney governed by this division).

Comment (1994 Revised). Subdivision (a) of Section 4123 is new and is consistent with the general agency rules in Civil Code Sections 2304 and 2305. For provisions concerning the duties and powers of an attorney-in-fact, see Sections 4230-4266. See also Sections 4014 (“attorney-in-fact” defined), 4022 (“power of attorney” defined), 4026 (“principal” defined).

Subdivision (b) continues former Civil Code Section 2513 without substantive change. This subdivision makes clear that a power of attorney may by its terms apply to all real property of the principal, including, after-acquired property, without the need for a specific description of the real property to which the power applies. This section is consistent with Section 4464 (after-acquired property under statutory form power of attorney).

Subdivision (c) is new and acknowledges the existing practice of providing authority to make personal care decisions in durable powers of attorney. For a comparable provision in the Health Care Decisions Law, see Section 4671.

Prob. Code § 4128 (amended). Warning statement in durable power of attorney

SEC. ____. Section 4128 of the Probate Code is amended to read:

4128. (a) Subject to subdivision (b), a printed form of a durable power of attorney that is sold or otherwise distributed in this state for use by a person who does not have the advice of legal counsel shall contain, in not less than 10-point boldface type or a reasonable equivalent thereof, the following warning statement:
NOTICE TO PERSON EXECUTING DURABLE POWER OF ATTORNEY

A durable power of attorney is an important legal document. By signing the durable power of attorney, you are authorizing another person to act for you, the principal. Before you sign this durable power of attorney, you should know these important facts:

Your agent (attorney-in-fact) has no duty to act unless you and your agent agree otherwise in writing.

This document gives your agent the powers to manage, dispose of, sell, and convey your real and personal property, and to use your property as security if your agent borrows money on your behalf.

Your agent will have the right to receive reasonable payment for services provided under this durable power of attorney unless you provide otherwise in this power of attorney.

The powers you give your agent will continue to exist for your entire lifetime, unless you state that the durable power of attorney will last for a shorter period of time or unless you otherwise terminate the durable power of attorney. The powers you give your agent in this durable power of attorney will continue to exist even if you can no longer make your own decisions respecting the management of your property.

You can amend or change this durable power of attorney only by executing a new durable power of attorney or by executing an amendment through the same formalities as an original. You have the right to revoke or terminate this durable power of attorney at any time, so long as you are competent.

This durable power of attorney must be dated and must be acknowledged before a notary public or signed by two witnesses. If it is signed by two witnesses, they must witness either (1) the signing of the power of attorney or (2) the principal’s signing or acknowledgment of his or her signature. A durable power of attorney that may affect real property should be acknowledged before a notary public so that it may easily be recorded.

You should read this durable power of attorney carefully. When effective, this durable power of attorney will give your agent the right to deal with property that you now have or might acquire in the future. The durable power of attorney is important to you. If you do not understand the durable power of attorney, or any provision of it, then you should obtain the assistance of an attorney or other qualified person.

(b) Nothing in subdivision (a) invalidates any transaction in which a third person relied in good faith on the authority created by the durable power of attorney.

(c) This section does not apply to the following:

(1) A statutory form power of attorney under Part 3 (commencing with Section 4400).

(2) A durable power of attorney for health care under Part 4 (commencing with Section 4600).
Comment. Subdivision (c) of Section 4128 is amended to delete a reference to powers of attorney for health care, which are governed by Division 4.7 (commencing with Section 4600) (Health Care Decisions Law). This is a technical, nonsubstantive change.

Comment (1994 Revised). The warning statement in subdivision (a) of Section 4128 replaces the statement provided in former Civil Code Section 2510(b). Subdivision (b) restates former Civil Code Section 2510(c) without substantive change. Subdivision (c) restates former Civil Code Section 2510(a) without substantive change, but the reference to statutory short form powers of attorney under former Civil Code Section 2450 is omitted as obsolete. This section is not subject to limitation in the power of attorney. See Section 4101(b).

Other provisions prescribe the contents of the warning statements for particular types of durable powers of attorney. See Section 4401 (statutory form power of attorney).

Section 4102 permits a printed form to be used after January 1, 1995, if the form complies with prior law. A form printed after January 1, 1986, may be sold or otherwise distributed in this state only if it complies with the requirements of Section 4128 (or its predecessor, former Civil Code Section 2510). See Section 4102(b).

See also Sections 4014 (“attorney-in-fact” defined), 4018 (“durable power of attorney” defined), 4026 (“principal” defined), 4034 (“third person” defined).


SEC. ____. Section 4203 of the Probate Code is amended to read:

4203. (a) A principal may designate one or more successor attorneys-in-fact to act if the authority of a predecessor attorney-in-fact terminates.
(b) The principal may grant authority to another person, designated by name, by office, or by function, including the initial and any successor attorneys-in-fact, to designate at any time one or more successor attorneys-in-fact. This subdivision does not apply to a durable power of attorney for health care under Part 4 (commencing with Section 4600).
(c) A successor attorney-in-fact is not liable for the actions of the predecessor attorney-in-fact.

Comment. Section 4203 is amended to delete a reference to powers of attorney for health care, which are governed by Division 4.7 (commencing with Section 4600) (Health Care Decisions Law). This is a technical, nonsubstantive change.


SEC. ____. Section 4206 of the Probate Code is amended to read:

4206. (a) If, following execution of a durable power of attorney, a court of the principal’s domicile appoints a conservator of the estate, guardian of the estate, or other fiduciary charged with the management of all of the principal’s property or all of the principal’s property except specified exclusions, the attorney-in-fact is accountable to the fiduciary as well as to the principal. Except as provided in subdivision (b), the fiduciary has the same power to revoke or amend the durable power of attorney that the principal would have had if not incapacitated, subject to any required court approval.
(b) If a conservator of the estate is appointed by a court of this state, the conservator can revoke or amend the durable power of attorney only if the court in which the conservatorship proceeding is pending has first made an order...
authorizing or requiring the fiduciary to modify or revoke the durable power of attorney and the modification or revocation is in accord with the order.

(c) This section does not apply to a durable power of attorney for health care.

d) This section is not subject to limitation in the power of attorney.

Comment. Section 4206 is amended to delete a reference to powers of attorney for health care, which are governed by Division 4.7 (commencing with Section 4600) (Health Care Decisions Law). This is a technical, nonsubstantive change.

Prob. Code § 4260 (amended). Limitation on article

SEC. ____. Section 4260 of the Probate Code is amended to read:

4260. This article does not apply to the following:

(a) Statutory statutory form powers of attorney under Part 3 (commencing with Section 4400).

(b) Durable powers of attorney for health care under Part 4 (commencing with Section 4600).

Comment. Section 4260 is amended to delete a reference to powers of attorney for health care, which are governed by Division 4.7 (commencing with Section 4600) (Health Care Decisions Law). This is a technical, nonsubstantive change.

Prob. Code § 4265 (amended). Excluded authority

SEC. ____. Section 4265 of the Probate Code is amended to read:

4265. A power of attorney may not authorize an attorney-in-fact to perform any of the following acts:

(a) Make, publish, declare, amend, or revoke the principal’s will.

(b) Consent to any action under a durable power of attorney for health care forbidden by Section 4722.

Comment. Section 4265 is amended to delete a reference to powers of attorney for health care, which are governed by Division 4.7 (commencing with Section 4600) (Health Care Decisions Law). See Section 4050 (scope of division).

Section 4265 is consistent with the general agency rule in Civil Code Section 2304. See also Sections 4014 (“attorney-in-fact” defined), 4022 (“power of attorney” defined), 4026 (“principal” defined).
**Prob. Code §§ 4500-4545 (added). Judicial proceedings concerning powers of attorney**

SEC. ____. Part 4 (commencing with Section 4500) is added to Division 4.5 of the Probate Code, to read:

**PART 4. JUDICIAL PROCEEDINGS CONCERNING POWERS OF ATTORNEY**

**CHAPTER 1. GENERAL PROVISIONS**

§ 4500. Power of attorney freely exercisable

4500. A power of attorney is exercisable free of judicial intervention, subject to this part.

Comment. Section 4500 continues former Section 4900 without change. See also Section 4022 ("power of attorney" defined).

§ 4501. Cumulative remedies

4501. The remedies provided in this part are cumulative and not exclusive of any other remedies provided by law.

Comment. Section 4501 continues former Section 4901 without change.

§ 4502. Effect of provision in power of attorney attempting to limit right to petition

4502. Except as provided in Section 4503, this part is not subject to limitation in the power of attorney.

Comment. Section 4502 continues former Section 4902 without change. See also Sections 4022 ("power of attorney" defined), 4101(b) (general rule on limitations provided in power of attorney).

§ 4503. Limitations on right to petition

4503. (a) Subject to subdivision (b), a power of attorney may expressly eliminate the authority of a person listed in Section 4540 to petition the court for any one or more of the purposes enumerated in Section 4541 if both of the following requirements are satisfied:

(1) The power of attorney is executed by the principal at a time when the principal has the advice of a lawyer authorized to practice law in the state where the power of attorney is executed.

(2) The principal’s lawyer signs a certificate stating in substance:

“I am a lawyer authorized to practice law in the state where this power of attorney was executed, and the principal was my client at the time this power of attorney was executed. I have advised my client concerning his or her rights in connection with this power of attorney and the applicable law and the consequences of signing or not signing this power of attorney, and my client, after being so advised, has executed this power of attorney.”
(b) A power of attorney may not limit the authority of the following persons to petition under this part:

(1) The attorney-in-fact, the principal, the conservator of the estate of the principal, or the public guardian, with respect to a petition for a purpose specified in Section 4541.

(2) The conservator of the person of the principal, with respect to a petition relating to a durable power of attorney for health care for a purpose specified in subdivision (a), (c), or (d) of Section 4541.

(3) The attorney-in-fact, with respect to a petition relating to a durable power of attorney for health care for a purpose specified in subdivision (a) or (b) of Section 4542.

Comment. Subdivision (a) of Section 4503 continues former Section 4903(a) without change, except that the reference to the section governing petitions relating to powers of attorney for health care (former Section 4942) is omitted. Powers of attorney for health care are governed by Division 4.7 (commencing with Section 4600).

Subdivision (a) makes clear that a power of attorney may limit the applicability of this part only if it is executed with the advice and approval of the principal’s counsel. This limitation is designed to ensure that the execution of a power of attorney that restricts the remedies of this part is accomplished knowingly by the principal. The inclusion of a provision in the power of attorney making this part inapplicable does not affect the right to resort to any judicial remedies that may otherwise be available. See Section 4501.

Subdivision (b) continues the part of former Section 4903(b) relating to non-health care powers of attorney without substantive change.

See also Sections 4014 (“attorney-in-fact” defined), 4022 (“power of attorney” defined), 4026 (“principal” defined).

§ 4504. Jury trial

4504. There is no right to a jury trial in proceedings under this division.

Comment. Section 4504 continues former Section 4904 without change. This section is consistent with the rule applicable to other fiduciaries. See Prob. Code §§ 1452 (guardianships and conservatorships), 7200 (decedents’ estates), 17006 (trusts).

§ 4505. Application of general procedural rules

4505. Except as otherwise provided in this division, the general provisions in Division 3 (commencing with Section 1000) apply to proceedings under this division.

Comment. Section 4505 continues former Section 4905 without change, and provides a cross reference to the general procedural rules that apply to this division. See, e.g., Sections 1003 (guardian ad litem), 1021 (verification required), 1041 (clerk to set matters for hearing), 1046 (hearing and orders), 1203 (order shortening time for notice), 1215-1216 (service), 1260 (proof of service).

CHAPTER 2. JURISDICTION AND VENUE

§ 4520. Jurisdiction and authority of court or judge

4520. (a) The superior court has jurisdiction in proceedings under this division.
(b) The court in proceedings under this division is a court of general jurisdiction and the court, or a judge of the court, has the same power and authority with respect to the proceedings as otherwise provided by law for a superior court, or a judge of the superior court, including, but not limited to, the matters authorized by Section 128 of the Code of Civil Procedure.

Comment. Section 4520 continues former Section 4920 without change, and is comparable to Section 7050 governing the jurisdiction and authority of the court in proceedings concerning administration of decedents’ estates. See Section 7050 Comment.

§ 4521. Basis of jurisdiction

4521. The court may exercise jurisdiction in proceedings under this division on any basis permitted by Section 410.10 of the Code of Civil Procedure.

Comment. Section 4521 continues former Section 4921 without change, and is comparable to Section 17004 (jurisdiction under Trust Law). This section recognizes that the court, in proceedings relating to powers of attorney under this division, may exercise jurisdiction on any basis that is not inconsistent with the California or United States Constitutions, as provided in Code of Civil Procedure Section 410.10. See generally Judicial Council Comment to Code Civ. Proc. § 410.10; Prob. Code § 17004 Comment (basis of jurisdiction under Trust Law).

§ 4522. Jurisdiction over attorney-in-fact

4522. Without limiting Section 4521, a person who acts as an attorney-in-fact under a power of attorney governed by this division is subject to personal jurisdiction in this state with respect to matters relating to acts and transactions of the attorney-in-fact performed in this state or affecting property or a principal in this state.

Comment. Section 4522 continues former Section 4922 without change, and is comparable to Sections 3902(b) (jurisdiction over custodian under Uniform Transfers to Minors Act) and 17003(a) (jurisdiction over trustee). This section is intended to facilitate exercise of the court’s power under this part when the court’s jurisdiction is properly invoked. As recognized by the introductory clause, constitutional limitations on assertion of jurisdiction apply to the exercise of jurisdiction under this section. Consequently, appropriate notice must be given to an attorney-in-fact as a condition of personal jurisdiction. Cf. Mullane v. Central Hanover Bank & Trust Co., 339 U.S. 306 (1950).

See also Sections 4014 (“attorney-in-fact” defined), 4022 (“power of attorney” defined), 4026 (“principal” defined).

§ 4523. Venue

4523. The proper county for commencement of a proceeding under this division shall be determined in the following order of priority:

(a) The county in which the principal resides.

(b) The county in which the attorney-in-fact resides.

(c) A county in which property subject to the power of attorney is located.

(d) Any other county that is in the principal’s best interest.

Comment. Section 4523 continues former Section 4923 without change. This section is drawn from the rules applicable to guardianships and conservatorships. See Sections 2201-2202. See also Section 4053 (durable powers of attorney under law of another jurisdiction).
§ 4540. Petitioners

4540. Subject to Section 4503, a petition may be filed under this part by any of the following persons:

(a) The attorney-in-fact.
(b) The principal.
(c) The spouse of the principal.
(d) A relative of the principal.
(e) The conservator of the person or estate of the principal.
(f) The court investigator, described in Section 1454, of the county where the power of attorney was executed or where the principal resides.
(g) The public guardian of the county where the power of attorney was executed or where the principal resides.
(h) The personal representative or trustee of the principal’s estate.
(i) The principal’s successor in interest.
(j) A person who is requested in writing by an attorney-in-fact to take action.
(k) Any other interested person or friend of the principal.

Comment. Section 4540 continues former Section 4940 without change, except that the reference to the treating health care provider in former subdivision (h) is omitted. Powers of attorney for health care are governed by Division 4.7 (commencing with Section 4600). The purposes for which a person may file a petition under this part are limited by other rules. See Sections 4502 (effect of provision in power of attorney attempting to limit right to petition), 4503 (limitations on right to petition); see also Section 4501 (other remedies not affected). See also the comparable rules governing petitioners for appointment of a conservator under Section 1820. See also Sections 4014 (“attorney-in-fact” defined), 4022 (“power of attorney” defined), 4026 (“principal” defined).

§ 4541. Petition as to powers of attorney

4541. A petition may be filed under this part for any one or more of the following purposes:

(a) Determining whether the power of attorney is in effect or has terminated.
(b) Passing on the acts or proposed acts of the attorney-in-fact, including approval of authority to disobey the principal’s instructions pursuant to subdivision (b) of Section 4234.
(c) Compelling the attorney-in-fact to submit the attorney-in-fact’s accounts or report the attorney-in-fact’s acts as attorney-in-fact to the principal, the spouse of the principal, the conservator of the person or the estate of the principal, or to any other person required by the court in its discretion, if the attorney-in-fact has failed to submit an accounting or report within 60 days after written request from the person filing the petition.
(d) Declaring that the authority of the attorney-in-fact is revoked on a determination by the court of all of the following:
(1) The attorney-in-fact has violated or is unfit to perform the fiduciary duties under the power of attorney.

(2) At the time of the determination by the court, the principal lacks the capacity to give or to revoke a power of attorney.

(3) The revocation of the attorney-in-fact’s authority is in the best interest of the principal or the principal’s estate.

(e) Approving the resignation of the attorney-in-fact:
   (1) If the attorney-in-fact is subject to a duty to act under Section 4230, the court may approve the resignation, subject to any orders the court determines are necessary to protect the principal’s interests.
   (2) If the attorney-in-fact is not subject to a duty to act under Section 4230, the court shall approve the resignation, subject to the court’s discretion to require the attorney-in-fact to give notice to other interested persons.

(f) Compelling a third person to honor the authority of an attorney-in-fact.

Comment. Section 4541 continues former Section 4941 without change, except that the reference to powers of attorney for health care in the introductory paragraph of former law is omitted. Powers of attorney for health care are governed by Division 4.7 (commencing with Section 4600). This section applies to petitions concerning both durable and nondurable powers of attorney. See Sections 4022 (“power of attorney” defined), 4050 (scope of division).

Subdivision (a) makes clear that a petition may be filed to determine whether the power of attorney was ever effective, thus permitting, for example, a determination that the power of attorney was invalid when executed because its execution was induced by fraud. See also Section 4201 (unqualified attorney-in-fact).

The authority to petition to disobey the principal’s instructions in subdivision (b) is new. This is a limitation on the general agency rule in Civil Code Section 2320. See Section 4234 (duty to follow instructions) & Comment.

Subdivision (d) requires a court determination that the principal has become incapacitated before the court is authorized to declare the power of attorney terminated because the attorney-in-fact has violated or is unfit to perform the fiduciary duties under the power of attorney.

Subdivision (e) provides a procedure for accepting the attorney-in-fact’s resignation. The court’s discretion in this type of case depends on whether the attorney-in-fact is subject to any duty to act under Section 4230, as in the situation where the attorney-in-fact has agreed in writing to act or is involved in an ongoing transaction. Under subdivision (e)(1) the court may make any necessary protective order. Under subdivision (e)(2), the court’s discretion is limited to requiring that notice be given to others who may be expected to look out for the principal’s interests, such as a public guardian or a relative. In addition, the attorney-in-fact is required to comply with the statutory duties on termination of authority. See Section 4238. The availability of this procedure is not intended to imply that an attorney-in-fact must or should petition for judicial acceptance of a resignation where the attorney-in-fact is not subject to a duty to act.

Subdivision (f) provides a remedy to achieve compliance with the power of attorney through recognition of the attorney-in-fact’s authority. This remedy is also available to compel disclosure of information under Section 4235 (consultation and disclosure). See Section 4300 et seq. (relations with third persons).

A power of attorney may limit the authority to petition under this part. See Sections 4502 (effect of provision in power of attorney attempting to limit right to petition), 4503 (limitations on right to petition).

See also Sections 4014 (“attorney-in-fact” defined), 4022 (“power of attorney” defined), 4026 (“principal” defined).
§ 4542. Commencement of proceeding

4542. A proceeding under this part is commenced by filing a petition stating facts showing that the petition is authorized under this part, the grounds of the petition, and, if known to the petitioner, the terms of the power of attorney.

Comment. Section 4542 continues former Section 4943 without change. For a comparable provision, see Section 17201 (commencement of proceeding under Trust Law). A petition is required to be verified. See Section 1021. See also Section 4022 (“power of attorney” defined).

§ 4543. Dismissal of petition

4543. The court may dismiss a petition if it appears that the proceeding is not reasonably necessary for the protection of the interests of the principal or the principal’s estate and shall stay or dismiss the proceeding in whole or in part when required by Section 410.30 of the Code of Civil Procedure.

Comment. Section 4543 continues former Section 4944 without change. Under former Section 4944, the dismissal standard was revised to permit dismissal when the proceeding is not “reasonably necessary,” rather than “necessary” as under the prior section (Civil Code Section 2416). Under this section, the court has authority to stay or dismiss a proceeding in this state if, in the interest of substantial justice, the proceeding should be heard in a forum outside this state. See Code Civ. Proc. § 410.30. See also Section 4026 (“principal” defined).

§ 4544. Notice of hearing

4544. (a) Subject to subdivision (b), at least 15 days before the time set for hearing, the petitioner shall serve notice of the time and place of the hearing, together with a copy of the petition, on the following:

(1) The attorney-in-fact if not the petitioner.

(2) The principal if not the petitioner.

(b) In the case of a petition to compel a third person to honor the authority of an attorney-in-fact, notice of the time and place of the hearing, together with a copy of the petition, shall be served on the third person in the manner provided in Chapter 4 (commencing with Section 413.10) of Title 5 of Part 2 of the Code of Civil Procedure.

Comment. Subdivision (a) of Section 4544, pertaining to internal affairs of the power of attorney, continues former Section 4945(a) without change. Subdivision (b) continues former Section 4945(b) without change, and provides a special rule applicable to service of notice in proceedings involving third persons, i.e., not internal affairs of the power of attorney. See Section 4541(f) (petition to compel third person to honor attorney-in-fact’s authority). See also Sections 4014 (“attorney-in-fact” defined), 4026 (“principal” defined).

§ 4545. Award of attorney’s fees

4545. In a proceeding under this part commenced by the filing of a petition by a person other than the attorney-in-fact, the court may in its discretion award reasonable attorney’s fees to one of the following:
(a) The attorney-in-fact, if the court determines that the proceeding was commenced without any reasonable cause.
(b) The person commencing the proceeding, if the court determines that the attorney-in-fact has clearly violated the fiduciary duties under the power of attorney or has failed without any reasonable cause or justification to submit accounts or report acts to the principal or conservator of the estate or of the person, as the case may be, after written request from the principal or conservator.

Comment. Section 4545 continues former Section 4947 without change. See also Sections 4014 (“attorney-in-fact” defined), 4022 (“power of attorney” defined), 4026 (“principal” defined).

Prob. Code §§ 4600-4806 (repealed). Durable powers of attorney for health care

SEC. ____. Part 4 (commencing with Section 4600) of Division 4.5 of the Probate Code is repealed.

Comment. Former Sections 4600-4806 are superseded by relevant parts of the Health Care Decisions Law, Division 4.7 (commencing with Section 4600). See former Section 4600-4806 Comments.

§ 4600 (repealed). Application of definitions

Comment. Former Section 4600 is continued in Section 4603 without substantive change.

§ 4603 (repealed). Community care facility

Comment. Former Section 4603 is continued in Section 4611 without substantive change.

§ 4606 (repealed). Durable power of attorney for health care

Comment. Former Section 4606 is superseded by Section 4629 (“power of attorney for health care” defined). See Section 4629 Comment. The durability of powers of attorney for health care is implicit, so the term has been shortened in the new law to “power of attorney for health care.”

§ 4609 (repealed). Health care

Comment. The first part of former Section 4609 is continued in Section 4615 without substantive change. The language relating to decisions affecting the principal after death is not continued in the definition, but the authority is continued in Section 4683(b) without substantive change.

§ 4612 (repealed). Health care decision

Comment. Former Section 4612 is superseded by Section 4617. See Section 4617 Comment.

§ 4615 (repealed). Health care provider

Comment. Former Section 4615 is continued in Section 4621 without substantive change.

§ 4618 (repealed). Residential care facility for the elderly

Comment. Former Section 4618 is continued in Section 4635 without substantive change.

§ 4621 (repealed). Statutory form durable power of attorney for health care

Comment. Former Section 4621 is not continued. For the replacement statutory form, see Section 4701 (optional form of advance health care directive).
§ 4650 (repealed). Application of chapter

Comment. Former Section 4650 is superseded by Section 4671 and related authority in the Health Care Decisions Law. For the application of the new law to existing advance health care directives, see Section 4665 & Comment.

§ 4651 (repealed). Form of durable power of attorney for health care after January 1, 1995

Comment. Former Section 4651 is not continued. See Section 4701 (optional form of advance health care directive).

§ 4652 (repealed). Other authority not affected

Comment. Subdivision (a) of former Section 4652 is superseded by Sections 4685 (agent’s priority) and 4687 (other authority of person named as agent not affected).

Subdivision (b) is continued in Section 4651(b)(2) (emergency treatment) without substantive change.

§ 4653 (repealed). Validity of durable power of attorney for health care executed elsewhere

Comment. Former Section 4653 is continued in Section 4674(a) without substantive change.

§ 4654 (repealed). Durable power of attorney for health care subject to former 7-year limit

Comment. Former Section 4654 is not continued. See Section 4665 (application of Health Care Decisions Law to existing advance directives).

§ 4700 (repealed). Requirements for durable power of attorney for health care

Comment. Former Section 4700 is superseded by Section 4671 and related provisions. See Section 4671 Comment.

§ 4701 (repealed). Witnesses of durable power of attorney for health care

Comment. Former Section 4701 is continued in Section 4673(a)-(c) without substantive change, but the witnessing rules apply only to patients in skilled nursing facilities.

§ 4702 (repealed). Limitations on who may be attorney-in-fact

Comment. Former Section 4702 is continued in Section 4660(a)-(c) without substantive change. See Section 4660 Comment.

§ 4703 (repealed). Printed form of durable power of attorney for health care

Comment. Former Section 4703 is not continued. See Section 4701 (optional form of advance health care directive).

§ 4704 (repealed). Warnings not on printed form

Comment. Former Section 4704 is not continued. See Section 4701 (optional form of advance health care directive).

§ 4720 (repealed). Attorney-in-fact’s authority to make health care decisions

Comment. Subdivision (a) of former Section 4720 is continued in Sections 4682 (when agent’s authority effective) and 4685 (agent’s priority) without substantive change.

Subdivision (b) is continued in Section 4683 without substantive change.

Subdivision (c) is continued in Section 4684 without substantive change.

Subdivision (d) is continued in Section 4687 without substantive change.
§ 4721 (repealed). Availability of medical information to attorney-in-fact
Comment. Former Section 4721 is continued in Section 4676 without substantive change.

§ 4722 (repealed). Limitations on attorney-in-fact’s authority
Comment. Former Section 4722 is continued in Section 4652 without substantive change.

§ 4723 (repealed). Unauthorized acts and omissions
Comment. Former Section 4723 is continued in Section 4653 without substantive change.

§ 4724 (repealed). Principal’s objections
Comment. Former Section 4724 is continued in Section 4659 without substantive change.

§ 4725 (repealed). Restriction on execution of durable power of attorney for health care as condition for admission, treatment, or insurance
Comment. Former Section 4725 is continued in Section 4675 without substantive change.

§ 4726 (repealed). Alteration or forging, or concealment or withholding knowledge of revocation of durable power of attorney for health care
Comment. Former Section 4726 is continued in Section 4743 without substantive change.

§ 4727 (repealed). Revocation of durable power of attorney for health care
Comment. Subdivision (a) of former Section 4727 is superseded by Section 4695(a) (revocation of advance health care directive).
Subdivision (b) is continued in Section 4731 (duty of supervising health care provider to record relevant information) without substantive change.
The first sentence of subdivision (c) is continued in Section 4657 (presumption of capacity) without substantive change. The second sentence is not continued.
Subdivision (d) is superseded by Section 4698 (effect of later advance directive on earlier advance directive).
Subdivision (e) is continued in Section 4697 (effect of dissolution or annulment) without substantive change.
Subdivision (f) is superseded by Section 4740 (immunities of health care provider and institution). See Section 4740 Comment.

§ 4750 (repealed). Immunities of health care provider
Comment. Former Section 4750 is superseded by Section 4740. See Section 4740 Comment.

§ 4751 (repealed). Convincing evidence of identity of principal
Comment. Former Section 4751 is continued in Section 4673(d)-(e) without substantive change. The scope of the new provision is different, however. See Section 4673 Comment.

§ 4752 (repealed). Presumption concerning power executed in other jurisdiction
Comment. Former Section 4752 is continued in Section 4674(b) without substantive change.

§ 4753 (repealed). Request to forgo resuscitative measures
Comment. Former Section 4753 is continued in Part 4 (commencing with Section 4780) of Division 4.7 without substantive change. Subdivision (a) is continued in Section 4782 without substantive change.
Subdivision (b) is continued in Section 4780 without substantive change.
Subdivisions (c) and (d) are continued in Section 4783 without substantive change.
Subdivision (e) is continued in Section 4784 without change.
Subdivision (f) is continued in Section 4785 without substantive change.
Subdivision (g) is continued in Section 4781 without substantive change.
Subdivision (h) is continued in Section 4786 without substantive change.

§ 4770 (repealed). Short title
Comment. Former Section 4770 is not continued. The statutory form durable power of attorney for health care is replaced by the optional form of an advance health care directive in Section 4701.

§ 4771 (repealed). Statutory form durable power of attorney for health care
Comment. The statutory form set out in former Section 4771 is superseded by the optional advance health care directive form provided by Section 4701. See Section 4701 Comment. See also Section 4665 (application of Health Care Decisions Law to existing advance directives).

§ 4772 (repealed). Warning or lawyer’s certificate
Comment. Former Section 4772 is not continued. See Section 4701 (optional advance directive form) & Comment.

§ 4773 (repealed). Formal requirements
Comment. Former Section 4773 is not continued. For execution requirements, see Section 4680. See also Sections 4700 (substantive rules applicable to form), 4701 (optional advance directive form) & Comment.

§ 4774 (repealed). Requirements for statutory form
Comment. Former Section 4774 is not continued. For execution requirements, see Section 4680. See also Sections 4700 (substantive rules applicable to form), 4701 (optional advance directive form) & Comment.

§ 4775 (repealed). Use of forms valid under prior law
Comment. Former Section 4775 is not continued. See Section 4665 (application of Health Care Decisions Law to existing advance directives).

§ 4776 (repealed). Language conferring general authority
Comment. Former Section 4776 is not continued. See Section 4701 (optional advance directive form) & Comment.

§ 4777 (repealed). Effect of documents executed by attorney-in-fact
Comment. Former Section 4777 is not continued. See Sections 4683 (scope of agent’s authority), 4701 (optional advance directive form) & Comment.

§ 4778 (repealed). Termination of authority; alternate attorney-in-fact
Comment. Former Section 4778 is not continued. See Section 4701 (optional advance directive form) & Comment.

§ 4779 (repealed). Use of other forms
Comment. Former Section 4779 is superseded by Section 4700.
§ 4800 (repealed). Registry system established by Secretary of State

Comment. Former Section 4800 is continued in new Section 4800 without substantive change. However, the registry provisions in Sections 4800-4806 of former law are revised to permit registration of individual health care instructions, as well as powers of attorney for health care in new Sections 4800-4805. See new Section 4800 Comment.

§ 4801 (repealed). Identity and fees

Comment. Former Section 4801 is continued in new Section 4801 without change.

§ 4802 (repealed). Notice

Comment. Former Section 4802 is continued in new Section 4802 without substantive change. See Section 4800 Comment.

§ 4804 (repealed). Effect of failure to register

Comment. Former Section 4804 is continued in Section 4803 without substantive change. See Section 4800 Comment.

§ 4805 (repealed). Effect of registration on revocation and validity

Comment. Former Section 4805 is continued in Section 4804 without substantive change. See Section 4800 Comment.

§ 4806 (repealed). Effect on health care provider

Comment. Former Section 4806 is continued in Section 4805 without substantive change. See Section 4800 Comment.


SEC. ____. Part 5 (commencing with Section 4900) of Division 4.5 of the Probate Code is repealed.

Comment. Sections 4900-4947 have been moved to a new Part 4 (commencing with Section 4500) as part of the reorganization related to enactment of the Health Care Decisions Law, Division 4.7 (commencing with Section 4600). With respect to powers of attorney for health care, this part of former law is replaced by a new Part 3 (commencing with Section 4750) in Division 4.7.

§ 4900 (repealed). Power of attorney freely exercisable

Comment. Former Section 4900 is continued in Sections 4500 (property powers) and 4750 (health care powers) without substantive change.

§ 4901 (repealed). Cumulative remedies

Comment. Former Section 4901 is continued in Sections 4501 (property powers) and 4751 (health care powers) without substantive change.

§ 4902 (repealed). Effect of provision in power of attorney limiting right to petition

Comment. Former Section 4902 is continued in Sections 4502 (property powers) and 4752 (health care powers) without substantive change.
§ 4903 (repealed). Limitations on right to petition

Comment. Former Section 4903 is continued in Sections 4503 (property powers) and 4753 (health care powers) without substantive change.

§ 4904 (repealed). Jury trial

Comment. Former Section 4904 is continued in Sections 4504 (property powers) and 4754 (health care powers) without substantive change.

§ 4905 (repealed). Application of general procedural rules

Comment. Former Section 4905 is continued in Sections 4505 (property powers) and 4755 (health care powers) without substantive change.

§ 4920 (repealed). Jurisdiction and authority of court or judge

Comment. Former Section 4920 is continued in Sections 4520 (property powers) and 4760 (health care powers) without substantive change.

§ 4921 (repealed). Basis of jurisdiction

Comment. Former Section 4921 is continued in Sections 4521 (property powers) and 4761 (health care powers) without substantive change.

§ 4922 (repealed). Jurisdiction over attorney-in-fact

Comment. Former Section 4922 is continued in Sections 4522 (property powers) and 4762 (health care powers) without substantive change.

§ 4923 (repealed). Venue

Comment. Former Section 4923 is continued in Sections 4523 (property powers) and 4763 (health care powers) without substantive change.

§ 4940 (repealed). Petitioners

Comment. Former Section 4940 is continued in Section 4540 without change, except that the reference to the treating health care provider in subdivision (h) is omitted. Powers of attorney for health care are governed by Division 4.7 (commencing with Section 4600). As to health care powers, the former section is continued in Section 4765, with several changes. See Section 4765 Comment.

§ 4941 (repealed). Petition as to powers of attorney other than for health care

Comment. As to property powers, former Section 4941 is continued in Section 4541 without change, except that the reference to powers of attorney for health care in the introductory paragraph is omitted. Powers of attorney for health care are governed by Division 4.7 (commencing with Section 4600).

§ 4942 (repealed). Petition as to durable power of attorney for health care

Comment. Former Section 4942 is continued in Section 4766 with several changes. See Section 4766 & Comment.

§ 4943 (repealed). Commencement of proceeding

Comment. Former Section 4943 is continued in Sections 4542 (property powers) and 4767 (health care powers) without substantive change.
§ 4944 (repealed). Dismissal of petition

Comment. Former Section 4944 is continued in Sections 4543 (property powers) and 4768 (health care powers) without substantive change.

§ 4945 (repealed). Notice of hearing

Comment. Former Section 4945 is continued in Sections 4544 (property powers) and 4769 (health care powers) without substantive change.

§ 4946 (repealed). Temporary health care order

Comment. Former Section 4946 is continued in Section 4770 without several changes. See Section 4770 Comment.

§ 4947 (repealed). Award of attorney’s fees

Comment. Former Section 4947 is continued in Sections 4545 (property powers) and 4771 (health care powers) without substantive change.

REVISED COMMENTS

Prob. Code § 2 (revised comment). Continuation of existing law; construction of provisions drawn from uniform acts

Revised Comment. Section 2 continues Section 2 of the repealed Probate Code without change. See also Gov’t Code §§ 9604 (reference made in statute, charter, or ordinance to provisions of one statute carried into another statute under circumstances in which they are required to be construed as restatements and continuations and not as new enactments), 9605 (construction of amended statutory provision).

Some of the provisions of this code are the same as or similar to provisions of uniform acts. Subdivision (b) provides a rule for interpretation of these provisions. Many of the provisions of this code are drawn from the Uniform Probate Code (1987). Some provisions are drawn from other uniform acts:

Sections 220-224 — Uniform Simultaneous Death Act (1953)
Sections 260-288 — Uniform Disclaimer of Transfers by Will, Intestacy or Appointment Act (1978)
Sections 3900-3925 — Uniform Transfers to Minors Act (1983)
Sections 4001, 4124-4127, 4206, 4304-4305 — Uniform Durable Power of Attorney Act
Sections 4400-4465 — Uniform Statutory Form Power of Attorney Act
Sections 4670-4743 — Uniform Health-Care Decisions Act (1993)
Sections 6300-6303 — Uniform Testamentary Additions to Trusts Act (1960)
Sections 6380-6390 — Uniform International Wills Act (1977). See also Section 6387 (need for uniform interpretation of Uniform International Wills Act)
Sections 16002(a), 16003, 16045-16054 — Uniform Prudent Investor Act (1994)
Sections 16200-16249 — Uniform Trustees’ Powers Act (1964)
Sections 16300-16313 — Revised Uniform Principal and Income Act (1962)

A number of terms and phrases are used in the Comments to the sections of the new Probate Code (including the “Background” portion of each Comment) to indicate the sources of the new provisions and to describe how they compare with prior law. The portion of the Comment giving the background on each section of the repealed code may also use terms and phrases to indicate the source or sources of the repealed section and to describe how the repealed section compared with the prior law.
The following discussion is intended to provide guidance in interpreting the terminology most commonly used in the Comments.

(1) Continues without change. A new provision “continues” a former provision “without change” if the two provisions are identical or nearly so. In some cases, there may be insignificant technical differences, such as where punctuation is changed without a change in meaning. Some Comments may describe the relationship by simply stating that a new provision “continues” or is “the same as” a former provision of the repealed Probate Code, or is “the same as” a provision of the Uniform Probate Code or another uniform act.

(2) Continues without substantive change. A new provision “continues” a former provision “without substantive change” if the substantive law remains the same but the language differs to an insignificant degree.

(3) Restates without substantive change. A new provision “restates” a former provision “without substantive change” if the substantive law remains the same but the language differs to a significant degree. Some Comments may describe the new provision as being the “same in substance.”

(4) Exceptions, additions, omissions. If part of a former provision is “continued” or “restated,” the Comment may say that the former provision is continued or restated but also note the specific differences as “exceptions to,” “additions to,” or “omissions from” the former provision.

(5) Generalizes, broadens, restates in general terms. A new provision may be described as “generalizing,” “broadening,” or “restating in general terms” a provision of prior law. This description means that a limited rule has been expanded to cover a broader class of cases.

(6) Supersedes, replaces. A provision “supersedes” or “replaces” a former provision if the new provision deals with the same subject as the former provision but treats it in a significantly different manner.

(7) New. A provision is described as “new” where it has no direct source in prior statutes.

(8) Drawn from, similar to, consistent with. A variety of terms is used to indicate a source for a new provision, typically a source other than California statutes. For example, a provision may be “drawn from” a uniform act, model code, Restatement, or the statutes of another state. In such cases, it may be useful to consult any available commentary or interpretation of the source from which the new provision is drawn for background information.

(9) Codifies. A Comment may state that a new provision “codifies” a case-law rule that has not previously been enacted into statutory law. A provision may also be described as codifying a Restatement rule, which may or may not represent previously existing common law in California.

(10) Makes clear, clarifies. A new provision may be described as “making clear” a particular rule or “clarifying” a rule as a way of emphasizing the rule, particularly if the situation under prior law was doubtful or contradictory.

(11) Statement in Comment that section is “comparable” to another section. A Comment may state that a provision is “comparable” to another provision. If the Comment to a section notes that another section is “comparable” that does not mean that the other section is the same or substantially the same. The statement is included in the Comment so that the statute user is alerted to the other section and can review the cases under that section for possible use in interpreting the section containing the statement in the Comment.


Revised Comment. Subdivision (a) of Section 4014 supersedes part of former Civil Code Section 2400 and former Civil Code Section 2410(a), and is comparable to the first sentence of Civil Code Section 2295.

Subdivision (b) is comparable to Section 84 (“trustee” includes successor trustee). See Sections 4202 (multiple attorneys-in-fact), 4203 (successor attorneys-in-fact), 4205 (delegation of attorney-in-fact’s authority). The purpose of subdivision (b) is to make clear that the rules applicable to attorneys-in-fact under the Power of Attorney Law apply as well to successors and alternates of the original attorney-in-fact, and to other persons who act in place of the attorney-in-fact.
See also Sections 4022 ("power of attorney" defined), 4026 ("principal" defined).

Prob. Code § 4053 (revised comment). Recognition of durable powers of attorney executed under law of another state

Revised Comment. Section 4053 is new. This section promotes use and enforceability of durable powers of attorney executed in other states. See also Section 4018 ("durable power of attorney" defined).

Prob. Code § 4054 (revised comment). Application to existing powers of attorney and pending proceedings

Revised Comment (1994). Section 4054 is comparable to Section 15001 (application of Trust Law). Subdivision (a) provides the general rule that this division applies to all powers of attorney, regardless of when created.

Subdivision (b) is a specific application of the general rule in subdivision (a). See Section 4900 et seq. (judicial proceedings concerning powers of attorney). Subdivision (c) provides discretion to the court to resolve problems arising in proceedings commenced before the operative date.

For special transitional provisions, see Sections 4102 (durable power of attorney form); see also Section 4129(c) (springing powers).

See also Section 4022 ("power of attorney" defined).

Prob. Code § 4101 (revised comment). Priority of provisions of power of attorney

Revised Comment. Section 4101 is new. This section makes clear that many of the statutory rules provided in this division are subject to express or implicit limitations in the power of attorney. If a statutory rule is not subject to control by the power of attorney, this is stated explicitly, either in a particular section or as to a group of sections. See, e.g., Sections 4130 (inconsistent authority), 4151(a)(2) (revocation of power of attorney by writing), 4153(a)(2)-(3) (revocation of attorney-in-fact’s authority), 4155 (termination of authority under nondurable power of attorney on principal’s incapacity), 4206 (relation of attorney-in-fact to court-appointed fiduciary), 4207 (resignation of attorney-in-fact), 4232 (duty of loyalty), 4233 (duty to keep principal’s property separate and identified), 4234(b) (authority to disobey instructions with court approval), 4236 (duty to keep records and account; availability of records to other persons), 4502 (effect of provision in power of attorney attempting to limit right to petition), 4503 (limitations on right to petition).

See also Sections 4014 (“attorney-in-fact” defined), 4022 (“power of attorney” defined), 4026 (“principal” defined).

Prob. Code § 4121 (revised comment). Formalities for executing a power of attorney

Revised Comment. Section 4121 provides the general execution formalities for a power of attorney under this division. A power of attorney that complies with this section is legally sufficient as a grant of authority to an attorney-in-fact. Special rules apply to a statutory form power of attorney. See Section 4402.

The dating requirement in subdivision (a) generalizes the rule applicable to durable powers of attorney for health care under former Civil Code Section 2432(a)(2). This rule is also consistent with the statutory forms. See Sections 4401 (statutory form power of attorney).

In subdivision (b), the requirement that a power of attorney be signed by the principal or at the principal’s direction continues a rule implicit in former law. See former Civ. Code §§ 2400, 2410(c). In addition, it generalizes the rule applicable to durable powers of attorney for health care under former Civil Code Section 2432.

The requirement that the power of attorney be either acknowledged or signed by two witnesses, in subdivision (c), generalizes part of the rule applicable to durable powers of attorney for health care under former Civil Code Section 2432(a)(3). Former general rules did not require either acknowledgment or witnessing. However, the statutory form power of attorney provided for...
acknowledgment. See former Civ. Code § 2475 (now Prob. Code § 4401). This rule still applies to the statutory form power of attorney; witnessing does not satisfy Section 4402. Subdivision (c) provides the general rule as to witnessing; specific qualifications for witnesses are provided in Section 4122.

Nothing in this section affects the requirements concerning recordable instruments. A power of attorney legally sufficient as a grant of authority under this division must satisfy the general rules concerning recordation in Civil Code Sections 1169-1231. To facilitate recordation of a power of attorney granting authority concerning real property, the power of attorney should be acknowledged before a notary, whether or not it is witnessed.

See also Sections 4022 (“power of attorney” defined), 4026 (“principal” defined).

Prob. Code § 4124 (revised comment). Requirements for durable power of attorney

Revised Comment. Section 4124 restates former Civil Code Section 2400 without substantive change. For special rules applicable to statutory form powers of attorney, see Sections 4401, 4402. See also Section 4050 (powers subject to this division).

Section 4124 is similar to the official text of Section 1 of the Uniform Durable Power of Attorney Act (1984), Uniform Probate Code Section 5–501 (1991). See Section 2(b) (construction of provisions drawn from uniform acts). The reference in the uniform act to the principal’s “disability” is omitted. Under Section 4155, it is the principal’s incapacity to contract which would otherwise terminate the power of attorney. In addition, the phrase “or lapse of time” has not been included in the language set forth in subdivision (a) of Section 4124 because it is unnecessary. As a matter of law, unless a durable power of attorney states an earlier termination date, it remains valid regardless of any lapse of time since its creation. See, e.g., Sections 4127 (lapse of time), 4152(a)(1) (termination of attorney-in-fact’s authority pursuant to terms of power of attorney).

See also Sections 4014 (“attorney-in-fact” defined), 4018 (“durable power of attorney” defined), 4022 (“power of attorney” defined), 4026 (“principal” defined).

Prob. Code § 4130 (revised comment). Inconsistent authority

Revised Comment. Section 4130 is new. See also Sections 4014 (“attorney-in-fact” defined), 4022 (“power of attorney” defined), 4026 (“principal” defined).

Prob. Code § 4152 (revised comment). Termination of attorney-in-fact’s authority

Revised Comment. Section 4152 is drawn from the general agency rules provided in Civil Code Sections 2355 and 2356. This section continues the substance of former law as to termination of the authority of an attorney-in-fact under a power of attorney. For a special rule as to termination of nondurable powers of attorney on principal’s incapacity, see Section 4155.

Subdivision (a)(1) is the same as Civil Code Section 2355(a). Subdivision (a)(2) is the same as Civil Code Section 2355(b), but the reference to fulfillment of the purpose of the power of attorney is new. Subdivision (a)(3) is the same as Civil Code Section 2356(a)(1). These subdivisions recognize that the authority of an attorney-in-fact necessarily ceases when the underlying power of attorney is terminated.

Subdivision (a)(4) is the same as Civil Code Section 2356(a)(2), but recognizes that certain tasks may remain to be performed after death. See, e.g., Sections 4238 (attorney-in-fact’s duties on termination of authority).

Subdivision (a)(5) is generalized from Civil Code Section 2355(c)-(f). Subdivision (a)(6) is similar to Civil Code Section 2355(d) (renunciation by agent). For the manner of resignation, see Section 4207. Subdivision (a)(7) is similar to Civil Code Section 2355(e). Subdivision (a)(8) cross-references to the rules governing the effect of dissolution and annulment of marriage. Subdivision (a)(9) is the same as Civil Code Section 2355(c).
Subdivision (b) preserves the substance of the introductory clause of Civil Code Section 2355 and Civil Code Section 2356(b), which protect persons without notice of events that terminate an agency.

See also Sections 4014 (“attorney-in-fact” defined), 4022 (“power of attorney” defined), 4026 (“principal” defined), 4034 (“third person” defined); Civ. Code § 1216 (recordation of revocation of recorded instruments).

Prob. Code § 4200 (revised comment). Qualifications of attorney-in-fact

Revised Comment. Section 4200 supersedes the last part of Civil Code Section 2296 (“any person may be an agent”) to the extent that it applied to attorneys-in-fact under powers of attorney.

See also Sections 56 (“person” defined), 4014 (“attorney-in-fact” defined).

Prob. Code § 4207 (revised comment). Resignation of attorney-in-fact

Revised Comment. Section 4207 is new. For judicial procedures for approving the attorney-in-fact’s resignation, see Section 4541(e) (petition as to power of attorney other than durable power of attorney for health care).

See also Sections 4014 (“attorney-in-fact” defined), 4022 (“power of attorney” defined), 4026 (“principal” defined).

Prob. Code § 4234 (revised comment). Duty to keep principal informed and follow instructions

Revised Comment. Section 4234 is drawn from general agency rules. The duty to follow the principal’s instructions is consistent with the general agency rule in Civil Code Section 2309. See also Civ. Code § 2019 (agent not to exceed limits of actual authority). The duty to communicate with the principal is consistent with the general agency rule in Civil Code Sections 2317 and 2332.

Subdivision (b) is a limitation on the general agency rule in Civil Code Section 2320 (power to obey instructions). For provisions relating to judicial proceedings, see Section 4500 et seq.

See also Sections 4014 (“attorney-in-fact” defined), 4022 (“power of attorney” defined), 4026 (“principal” defined).

Prob. Code § 4235 (revised comment). Consultation and disclosure

Revised Comment. Section 4235 is drawn in part from Minnesota law. See Minn. Stat. Ann. § 4500 et seq. (West Supp. 1994). For provisions relating to judicial proceedings, see Section 4500 et seq.

See also Sections 4014 (“attorney-in-fact” defined), 4026 (“principal” defined).

Prob. Code § 4236 (revised comment). Duty to keep records and account; availability of records to other persons

Revised Comment. Section 4236 is drawn in part from Minnesota law. See Minn. Stat. Ann. § 523.21 (West Supp. 1994). For provisions relating to judicial proceedings, see Section 4500 et seq.

See also Sections 4014 (“attorney-in-fact” defined), 4026 (“principal” defined).
Prob. Code § 4300 (revised comment). Third persons required to respect attorney-in-fact’s authority

Revised Comment. Section 4300 is new. This section provides the basic rule concerning the position of an attorney-in-fact: that the attorney-in-fact acts in place of the principal, within the scope of the power of attorney, and is to be treated as if the principal were acting. The second sentence generalizes a rule in former Civil Code Section 2480.5, which was applicable only to the Uniform Statutory Form Power of Attorney. Under this rule, a third person may be compelled to honor a power of attorney only to the extent that the principal, disregarding any legal disability, could bring an action to compel the third person to act. A third person who could not be forced to do business with the principal consequently may not be forced to deal with the attorney-in-fact. However, a third person who holds property of the principal, who owes a debt to the principal, or who is obligated by contract to the principal may be compelled to accept the attorney-in-fact’s authority.

This general rule is subject to some specific exceptions. See, e.g., Sections 4309 (prior breach by attorney-in-fact), 4310 (transactions relating to accounts and loans in financial institution).

See also Sections 4014 (“attorney-in-fact” defined), 4022 (“power of attorney” defined), 4026 (“principal” defined), 4034 (“third person” defined).

Prob. Code § 4301 (revised comment). Reliance by third person on general authority

Revised Comment. Section 4301 is drawn from the Missouri Durable Power of Attorney Law. See Mo. Ann. Stat. § 404.710(8) (Vernon 1990). This general rule is subject to specific limitations provided elsewhere. See, e.g., Sections 4264 (authority that must be specifically granted).

See also Sections 4014 (“attorney-in-fact” defined), 4022 (“power of attorney” defined), 4034 (“third person” defined).


See also Sections 4014 (“attorney-in-fact” defined), 4022 (“power of attorney” defined), 4026 (“principal” defined), 4034 (“third person” defined).

Prob. Code § 4303 (revised comment). Protection of third person relying in good faith on power of attorney

Revised Comment. Section 4303 continues former Civil Code Section 2512 without substantive change, with the addition of the witnessing rule in subdivision (a)(3). This section is intended to ensure that a power of attorney, whether durable or nondurable, will be accepted and relied on by third persons. The person presenting the power of attorney must actually be the attorney-in-fact designated in the power of attorney. If the person purporting to be the attorney-in-fact is an impostor, the immunity does not apply. The third person can rely in good faith on the notary public’s certificate of acknowledgment or the signatures of the witnesses that the person who executed the power of attorney is the principal.

Subdivision (b) makes clear that this section provides an immunity from liability where the requirements of the section are satisfied. This section has no relevance in determining whether or not a third person who acts in reliance on a power of attorney is liable under the circumstances where, for example, the power of attorney does not include a notary public’s certificate of acknowledgment.

For other immunity provisions not affected by Section 4303, see, e.g., Sections 4128(b) (reliance in good faith on durable power of attorney not containing “warning” statement required by Section 4128), 4301 (reliance by third person on general authority), 4304 (lack of knowledge of death or incapacity of principal). See also Section 3720 (“Any person who acts in reliance
upon the power of attorney [of an absentee as defined in Section 1403] when accompanied by a
1 copy of a certificate of missing status is not liable for relying and acting upon the power of
2 attorney.’
3 See also Sections 4014 (“attorney-in-fact” defined), 4018 (“durable power of attorney”
4 defined), 4022 (“power of attorney” defined), 4026 (“principal” defined), 4034 (“third person”
5 defined).

Prob. Code § 4307 (revised comment). Certified copy of power of attorney

Revised Comment. Section 4307 is new. This section facilitates use of a power of attorney
executed in this state as well as powers of attorney executed in other states. Subdivision (d)
makes clear that certification under this section is not a requirement for use of copies of powers of
11 attorney. This recognizes, for example, the existing practice of good faith reliance on copies of
durable powers of attorney for health care. See former Section 4750 (immunities of health care
12 provider); new Section 4740.

See also Section 4022 (“power of attorney” defined).

Prob. Code § 4401 (revised comment). Statutory form power of attorney

Revised Comment. Section 4401 continues former Civil Code Section 2475 without change,
except for the revision of cross-references to other provisions, the restoration of language
19 erroneously omitted in 1993, and inclusion of a general reference to the law governing the
19 notary’s certificate of acknowledgment. Section 4401 is the same in substance as Section 1(a) of
20 the Uniform Statutory Form Power of Attorney Act (1988), with the addition of provisions to
21 permit designation of co-agents. See Section 2(b) (construction of provisions drawn from uniform
22 acts).

The provisions added by former Civil Code Section 2475 were drawn from the former
24 Statutory Short Form Power of Attorney statute. See former Civ. Code § 2450 (repealed by 1990
25 Cal. Stat. ch. 986, § 1). The acknowledgment portion of the form was revised to be consistent
26 with the form used under California law. The word “incapacitated” was substituted for the words
27 “disabled, incapacitated, or incompetent” used in the uniform act. This substitution conforms the
28 statutory form to the California version of the Uniform Durable Power of Attorney Act. See
29 Section 4018 (requirements for creation of durable power of attorney).

Section 4401 provides the text of the form that is sufficient and necessary to bring this part into
31 operation. The statutory form can be used in whole or part instead of individually drafted forms or
32 forms adapted from a form book.

A form used to create a power of attorney subject to this part should use the language provided
34 in Section 4401. Minor variances in wording will not take it out of the scope of the part. For
35 example, the use of the language of the official text of the uniform act in the last paragraph of the
36 text of the statutory form (protection of third party who receives a copy of the statutory form
37 power of attorney and acts in reliance on it) instead of the language provided in Section 4401
38 does not take the form out of the scope of this part. See Section 4402(a). Nor does the omission of
39 the provisions relating to designation of co-agents take the form out of the scope of this part. See
40 Section 4402(a).

After the introductory phrase, the term “agent” is used throughout the uniform act in place of
41 the longer and less familiar “attorney-in-fact.” Special effort is made throughout the uniform act
42 to make the language as informal as possible without impairing its effectiveness.

The statutory form contains a list of powers. The powers listed relate to various separate classes
44 of activities, except the last, which includes all the others. Health care matters are not included.
45 For a power of attorney for health care, see Section 4701.

Space is provided in the statutory form for “Special Instructions.” In this space, the principal
48 can add specially drafted provisions limiting or extending the powers granted to the agent. (If the
49 space provided is not sufficient, a reference can be made in this space to an attached sheet or
50 sheets, and the special provisions can be included on the attached sheet or sheets.)
The statutory form contains only a limited list of powers. If it is desired to give the agent the broadest possible powers, language similar to the following can be added under the “Special Instructions” portion of the form:

In addition to all of the powers listed in lines (A) to (M) above, I grant to my agent full power and authority to act for me, in any way which I myself could act if I were personally present and able to act, with respect to all other matters and affairs not listed in lines (A) to (M) above, but this authority does not include authority to make health care decisions.

Neither the form in this section, nor the constructional provisions in Sections 4450-4465, attempt to allow the grant of the power to make a will or to give the agent extensive estate planning authority, although several of the powers, especially lines (G), (H), and (L) of the statutory form, may be useful in planning the disposition of an estate. An individually tailored power of attorney can be used if the principal wants to give the agent extensive estate planning authority, or additional estate planning powers can be granted to the agent by stating those additional powers in the space provided in the form for “Special Instructions.” For example, provisions like the following might be included under the special instructions portion of the statutory form:

In addition to the powers listed in lines (A) to (M) above, the agent is empowered to do all of the following:

1. Establish a trust with property of the principal for the benefit of the principal and the spouse and descendants of the principal, or any one or more of them, upon such terms as the agent determines are necessary or proper, and transfer any property in which the principal has an interest to the trust.

2. Exercise in whole or in part, release, or let lapse any power the principal may have under any trust whether or not created by the principal, including any power of appointment, revocation, or withdrawal, but a trust created by the principal may only be modified or revoked by the agent as provided in the trust instrument.

3. Make a gift, grant, or other transfer without consideration to or for the benefit of the spouse or descendants of the principal or a charitable organization, or more than one or all of them, either outright or in trust, including the forgiveness of indebtedness and the completion of any charitable pledges the principal may have made; consent to the splitting of gifts under Internal Revenue Code Section 2513, or successor sections, if the spouse of the principal makes gifts to any one or more of the descendants of the principal or to a charitable institution; pay any gift tax that may arise by reason of those gifts.

4. Loan any of the property of the principal to the spouse or descendants of the principal, or their personal representatives or a trustee for their benefit, the loan bearing such interest, and to be secured or unsecured, as the agent determines advisable.

5. In general, and in addition to all the specific acts enumerated, do any other act which the principal can do through an agent for the welfare of the spouse, children, or dependents of the principal or for the preservation and maintenance of other personal relationships of the principal to parents, relatives, friends, and organizations.

It should be noted that a trust may not be modified or revoked by an agent under a statutory form power of attorney unless it is expressly permitted by the instrument granting the power and by the trust instrument. See Section 15401(b).

Section 4404 and the statutory form itself make the power of attorney a durable power of attorney, remaining in effect after the incapacity of the principal, unless the person executing the form strikes out the language in the form that makes the instrument a durable power of attorney. See also Section 4018 (“durable power of attorney” defined).

The last paragraph of the text of the statutory form protects a third party who receives a copy of the statutory form power of attorney and acts in reliance on it. See also Section 4034 (“third
person” defined). The statement in the statutory form — that revocation of the power of attorney is not effective as to a third party until the third party has actual knowledge of the revocation — is consistent with Sections 4304 (good faith reliance on power of attorney without actual knowledge of death or incapacity of principal), 4305 (affidavit of lack of knowledge of termination of power). See also Sections 4300 (third persons required to respect agent’s authority), 4301 (immunities of third person), 4303 (protection of person who acts in good faith reliance upon power of attorney where specified requirements are satisfied). The protection provided by these sections and other immunities that may protect persons who rely on a power of attorney (see Section 4303(b)) apply to a statutory form power of attorney. See Sections 4100 (application of division to statutory form power of attorney), 4407 (general provisions applicable to statutory form power of attorney).

The language of the last portion of the text of the statutory form set forth in Section 4401 substitutes the phrase “has actual knowledge of the revocation” for the phrase “learns of the revocation” which is used in the uniform act form. This substitution does not preclude use of a form including the uniform act language. See Section 4402(a) (third sentence).

Neither this section, nor the part as a whole, attempts to provide an exclusive method for creating a power of attorney. Other forms may be used and other law employed to create powers of attorney. See Section 4408. However, this part should be sufficient for most purposes.

For provisions relating to court enforcement of the duties of the agent, see Sections 4500-4545.

The form provided by Section 4401 supersedes the former statutory short form power of attorney under former Civil Code Sections 2450-2473 (repealed by 1990 Cal. Stat. ch. 986, § 1). But older forms consistent with former Civil Code Sections 2450-2473 are still effective. See Section 4409 & Comment.

See also Sections 4014 (“attorney-in-fact” defined to include agent), 4026 (“principal” defined), 4034 (“third person” defined).

**Prob. Code § 4405 (revised comment). Springing statutory form power of attorney**

**Revised Comment.** Section 4405 continues former Civil Code Section 2479 without substantive change. Section 4405 is not found in the Uniform Statutory Form Power of Attorney Act (1988). This section is drawn from Section 5-1602 of the New York General Obligations Law. A provision described in subdivision (a) protects a third person who relies on the declaration under penalty of perjury of the person or persons designated in the power of attorney that the specified event or contingency has occurred. The principal may designate the agent or another person, or several persons, to make this declaration.

Subdivision (d) makes clear that subdivisions (a) and (b) are not the exclusive method for creating a “springing power” (a power of attorney that goes into effect upon the occurrence of a specified event or contingency). The principal is free to set forth in a power of attorney under this part any provision the principal desires to provide for the method of determining whether the specified event or contingency has occurred. For example, the principal may provide that his or her “incapacity” be determined by a court under Part 4 (commencing with Section 4500). See Section 4541(a). If the power of attorney provides only that it shall become effective “upon the incapacity of the principal,” the determination whether the power of attorney is in effect also may be made under Part 4 (commencing with Section 4500).

See also Sections 4026 (“principal” defined), 4030 (“springing power of attorney” defined).

**Prob. Code § 4407 (revised comment). General provisions applicable to statutory form power of attorney**

**Revised Comment.** Section 4407 restates the substance of former Civil Code Section 2480. Section 4407 makes clear that the general provisions that apply to powers of attorney generally apply to statutory form powers of attorney under this part. Thus, for example, the following provisions apply to a power of attorney under this part:

Section 4123(b) (application of power of attorney to all or part of principal’s property; unnecessary to describe items or parcels of property).
Section 4124 (requirements for durable power of attorney). The statutory form set forth in Section 4401 satisfies the requirements for creation of a durable power of attorney, unless the provision making the power of attorney durable is struck out on the form. Section 4125 (effect of acts by attorney-in-fact during incapacity of principal).

Section 4206 (relation of attorney-in-fact to court-appointed fiduciary). Section 4303 (protection of person relying in good faith on power of attorney).

Section 4304 (good faith reliance on power of attorney after death or incapacity of principal). Section 4306 (good faith reliance on attorney-in-fact’s affidavit as conclusive proof of the nonrevocation or nontermination of the power).

Sections 4500-4545 (judicial proceedings).


Revised Comment. Section 4450 continues former Civil Code Section 2485 without change, except for the revision of a cross-reference to another provision. Section 4450 is the same in substance as Section 3 of the Uniform Statutory Form Power of Attorney Act (1988). See Section 2(b) (construction of provisions drawn from uniform acts). See the Comment to this chapter under the chapter heading. See also Sections 4500-4545 (court enforcement of agent’s duties). See also Sections 4014 (“attorney-in-fact” defined to include agent), 4022 (“power of attorney” defined), 4026 (“principal” defined).
## Table Showing Location of UHCDA Provisions in Tentative Recommendation

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