

Memorandum 99-61

Family Consent in Health Care Decisionmaking

The “family consent” or “statutory surrogate” provisions in the Commission’s recommendation on *Health Care Decisions for Adults Without Decisionmaking Capacity* were removed from AB 891 for additional study, due to concerns expressed by the Assembly Judiciary Committee Chairperson and consultant. This memorandum reviews the status of this part of the Commission’s proposed law and suggests some revisions to address issues that have been raised. The Commission has already expressed its desire to introduce follow-up legislation on this point in the 2000 legislative year.

For reference purposes, the original family consent provisions in Chapter 3 (Prob. Code §§ 4710-4716) (Health Care Surrogates) from the Commission’s printed recommendation, with explanatory text, are attached. (Exhibit pp. 1-21.) The chapter as enacted (Prob. Code §§ 4711, 4714, 4715), with revised Comments, is also attached. (Exhibit pp. 23-24.)

BACKGROUND

Before AB 891 was heard in the Assembly Judiciary Committee, Chairperson Sheila Kuehl, Assembly Member Elaine Alquist (who carried the bill for the Commission), and staff had a brief meeting, at which it was strongly suggested that the bill would be best served if the family consent provisions were removed for the time being and given further study. The understanding was that the family consent provisions would then be amended back into the bill in revised form on the Senate side. The consultant’s analysis for the April 26 hearing in the Assembly Judiciary Committee reported on this issue as follows:

Committee staff raised concerns regarding these provisions with the author and the sponsor, they concurred the best approach is to limit the bill at this time to the noncontroversial provisions described above and to work with Committee staff and other interested parties as the bill progresses in an attempt to achieve consensus on these issues. The recent amendments to the bill deleted these controversial provisions.

At that stage, we made it clear in the bill summary communicated to members of the Legislature that the author and sponsor intended to restore family consent provisions to the bill in the Senate.

Representatives of the author, the Committee, and the Commission, along with a handful of interested persons, met twice to consider and resolve the Committee's concerns. Had we come to a consensus, the staff would have presented the proposed revisions to the Commission, and the bill would have been amended accordingly in the Senate.

The two working group meetings were interesting, but it turned out that the Committee consultant did not believe he was in a position to agree to any specific amendments. This state of affairs was explained to the Commission at the July meeting, and the Commission approved the staff recommendation that AB 891 move forward without the family consent provisions. The bill passed the Legislature without the special rules governing surrogate selection. However, the Committee consultant was enthusiastic about keeping the general rules governing the patient's designation of a surrogate (Section 4711), the standard for surrogate decisionmaking (Section 4714), and the disqualification of a person as surrogate (Section 4715). These provisions, as enacted, are set out in the Exhibit at pp. 23-24. Most significant is Section 4714, which provides important rules governing persons acting as surrogates, although the statute remains silent on how a surrogate can be selected without an advance directive or designation by the patient.

Thus, the statutory surrogate provisions remaining in AB 891 are harmonious with existing practice. However, the some problems and opportunities discussed in the Commission's recommendation (see Exhibit pp. 1-14) remain unresolved.

ISSUES

Based on the meetings and discussions we have had, there appear to be a number of issues that concern the Assembly Judiciary Committee Chair and consultant, and other interested persons. The remainder of this memorandum discusses these issues and suggests ways to address some of the concerns. It should be noted, however, that some opposition to the family consent provisions is implacable. Some groups will oppose any statute that recognizes a physician's role in selecting surrogates, determining capacity, or other involvement in health care decisionmaking other than providing advice. (See, e.g., discussion in

Memorandum 98-63, pp. 4-7, considering comments received on the tentative recommendation, at the September 1998 Commission meeting.) Obviously we cannot devise rules to satisfy their concerns and also accomplish our goals, but we hope that they can recognize that the statutory proposal is an improvement on the existing situation.

(1) Capacity Determinations — Section 4710

Section 4710(a), in the bill as introduced, limits the statutory surrogate procedure to cases where the primary physician has determined that the patient lacks capacity:

§ 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.

“Capacity” is defined in Section 4609 to mean “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.” These rules are consistent with existing practice and general law; physicians routinely determine capacity. That being the case, it is not essential that this surrogate section specifically provide for it.

The bill includes record-keeping duties, and liability and immunity provisions, that are all part of a comprehensive statutory scheme. The critics of Section 4710(a) have focused on an existing situation they dislike, without recognizing that the statute has the effect of placing a duty on the primary physician, with the consequent recordkeeping and professional duties. Section 4732 requires that capacity determinations be recorded in the patient’s medical records. But, again, it is not essential that the family consent statute provide *who* determines capacity, if its presence here causes concern.

The staff believes that supporters of the Commission’s efforts, such as the California Healthcare Association (CHA), the California Medical Association (CMA), and the State Bar Advance Directive Committee, favor the Commission’s

original recommendation on this point, but we think they can understand that it is not a change in existing law or a step backward if the Commission removes the specific capacity determination rules in response to objections.

The staff proposes to leave Section 4710 out. The capacity rule does not need to be repeated here. The primacy of the power of attorney for health care is provided in Section 4685. The authority of a conservator is governed by Section 2355. The section does not contribute enough to the proposed statutory scheme to survive, in light of the objections it has spawned.

(2) Qualifications and Selection of Surrogate — Section 4712

A June 19 letter from Dr. Robert D. Orr, speaking for the California Medical Association's Council on Ethical Affairs, provides a useful overview of the importance of this section:

Our Council very strongly supports the retention of this section. Currently, without statutory guidance on this issue, physicians follow tradition and seek family consensus or, failing consensus, endeavor to identify the person who knows the patient best and has demonstrated caring for the patient. That is, the proposal merely codifies current practice. But the proposal does [two] additional very important things:

- (a) It gives formal recognition to the moral standing of domestic partners. It is not uncommon currently for such individuals to be pushed to the sidelines by estranged family.
- (b) It gives statutory guidance to physicians in the selection of a surrogate when there is more than one individual who might qualify or think they might qualify. Currently, physicians are on their own in deciding [whom] to choose. We believe it is this non-directed physician authority to which critics appeal when they claim that physicians may merely choose the family member who agrees with them. Therefore the flexibility and statutory guidance given in [Section] 4712 (b) and (c) is a major improvement over the current practice.

Some are concerned that too much power would be vested by statute in the primary physician (notwithstanding the reality that in clinical practice, these functions are commonplace). The Commission has not set out to create this situation, but has attempted to reinforce sound, ethical practice and bring the procedure into the open. The Commission's recommendations in this area were drafted in the light of practical experience and common expectations. If there are no statutory rules concerning who can act as surrogate decisionmaker when

there is no agent or conservator, this does not mean the long-standing, case-law sanctioned practice of the medical profession and families will cease. Doctors will continue to rely on close relatives and friends. Parents and children and siblings of incapacitated adults will continue to expect that they are the most appropriate persons to make decisions for their loved ones. And they are correct.

The suggestion has been made that the proposed statutory standards for selection of a surrogate outside of the statutory priority need to be tightened up. We do not have any specific suggestions on what should be added or changed, other than a reference to the CHA Consent Manual for useful guidance. The staff has examined the Consent Manual (26th ed. 1999), and recommends revising proposed Section 4712 as follows:

§ 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~~ may be selected to make health care decisions for the patient from among the following adults with a relationship to the patient:

(1) The spouse, unless legally separated.

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

(3) Children.

(4) Parents.

(5) Brothers and sisters.

(6) Grandchildren.

(7) Close friends.

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

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

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

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

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

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

(3) Demonstrated care and concern for the patient.

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

(5) Availability to visit the patient.

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

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

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

(e)

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

Comment. Section 4712 is a new provision, drawn in part from West Virginia law and the Uniform Health-Care Decisions Act (1993). See W.Va. Code § 16-30B-7 (1997); Unif. Health-Care Decisions Act § 5(b)-(c) (1993). Subdivision (a)(2) is drawn in part from New Mexico law. See N.M. Stat. Ann. § 24-7A-5(B)(2) (Westlaw 1998). "Adult" includes an emancipated minor. See Fam. Code § 7002 (emancipation). A prospective surrogate and other persons may also seek judicial relief as provided in Sections 4765-4766. Subdivision (d) recognizes existing practice. See Cal. Healthcare Ass'n, Consent Manual at 2-17 (26th ed. 1999).

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

(3) Type of Treatment

Concern has been expressed that a "one size fits all" approach is inappropriate, and that additional protections may be needed in cases involving more serious treatments. In our discussions, mention was made of "invasive treatment" and administration of psychotropic drugs. Clearly withholding or

withdrawal of life-sustaining treatment, nutrition, and hydration are in the serious category. Routine or common treatments, or “medical interventions” in the terminology of Health and Safety Code Section 1418.8, would be in a lesser category.

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

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

issues, even here the standards and procedure governing selection of the statutory surrogate are distinct and separate from the procedure governing the making of the health care decision for the patient.

The staff does not believe it is appropriate to attempt to condition selection of the surrogate directly on the type, seriousness, invasiveness, or other characterization of recommended or potential health care decisions.

If the surrogate selection process needs to be conditioned in some way, however, we would suggest considering more administrative checks, such as by requiring review by another physician or referral to an ethics committee or consultant. The staff would like to hear the Commission's take on these approaches. The problem will remain, however, that it is extremely difficult to set out which types of treatments or conditions would require a different standard. Our reading and discussions with medical experts, as well as with those who urge a dual standard, has yet to suggest an acceptable, much less desirable, approach to dividing treatments into two categories — other than the commonly used distinction between life-sustaining treatments and other types of treatments, and even that distinction may not make much sense in the clinical setting.

(4) Family or Surrogate Discord

The concern has been expressed that the statute needs to address situations where there is disagreement about who should act as surrogate or what health care decision should be made. In most cases, health care providers and institutions will not proceed if there is a real dispute in these cases. This is the history reflected in the reported cases and countless newspaper articles. The CHA Consent Manual advises that the “hospital should not rely upon authorization from the closest available relative if ... another close relative objects to the medical procedure.” (*Id.*)

In addition, AB 891's recordkeeping, notice, and court review provisions give a great deal of protection in cases where there is a dispute. This is not to say that some language changes might not improve the linkage of these rules, but the staff does not think the bill is defective in this respect.

It is difficult to address this concern with statutory language, because the objection has not been articulated with any specificity. It is an area that we could continue to work on, but the staff thinks it is undesirable to put into the statute a rule that suspends the surrogate's authority automatically if any other family

member, or potential surrogate on the list in Section 4712, objects in any way. As noted, there is an expeditious judicial remedy.

We could attempt implementing a limited non-judicial (or pre-judicial) procedure, perhaps along these lines:

§ 4717. Objection to surrogate's selection or decisionmaking

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

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

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

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

This draft is offered for discussion; the staff is not recommending it for inclusion at this point.

Conclusion

The staff recommends that the Commission seek enactment of the revised family consent statute in the 2000 legislative year. There is not really time to prepare and circulate a tentative recommendation — but then this would not be a new recommendation. Our problem has been to find a way to get people with major objections to work with the Commission to find a solution. It is difficult to determine whether the revised proposal would be acceptable, but we probably won't be able to find out until we have a bill set for hearing. The groups we have been working with over the last three years have been supportive of AB 891 as introduced, and a number of them expressed unhappiness that the family consent sections were removed from the bill.

Based on Commission decisions at this meeting, the staff proposes to prepare a draft final recommendation for the December meeting. This will be circulated to interested persons (as has this memorandum) and by that process

the Commission should be able to judge whether we have done what we can to meet the legitimate concerns with the family consent rules.

Respectfully submitted,

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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. 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 health care directives.³⁷ 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.

37. See *supra* note 10.

Existing California Law

California statutory law does not provide general rules governing surrogate decisionmaking. However, in the nursing home context, the procedure governing consent to “medical interventions” implies that the “next of kin” can make decisions for incapacitated persons by including them in the group of persons “with legal authority to make medical treatment decisions on behalf of a patient.”³⁸

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.³⁹

But this language is not a holding of the case.⁴⁰

The leading case of *Barber v. Superior Court*⁴¹ contains a thorough discussion of the problems:

38. Health & Safety Code § 1418.8(c).

39. 8 Cal. 3d 229, 243-44, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) (citations omitted).

40. 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.

41. 147 Cal. App. 3d 1006, 1020-21, 195 Cal. Rptr. 484 (1983).

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 in the case that the wife, children, and sister-in-law were all family members. However, the court’s statement that the “wife was the proper person to act as a surrogate for the patient” based on the assumption she would have been qualified if judicial approval had been sought, is not completely consistent with other statements referring to the “family’s decision” and that the “wife and children were the most obviously appropriate surrogates,” and speculation on what would have happened if “the family had insisted on continued treatment.”

Nevertheless, *Barber* has been characterized as an “enormously important” decision: “Indeed, literature gener-

ated 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.”⁴²

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.

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

(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 is likely in practice that these are the persons doctors will ask, as stated in the pamphlet.⁴³

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

43. 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.").

desires of the patient and to determine the patient's best interests.⁴⁴

Priority schemes among relatives and friends seem natural. Intestate succession law⁴⁵ 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.⁴⁶ 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:⁴⁷

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.

44. See generally 2 A. Meisel, *The Right to Die* §§ 14.1-14.10 (2d ed. 1995).

45. Prob. Code § 6400 *et seq.*

46. Prob. Code § 1812.

47. 2 A. Meisel, *The Right to Die* § 14.1, at 249-50 (2d ed. 1995).

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:⁴⁸

(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 within classes can be made by majority vote under the UHCDA. This is not likely to be a common approach to making decisions where there are disagreements, but could be useful to validate a decision of a majority where there are other class members whose views are unknown or in doubt.

(3) Orally designated surrogates are first on the UHCDA priority list, in an attempt to deal with the fact that a strict statutory priority list does not necessarily reflect reality. The “orally designated surrogate was added to the Act not because its use is recommended but because it is how decision makers are often designated in clinical practice.”⁴⁹

(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.”⁵⁰ In a special procedure applicable

48. UHCDA § 5.

49. English, *Recent Trends in Health Care Decisions Legislation* 17 (1998) (unpublished manuscript, on file with California Law Revision Commission).

50. 2 A. Meisel, *The Right to Die* §14.4, at 51 (2d ed. Supp. #1 1997). *But cf.* *Conservatorship of Drabick*, 200 Cal. App. 3d 185, 204, 245 Cal. Rptr. 840 (1988) (“[F]aced with a persistently vegetative patient and a diagnosis establishing that further treatment offers no reasonable hope of returning the patient to cognitive life, the decision whether to continue noncurative treatment is an ethi-

to “medical interventions” in nursing homes, California law requires consultation with friends of nursing home patients and authorizes a friend to be appointed as the patient’s representative,⁵¹ 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 fundamental principle that decisions should be based on the patient’s desires or, where not known, should be made in the patient’s best interest. The focus of statutory surrogacy rules should be to provide some needed clarity without creating technical rules that would make compliance confusing or risky, thereby bogging the process down or paralyzing medical decisionmaking. Just as California courts have consistently resisted judicial involvement in health care decisionmaking, except as a last resort, the statutory surrogacy scheme should assist, rather than disrupt, existing practice.

Professor Meisel describes this fundamental problem with priority classes as follows:⁵²

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

cal one for the physicians and family members or other persons who are making health care decisions for the patient.”).

51. 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).

52. 2 A. Meisel, *The Right to Die* § 14.4 at 255 (2d ed. 1995) (footnotes omitted).

patient's wishes or best interests. This would occur, for example, if the patient were estranged from his spouse or parents. However, it is not clear that the result would be much different in the absence of a statute because the ordinary custom of physicians sanctioned by judicial decision, is to look to incompetent patients' close family members to make decisions for them. In the absence of a statute, the physician might ignore a spouse known to be estranged from the patient in favor of another close family member as surrogate, but because there is nothing in most statutes to permit a physician to ignore the statutory order of priority, the result could be worse under a statute than in its absence.

In recognition of the problems as well as the benefits of a priority scheme, the proposed law sets out a default list of adult statutory surrogates: (1) The spouse, unless legally separated, (2) a domestic partner,⁵³ (3) children, (4) parents, (5) brothers and sisters, (6) grandchildren, and (7) close friends.

As a general rule, the primary physician is required to select the surrogate, with the assistance of other health care providers or institutional committees, in the order of priority set out in the statute. However, where there are multiple possible surrogates at the same priority level, the primary physician has a duty to select the individual who reasonably appears after a good faith inquiry to be best qualified.⁵⁴ The primary physician may select as the surrogate an individual who is positioned lower in statutory list if, in the primary physician's judgment, the individual is best qualified to serve

53. Proposed Probate Code Section 4712(a)(2) defines this class as follows: "An adult in a long-term relationship of indefinite duration with the patient in which the individual has demonstrated an actual commitment to the patient similar to the commitment of a spouse and in which the individual and the patient consider themselves to be responsible for each other's well-being and reside or have been residing together...."

54. The recommended procedure is drawn, in part, from West Virginia law. See W.Va. Code § 16-30B-7 (Westlaw 1999). Elements are also drawn from New Mexico's implementation of the UHCDA. See N.M. Stat. Ann. § 24-7A-5 (Westlaw 1998).

as the patient's surrogate. These rules are directly related to the fundamental principal that the law should attempt to find the best surrogate — the person who can make health care decisions according to the patient's known desires or in the patient's best interest.

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

- (1) Whether the proposed surrogate appears to be best able to make decisions in accordance with the statutory standard (patient's instructions, if known, or if not known, patient's best interest, taking into account personal values).
- (2) The degree of the person's 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 surrogate is required to communicate his or her assumption of authority to other family members, including the spouse, domestic partner, adult children, parents, and adult siblings of the patient.

The recommended procedure 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 fixed priority scheme between classes of close relatives and provides for voting within a class with multiple members.⁵⁵ 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.⁵⁶ In this procedure, the class of potential surrogates, composed of close family members and friends, is given the responsibility and duty to select a surrogate from among their number. It is difficult to judge how well this type of procedure would work in practice. The concern is that it might result in too much confusion and administrative burden, without improving the prospects for effective decisionmaking or resolving disputes. But there is nothing in the proposed law that would prevent a family from voluntarily acting in this fashion, and it is likely that the selected surrogate would satisfy the standards of the flexible priority scheme.

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

55. UHCDA § 5.

56. See Colo. Rev. Stat. Ann. § 15-18.5-103 (West 1997). Illinois and Louisiana also implement some consensus standards. See generally, 2 A. Meisel, *The Right to Die* § 14.1 *et seq.* (2d ed. 1995 & Supp. #1 1997).

the consensus approach. Notice of the selection should be given to other family members. The surrogate is required to communicate the assumption of surrogate's authority to other adults in the first five categories of statutory surrogates: spouse, domestic partner, children, parents, and siblings. Potential surrogates or other interested persons with serious objections to the selection of the surrogate or the decisions being made by the surrogate would still have the right to bring a judicial challenge⁵⁷ or seek appointment of a conservator.

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

DECISIONMAKING WHERE NO SURROGATE IS AVAILABLE

The law does not address one of the most important problems if it stops at providing rules on advance directives and "family consent." The statutory surrogate rules will not apply to a significant group of incapacitated adults for whom there 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. While the conservatorship statutes provide a remedy of last resort, practically speaking, the conservatorship rules can be cumbersome, inefficient, and expensive, and do not provide the answer in most cases.

Existing law addresses this problem with respect to "medical interventions" involving patients in the nursing home context,⁵⁸ but there is no general surrogacy rule appli-

57. See *infra* text accompanying notes 77-80.

58. Health & Safety Code § 1418.8. See *Rains v. Belshé*, 32 Cal. App. 4th 157, 166, 170, 38 Cal. Rptr. 2d 185 (1995) (upholding the constitutionality of the procedure for patients in nursing homes who lack capacity to make health

interpretation of those instructions made by an authorized agent, [conservator], 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 § 4660] 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).]

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), 4643 (“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), 4635 (“reasonably available” defined), 4643 (“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 [conservator] has been appointed or the agent or [conservator] 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),

4643 (“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), 4635 (“reasonably available” defined), 4641 (“supervising health care provider” defined), 4643 (“surrogate” defined).

Background from Uniform Act. While a designation of an agent in a written power of attorney for health care is preferred, situations may arise where an individual will not be in a position to execute a power of attorney for health care. In that event, 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) An adult in a long-term relationship of indefinite duration with the patient in which the individual has demonstrated an actual commitment to the patient similar to the commitment of a spouse and in which the individual and the patient consider themselves to be responsible for each other’s well-being and reside or have been residing together. This individual may be known as a domestic partner.

(3) Children.

(4) Parents.

- (5) Brothers and sisters.
- (6) Grandchildren.
- (7) Close friends.

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

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

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

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

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

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

(3) Demonstrated care and concern for the patient.

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

(5) Availability to visit the patient.

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

(d) 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.

Comment. Section 4712 is a new provision, drawn in part from West Virginia law and the Uniform Health-Care Decisions Act (1993). See W.Va. Code § 16-30B-7 (1997); Unif. Health-Care Decisions Act § 5(b)-(c) (1993). Subdivision (a)(2) is drawn from New Mexico law. See N.M. Stat. Ann. § 24-7A-5(B)(2) (Westlaw 1998). "Adult" includes an emancipated minor. See Fam. Code § 7002 (emancipation). A prospective surrogate and other persons may also seek judicial relief as provided in Sections 4765-4766.

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

§ 4713. Selection of statutory surrogate

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

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

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

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

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

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

§ 4714. Standard governing surrogate's health care decisions

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

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

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

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

§ 4715. Disqualification of surrogate

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

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

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

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

§ 4716. Reassessment of surrogate selection

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

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

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

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

CHAPTER 3. HEALTH CARE SURROGATES

§ 4711. Patient's designation of surrogate

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

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

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

Background from Uniform Act. While a designation of an agent in a written power of attorney for health care is preferred, situations may arise where an individual will not be in a position to execute a power of attorney for health care. In that event, 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).]

§ 4714. Standard governing surrogate's health care decisions

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

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

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

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

surrogate is to consider the patient's personal values to the extent known to the surrogate. [Adapted from Unif. Health-Care Decisions Act § 5(f) comment (1993).]

§ 4715. Disqualification of surrogate

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

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

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

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