Study L-4003 October 29, 1999

Memorandum 99-82

Family Consent in Health Care Decisionmaking for Adults

Attached to this memorandum is a draft Recommendation on *Family Consent in Health Care Decisionmaking for Adults*, which implements decisions made at the October meeting.

The material in the draft recommendation is substantially the same as the Commission's original recommendation on this subject, with several revisions intended to address concerns raised in the legislative process. We have no new issues to raise at this point.

The staff recommends approval of the draft for printing and introduction in the 2000 legislative session.

Respectfully submitted,

Stan Ulrich
Assistant Executive Secretary

APPENDIX 11

STATE OF CALIFORNIA

CALIFORNIA LAW REVISION COMMISSION

Staff Draft RECOMMENDATION

Family Consent in Health Care Decisionmaking for Adults

November 1999

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

NOTE

This report includes an explanatory Comment to each section of the recommended legislation. The Comments are written as if the legislation were already operative, since their primary purpose is to explain the law as it will exist to those who will have occasion to use it after it is operative.

Cite this report as *Family Consent in Health Care Decisionmaking for Adults*, 29 Cal. L. Revision Comm'n Reports ____ (1999). This report is part of publication #206 [*1999-2000 Annual Report*].

STATE OF CALIFORNIA

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November 30, 1999

To: The Honorable Gray Davis
Governor of California, and
The Legislature of California

This recommendation proposes additions to the new Health Care Decisions Law to recognize the role of family members and close friends in making surrogate health care decisions for adults without decisionmaking capacity and to provide guidance on selection of surrogates and resolution of disputes among potential surrogates.

This recommendation is submitted pursuant to Resolution Chapter 81 of the Statutes of 1999.

Respectfully submitted,

Howard Wayne
Chairperson

FAMILY CONSENT IN HEALTH CARE DECISIONMAKING FOR ADULTS

California has been a pioneer in the area of health care decisionmaking for adults without decisionmaking capacity, with the enactment of the 1976 Natural Death Act,[1] the 1983 Durable Power of Attorney for Health Care,[2] and the 1999 Health Care Decisions Law.[3] However, California law does

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1. 1976 Cal. Stat. ch. 1439. This was also the year the New Jersey Supreme Court decided the well-known Karen Ann Quinlan case. *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied*, 429 U.S. 922 (1976).

2. 1983 Cal. Stat. ch. 1204. See former Prob. Code § 4600 *et seq.* (repealed by 1999 Cal. Stat. ch. 658, § 38). This statute and its predecessor in the Civil Code were enacted on Commission recommendation. See:

Recommendation Relating to Durable Power of Attorney for Health Care Decisions, 17 Cal. L. Revision Comm'n Reports 101 (1984) (enacted as 1983 Cal. Stat. ch. 1204). For legislative history, see 17 Cal. L. Revision Comm'n Reports 822 (1984); *Report of Assembly Committee on Judiciary on Senate Bill 762*, 17 Cal. L. Revision Comm'n Reports 889 (1984).

Recommendation Relating to Statutory Forms for Durable Powers of Attorney, 17 Cal. L. Revision Comm'n Reports 701 (1984) (enacted as 1984 Cal. Stat. chs. 312 & 602). For legislative history, see 18 Cal. L. Revision Comm'n Reports 18-19 (1986); *Report of Assembly Committee on Judiciary on Senate Bill 1365*, 18 Cal. L. Revision Comm'n Reports 45 (1986).

Recommendation Relating to Elimination of Seven-Year Limit for Durable Power of Attorney for Health Care, 20 Cal. L. Revision Comm'n Reports 2605 (1990) (enacted as 1991 Cal. Stat. ch. 896). For legislative history, see 21 Cal. L. Revision Comm'n Reports 22 (1991).

Comprehensive Power of Attorney Law, 24 Cal. L. Revision Comm'n Reports 111 (1994) (enacted as 1994 Cal. Stat. ch. 307). For legislative history, see 24 Cal. L. Revision Comm'n Reports 567 (1994). The law as enacted, with revised Comments and explanatory text, was printed as *1995 Comprehensive Power of Attorney Law*, 24 Cal. L. Revision Comm'n Reports 323 (1994).

3. 1999 Cal. Stat. ch. 658, enacted on Commission recommendation. See *Health Care Decisions for Adults Without Decisionmaking Capacity*, 29 Cal. L. Revision Comm'n Reports 1 (1999). For legislative history, see 29 Cal. L. Revision Comm'n Reports ____ (1999).

not yet adequately address a number of important issues in the law concerning health care decisionmaking for adults who are unable to make decisions for themselves.

This recommendation proposes amendments to the new Health Care Decisions Law to recognize the role of close family members and friends in making decisions for adults without decisionmaking capacity and to codify ethical standards for selecting the best surrogate decisionmaker where there is no authorized agent under a power of attorney for health care or conservator with health care decisionmaking powers.

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.[4] 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. The right of

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4. 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 (Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4206, 4751, 104 Stat. 1388, 1388-115 to 1388-117, 1388-204 to 1388-206, particularly 42 U.S.C.A. §§ 1395cc(a), 1396a(w)(1) (Westlaw 1998)) 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.

incapacitated adults to have appropriate decisions made when they cannot do so[5] should be recognized in the law.

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."[6]

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*,[7] 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 deci-

5. For a persuasive articulation of this perspective, see *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.

6. Health & Safety Code § 1418.8(c).

7. 8 Cal. 3d 229, 243-44, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) (citations omitted).

> sion whether or not to undertake treatment is vested in the party most directly affected: the patient.

While this language is not a holding of the case,[8] *Cobbs* has frequently been cited in later cases involving consent or withdrawal of consent to medical treatment, and in medical decisionmaking guidelines routinely used in the medical profession and distributed to patients.

The leading case of *Barber v. Superior Court* [9] 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

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8. 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.

9. 147 Cal. App. 3d 1006, 1020-21, 195 Cal. Rptr. 484 (1983).

> 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 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."[10]

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 with-

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

out 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 is likely in practice that these are the persons doctors will ask, as stated in the pamphlet.[11]

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11. 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 2-17 (26th ed. 1999) ("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 decision-maker should be designated. Ordinarily this will be the patient's next of kin,

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.[12]

Priority schemes among relatives and friends seem natural. Intestate succession law[13] 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.[14] 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,

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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.").

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

13. Prob. Code § 6400 *et seq*.

14. Prob. Code § 1812.

the problem needs to be addressed with some sort of default rules, perhaps based on an intestate succession analogy. As described by Professor Meisel:[15]

> 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 Uniform Health-Care Decisions Act[16] lists the familiar top four classes of surrogates (spouse, children, parents, siblings), but is less restrictive than many state statutes in several respects:[17]

(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.

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15. 2 A. Meisel, The Right to Die § 14.1, at 249-50 (2d ed. 1995).
16. 9 (Pt. 1) U.L.A. 285 (West Supp. 1998) [hereinafter UHCDA].
17. UHCDA § 5.

(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."[18]

(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."[19] In a special procedure applicable 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,[20] but the health care decision is made by an "interdisciplinary team."

Statutory Surrogates — "Family Consent" — 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,

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18. English, *Recent Trends in Health Care Decisions Legislation* 17 (1998) (unpublished manuscript, on file with California Law Revision Commission); see also English, *The Health-Care Decisions Act Represents a Major Advance*, 133 Tr. & Est. 32, 37 (May 1994).

19. 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 ethical one for the physicians and family members or other persons who are making health care decisions for the patient.").

20. 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).

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:[21]

> 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 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 from the patient, (2) a domestic partner,[22] (3) children,

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21. 2 A. Meisel, The Right to Die § 14.4 at 255 (2d ed. 1995) (footnotes omitted).

22. 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 simi-

(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.[23] An individual who is positioned lower in the statutory list may be selected as the surrogate if, in the individual is best qualified to serve as the patient's surrogate, based on a number of statutory standards. 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 Section 4714.
>
> (2) The degree of regular contact with the patient before and during the patient's illness.

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lar 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.…"

23. 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).

(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.

The statute also makes clear that an individual may not be selected as a surrogate if the individual's competence or motives are questionable.[24]

Moreover, the process of applying these standards and making the required determinations 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 should reduce 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, however, 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.[25] 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 pro-

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24. This standard is drawn from the California Healthcare Ass'n, Consent Manual 2-17 (26th ed. 1999).

25. UHCDA § 5.

cedure seems overly mechanical and lacking in needed flexibility.

The Commission also considered a family consensus approach, such as that provided under Colorado law.[26] 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 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 challenge[27] or seek appointment of a conservator.

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26. 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).

27. See Prob. Code § 4750 *et seq.*

Like the UHCDA, the proposed law gives priority over the statutory list to a surrogate who has been designated by the patient.[28]

28. See Prob. Code § 4711 (patient's designation of surrogate).

PROPOSED LAW

☞ **Note.** For the reader's convenience, this report includes the complete text of Chapter 3 (commencing with Section 4711) of Part 2 of Division 4.7 of the Probate Code (as enacted by 1999 Cal. Stat. ch. 658, operative July 1, 2000), as proposed to be amended. Unchanged provisions from the Health Care Decisions Law are so indicated in the section heading.

CHAPTER 3. HEALTH CARE SURROGATES

Prob. Code § 4711 (unchanged). 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, [Prob. Code § 4711] 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).]

Prob. Code § 4712 (added). Selection of statutory surrogate

SECTION 1. Section 4712 is added to the Probate Code, to read:

4712. (a) Subject to Sections 2355 (authority of conservator) and 4685 (authority of agent under power of attorney for health care), if no surrogate has been designated under Section 4711 or if the designated surrogate is not reasonably available, 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.

(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 (Westlaw 1999); 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 1999).

"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 California Healthcare Ass'n, Consent Manual 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).

Prob. Code § 4713 (added). Notice to other potential surrogates

SEC. 2. Section 4713 is added to the Probate Code, to read:

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).]

Prob. Code § 4714 (unchanged). 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).]

Prob. Code § 4715 (unchanged). 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).]

Prob. Code § 4716 (added). Reassessment of surrogate selection

SEC. 3. Section 4716 is added to the Probate Code, to read:

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).