

Memorandum 2000-49

Family Consent in Health Care Decisionmaking for Adults

At the February meeting, the Commission deferred review of the Draft Recommendation on *Family Consent in Health Care Decisionmaking for Adults* and other related issues until this meeting. It was too late to resolve the issues in time for the 2000 legislative year and it was hoped that additional members would be appointed before the July meeting. While the Commission's Senate member has now been appointed, no new appointments have been made by the Governor. However, we need to start work on this topic again, regardless of vacancies, if the Commission wants to be able to submit a recommendation to the 2001 legislative session.

For reference purposes, a copy of the November 1999 Draft Recommendation is attached. Its introductory text summarizes the issues, provides important background, and explains the revisions recommended up to that time. Additional issues are discussed in this memorandum and some alternate drafts and other approaches are discussed.

Background

The fundamental issue before the Commission is how best to implement an incapacitated patient's wishes concerning health care decisionmaking. This question naturally focuses on administration, withholding, or withdrawal of life-sustaining treatment, but it is a broader problem that is encountered whenever a health care decision needs to be made in non-emergency circumstances. The Commission has limited the scope of this inquiry to finding surrogates from among the patient's family and friends; the important issue of decisionmaking for the "friendless" patient has been put on hold.

A useful overview of the family consent issues drawn from the Commission's original recommendation on *Health Care Decisions for Adults Without Decisionmaking Capacity*, 29 Cal. L. Revision Comm'n Reports 1 (1999), is set out in the attached November 1999 Draft Recommendation. California law and practice are summarized on pages 1-5. The main alternative approaches considered by the Commission in development of the Health Care Decisions Law

proposal are discussed on pages 6-10 (rigid hierarchy, Uniform Health Care Decisions Act class hierarchy with assumption of authority, family consensus, and flexible priority subject to standards).

As introduced in 1999, the Commission's recommendation in AB 891 (Alquist) sought to fill four gaps in the law: (1) authority for health care instructions outside of durable powers of attorney for health care and Natural Death Act declarations, (2) principles governing family consent or surrogate decisionmaking in the absence of an advance health care directive, (3) decisionmaking for persons with no advance directive or potential surrogate, and (4) limitations on the scope of court-authorized medical treatment. Most of the Commission's recommendation was enacted with minimal amendment, but the "surrogate committee" proposal (decisionmaking for the friendless) was removed from the bill as too controversial, and the family consent provisions were removed for retooling. Originally the intention was to revise the family consent rules and amend the new provisions back into the bill before final passage. However, finding a consensus was not possible in 1999 — we continue the search at this meeting.

The importance of family consent rules is summarized from the medical perspective in a June 19, 1999, letter from Dr. Robert D. Orr, speaking for the California Medical Association's Council on Ethical Affairs:

Our Council very strongly supports the retention of [Section 4712 as originally proposed]. 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.

A discussion of family consent rules has a tendency to turn into an evaluation of competing “rights” of relatives of different degrees, crafting elaborate procedures, and inventing notice and appeal procedures. This has not been the Commission’s focus in developing the Health Care Decisions Law. Health care decisionmaking is not the same as property distribution at death. While procedures are important to protect rights, and the involvement of lawyers and courts is necessary in contested cases and novel situations, it must be remembered that these issues are handled on a daily basis in the clinical setting everywhere in California. The law should improve the situation and provide needed guidance, not destroy a viable system by an overemphasis on procedures and priorities.

Consider the remarks of Professor Meisel, discussing how to resolve disagreement among possible surrogates:

[S]tatutory provisions addressing disagreements between potential surrogates seem to have been drafted without any awareness that the proper role of the surrogate is not to make a decision *per se* but to make a decision on the basis of a particular substantive standard, and that the standard dictates the kind of evidence that is to be taken into account. The statutory provisions that do address the resolution of conflicts among members of a class of surrogates are **unduly concerned with procedure at the expense of substance**. The role of surrogates — or of all members of a class of surrogates if there is more than one — should be to discern and articulate the wishes of the *patient*, not their own wishes; and if the patient’s actual or probably wishes are unknown, in some jurisdictions it is their role to determine the *interests* of the patient, not their own wishes or interests. Any decision made by a surrogate that is not based on some conception of the *patient’s* wishes or interests is almost certain to be an illegitimate decision.

If the focus is on the patient’s actual or probable treatment preferences — or if unknown, the patient’s interests — it might be less likely for there to be conflicts between members of a class of surrogates than if the focus is, wrongly, on the wishes or interests of the surrogates. **If members of the health care team can get the disputants to focus on the patient’s wishes and interests rather than on the disputants’ own wishes and interests, it might prove easier to avoid or resolve disputes while remaining faithful to the statutory and common-law standards for decisionmaking by surrogates. This is an extremely important point, not only as a matter of law but also as a matter of clinical practice.** When members of a class of surrogates are warring with each other over what decision is to be made about a relative’s medical treatment, it

may prove helpful for physicians (and lawyers, if they are involved at this stage) to remind the warring parties of their proper role.

None of the surrogate decisionmaking statutes have such a focus....

2A. Meisel, *The Right to Die* § 14.6, at 258 (2d ed. 1995) [emphasis added].

Concerns with Commission's Family Consent Proposal

In meetings since last summer, the Commission has discussed the concerns of the Assembly Judiciary Committee Chair and counsel, which are mainly the following: (1) the physician is given too much authority to determine capacity, select or participate in selecting the surrogate, and recommend treatments to the surrogate selected; (2) a "one size fits all" approach is inappropriate and that additional protections may be needed in cases involving more serious treatments; (3) the statute needs to deal with the situation where there is disagreement within the family as to the appropriate decision.

Recently the Commission has heard the concerns of Eric Carlson of Bet Tzedek, mainly directed toward eliminating or minimizing the role of physicians in the surrogate selection process. At the February meeting, the Commission considered a proposal from Mr. Carlson largely drawn from the Uniform Health-Care Decisions Act (see Memorandum 2000-5, considered at the February meeting). The gist of that proposal was to provide a rigid hierarchy of surrogate classes resembling intestate succession, with no standards-based selection criteria. Several years ago, the Commission rejected this approach in developing its original recommendation, since a rigid hierarchy violates the fundamental principle that guides policymaking in this area — the patient has the right to have the *most appropriate* person make decisions in his or her behalf, not just the closest relative on a chart of degrees of kinship.

Qualifying Factors or Disqualifying Factors

One approach the Commission has investigated is to recast the surrogate selection rules in the form of *disqualifying* factors instead of *qualifying* factors. This has the effect of bolstering the priority scheme because the surrogate claiming authority to act can only be bumped by a higher ranking surrogate or by failure to satisfy the statutory standard. The presumption is in favor of the person having statutory priority in this approach, whereas the earlier recommendation (as reflected in Section 4712 on pages 11-12 of the attached November 1999 Draft

Recommendation) permitted the replacement of one surrogate with a lower priority surrogate who better satisfied the statutory standards.

This important change in emphasis has apparently not satisfied the concerns of some objectors. Mr. Carlson proposed only a very limited exception to his hierarchy proposal at the February meeting that would permit a supervising health care provider to

refuse to accept the authority of a surrogate ... if the physician determines, and documents in the patient's health care record, that the surrogate proposes a course of action that clearly is not in the best interests of the patient, AND that the surrogate's proposed course of action is either [1.] a result of the surrogate's lack of mental capacity or [2] motivated by the surrogate's financial interests.

The lack of mental capacity is not an addition to the law, since any surrogate would have to have capacity. The exception boils down to allowing exclusion of surrogates who, motivated by selfish financial interests, propose to make a decision that is clearly not in the patient's best interest. In this form, it does nothing to mitigate the harsh results of a rigid hierarchy of surrogates. The staff thinks this exception is unworkable in this form. As worded, the language appears to permit a surrogate lacking mental capacity to make decisions as long as they are in the best interests of the patient.

The Commission has expressed concern that the use of factors to reject a surrogate based on questionable motives or other negative factors could expose the physician to liability for defamation. If the statute imposes a duty on physicians to make the determination and record it in the patient's records, there shouldn't be any liability. Probate Code Section 4740 provides an immunity from civil and criminal liability for health care providers and institutions "acting in good faith and in accordance with generally accepted health care standards ... for any actions in compliance" with the Health Care Decisions Law. If that isn't sufficient, then a specific reference to making and recording a determination that a surrogate is qualified or unqualified could be added to the section.

Distinguishing Between Choosing Surrogates and Making Health Care Decisions

At the February meeting, the Commission discussed how to distinguish in the statute between the choice of a surrogate and the choice of a treatment. The Commission's family consent proposals have been directed toward qualifications

of and the manner of choosing the surrogate. Once qualified to act, the surrogate is authorized to make health care decisions according to the statutory standards in Section 4714 and any other relevant law. It has been argued that the two types of decisions overlap, so that there is a significant risk that the authority to choose a surrogate can result in making the health care decision.

The Commission has properly focused on surrogate selection itself, not on choosing a person to make a particular decision. This insulates the surrogate selection process from the health care decisionmaking process. The fundamental concern is to find the most appropriate *surrogate decisionmaker*. This is the person who can make decisions in the place of the incapacitated patient. The kind of decision the surrogate may make or is likely to make should not enter into the surrogate selection process. This clear distinction underlies the Commission's recommendations in this area, as well as the Uniform Health Care Decisions Act, and other sources we have relied upon. The Health Care Decisions Law and later draft proposals have been clear and we detect no cross-pollination of these concepts. We don't know how to prevent critics from confabulating the two processes and arguing that the selection of a surrogate is tantamount to determining the course of treatment. However, in an effort to remedy the confusion of the two processes, the staff has added language in the draft later in this memorandum stating the rule that the decision a surrogate may make or refuse to make is not a proper consideration in determining the qualifications of a surrogate.

Family Consensus

The Commission decided the statute should recognize the ability of the patient's family and friends to choose the surrogate. Mr. Carlson also suggested that family determinations would be a preferable alternative to a rigid priority. As noted in the background materials, the Commission considered a family consensus approach as an alternative to the guided flexibility standard eventually proposed. (See the attached November 1999 Draft Recommendation, p. 9, lines 29-38.) However, the Commission did not consider a statutory implementation of a family consensus rule as an additional alternative to the general standards. The staff has assumed that this option would work under the Commission's proposals without the necessity for statutory validation. Of course, in a rigid priority regime, special recognition of such an exception to the hierarchy might be necessary.

In 1997, the Commission considered a number of different approaches, including the Colorado statute which, in relevant part, provides as follows :

(3) Upon a determination that an adult patient lacks decisional capacity to provide informed consent to or refusal of medical treatment, the attending physician, or such physician's designee, shall make reasonable efforts to notify the patient of the patient's lack of decisional capacity. In addition, the attending physician, or such physician's designee, shall make reasonable efforts to locate as many interested persons as defined in this subsection (3) as practicable and the attending physician may rely on such individuals to notify other family members or interested persons. For the purposes of this section, "interested persons" means the patient's spouse, either parent of the patient, any adult child, sibling, or grandchild of the patient, or any close friend of the patient. Upon locating an interested person, the attending physician, or such physician's designee, shall inform such person of the patient's lack of decisional capacity and that a proxy decision-maker should be selected for the patient.

(4)(a) It shall be the responsibility of the interested persons specified in subsection (3) of this section to make reasonable efforts to reach a consensus as to whom among them shall make medical treatment decisions on behalf of the patient. The person selected to act as the patient's proxy decision-maker should be the person who has a close relationship with the patient and who is most likely to be currently informed of the patient's wishes regarding medical treatment decisions. If any of the interested persons specified in subsection (3) of this section disagrees with the selection or the decision of the proxy decision-maker or, if, after reasonable efforts, the interested persons specified in subsection (3) of this section are unable to reach a consensus as to who should act as the proxy decision-maker, then any of the interested persons specified in subsection (3) of this section may seek guardianship of the patient Only said persons may initiate such proceedings with regard to the patient.

Colo. Rev. Stat. Ann. § 15-18.5-103 (Westlaw 2000) (emphasis added) (see Memorandum 97-63).

This approach is based on the assumption that interested persons will become involved and should be able to work together, but if they can't, the process ends in a petition for guardianship. The consensus approach recognizes the family and close friends as a social system and relies on them to make the right decisions, rather than attempting to prescriptively determine who in the family should make decisions by a statutory hierarchy. A consensus approach cannot solve

intractable problems arising where there is significant disagreement among the interested persons. In these cases, court proceedings will be likely no matter what the statutory scheme. If a patient's parent disagrees strongly enough with the spouse under existing law or a priority scheme, or if the children can't agree among themselves, informal procedures are likely to be stymied and the dispute may end up in court, regardless of what the statute says. The same thing will happen under the consensus approach. A priority scheme is not likely to work where there are significant disagreements, even though such a scheme on its face permits a higher priority (such as spouse or domestic partner) to determine the outcome notwithstanding disagreements from lower priorities (such as children and parents).

Dispute Resolution

On a number of occasions the Commission has heard the objection that the proposal does not adequately address the situation where there is disagreement among potential surrogates. The staff believes the existing procedures, as set forth in the Health Care Decisions Law, are adequate — if anything, they are too permissive. In our experience, it has been universally recognized in commentary spanning the 20-plus years the Commission has considered issues relating to durable powers of attorney for health care and health care decisionmaking for incapacitated adults in general, that when there is a genuine dispute, the medical decisionmaking process stops. This was reaffirmed by health care professionals attending the February Commission meeting. The staff has made further inquiries about this issue in meetings of the Santa Clara County Medical Association Bioethics Committee, with the same conclusion. Barring an emergency, when there is a dispute, the medical team and the health care institution go into a holding pattern until the dispute can be resolved. Whether from fear of law suits and potential liability or a genuine desire to make the best informed and most ethical decision, this is how health care professionals and institutions behave. It is difficult to see the need for special, new statutory procedures.

The best way to resolve family disputes is to give the parties time to work the problems out. (Dr. Orr discusses some of these issues in his letter excerpted in the First Supplement to Memorandum 2000-5, considered at the February meeting.) The Commission's approach has relied on giving notice to known surrogate candidates, informing the surrogate of the duty to notify other potential

surrogates, recordkeeping obligations, and the broad availability of judicial remedies. The staff continues to believe that these rules, along with medical ethics, professionalism, and institutional practices, will more than adequately deal with the issues.

Legislating “majority rules in each class” seems to be overly legalistic. The classes are arbitrary and membership in a class may not be clear. If a class of five children is at the plate, and two of them are unreachable or estranged, can they be ignored? What if one of the three remaining has serious objections that need to be considered from an ethical perspective? Do the other two “win” just by voting? Under Mr. Carlson’s proposal, drawn from the uniform act, if there is a draw among “voting” class members, that class and all lower classes are disqualified from further participation and the matter is possibly bumped to the courts, where someone will be expected to be appointed as a conservator of the person with authority to make health care decisions. The staff does not think that any clockworks scheme of this type can do justice to the issues inherent in health care decisionmaking.

Appropriate judicial remedies are clearly set out in the new Health Care Decisions Law. See Prob. Code §§ 4750-4771 (operative July 1, 2000). Section 4765 permits the following persons to petition: (a) the patient, (b) the patient’s spouse, unless legally separated, (c) a relative of the patient, (d) the patient’s agent or surrogate, (e) the conservator of the person of the patient, (f) the court investigator of the county where the patient resides, (g) the public guardian of the county where the patient resides, (h) the supervising health care provider or health care institution involved with the patient’s care, and (i) any other interested person or friend of the patient. Section 4766 permits filing a petition for any of the following purposes:

(a) Determining whether or not the patient has capacity to make health care decisions.

(b) Determining whether an advance health care directive is in effect or has terminated.

(c) Determining whether the acts or proposed acts of an agent or surrogate are consistent with the patient’s desires as expressed in an advance health care directive or otherwise made known to the court or, where the patient’s desires are unknown or unclear, whether the acts or proposed acts of the agent or surrogate are in the patient’s best interest.

(d) Declaring that the authority of an agent or surrogate is terminated, upon a determination by the court that the agent or

surrogate has made a health care decision for the patient that authorized anything illegal or upon a determination by the court of both of the following:

(1) The agent or surrogate has violated, has failed to perform, or is unfit to perform, the duty under an advance health care directive to act consistent with the patient's desires or, where the patient's desires are unknown or unclear, is acting (by action or inaction) in a manner that is clearly contrary to the patient's best interest.

(2) At the time of the determination by the court, the patient lacks the capacity to execute or to revoke an advance health care directive or disqualify a surrogate.

In addition to this broad procedure, an interested person can petition for appointment of a conservator of the person of the patient, can petition for court authorized medical treatment, or employ any other remedy suitable in the case.

Perhaps the only real issue here — that can be addressed by statute — is to make the availability of the judicial remedy clear in cases where there is disagreement between surrogates or potential surrogates. There is concern in some quarters that, notwithstanding our conclusion that physicians stop when faced with a genuine dispute, some physicians might be willing to proceed based on the consent of a hand-picked surrogate even in the face of objections from other family members. Hence, it may be useful to provide additional cross-references or to trigger court proceedings. But we should be very reluctant to impose burdensome or complicating procedures.

In an effort to provide some additional guidance, however, the staff has proposed implementing a limited non-judicial (or pre-judicial) procedure 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. It is phrased for consistency with the version of Section 4712 in the attached November 1999 draft recommendation, but it could be adapted to encourage mediation within a class or where there are objections from lower classes in the priority list. The staff is not recommending this language because it is probably too mechanical and relies too heavily on the artificial notion of “entitled” classes of surrogacy.

Administrative Procedures

Hospitals are likely to develop administrative procedures to assist in implementing and interpreting a statutory surrogate scheme. Our discussions with health care professionals, CMA and CHA representatives, the Compassionate Care Coalition, and the Santa Clara County Medical Association Bioethics Committee, as well as numerous comments in correspondence to the Commission over the years, demonstrates that the health care profession is genuinely interested in working through these issues. But there is only so much that can be achieved by in-house procedures, county-wide association statements of principles, or statewide manuals. Should additional encouragement be provided by statute or regulation?

A basic set of rules can assist health care professionals in focusing their efforts and provide some needed assurance that practices and procedures consistent with the statute have legal authority and provide protection. The staff does not recommend going any farther than this, because we are convinced that the health care bureaucracies will respond. However, more could be done by statute or regulation. For example, the statute could require that health care institutions develop procedures consistent with the statute and provide protection from liability where the procedures are followed. Similarly, the statute could direct the Department of Health Services to develop appropriate procedures through the regulatory process or, less invasively, direct DHS to act as overseer and approver of implementation plans developed by each type of health care institution under its jurisdiction. This approach may not be welcomed, however, either by DHS or the regulated institutions.

At most, the staff would suggest including language in a relevant Comment approving the use of in-house and association procedures and codes of ethics. Statutorily mandating the creation of a procedure by a health care institution does not seem sufficient if there is no procedure for approving them. We should also avoid too draconian an approach that would squelch the creativity of health care professionals in addressing these issues.

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. Withholding or withdrawing life-sustaining treatment, nutrition, and hydration are clearly 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.” (Section 4722 in original recommendation, 29 Cal. L. Revision Comm’n Reports at 119.) 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 last year 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.

At the November 1999 meeting, the subject of applying different procedures in different treatment categories was discussed, but the staff has not yet found a

way to implement these ideas. We have examined regulations concerning “informed consent,” as suggested, but have not discovered any useful principles for statutory implementation. There are some details in the regulations governing different types of health care providers, but they should not and need not be added to the statutes. The more general regulations, such as those concerning patients’ rights, do not make any meaningful distinctions based on the “seriousness,” “invasiveness,” or importance of the treatment. We find ourselves again looking at very general language, such as “serious” or “major” — but with what effect? The rules in the draft recommendation as well as those proposed by Mr. Carlson and in the UHCDA apply to all cases, including the most serious ones. If we were to find a way to distinguish “lesser” health care decisions, the result would presumably be to exempt them from the surrogate decisionmaking rules. The staff believes it would be best to find an appropriate size that does fit all, rather than creating additional complications.

Under draft Section 4712 in the attached November 1999 Draft Recommendation, the goal is to select the best decisionmaker, not to determine a treatment, so the gravity of the decision is not relevant. Again, 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 most likely to have been selected by the patient if the patient had executed an advance directive naming a health care agent.

Legislative Developments

The Commission’s recommendation in AB 891 as introduced in 1999 would have addressed the issue of health care decisionmaking by a domestic partner, broadly defined as “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.”

Last year saw enactment of a domestic partner registration scheme (1999 Cal. Stat. ch. 588 (AB 26)), which employs a detailed definition in Family Code Section 297:

297. (a) Domestic partners are two adults who have chosen to share one another’s lives in an intimate and committed relationship of mutual caring.

(b) A domestic partnership shall be established in California when all of the following requirements are met:

(1) Both persons have a common residence.

(2) Both persons agree to be jointly responsible for each other's basic living expenses incurred during the domestic partnership.

(3) Neither person is married or a member of another domestic partnership.

(4) The two persons are not related by blood in a way that would prevent them from being married to each other in this state.

(5) Both persons are at least 18 years of age.

(6) Either of the following:

(A) Both persons are members of the same sex.

(B) Both persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless both persons are over the age of 62.

(7) Both persons are capable of consenting to the domestic partnership.

(8) Neither person has previously filed a Declaration of Domestic Partnership with the Secretary of State pursuant to this division that has not been terminated under Section 299.

(9) Both file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division.

(c) "Have a common residence" means that both domestic partners share the same residence. It is not necessary that the legal right to possess the common residence be in both of their names. Two people have a common residence even if one or both have additional residences. Domestic partners do not cease to have a common residence if one leaves the common residence but intends to return.

(d) "Basic living expenses" means, shelter, utilities, and all other costs directly related to the maintenance of the common household of the common residence of the domestic partners. It also means any other cost, such as medical care, if some or all of the cost is paid as a benefit because a person is another person's domestic partner.

(e) "Joint responsibility" means that each partner agrees to provide for the other partner's basic living expenses if the partner is unable to provide for herself or himself. Persons to whom these expenses are owed may enforce this responsibility if, in extending credit or providing goods or services, they relied on the existence of the domestic partnership and the agreement of both partners to be jointly responsible for those specific expenses.

While these qualifications and technical requirements may be appropriate for a domestic partner registration scheme, these limitations should not be imported into a health care decisionmaking statute without compelling reasons. The purpose of finding the person best qualified to serve as the patient's surrogate would be defeated by some of these technical requirements. On the other hand, to the extent that registered domestic partnerships are akin to marriage, there is a logic to treating both categories in a similar fashion. Where partners and companions are not married or registered under the new statute, then a health care decisionmaking statute should cover them in some appropriate fashion. The various iterations of the Commission's proposals have always covered close friends; the current description is "individuals with a close personal relationship to the patient." (See Memorandum 2000-5, p. 11, considered at the February meeting.)

In the guided flexibility proposal the Commission has favored, the order of surrogates has not been determinative (as distinct from the rigid priority scheme), since the surrogate is ultimately qualified by statutory standards, not kinship status. Still, there is a potential psychological effect of putting the spouse first, registered domestic partner second, and close friends seventh, after a number of relatives. The order can matter, even in a "soft priority" scheme. If the Commission is inclined to recommend giving greater weight to the priority list, then careful consideration must be given as to the treatment of unregistered domestic partners (regardless of gender or age).

The domestic partner registration system, presumably for political reasons, states specifically in Family Code Section 299.5:

(a) The obligations that two people have to each other as a result of creating a domestic partnership are those described in Section 297. Registration as a domestic partner under this division shall not be evidence of, or establish, any rights existing under law other than those expressly provided to domestic partners in this division and Section 1261 of the Health and Safety Code.

With this rule in mind, the staff has suggested that the Commission steer clear of the registration rules in describing who is an appropriate surrogate. Bills attempting to add additional rights are finding it necessary to amend Section 299.5 to provide explicit exceptions. These technicalities do not serve the goal of a family consent statute and it is best to avoid them if we can.

But it may not be easy to avoid these entanglements. Assembly Bill 1990 (Romero), in the words of the Legislative Counsel's digest, would "authorize a domestic partner to make medical treatment decisions on behalf of a patient in certain circumstances." (The operative language of the proposed Health and Safety Code Section 1261.1 is not altogether clear to the staff; a literal reading can support the conclusion that the new section would only impose a duty on a physician to inform the health facility when there is no person with legal authority to make decisions for the patient, without actually granting any authority.) This bill also amends Family Code Section 299.5 to provide an exception to the limitation on rights flowing from domestic partnership registration.

The substance of AB 1990 (and some other bills) has been combined into AB 2047 (Romero, Kuehl, Migden, Steinberg; Coauthor, Hertzberg) with no change in the language. In its current form, AB 2047 would add Section 1261.1 to the Health and Safety Code, reading as follows:

1261.1. (a) If the attending physician and surgeon of a patient in a health facility prescribes or orders a medical intervention that requires informed consent be obtained prior to administration of the medical intervention, but is unable to obtain informed consent because the physician and surgeon determines that the patient lacks capacity to make decisions concerning his or her health care and that there is no person with legal authority to make those decisions on behalf of the patient, the physician and surgeon shall inform the health facility.

(b) For purposes of subdivision (a), a patient lacks capacity to make a decision regarding his or her health care if the patient is unable to understand the nature and consequences of the proposed medical intervention, including its risks and benefits, or is unable to express a preference regarding the intervention. To make the determination regarding capacity, the physician shall interview the patient, review the patient's medical records, and consult with the health facility staff, as appropriate, and family members and friends of the patient, if any have been identified.

(c) For purposes of subdivision (a), a person with legal authority to make medical treatment decisions on behalf of a patient is a person designated under a valid Power of Attorney for Health Care, a guardian, a conservator, or the patient's family members. To determine the existence of a person with legal authority, the physician shall interview the patient, review the medical records of the patient and consult with the health facility staff, as appropriate, and family members and friends of the patient, if any have been

identified. For purposes of determining the existence of a person with legal authority, family members include, but are not limited to, a patient's domestic partner, the children of the patient's domestic partner, and the domestic partner of the patient's parent or child.

(d) For purposes of this section, "domestic partner" means a person who has filed a 'Declaration of Domestic Partnership' with the Secretary of State pursuant to Division 2.5 (commencing with Section 297) of the Family Code as long as that domestic partnership has not been terminated pursuant to Section 299 of the Family Code.

Note that the last part of subdivision (c) includes "children of the patient's domestic partner, and the domestic partner of the patient's parent or child." The Commission's priority list has always referred to children and parents, but not to the spouse's children (stepchildren), parents-in-law, or children-in-law. The focus of the Health Care Decisions Law was on the qualifications of the surrogate, not the technicality of relationship. The Commission has used general language like "parents" without trying to define the terms. However, "parent" is defined in the Probate Code to mean a person who would take by intestate succession from the child, and "child" is similarly defined. These are not ideal definitions, because they assume an understanding of the rules in Section 6450 *et seq.* which may not serve the broader purposes of the Health Care Decisions Law. Section 1261.1 in AB 2047 is drafted solely on the basis of relationships, not standards, and makes clear how it applies to domestic partner relationships.

If this provision becomes law, it presents some challenges for the Commission's study. The new section is not limited to domestic partners, but addresses any patient who lacks capacity and who does not have a surrogate decisionmaker ("person with legal authority to make medical treatment decisions on behalf of a patient"). We don't intend to dissect this proposed section here, but it appears to be intended to cover much of the same ground covered by the Commission's family consent drafts. As Commissioners know, custom and common sense suggest that it is unwise to attempt to repeal or substantially amend very recent legislative enactments, particularly in a highly politicized area. At this writing, heading into the summer legislative recess, AB 2047 is pending in the Assembly (in Appropriations Committee). Given the difficulties the Commission has faced in developing a consensus in favor of its family consent proposal, it is tempting to postpone or abandon any further efforts, unless AB 2047 (and any similar bills) are not enacted.

New Draft Language

The following draft sections implement a number of ideas that the Commission has been considering as a way to address the concerns of the critics of the “guided flexibility” approach reflected in the November 1999 Draft Recommendation and the earlier full recommendation.

For completeness, we have also set out the three existing sections in this chapter that were enacted in 1999 in the Health Care Decisions Law.

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.

Prob. Code § 4712 (added). Statutory surrogate

4712. (a) Subject to Sections 2355 (authority of conservator) and 4685 (authority of agent under power of attorney for health care), if the patient has not designated a surrogate under Section 4711 or if the designated surrogate is not reasonably available, a surrogate determined pursuant to this section may make health care decisions for the patient.

(b) Subject to Section 4713, preference to act as the surrogate health care decisionmaker for the patient is given in the following order of priority to 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.

(3) Children.

(4) Parents.

(5) Brothers and sisters.

(6) Grandchildren.

(7) Individuals with a close personal relationship to the patient.

(c) A surrogate shall communicate his or her assumption of authority to the supervising health care provider and to all adults described in paragraphs (1) to (5), inclusive, of subdivision (b) who

can readily be contacted. The supervising health care provider shall inform the surrogate of the duty under this subdivision.

(d) If more than one member of a priority class assumes authority to act as surrogate, and the supervising health care provider is informed that they do not agree on a health care decision, the surrogate supported by the majority of the members of the class who have communicated their views to the supervising health care provider has authority and shall be recognized as the surrogate. If there is no majority in favor of a surrogate, the members of that priority class and all individuals in lower classes are disqualified from assuming authority under this section until the disagreement is resolved.

(e) As an alternative to determination of a surrogate under subdivision (b), the family and friends of the patient, including but not limited to the persons listed in subdivision (b), may undertake the responsibility of choosing the patient's surrogate. The individual chosen as surrogate should have a close relationship with the patient and be currently informed of the patient's wishes regarding health care decisions and the patient's personal values. The individual chosen as surrogate shall communicate his or her assumption of authority to the supervising health care provider and provide an explanation of who was involved in the selection process and other relevant information requested by the supervising health care provider.

This version of Section 4712 provides a stronger hierarchy approach and puts the responsibility on the surrogate to assume authority, a feature drawn from the UHCDA and recommended by Eric Carlson in his January 11, 2000, letter. Subdivision (d) provides for voting within classes, although the staff thinks this is artificial and probably unworkable in most cases. It is possible to imagine a case where a dissenting child could be silenced by being outvoted by the other children using the authority of the statute.

As discussed above in connection with AB 2047, subdivision (b)(2) is intended to be broad, but the Commission needs to consider whether to refer instead to "domestic partner." If AB 2047 is enacted, a technical definition of "domestic partner" would be added to the Probate Code ("one of two persons who have filed a Declaration of Domestic Partnership with the Secretary of State pursuant to Division 2.5 (commencing with Section 297) of the Family Code, provided that the domestic partnership has not been terminated pursuant to Section 299 of the Family Code").

Subdivision (e) is an attempt to codify recognition of a surrogate selected through the family's general consensus. At the February meeting, the Commission decided that a statutory priority scheme should not have the effect of disrupting selection of a surrogate by family consensus. The staff is not sure this consensus rule fits very well with the technical rules in the class voting provision.

Prob. Code 4713 (added). Disqualification of surrogate

4713. (a) If an individual who assumes authority as surrogate under Section 4712 does not meet the standards provided in this section, the primary physician, after consultation with the patient's family and friends, health care providers, institutional committees, and other interested persons, may refuse to accept the individual's claim of authority as surrogate.

(b) To determine whether an individual is qualified to act as a surrogate under Section 4712, the following factors shall be considered and applied:

(1) Whether the individual 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.

(c) An individual may not act as a surrogate if the individual's competence or motives are questionable.

(d) The primary physician may not refuse to accept the authority of an individual to act as surrogate on the grounds that the individual refuses to make a health care decision recommended by the primary physician or other health care provider.

(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, friends, and others concerning the selection of the surrogate and communicate with them concerning health care decisions for the patient.

(f) The primary physician shall document determinations under this section in the patient's health care record.

This draft section addresses the concern that the November 1999 draft granted too much discretion to physicians. The earlier approach permitted the physician

to recognize as surrogate a person lower in priority by application of the ethical standards (see draft Section 4712(b)-(d), on pages 11-12 in the attached November 1999 Draft Recommendation). The new draft is phrased in terms of refusal to accept as surrogate a person who does not satisfy the ethical standards essential to finding the person who should act as surrogate. It does not permit the physician to select the surrogate. In addition, subdivision (d) reminds that the qualification of the person as surrogate is distinct from making health care decisions.

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.

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.

Conclusion

The origin of the Commission's proposals on family consent was the lack of good authority to determine who can make decisions for an incapacitated adult. Most commentators think it is a problem worth addressing, although some, particularly in the medical field, may fear that any legislative tinkering is likely to be a step backward. The more detailed a proposal, the more opposition that can arise. The attempt to have both the comfort of a presumptive priority scheme and the ethical integrity of the standards-based approach has been supported by most commentators in the health care professions, hospitals, and elder law attorneys, but has encountered concern and opposition from some advocacy groups, legal services attorneys, and legislative sources. Our struggle since April 1999 to find a consensus approach has not succeeded, and the staff suspects that it is impossible to satisfy those calling for more rigid priority schemes (meaning

less or almost no physician discretion) without losing the support of health care professionals and institutions. We are not optimistic that further refinement and adjustment of the November 1999 draft or its successors will lead us to the desired goal.

Perhaps inspired by the domestic partner bills in this session, **the staff wonders whether it might be most profitable to address only the issue of who may act as surrogate, without specifying how they are selected.** Enacting a simple statement along these lines would provide statutory authority for what many people believe the law has been for years. The dictum in *Cobbs v. Grant* (see attached November 1999 Draft Recommendation, p. 2) would finally be validated, as well as language in the Patient Information Pamphlet (*id.* p. 5) and other ethical guidelines in current use.

In summary, the staff sees four valid approaches:

- (1) The draft recommendation in the November 1999 form (with possible additional features).
- (2) A combination of the Carlson proposal and the standards-based rule (as set out above).
- (3) The constellation approach — list legally recognized surrogates and stop there.
- (4) Leave the subject uncodified — i.e., drop this study, at least for the near future.

As noted, if AB 2047 is enacted with Health and Safety Code Section 1261.1 in its present or similar form, then Option 3 will be accomplished, though not in the form the Commission would draft it. By the October meeting, we will know the fate of AB 2047. If the Commission decides that Option 3 is the best approach, and Section 1261.1 in AB 2047 is not enacted, there would probably be time to prepare a staff Discussion Draft to be circulated for comment, enabling the Commission to seek legislation in the 2001 Legislature.

Respectfully submitted,

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Assistant Executive Secretary

FAMILY CONSENT IN HEALTH CARE DECISIONMAKING FOR ADULTS

1 California has been a pioneer in the area of health care decisionmaking for adults
2 without decisionmaking capacity, with the enactment of the 1976 Natural Death
3 Act,¹ the 1983 Durable Power of Attorney for Health Care,² and the 1999 Health
4 Care Decisions Law.³ However, California law does not yet adequately address a
5 number of important issues in the law concerning health care decisionmaking for
6 adults who are unable to make decisions for themselves.

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

13 Most incapacitated adults for whom health care decisions need to be made will
14 not have formal written advance health care directives. It is likely that less than
15 one-fifth of adults have executed written advance health care directives.⁴ The law,

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 604-05 (1999).

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,

1 focusing as it does on execution of advance directives, is deficient if it does not
2 address the health care decisionmaking process for the great majority of inca-
3 pacitated adults who have not executed written advance directives. The right of
4 incapacitated adults to have appropriate decisions made when they cannot do so⁵
5 should be recognized in the law.

6 Existing California Law

7 California statutory law does not provide general rules governing surrogate deci-
8 sionmaking. However, in the nursing home context, the procedure governing
9 consent to “medical interventions” implies that the “next of kin” can make deci-
10 sions for incapacitated persons by including them in the group of persons “with
11 legal authority to make medical treatment decisions on behalf of a patient.”⁶

12 There are supportive statements in case law, but due to the nature of the cases,
13 they do not provide comprehensive guidance as to who can make health care deci-
14 sions for incapacitated persons. For example, in *Cobbs v. Grant*,⁷ the Supreme
15 Court wrote:

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

23 While this language is not a holding of the case,⁸ *Cobbs* has frequently been cited
24 in later cases involving consent or withdrawal of consent to medical treatment, and

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.

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).

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.

1 in medical decisionmaking guidelines routinely used in the medical profession and
2 distributed to patients.

3 The leading case of *Barber v. Superior Court*⁹ contains a thorough discussion of
4 the problems:

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

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

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

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

23

24 The authorities are in agreement that any surrogate, court appointed or other-
25 wise, ought to be guided in his or her decisions first by his knowledge of the
26 patient's own desires and feelings, to the extent that they were expressed before
27 the patient became incompetent....

28 If it is not possible to ascertain the choice the patient would have made, the sur-
29rogate ought to be guided in his decision by the patient's best interests. Under this
30 standard, such factors as the relief of suffering, the preservation or restoration of
31 functioning and the quality as well as the extent of life sustained may be consid-
32 ered. Finally, since most people are concerned about the well-being of their loved
33 ones, the surrogate may take into account the impact of the decision on those
34 people closest to the patient....

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

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

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

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

1 Despite the breadth of its language, *Barber* does not dispose of the issue of who
2 can consent, due to the way in which the case arose — reliance on requests from
3 the family of the patient as a defense to a charge of murder against the doctors who
4 removed the patient’s life support. Note also that the court is not in a position to
5 determine issues such as who is included in the patient’s “family.” It is implicit in
6 the case that the wife, children, and sister-in-law were all family members. How-
7 ever, the court’s statement that the “wife was the proper person to act as a surro-
8 gate for the patient” based on the assumption she would have been qualified if
9 judicial approval had been sought, is not completely consistent with other state-
10 ments referring to the “family’s decision” and that the “wife and children were the
11 most obviously appropriate surrogates,” and speculation on what would have hap-
12 pened if “the family had insisted on continued treatment.”

13 Nevertheless, *Barber* has been characterized as an “enormously important” deci-
14 sion: “Indeed, literature generated from within the medical community indicates
15 that health care providers rely upon *Barber* — presumably every day — in
16 deciding together with families to forego treatment for persistently vegetative
17 patients who have no reasonable hope of recovery.”¹⁰

18 **Current Practice: LACMA-LACBA Pamphlet**

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

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

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

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

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

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

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

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

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

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

14 **Current Practice: Patient Information Pamphlet**

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

23 *What if I’m too sick to decide?*

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

30 Based on the case law, the Commission is not confident that California law says
31 the *closest* available relative *or friend* can make health care decisions. However, it
32 is likely in practice that these are the persons doctors will ask, as stated in the
33 pamphlet.¹¹

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 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.”).

1 **Alternative Approaches to Statutory Surrogate Priorities**

2 The general understanding is that close relatives and friends who are familiar
3 with the patient’s desires and values should make health care decisions in
4 consultation with medical professionals. Wives, brothers, mothers, sisters-in-law,
5 and domestic partners have been involved implicitly as “family” surrogate
6 decisionmakers in reported California cases. The practice, as described in
7 authoritative sources, is consistent with this understanding. Courts and legislatures
8 nationwide naturally rely on a family or next-of-kin approach because these are the
9 people who are presumed to best know the desires of the patient and to determine
10 the patient’s best interests.¹²

11 Priority schemes among relatives and friends seem natural. Intestate succession
12 law¹³ provides a ready analogy — thus, the spouse, children, parents, siblings, and
13 so forth, seem to be a natural order. The same order is established in the preference
14 for appointment as conservator.¹⁴ But the analogy between health care, life-
15 sustaining treatment, and personal autonomy, on one hand, and succession to prop-
16 erty, on the other, is weak. A health care decision cannot be parceled out like
17 property in an intestate’s estate. The consequences of a serious health care deci-
18 sion are different in kind from decisions about distributing property.

19 The trend in other states is decidedly in favor of providing statutory guidance,
20 generally through a priority scheme. The collective judgment of the states would
21 seem to be that, since most people will not execute any form of advance directive,
22 the problem needs to be addressed with some sort of default rules, perhaps based
23 on an intestate succession analogy. As described by Professor Meisel:¹⁵

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

32 The Uniform Health-Care Decisions Act¹⁶ lists the familiar top four classes of
33 surrogates (spouse, children, parents, siblings), but is less restrictive than many
34 state statutes in several respects:¹⁷

35 (1) Class members *may* act as surrogate and need to *assume authority* to do so. It
36 is not clear whether a class member must affirmatively decline to act or may be

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.

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.

1 disregarded if he or she fails to assume authority, but unlike some state statutes, an
2 abstaining class member does not prevent action.

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

7 (3) Orally designated surrogates are first on the UHCDA priority list, in an
8 attempt to deal with the fact that a strict statutory priority list does not necessarily
9 reflect reality. The “orally designated surrogate was added to the Act not because
10 its use is recommended but because it is how decision makers are often designated
11 in clinical practice.”¹⁸

12 (4) The authorization for adults who have “exhibited special care and concern”
13 is relatively new. Under the common law, the status of friends as surrogates is, in
14 Professor Meisel’s words, “highly uncertain.”¹⁹ In a special procedure applicable
15 to “medical interventions” in nursing homes, California law requires consultation
16 with friends of nursing home patients and authorizes a friend to be appointed as
17 the patient’s representative,²⁰ but the health care decision is made by an
18 “interdisciplinary team.”

19 **Statutory Surrogates — “Family Consent” — Under Proposed Law**

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

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).

1 Professor Meisel describes this fundamental problem with priority classes as
2 follows:²¹

3 Although the intent of such priority lists is a good one — to eliminate possible
4 confusion about who has the legal authority to make decisions for incompetent
5 patients — the result of surrogate-designation pursuant to statute is not only
6 mechanical but can be contrary or even inimical to the patient’s wishes or best
7 interests. This would occur, for example, if the patient were estranged from his
8 spouse or parents. However, it is not clear that the result would be much different
9 in the absence of a statute because the ordinary custom of physicians sanctioned
10 by judicial decision, is to look to incompetent patients’ close family members to
11 make decisions for them. In the absence of a statute, the physician might ignore a
12 spouse known to be estranged from the patient in favor of another close family
13 member as surrogate, but because there is nothing in most statutes to permit a
14 physician to ignore the statutory order of priority, the result could be worse under
15 a statute than in its absence.

16 In recognition of the problems as well as the benefits of a priority scheme, the
17 proposed law sets out a default list of adult statutory surrogates: (1) The spouse,
18 unless legally separated from the patient, (2) a domestic partner,²² (3) children, (4)
19 parents, (5) brothers and sisters, (6) grandchildren, and (7) close friends.

20 As a general rule, the primary physician is required to select the surrogate, with
21 the assistance of other health care providers or institutional committees, in the
22 order of priority set out in the statute. However, where there are multiple possible
23 surrogates at the same priority level, the primary physician has a duty to select the
24 individual who reasonably appears after a good faith inquiry to be best qualified.²³
25 An individual who is positioned lower in the statutory list may be selected as the
26 surrogate if, in the individual is best qualified to serve as the patient’s surrogate,
27 based on a number of statutory standards. These rules are directly related to the
28 fundamental principal that the law should attempt to find the best surrogate — the
29 person who can make health care decisions according to the patient’s known
30 desires or in the patient’s best interest.

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

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 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....”

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).

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

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

5 (3) Demonstrated care and concern for the patient.

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

7 (5) Availability to visit the patient.

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

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

12 Moreover, the process of applying these standards and making the required
13 determinations must be documented in the patient's medical record. The surrogate
14 is required to communicate his or her assumption of authority to other family
15 members, including the spouse, domestic partner, adult children, parents, and
16 adult siblings of the patient.

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

23 As discussed, the UHCDA provides a fixed priority scheme between classes of
24 close relatives and provides for voting within a class with multiple members.²⁵ If a
25 class is deadlocked, then the surrogacy procedure comes to a halt; lower classes do
26 not get an opportunity to act, although it is possible for a higher class to reassert its
27 priority, and the evenly split class could resolve the deadlock over time. This type
28 of procedure seems overly mechanical and lacking in needed flexibility.

29 The Commission also considered a family consensus approach, such as that pro-
30 vided under Colorado law.²⁶ In this procedure, the class of potential surrogates,
31 composed of close family members and friends, is given the responsibility and
32 duty to select a surrogate from among their number. It is difficult to judge how
33 well this type of procedure would work in practice. The concern is that it might
34 result in too much confusion and administrative burden, without improving the
35 prospects for effective decisionmaking or resolving disputes. But there is nothing
36 in the proposed law that would prevent a family from voluntarily acting in this
37 fashion, and it is likely that the selected surrogate would satisfy the standards of
38 the flexible priority scheme.

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

25. UHCDA § 5.

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).

1 The proposed law adopts a presumptive “pecking order” like the UHCDA, but
2 places the responsibility on the primary physician to select the best-situated person
3 based on standards set out in the statute. This avoids the rigidity of the UHCDA
4 approach and the indefiniteness and administrative burden of the consensus
5 approach. Notice of the selection should be given to other family members. The
6 surrogate is required to communicate the assumption of surrogate’s authority to
7 other adults in the first five categories of statutory surrogates: spouse, domestic
8 partner, children, parents, and siblings. Potential surrogates or other interested
9 persons with serious objections to the selection of the surrogate or the decisions
10 being made by the surrogate would still have the right to bring a judicial
11 challenge²⁷ or seek appointment of a conservator.

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

27. See Prob. Code § 4750 *et seq.*

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

PROPOSED LAW

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

CHAPTER 3. HEALTH CARE SURROGATES

6 **Prob. Code § 4711 (unchanged). Patient’s designation of surrogate**

7 4711. A patient may designate an adult as a surrogate to make health care
8 decisions by personally informing the supervising health care provider. An oral
9 designation of a surrogate shall be promptly recorded in the patient’s health care
10 record and is effective only during the course of treatment or illness or during the
11 stay in the health care institution when the designation is made.

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

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

21 **Background from Uniform Act.** While a designation of an agent in a written power of
22 attorney for health care is preferred, situations may arise where an individual will not be in a
23 position to execute a power of attorney for health care. In that event, [Prob. Code § 4711] affirms
24 the principle of patient autonomy by allowing an individual to designate a surrogate by personally
25 informing the supervising health-care provider. The supervising health-care provider would then,
26 in accordance with Section 7(b) [Prob. Code § 4731], be obligated to promptly record the
27 designation in the individual’s health-care record. An oral designation of a surrogate made by a
28 patient directly to the supervising health-care provider revokes a previous designation of an agent.
29 See Section 3(a) [Prob. Code § 4695(a)]. [Adapted from Unif. Health-Care Decisions Act § 5(b)
30 comments (1993).]

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

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

33 4712. (a) Subject to Sections 2355 (authority of conservator) and 4685 (authority
34 of agent under power of attorney for health care), if no surrogate has been
35 designated under Section 4711 or if the designated surrogate is not reasonably
36 available, a surrogate may be selected to make health care decisions for the patient
37 from among the following adults with a relationship to the patient:

38 (1) The spouse, unless legally separated.

39 (2) An adult in a long-term relationship of indefinite duration with the patient in
40 which the individual has demonstrated an actual commitment to the patient similar
41 to the commitment of a spouse and in which the individual and the patient

1 consider themselves to be responsible for each other's well-being and reside or
2 have been residing together.

3 (3) Children.

4 (4) Parents.

5 (5) Brothers and sisters.

6 (6) Grandchildren.

7 (7) Close friends.

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

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

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

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

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

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

23 (3) Demonstrated care and concern for the patient.

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

25 (5) Availability to visit the patient.

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

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

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

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

37 **Comment.** Section 4712 is a new provision, drawn in part from West Virginia law and the
38 Uniform Health-Care Decisions Act (1993). See W.Va. Code § 16-30B-7 (Westlaw 1999); Unif.
39 Health-Care Decisions Act § 5(b)-(c) (1993). Subdivision (a)(2) is drawn in part from New
40 Mexico law. See N.M. Stat. Ann. § 24-7A-5(B)(2) (Westlaw 1999). The person described in
41 subdivision (a)(2), commonly known as a "domestic partner," may or may not satisfy the
42 definition in Family Code Section 297. Qualification under subdivision (a)(2) is intended only to
43 apply to the surrogate decisionmaking rules in this division, the Health Care Decisions Law.

1 “Adult” includes an emancipated minor. See Fam. Code § 7002 (emancipation). A prospective
2 surrogate and other persons may also seek judicial relief as provided in Sections 4765-4766.
3 Subdivision (d) recognizes existing practice. See California Healthcare Ass’n, Consent Manual 2-
4 17 (26th ed. 1999).

5 See also Sections 4617 (“health care decision” defined), 4625 (“patient” defined), 4635
6 (“reasonably available” defined), 4641 (“supervising health care provider” defined), 4643
7 (“surrogate” defined).

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

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

10 4713. (a) The surrogate designated or selected under this chapter shall promptly
11 communicate his or her assumption of authority to all adults described in
12 paragraphs (1) to (5), inclusive, of subdivision (a) of Section 4712 who can readily
13 be contacted.

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

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

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

26 See also Sections 4629 (“primary physician” defined), 4639 (“supervising health care provider”
27 defined), 4643 (“surrogate” defined).

28 **Background from Uniform Act.** Section 5(d) [Prob. Code § 4713(a)] requires a surrogate who
29 assumes authority to act to immediately so notify [the persons described in subdivision (a)(1)-(5)]
30 who in given circumstances would be eligible to act as surrogate. Notice to the specified family
31 members will enable them to follow health-care developments with respect to their now
32 incapacitated relative. It will also alert them to take appropriate action, including the appointment
33 of a [conservator] or the commencement of judicial proceedings under Section 14 [Prob. Code §
34 4750 *et seq.*], should the need arise. [Adapted from Unif. Health-Care Decisions Act § 5(d)
35 comment (1993).]

36 **Prob. Code § 4714 (unchanged). Standard governing surrogate’s health care decisions**

37 4714. A surrogate, including a person acting as a surrogate, shall make a health
38 care decision in accordance with the patient’s individual health care instructions, if
39 any, and other wishes to the extent known to the surrogate. Otherwise, the
40 surrogate shall make the decision in accordance with the surrogate’s determination
41 of the patient’s best interest. In determining the patient’s best interest, the
42 surrogate shall consider the patient’s personal values to the extent known to the
43 surrogate.

44 **Comment.** Section 4714 is drawn from Section 5(f) of the Uniform Health-Care Decisions Act
45 (1993). This standard is consistent with the health care decisionmaking standard applicable to
46 agents. See Section 4684.

1 See also Sections 4617 (“health care decision” defined), 4623 (“individual health care
2 instruction” defined), 4625 (“patient” defined), 4643 (“surrogate” defined).

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

10 **Prob. Code § 4715 (unchanged). Disqualification of surrogate**

11 4715. A patient having capacity at any time may disqualify another person,
12 including a member of the patient’s family, from acting as the patient’s surrogate
13 by a signed writing or by personally informing the supervising health care
14 provider of the disqualification.

15 **Comment.** Section 4715 is drawn from Section 5(h) of the Uniform Health-Care Decisions Act
16 (1993). See Section 4731 (duty to record surrogate’s disqualification). “Personally informing,” as
17 used in this section, includes both oral and written communications.

18 See also Sections 4625 (“patient” defined), 4641 (“supervising health care provider” defined),
19 4643 (“surrogate” defined).

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

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

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

26 4716. (a) If a surrogate selected pursuant to Section 4712 is not reasonably
27 available, the surrogate may be replaced.

28 (b) If an individual who ranks higher in priority under subdivision (a) of Section
29 4712 relative to a selected surrogate becomes reasonably available, the individual
30 with higher priority may be substituted for the selected surrogate unless the
31 primary physician determines that the lower ranked individual is best qualified to
32 serve as the surrogate.

33 **Comment.** Section 4716 is drawn from West Virginia law. See W. Va. Code § 16-30B-7
34 (1997). A surrogate is replaced in the circumstances described in this section by applying the
35 rules in Section 4712. The determination of whether a surrogate has become unavailable or
36 whether a higher priority potential surrogate has become reasonably available is made by the
37 primary physician under Section 4712 and this section. Accordingly, a person who believes it is
38 appropriate to reassess the surrogate selection would need to communicate with the primary
39 physician.

40 See also Sections 4631 (“primary physician” defined), 4635 (“reasonably available” defined),
41 4643 (“surrogate” defined).