

**Memorandum 2000-62****Family Consent in Health Care Decisionmaking for Adults  
(Revised Draft Statute)**

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At the July meeting, the Commission directed the staff to prepare a revised draft proposal concerning “family consent” for adults without decisionmaking capacity. The revised draft is attached to this memorandum and is discussed briefly below. At the meeting, we plan to consider the draft section by section.

Also attached is a letter from Eric M. Carlson, Bet Tzedek Legal Services, who raises an issue concerning the definition of “capacity” in Probate Code Section 4609. (See Exhibit pp. 1-2.) This issue and some other potential clean-up issues are discussed later in the memorandum.

**HEALTH CARE SURROGATES AND FAMILY CONSENSUS****Role of Family Consensus**

At the July meeting, the major decision was to implement a “super priority” for a surrogate chosen by family consensus. In this case, “family” includes *all* of the interested persons in the list of surrogate candidates: spouse, domestic partner, children, parents, siblings, grandchildren, and individuals with a close personal relationship to the patient. “Consensus” means unanimity of the involved family. This is covered in draft Section 4712(a)(1) and (c), but the statute does not attempt to implement voting procedures or other technical rules. The consensus is to be manifested as appropriate under the circumstances, and is intended to be flexible to accommodate different cultural attitudes and family traditions.

Should the statute actively encourage family consensus or only recognize the preference for a surrogate that is selected by a consensus? The Commission’s earlier recommendation and later drafts have always required the individual who assumes authority, or who is recognized as surrogate, to communicate with other family members. If the statute is drafted to recognize, but not encourage or require attempts at consensus, it may be in line with current practice, without the risk of imposing overly detailed technical requirements. A June 19, 1999, letter

from Dr. Robert D. Orr, speaking for the California Medical Association's Council on Ethical Affairs, described the current practice: "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." The Patient Information Pamphlet mandated by federal law, and prepared by a consortium of California health care experts, contains both singular and plural references:

*What if I'm too sick to decide?*

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

(Bold emphasis added.)

### **Assessing Family Consensus**

As noted in the Minutes of the July meeting, the Commission did not decide what effect the selection of a surrogate by consensus should have. The consensus surrogate should be given the highest priority level, but what other standards should apply? The surrogate selection process should lead to the person who can best make decisions in the place of the patient. A hierarchy based on degrees of kinship does not serve that purpose very well, although it may fit in many cases. The guided flexibility standard has been proposed as a way of combining the benefits of a priority scheme with the substantive standards derived from the fundamental purpose of the surrogacy statute. However, where the surrogate is selected by a consensus, ideally all viewpoints will be heard and considered and the substantive surrogate qualification standards will have been applied by the family members in making the selection.

We say "ideally" because it may not turn out that way. A consensus process may result in picking a person who is not the best surrogate under the statutory standards. The family consensus process may be dominated by a strong personality and not yield the best choice. It is also possible, no matter what the statute says, that one faction in the family may exclude another faction, without full disclosure to the health care professionals. But encouraging consensus is still probably the best practical alternative, notwithstanding its limitations.

The consensus surrogate should not be unimpeachable. Remember that the consensus process is simply a way whereby the family seeks to find the person who can best make decisions the patient can't make — neither the family nor the chosen surrogate has a “right” to make health care decisions (unlike a spouse or other intestate taker who does have a property right). And a surrogate selected by family consensus has no greater right than a surrogate determined by application of the statutory standards. There is likely to be a greater legitimacy, but there is not a greater right.

For drafting purposes, the issue is the extent to which the statute should provide an escape hatch. Should the statute provide the same approval authority to the primary physician or ethics committee? Should there be a more restricted authority, such as permitting the physician to reject a consensus surrogate only where the surrogate is “clearly” violating the decisionmaking standard? Or should the statute be silent, leaving the matter to medical ethics and standards of practice, including the right to refuse to implement ineffective care?

### **Overview of Draft Statute**

The staff draft attempts to merge several threads from earlier drafts and the decisions made at the July meeting, in an effort to achieve the best result, balance the various interests, and meet the concerns that have been expressed to the Commission:

(1) **The family consensus surrogate is given the top spot** in the priority list of draft Section 4712(a)(1). Beyond that, the current draft provides no special treatment. All surrogates are subject to the standards in draft Section 4713 (qualifications) and Section 4714 (decisionmaking standard), but the responsibility for applying the qualifications is assigned to the family in the consensus situation. One reason for not giving an ironclad status to the family consensus surrogate is that a family consensus may, for example, be the result of two siblings or children agreeing that one of them should be the surrogate. This is no different from one person coming forward and acting with the knowledge and acquiescence of the other, so it is difficult to find where to draw a bright line.

(2) The Uniform Health-Care Decisions Act concept of a surrogate **assuming authority** provides a statutory mechanism for identifying who is the surrogate. See draft Section 4713.5(a). This provides more emphasis on the surrogate coming forward, rather than being selected or determined by the primary physician.

(3) The **primary physician has the right to refuse to accept the surrogate** if the primary physician believes in good faith that the surrogate is unable to comply with the decisionmaking standard. It doesn't matter if the surrogate has come forward by herself or is the surrogate chosen by family consensus. This rule preserves the integrity of the decisionmaking process without giving too much authority to the primary physician.

(4) The **primary physician cannot replace a surrogate**, but only refuse to accept the surrogate's claim of authority. See draft Section 4713.5(b)-(c) and Comment. This answers the concern expressed at the last meeting that some physician's might "forum shop," looking for a compliant surrogate.

(5) **Where no surrogate comes forward** (or in the off chance that more than one person has claimed authority), the primary physician, in consultation with other health care providers or an ethics committee, may select a surrogate using the priority preferences from Section 4712(a), balanced by application of the statutory qualifying standards in Section 4713. This concept is preserved from the "November 1999 Draft" discussed at the last meeting, but is used in a more limited context in the current draft.

(6) The priority scheme is given further emphasis in draft Section 4716(b) permitting **replacement of a surrogate with a higher priority surrogate** who becomes available. This section was in the Commission's original recommendation to the Legislature in 1999, but we are not sure how useful or practicable it is.

(7) Ultimately, if there are conflicts that cannot be resolved within a family or between surrogate claimants and the primary physician and ethics committee, the **judicial remedy** is available to determine the qualification of a surrogate is available under draft Section 4766(e). The Commission specifically decided, however, that the court should not be able to select a surrogate. The consequence of a petition to review the selection process and qualifications would be to approve or reject the surrogate. If the court rejects the surrogate and no replacement can be agreed upon, the remedy would be to petition for the court to make health care decisions — in other words, the court would become the surrogate. Or a conservator of the person could be appointed.

## **Need for Flexibility**

The staff is still concerned that the more detailed the statutory provisions become, the more unrealistic and impracticable they may be. We are also concerned that, even with the family consensus provision, the statute is too rigid in focusing on one surrogate. It should not preclude the possibility of two or more relatives and friend, but less than the whole family, acting in a surrogate capacity. This is probably the more typical situation where there is no agent. Focusing too much on individual surrogates, particularly in the context of a hierarchy, will tend to ignore or marginalize other family members, and could encourage conflicts rather than avoid them. It is difficult to assess, but as we talk with more health care professionals and elder law attorneys, the statutory structure seems less realistic.

## **OTHER ISSUES**

### **Capacity Issues**

Eric Carlson, of Bet Tzedek Legal Services, has written concerning a problem in applying the definition of “capacity” in Section 4609 to the execution of an advance directive. (See Exhibit pp. 1-2.) He points out that capacity is defined with reference to “proposed health care” and at the time an advance directive is executed there is not likely to be any proposed health care. He suggests that a lesser standard should apply where a person is deciding

The definition, as enacted in the Health Care Decisions Law, reads as follows:

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

**Comment.** Section 4609 is a new provision drawn from Health and Safety Code Section 1418.8(b) and Section 1(3) of the Uniform Health-Care Decisions Act (1993). This standard replaces the capacity to contract standard that was formerly applicable to durable powers of attorney for health care under Section 4120 in the Power of Attorney Law.

For provisions in this division relating to capacity, see Sections 4651 (authority of person having capacity not affected), 4657 (presumption of capacity), 4658 (determination of capacity and other medical conditions), 4682 (when agent’s authority effective), 4670 (authority to give individual health care instruction), 4671 (authority to execute power of attorney for health care), 4683 (scope of agent’s authority), 4695 (revocation of power of attorney for

health care), 4715 (disqualification of surrogate), 4732 (duty of primary physician to record relevant information), 4733 (obligations of health care provider), 4766 (petition as to durable power of attorney for health care).

...

Capacity is a very fluid concept. In the Power of Attorney Law, the Commission did not attempt to flesh out the meaning of capacity, but adopted the rule in Probate Code Section 4120 that a “natural person having the capacity to contract may execute a power of attorney.” Civil Code Section 1556, in turn, provides: “All persons are capable of contracting, except minors, persons of unsound mind, and persons deprived of civil rights.” As discussed by Mr. Carlson, a general common law standard based on the person’s ability to understand the nature, purpose, and effect of the action would be more appropriate. This makes sense as applied to the appointment of an agent or revocation of an agent’s authority. It makes sense as applied to giving individual health care instructions, too, but there could be a point where giving explicit instructions as to treatment where there is proposed health care would more appropriately invoke the existing definition.

The quick answer to Mr. Carlson’s concern is that definitions in the Health Care Decisions Law govern its construction “unless the context otherwise requires.” See Section 4603. Mr. Carlson makes a good case for the conclusion that the context would otherwise require. Still, it would be better if the statute were not phrased in a way that might mislead or result in unnecessary study or even litigation.

The UHCDA avoided the problem by not using the word “capacity” — and so not invoking the specialized definition — in the provisions authorizing execution of advance directives. The HCDL, however, refers to “capacity” in the corresponding sections. See Sections 4670, 4671. One option would be to delete the reference to capacity in these sections, but that might cause confusion to anyone who was unfamiliar with the reason for the amendment.

The other option is to try to clarify the definition in Section 4609 without creating additional problems. **The staff proposes to amend the definition as follows:**

**4609. “Capacity” (a) With respect to making health care decisions, “capacity” means a patient’s ability to understand the nature and consequences of proposed health care, including its**

significant benefits, risks, and alternatives, and to make and communicate a health care decision.

(b) With respect to giving or revoking an advance health care directive or selecting or disqualifying a surrogate, “capacity” means the patient’s ability to understand the nature and consequences of the action.

**Comment.** Subdivision (b) is added to Section 4609 to recognize a contract standard of capacity as applied to actions involving advance health care directives. Subdivision (b) is consistent with the rule formerly applicable to durable powers of attorney for health care under Section 4120 in the Power of Attorney Law.

For provisions relating to the capacity definition in subdivision (b), see, e.g., Sections 4670 (authority to give individual health care instruction), 4671 (authority to execute power of attorney for health care), 4695 (revocation of power of attorney for health care), 4715 (disqualification of surrogate). See also Section 4657 (presumption of capacity).

### **Orally Designated Surrogate**

Section 4711, part of the Health Care Decisions Law as enacted, recognizes surrogates chosen directly by the patient, orally or in writing, by informing the supervising health care provider:

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.

The provision is drawn from Section 5(b) of the Uniform Health Care Decisions Act, but the limitation in the last clause of the second sentence was added by the Commission. The provision in the uniform act is not well integrated with the other rules on agents and revocation. It was explained that the provision was added late in the drafting process to recognize the reality of oral designations.

An “agent” can be designated only in writing, since a power of attorney must be in writing. However, a “surrogate” can be named by orally informing the supervising health care provider. Both agents and surrogates are subject to the same duties in making decisions for the patient. In practical effect there is no difference, but we have the two names because of the two traditions (powers of attorney and clinical practice) that are merged in the statute. Since a fundamental

goal of the statute is to effectuate the patient's intent, it is appropriate to permit designation of surrogates under the relatively informal rule in Section 4711.

The uniform act comment also notes that "oral designation of a surrogate made by a patient directly to the supervising health-care provider revokes a previous designation of an agent." This makes sense in a case where the patient intends that result, but we can imagine that there would be times when the patient did not intend to revoke the agent's authority, but may only have wanted another person to act as surrogate in that particular case because, for example, the named agent was on vacation or having personal problems.

Should the oral designation permanently revoke the agent's authority? Or should it be effective as a revocation only to the same extent as it is effective as an authorization? Or should we leave the statute alone and not attempt to resolve the issue?

### **Petition To Compel Compliance**

Further review of the statute brings an anomaly to light. There is a right under powers of attorney for property to petition for an order compelling third persons to honor the agent's authority. See Section 4541(f). This provision derives from the need to make banks and title companies recognize durable powers of attorney that were not executed on their forms. This type of petition involves persons who are not under the court's jurisdiction, so special notice provisions are needed. See Section 4544. The version of this provision in the HCDL reads as follows:

#### **Prob. Code § 4769. Notice of hearing**

4769. (a) Subject to subdivision (b), at least 15 days before the time set for hearing, the petitioner shall serve notice of the time and place of the hearing, together with a copy of the petition, on the following:

- (1) The agent or surrogate, if not the petitioner.
- (2) The patient, if not the petitioner.

(b) In the case of a petition to compel a third person to honor the authority of an agent or surrogate, notice of the time and place of the hearing, together with a copy of the petition, shall be served on the third person in the manner provided in Chapter 4 (commencing with Section 413.10) of Title 5 of Part 2 of the Code of Civil Procedure.

When the health care power and property power statutes were combined in the Power of Attorney Law, the notice provisions applied to both types of

powers, even though there was no statutory authority for petitioning to compel compliance with a health care power. When the procedures were split up in preparing the Health Care Decisions Law, it appears that the staff duplicated the general provision without noticing that there is no petition to compel a third person's compliance within the terms of subdivision (b). As a technical clean-up, **the staff proposes to delete subdivision (b)** since it refers to a petition that isn't authorized.

An alternative, however, would be to make the policy decision that such a petition *should* be authorized. The HCDL imposes a duty to comply with health care decisions of agents and with instructions (Section 4733), but the Commission has not yet provided an explicit judicial remedy to enforce that duty.

### **Supervising Health care Provider as Agent**

We recently received a telephone inquiry concerning the meaning of the limitations on who can be an agent and the exceptions to that rule in Section 4659. In relevant part, it provides:

4659. (a) Except as provided in subdivision (b), none of the following persons may make health care decisions as an agent under a power of attorney for health care or a surrogate under this division:

(1) The supervising health care provider or an employee of the health care institution where the patient is receiving care.

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

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

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

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

...

**Comment.** Section 4659 restates former Section 4702 without substantive change, and extends its principles to cover surrogates. The terms "supervising health care provider" and "health care institution" have been substituted for "treating health care provider" as appropriate, for consistency with the terms used in this division. See Section 4641 ("supervising health care provider" defined).

Subdivisions (a) and (b) serve the same purpose as Section 2(b) (fourth sentence) and Section 5(i) of the Uniform Health-Care

Decisions Act (1993). Subdivision (a) does not preclude a person from appointing, for example, a friend who is a physician as the agent under the person's power of attorney for health care, but if the physician becomes the person's "supervising health care provider," the physician is precluded from acting as the agent under the power of attorney. See also Section 4675 (witnessing requirements in skilled nursing facilities).

Subdivision (b) provides a special exception to subdivision (a). This will, for example, permit a nurse to serve as agent for the nurse's spouse when the spouse is being treated at the hospital where the nurse is employed.

...

Subdivision (a)(1) excludes both supervising health care providers and employees of the health care institution involved in the patient's care as agents and surrogates. Supervising health care providers need to be listed separately because they may not be employees of the institution. Subdivision (b)(1) provides an exception to the exclusion for employees who are relatives by "blood, marriage, or adoption." (Note that there are other issues with this language, such as the status of domestic partners, registered or not.)

If the intent was to absolutely bar supervising health care providers from acting in that role and also as the patient's agent (judge and executioner, as it were), then subdivision (b)(1) is defective because it doesn't bar supervising health care providers who are employees. The exception should clearly not depend on the happenstance of whether the health care provider is an employee or contractor. The same defect is in the coworker provision in subdivision (b)(2).

We doubt that this is a very significant issue in practice, but the statute isn't clear and the Comment doesn't clarify it much. People drafting instructions on how to execute advance health care directives in California are faced with either ignoring the limitation and its exceptions or trying to summarize them, perhaps inaccurately.

For example, the California Medical Association form states:

Your agent may **not** be:

- A. Your primary treating health care provider.
- B. An operator of a community care or residential care facility where you receive care.
- C. An employee of the health care institution or community or residential care facility where you receive care, unless your agent is related to you or is one of your co-workers.

The CMA form instructions state that you “may not choose your doctor,” and refer to the exception for “appointing a person who works for the health facility in which you are being treated, ... unless that person is related to you by blood, marriage, or adoption, or is a co-worker.”

Should the relative and coworker exceptions apply to all health care providers or should the bar against naming supervising health care provider be made absolute, regardless of the employment status?

#### NEXT STEP

If the Commission agrees on the language at this meeting, the staff can circulate the draft, with any needed revisions, as a tentative recommendation, with comments due for consideration at the next meeting (set for Nov. 30-Dec. 1). The explanatory text has not been revised yet because the staff doesn't know what the final draft will look like.

If the Commission wants to get further comment from interested persons, but does not want to issue a tentative recommendation, we could circulate a “discussion draft” instead. The Commission would then have time to approve a final recommendation at the next meeting, in time to seek introduction of a bill in the 2001 session.

Respectfully submitted,

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**Re: Health Care Decisions Law;  
Inapplicability of Definition of "Capacity"**

Dear Stan:

This letter follows up on our telephone conversation this morning.

### Problem in Current Law

Under the Health Care Decisions Law, an individual health care instruction or power of attorney for health care can be executed by "[a]n adult having capacity."<sup>1</sup> But "capacity," unfortunately, is defined in relation to a particular health care decision:

"Capacity" means a patient's ability to understand the nature and consequences of proposed health care, including its significant benefits, risks, and alternatives, and to make and communicate a health care decision.<sup>2</sup>

This definition of capacity is inconsistent with the standard used by witnesses, who declare under penalty of perjury that the principal "appears to be of sound mind and under no duress, fraud, or undue influence."<sup>3</sup> This definition of incapacity also is inconsistent with the common-sense standard

<sup>1</sup> Cal. Prob. Code §§ 4670, 4671.

<sup>2</sup> Cal. Prob. Code § 4609.

<sup>3</sup> Cal. Prob. Code §§ 4674(d), 4701.

*Bet Tzedek Legal Services provides free legal services to needy persons without regard to race, religion or national origin. BET TZEDEK is funded in part by the Jewish Federation Council of Los Angeles, United Way, the State Bar of California, the City and County of Los Angeles, the City of West Hollywood, and private donations. Bet Tzedek (The House of Justice) is a non-profit organization. Contributions are tax deductible.*

of whether the principal understands what she is doing, *e.g.*, whether she understands that she is appointing her son to make her health care decisions for her.

The problem appears to be that, in the Health Care Decisions Law, the word “capacity” is used for two separate purposes – 1) to determine when an individual can no longer make her own health care decisions,<sup>4</sup> and 2) to determine when an individual can execute an advance health care directive. The current definition of “capacity” makes sense only for the first purpose.

Indeed, the current definition of “capacity” is simply unworkable for the second purpose. Assume that the validity of an advance health care directive is challenged, based on the alleged incapacity of the principal when the directive was executed. It would be difficult or impossible for a court to apply the current capacity standard, which revolves around the principal’s level of understanding of “proposed health care” or “a health care decision.”

### Suggestion for Future Action

I suggest that the Health Care Decisions Law be amended to provide for two separate definitions of capacity: capacity to make a health care decision, and capacity to execute an advance health care directive. The concept of differing definitions of capacity is hardly unprecedented; for example, the capacity to execute a will is not equivalent to the capacity to enter into a contract. In this case, the capacity needed to execute an advance health care directive would be less than the capacity needed to make a health care decision.

If you have any interest in addressing this issue, please give me a call. Of course, feel free to call at any time, for any reason.

Sincerely,



Eric M. Carlson  
Attorney at Law

cc: Leah Granof  
Mark Hyjek  
Janet Morris

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<sup>4</sup> See Cal. Prob. Code § 4682 (under power of attorney for health care, agent assumes authority when principal is determined to lack capacity).

## PROPOSED LAW

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

### CHAPTER 3. HEALTH CARE SURROGATES

#### **Prob. Code § 4710. Authority of surrogate to make health care decisions**

6   SECTION 1. Section 4710 is added to the Probate Code, to read:

7   4710. Subject to Sections 2355 (authority of conservator) and 4685 (authority of  
8 agent under power of attorney for health care), a surrogate determined as provided  
9 in this chapter may make health care decisions for a patient who lacks capacity.  
10

11   **Comment.** Section 4710 provides the scope of this chapter. This section is drawn in part from  
12 Section 5(a) of the Uniform Health-Care Decisions Act (1993). Both the patient and the surrogate  
13 must be adults. See Sections 4625 (“patient” defined), 4643 (“surrogate” defined). “Adult”  
14 includes an emancipated minor. See Fam. Code §§ 7002 (emancipation), 7050 (emancipated  
15 minor considered as adult for consent to medical, dental, or psychiatric care).

16   As to capacity, see Sections 4609 (“capacity” defined), 4657 (presumption of capacity), 4658  
17 (determination of capacity). See also Sections 4613 (“conservator” defined), 4615 (“health care”  
18 defined), 4617 (“health care decision” defined), 4629 (“power of attorney for health care”  
19 defined).

20   **Background from Uniform Act.** Section 5(a) authorizes a surrogate to make a health-care  
21 decision for a patient who is an adult or emancipated minor if the patient lacks capacity to make  
22 health-care decisions and if no agent or [conservator] has been appointed or the agent or  
23 [conservator] is not reasonably available. Health-care decision making for unemancipated minors  
24 is not covered by this section. The subject of consent for treatment of minors is a complex one  
25 which in many states is covered by a variety of statutes and is therefore left to other state law.  
26 [Adapted from Unif. Health-Care Decisions Act § 5(a) comment (1993).]

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

27   4711. A patient may designate an adult as a surrogate to make health care  
28 decisions by personally informing the supervising health care provider. An oral  
29 designation of a surrogate shall be promptly recorded in the patient’s health care  
30 record and is effective only during the course of treatment or illness or during the  
31 stay in the health care institution when the designation is made.  
32

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

1 See also Sections 4617 (“health care decision” defined), 4619 (“health care institution”  
2 defined), 4635 (“reasonably available” defined), 4641 (“supervising health care provider”  
3 defined).

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

14 ☞ **Staff Note.** The significance of the boldface language in the uniform act comment above is  
15 discussed in Memorandum 2000-62.

#### 16 **Prob. Code § 4712 (added). Statutory surrogate preferences**

17 SEC. 2. Section 4712 is added to the Probate Code, to read:

18 4712. (a) Preference to act as the surrogate health care decisionmaker for the  
19 patient is given in the following order of priority to adults with a relationship to  
20 the patient and who satisfy the standards of Section 4713:

21 (1) An adult chosen by family consensus. As used in this section, “family  
22 consensus” means the agreement of all individuals described in this subdivision  
23 who are concerned about the patient’s health care and desire to participate in  
24 choosing the surrogate.

25 (2) The spouse, unless legally separated.

26 (3) An adult in a long-term relationship of indefinite duration with the patient in  
27 which the individual has demonstrated an actual commitment to the patient similar  
28 to the commitment of a spouse and in which the individual and the patient  
29 consider themselves to be responsible for each other’s well-being and reside or  
30 have been residing together.

31 (4) Children.

32 (5) Parents.

33 (6) Brothers and sisters.

34 (7) Grandchildren.

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

36 (b) The supervising health care provider, or designee, shall make a good faith  
37 effort to locate as many interested individuals listed in subdivision (a) as  
38 practicable and notify them of the patient’s lack of capacity and need for a  
39 surrogate, and may rely on notified individuals to notify others.

40 (c) Where a surrogate is chosen by family consensus, the family shall consider  
41 and apply the standards in Section 4713. Determination of the family consensus  
42 may be made in any manner that is appropriate in the circumstances of the  
43 individuals involved, but a family consensus does not exist if a concerned family  
44 member objects to the surrogate choice. Any objection shall be communicated to

1 the supervising health care provider. The composition of the family, the reasons  
2 for omitting any persons described in subdivision (a), and the manner of  
3 determining the consensus shall be communicated to the supervising health care  
4 provider, who shall record a summary in the patient’s record.

5 **Comment.** Section 4712 is a new provision implementing a presumptive priority scheme for  
6 selecting surrogate health care decisionmakers in cases where the patient has not named an agent  
7 in a power of attorney or made a surrogate designation under Section 4711, and there is no  
8 conservator. See Section 4710 (scope of chapter). “Adult” includes an emancipated minor. See  
9 Fam. Code § 7002 (emancipation). A prospective surrogate and other persons may also seek  
10 judicial relief as provided in Sections 4765-4766.

11 Subdivision (a)(1) gives top priority to a surrogate selected by a family consensus. It is not  
12 expected that participation of distant and uninvolved relatives or estranged family members is  
13 needed to form a family consensus. Note, however, that “family” is used very broadly in this  
14 section, and includes domestic partners (subdivision (a)(3) and close friends (subdivision (a)(8)).  
15 Subdivision (c) provides additional rules concerning the operation of a family consensus.

16 Subdivision (a)(3) is drawn in part from New Mexico law. See N.M. Stat. Ann. § 24-7A-  
17 5(B)(2) (Westlaw 2000). The person described in subdivision (a)(3), commonly known as a  
18 “domestic partner,” may or may not satisfy the definition in Family Code Section 297.  
19 Qualification under subdivision (a)(3) is intended to apply only to the surrogate decisionmaking  
20 rules in this division, the Health Care Decisions Law.

21 Subdivision (b) provides the supervising health care provider’s duty to make sure interested  
22 individuals are aware of the patient’s need for surrogate decisionmaking. This provision is drawn  
23 from Colorado law. See Colo. Rev. Stat. Ann. § 15-18.5-103(3) (Westlaw 2000).

24 Subdivision (c) provides flexible rules concerning composition of the interested family and the  
25 manner of seeking a consensus. This is intended to accommodate the wide variety of individual  
26 and cultural circumstances of families in California. However, the choice of a surrogate by family  
27 consensus must be based on the standards provided in Section 4713. This rule is founded on the  
28 principle that the surrogate is to make decisions consistent with the patient’s wishes and values,  
29 regardless of how the surrogate is selected. See Section 4714 (standard governing surrogate’s  
30 health care decisions).

31 See also Sections 4617 (“health care decision” defined), 4625 (“patient” defined), 4641  
32 (“supervising health care provider” defined), 4643 (“surrogate” defined).

33 ☞ **Staff Note.** Legislation concerning health care decisionmaking by registered domestic  
34 partners, discussed in Memorandum 2000-49 at the July meeting, was not enacted. Consequently,  
35 the staff is not suggesting any revisions in the broad domestic partner category in subdivision  
36 (b)(3). The broad definition in the Commission’s language is preferable to a rule based on  
37 technicalities of registration.

### 38 **Prob. Code 4713 (added). Qualifications of surrogate**

39 SEC. 3. Section 4713 is added to the Probate Code, to read:

40 4713. (a) In determining whether an individual is qualified to act as a surrogate  
41 under Section 4712, the following factors shall be considered and applied:

42 (1) Whether the individual appears to be best able to make decisions in  
43 accordance with Section 4714.

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

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

47 (4) Familiarity with the patient’s personal values.

48 (5) Availability to visit the patient.

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

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

5 **Comment.** Section 4713 is a new provision providing basic standards for determining the most  
6 appropriate person to act as a surrogate health care decisionmaker, i.e., the person best suited to  
7 apply the governing principles for surrogate decisionmaking in Section 4714. Subdivision (a) is  
8 drawn in part from West Virginia law. See W.Va. Code § 16-30B-7 (Westlaw 1999).

9 Subdivision (b) recognizes existing practice. See California Healthcare Ass'n, Consent Manual  
10 2-17 (26th ed. 1999).

11 See also Sections 4615 ("health care" defined), 4621 ("health care provider" defined), 4625  
12 ("patient" defined), 4643 ("surrogate" defined).

13 **Prob. Code § 4713.5 (added). Assumption of authority, determination of surrogate**

14 SEC. 4. Section 4713.5 is added to the Probate Code, to read:

15 4713.5. (a) A surrogate designated or determined under this chapter shall  
16 communicate his or her assumption of authority to the supervising health care  
17 provider and to individuals described in subdivision (a) of Section 4712 who can  
18 readily be contacted. The supervising health care provider shall inform the  
19 surrogate of the duty to give notice under this subdivision.

20 (b) The primary physician may refuse to accept the authority of a surrogate  
21 whom the primary physician believes in good faith is unable to comply with the  
22 surrogate's duties under Section 4714. The primary physician may not refuse to  
23 accept the authority of a surrogate on the grounds that the individual refuses to  
24 make a health care decision recommended by the primary physician or other health  
25 care provider.

26 (c) If no individual assumes authority or if more than one individual  
27 communicates an assumption of authority, a surrogate may be selected by the  
28 primary physician, with the assistance of other health care providers or  
29 institutional committees, by following the order of priority set forth in Section  
30 4712, subject to the following conditions:

31 (1) Where there are multiple possible surrogates at the same priority level, the  
32 primary physician shall select the individual who appears after a good faith inquiry  
33 to be best qualified under the standards in Section 4713.

34 (2) The primary physician may select as the surrogate an individual who is  
35 ranked lower in priority if the individual is best qualified to serve as the patient's  
36 surrogate under the standards in Section 4713. *[This paragraph does not apply to*  
37 *a surrogate chosen by family consensus in compliance with this chapter.]*

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

1 (e) The primary physician shall document communications and determinations  
2 under this section in the patient’s health care record.

3 **Comment.** Subdivision (a) of Section 4713 is drawn from Section 5(d) of the Uniform Health-  
4 Care Decisions Act (1993). The “assumption of authority” concept is intended to facilitate  
5 identification the surrogate. Subdivision (b) provides, however, that an assumption of authority  
6 does not empower a surrogate to make decisions contrary to Section 4714, and the primary  
7 physician may refuse to recognize the surrogate. The grounds for refusal to recognize the  
8 surrogate do not include the surrogates unwillingness to approve treatments recommended by the  
9 primary physician, as made clear in the second sentence of subdivision (b).

10 Subdivision (c) provides a means of finding a qualified person to act as surrogate where no one  
11 has come forward under subdivision (a). This subdivision is drawn in part from West Virginia  
12 law. See W.Va. Code § 16-30B-7 (Westlaw 1999). If the primary physician refuses to accept the  
13 surrogate’s authority under subdivision (b), the primary physician is not thereby empowered to  
14 pick a different surrogate. Subdivision (c) applies only where no surrogate has come forward or  
15 where there are competing surrogates.

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

18 **Background from Uniform Act.** Section 5(d) [Prob. Code § 4713(a)] requires a surrogate who  
19 assumes authority to act to immediately so notify [the persons described in subdivision (a)(1)-(5)]  
20 who in given circumstances would be eligible to act as surrogate. Notice to the specified family  
21 members will enable them to follow health-care developments with respect to their now  
22 incapacitated relative. It will also alert them to take appropriate action, including the appointment  
23 of a [conservator] or the commencement of judicial proceedings under Section 14 [Prob. Code §  
24 4750 *et seq.*], should the need arise. [Adapted from Unif. Health-Care Decisions Act § 5(d)  
25 comment (1993).]

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

27 4714. A surrogate, including a person acting as a surrogate, shall make a health  
28 care decision in accordance with the patient’s individual health care instructions, if  
29 any, and other wishes to the extent known to the surrogate. Otherwise, the  
30 surrogate shall make the decision in accordance with the surrogate’s determination  
31 of the patient’s best interest. In determining the patient’s best interest, the  
32 surrogate shall consider the patient’s personal values to the extent known to the  
33 surrogate.

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

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

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

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

2 4715. A patient having capacity at any time may disqualify another person,  
3 including a member of the patient’s family, from acting as the patient’s surrogate  
4 by a signed writing or by personally informing the supervising health care  
5 provider of the disqualification.

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

9 See also Sections 4625 (“patient” defined), 4641 (“supervising health care provider” defined),  
10 4643 (“surrogate” defined).

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

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

16 SEC. 5. Section 4716 is added to the Probate Code, to read:

17 4716. (a) If a surrogate selected pursuant to this chapter is not reasonably  
18 available, the surrogate may be replaced.

19 (b) If an individual who ranks higher in priority under subdivision (a) of Section  
20 4712 relative to a selected surrogate becomes reasonably available, the individual  
21 with higher priority may be substituted for the selected surrogate unless the  
22 primary physician determines that the lower ranked individual is best qualified to  
23 serve as the surrogate.

24 **Comment.** Section 4716 is drawn from West Virginia law. See W. Va. Code § 16-30B-7  
25 (1997). A surrogate is replaced in the circumstances described in this section by applying the  
26 rules in this chapter. The determination of whether a surrogate has become unavailable or whether  
27 a higher priority potential surrogate has become reasonably available is made by the primary  
28 physician under Section 4713.5 and this section. Accordingly, a person who believes it is  
29 appropriate to reassess the surrogate selection would need to communicate with the primary  
30 physician.

31 See also Sections 4631 (“primary physician” defined), 4635 (“reasonably available” defined),  
32 4643 (“surrogate” defined).

33  
34 **Heading of Chapter 3 (commencing with Section 4765) (technical amendment)**

35 SEC. 6. The heading of Chapter 3 (commencing with Section 4765) of Part 3 of  
36 Division 4.7 of the Probate Code is amended to read:

37 CHAPTER 3. PETITIONS, AND ORDERS, ~~APPEALS~~

38 **Comment.** The chapter heading is amended to reflect the contents of the chapter.

39 **Prob. Code § 4766 (amended). Purposes of petition**

40 SEC. 7. Section 4766 of the Probate Code is amended to read:

1 4766. A petition may be filed under this part for any one or more of the  
2 following purposes:

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

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

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

12 (d) Declaring that the authority of an agent or surrogate is terminated, upon a  
13 determination by the court that the agent or surrogate has made a health care  
14 decision for the patient that authorized anything illegal or upon a determination by  
15 the court of both of the following:

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

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

23 (e) Reviewing the process of selecting a surrogate and the qualifications of a  
24 surrogate pursuant to Chapter 3 (commencing with Section 4710).

25 **Comment.** The grounds for a petition under this division are expanded by adding subdivision  
26 (e) to Section 4766, permitting the court to review the selection and qualifications of a statutory  
27 surrogate under Chapter 3 (commencing with Section 4710). The court does not have authority to  
28 select a surrogate, but only to review the selection and qualification of a surrogate under the  
29 applicable statute. See also Sections 3200-3212 (capacity determinations and health care  
30 decisions for adult without conservator).

31 **Comment (1999).** Section 4766 continues the substance of former Section 4942 to the extent it  
32 applied to powers of attorney for health care, and adds language relating to advance directives and  
33 surrogates for consistency with the scope of this division.

34 A determination of capacity under subdivision (a) is subject to the Due Process in Competency  
35 Determinations Act. See Sections 810-813.

36 Under subdivision (c), the patient's desires as expressed in the power of attorney for health  
37 care, individual health care instructions, or otherwise made known to the court provide the  
38 standard for judging the acts of the agent or surrogate. See Section 4714 (standard governing  
39 surrogate's health care decisions). Where it is not possible to use a standard based on the patient's  
40 desires because they are not stated in an advance directive or otherwise known or are unclear,  
41 subdivision (c) provides that the "patient's best interest" standard be used.

42 Subdivision (d) permits the court to terminate health care decisionmaking authority where an  
43 agent or surrogate is not complying with the duty to carry out the patient's desires or act in the  
44 patient's best interest. See Section 4714 (standard governing surrogate's health care decisions).  
45 Subdivision (d) permits termination of authority under an advance health care directive not only  
46 where an agent, for example, is acting illegally or failing to perform the duties under a power of  
47 attorney or is acting contrary to the known desires of the principal, but also where the desires of

1 the principal are unknown or unclear and the agent is acting in a manner that is clearly contrary to  
2 the patient's best interest. The patient's desires may become unclear as a result of developments  
3 in medical treatment techniques that have occurred since the patient's desires were expressed,  
4 such developments having changed the nature or consequences of the treatment.

5 An advance health care directive may limit the authority to petition under this part. See  
6 Sections 4752 (effect of provision in advance directive attempting to limit right to petition), 4753  
7 (limitations on right to petition).

8 See also Sections 4605 ("advance health care directive" defined), 4607 ("agent" defined), 4609  
9 ("capacity" defined), 4613 ("conservator" defined), 4629 ("power of attorney for health care"  
10 defined), 4633 ("principal" defined), 4643 ("surrogate" defined).