

First Supplement to Memorandum 2000-62

Family Consent in Health Care Decisionmaking for Adults (Additional Commentary)

We have received some letters commenting on the staff draft statute attached to Memorandum 2000-62:

	<i>Exhibit p.</i>
1. Eric M. Carlson, Director, Nursing Home Advocacy Project, Bet Tzedek, Los Angeles (Sept. 25, 2000)	1
2. Patricia L. McGinnis, Executive Director, California Advocates for Nursing Home Reform, San Francisco (Sept. 26, 2000)	4
3. William Powers, Legislative Director, Congress of California Seniors, Sacramento (Sept. 28, 2000)	7
4. Eric M. Carlson, Director, Nursing Home Advocacy Project, Bet Tzedek, Los Angeles (Oct. 2, 2000)	8
5. Joan B. Lee, Legislative Liaison, Gray Panthers of Northern California, Sacramento (Sept. 28, 2000)	11
6. Betty Perry, Public Policy Director, Older Women's League of California, Sacramento (Sept. 30, 2000)	12

Surrogate Recognition

Eric Carlson writes that

it appeared that the Commission was moving towards a moderate compromise position, in which a statutory priority would generally control, although a physician would have the right to reject the priority-selected individual if (for example) that individual demonstrably was incompetent to act as a surrogate, or was estranged from the patient.

In fact, this generally describes the approach of the staff draft attached to Memorandum 2000-62. The examples quoted above, if they were the exclusive means for rejecting a surrogate candidate, resemble the proposal Mr. Carlson advocated at an earlier Commission meeting, although “estranged” is new. They represent a “moderate compromise” if the grounds for refusal to recognize a surrogate are consistent with ethical principles and the standard for making surrogate decisions, but not if limited in such a fashion as to yield the wrong surrogate, counter to the rights and interests of the patient. We had thought Mr.

Carlson's reference to "estranged" family members was an encouraging development, but his faxed letter reverts to the overly rigid suggestion he presented earlier this year. (See Exhibit p. 9.) A telephone discussion confirms that he has withdrawn the "estranged" standard.

Pat McGinnis expresses disappointment that "the Commission has chosen to disregard our and others' concerns." (Exhibit p. 4.) The staff's view is that the record shows the Commission has worked diligently to understand and accommodate the concerns of all interested persons. The staff draft statute is the third or fourth draft that has come before the Commission since the statutory surrogate material was removed from AB 891 in 1999.

Mr. Carlson's answer is to have courts selecting surrogates or appointing conservators. (Exhibit p. 2.) He argues that as practical matter, "physicians cannot have enough information to choose one family member over another." The benefit of the draft statute is that it would set standards for rejecting a surrogate or recognizing a surrogate where one has not come forward, and would require keeping records supporting the process.

Mr. Carlson writes that if the draft were to become law "abuses would occur." He relates an anecdote of a physician who refused to honor the authority of a health care agent under a power of attorney. This, of course, is no argument against the draft statute or earlier Commission drafts. Is there any statutory duty that cannot be ignored or disobeyed? Is there any scheme for health care decisionmaking that would prevent all abuse? There is nothing in the draft statute that permits or justifies the allegation that a physician could pick a compliant surrogate. In fact, the draft statute would provide authority so that Mr. Carlson could write a letter reminding the doctor of his or her duties, just as he was able to do under the (Commission-drafted) durable power of attorney for health care statute.

Reliance on a rigid statutory priority is inappropriate. Consider the following discussion of priority lists in a variety of state statutes:

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

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

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

Isn't this obvious? Why would anyone contend for an inflexible hierarchy?

Possible Revisions

The staff has had additional discussions with Eric Carlson and Pat McGinnis following receipt of the attached materials, which focus on some specific parts of the draft statute. The staff thinks that the only possibility for meeting some of their major concern would be to simplify the statute, and not attempt to address some issues.

Draft Section 4713.5(c). Physician selection if no surrogate or if conflict

Mr. Carlson maintains there are basic philosophical differences, which suggests that drafting may not result in a solution. However, as we discussed the philosophical differences (rigid priority versus substantive qualifications, being the gist), the authority in draft Section 4713.5(c) seemed to be the major concern. It reads:

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

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

(2) The primary physician may select as the surrogate an individual who is ranked lower in priority if the individual is best qualified to serve as the patient's surrogate under the standards in Section 4713.

The staff suggests that this provision be omitted; the statute would not cover the issue of what happens if no surrogate comes forward or if there are competing

surrogates. Thus, in these situations, if someone has the sophistication, financial resources, time, and determination, they can petition the court to make health care decisions or appoint a conservator or resolve conflicts between two surrogate claimants. Some groups are being given the impression that the draft statute empowers physicians to choose the patient's surrogate, even against the family's wishes. This erroneous impression apparently has its source in this language, exaggerated and taken out of context. Draft Section 4716 should also be omitted (reassessment of surrogate selection).

Draft Section 4713(b). Questionable competence and motives

Mr. Carlson objects to the standard in subdivision (b), which is drawn from the hospital Consent Manual and was added in response to concerns expressed by Daniel Pone, the Assembly Judiciary Committee consultant who analyzed on AB 891. Ms. McGinnis expresses a similar concern. (Exhibit p. 4.)

This provision reads: "An individual may not act as a surrogate if the individual's competence or motives are questionable." This seems like a good general rule to the staff, but if it is a source of objections, then it should be omitted. Perhaps, though, as a general rule, not as part of a physician-applied standard, Mr. Carlson could see its virtue. The rule applies as a substantive rule that applies to surrogate determinations under draft Section 4712. It is a guide for the family and for individuals engaged in deciding who is an appropriate surrogate. If the limited physician selection rule in draft Section 4713.5(c) is omitted, as discussed above, then the critics might be able to re-evaluate this provision.

Draft Section 4713.5(b). Refusal to accept authority

Mr. Carlson does not think physicians can or should be able to reject a surrogate who is unable to comply with the surrogate's duties. Thus, he objects to draft Section 4713.5(b), which reads:

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

He thinks it is sufficient that the physician can refuse to comply for reasons of conscience (Section 4734) or to provide "medically ineffective health care or

health care contrary to generally accepted health care standards” (Section 4735). In addition, the “readily available” standard applicable to agents (and set out in a different form in Section 4716) should be added to draft Section 4710. The Commission should consider what to do with this section; the staff thinks it summarizes an ethical duty, but the statute does not necessarily need to reinforce this duty.

Restrict Coverage to Acute Care Hospitals?

The experience of some commentators focuses on nursing homes. (See, e.g., Exhibit pp. 4-5.) A possible alternative response is to restrict the authority of physicians to acute care hospitals and mandate the use of ethics committees satisfying certain standards. We discussed this option with Eric Carlson, but he did not think it answered his objections.

Other Options

For the sake of completeness, other options include (1) doing nothing (leaving the law and practice in their current unsettled state), or (2) just listing potential surrogates so that domestic partners and close friends are given some recognition, without setting priorities or establishing standards or procedures (the “constellation” approach).

Orally-Designated Surrogate

Eric Carlson and Pat McGinnis suggest that the oral designation of a surrogate should act as a revocation only during the time that the oral designation is effective. (See Exhibit pp. 3, 5-6.)

The staff agrees that this should be the default rule. Section 4711 could be amended as follows to achieve this goal:

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. An orally-designed surrogate replaces an agent only during the time that the oral designation is effective, unless the patient revokes the designation of the agent pursuant to subdivision (a) of Section 4695.

Under the proposed language, where the patient also wants to revoke the appointment of the agent, that intent will have to be made clear by an appropriate statement that complies with the rule in Section 4695(a).

Capacity Standards

Eric Carlson supports the suggested revision of the definition of capacity to deal with the problem he highlighted in his letter attached to Memorandum 2000-62. (See Exhibit p. 2.) He also suggests revising the witness statement required by Section 4674(d) and included in the optional statutory form in Section 4701.

Under Section 4674(d), witnesses are required to make the following declaration “in substance”:

“I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual’s identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual’s health care provider, an employee of the individual’s health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.”

Mr. Carlson’s suggestion is directed to clause (3), that the patient “appears to be of sound mind.”

The staff would not revise the witness statement. “Sound mind” is traditional, familiar language. It is not inconsistent with the proposed statutory language to be added to the capacity definition in Section 4609 (“ability to understand the nature and consequences of the action”). Importing the more legalistic standard would not aid witnesses in understanding what they are asked to determine. There is a practical reason for leaving the witness statement alone: the new statute just became operative on July 1. Changes in mandatory language to be included in forms should be resisted unless there is no reasonable alternative. There is nothing wrong with the language of Section 4674(d) and it would be unfortunate to make all the new forms obsolete, or raise issues about the validity of the language, by tinkering with the witness statement.

Corrections and Commentary

Mr. Carlson states that the latest compromise draft contains “the same type of provision that was pulled from the Commission’s 1999 legislation at the insistence of the Assembly Judiciary Committee.” (Exhibit p. 1.) This statement is inaccurate. It is not the same type of provision. Furthermore, the earlier guided flexibility rule in Sections 4710 *et seq.* was not removed at the “insistence” of the Assembly Judiciary Committee, but because of concerns expressed by the Committee Chair and the Committee consultant who was analyzing the bill.

Mr. Carlson asserts that “physicians generally feel bound by an uncodified priority of spouse, child, parent, sibling, etc.” (Exhibit p. 1.) There is no such detail in California statutory or case law, nor in the Patient Information Pamphlet mandated by federal law. Dictum in *Cobbs v. Grant*, 8 Cal. 3d 229, 243-44, 502 P.2d 1, 104 Cal. Rptr. 505 (1972), referred to the “closest available relative.” Aside from being dictum, the phrase in *Cobbs* is far from a well-developed exposition of health care decisionmaking, and it does not set out the mechanical list favored by Mr. Carlson. Nor does it include domestic partners or close personal friends.

What do physicians think? Do they “feel bound” by Mr. Carlson’s list of relatives from spouse down to “etc.”? Do they prefer parents over children or the other way around? Do they ignore the views of siblings if one adult child has come forward? Do they ignore domestic partners or close friends? The staff’s conversations with medical professionals do not support his assertion. His statement was read to the Task Force on Medical Decisionmaking of the Santa Clara County Medical Association Bio-Ethics Committee last week. The ensuing discussion can be summarized by saying that most disagreed with the statement, although some thought that physicians might think that the law required something like that, in a vague way. However, the way they behave is quite different: physicians try to get a consensus of the family (and other caregivers). They do not follow down a priority list and reject input from a “lower” priority. If the Commission wants, we can do further research on what California physicians and other health care providers feel. But regardless of whether physicians “feel bound” by some sort of priority system, the critical issue is not degrees of kinship, as should be obvious to anyone who scratches the surface of this important issue. The *reason* that custom and law have looked to close relatives and friends is that *these are the people who are most likely to know the patient’s desires, values, and interests*. No one holds a “right” to be a surrogate by “virtue of office,” by the mere fact of blood or marital relationship.

Mr. Carlson states in his recent fax: “You in the past have cited legal authority for the proposition that courts should not be involved in health care decisionmaking.” (Exhibit p. 9.) He then cites, as contrary authority, Section 4650(c). Two things need to be said about this. (1) The authority cited comes from the Commission-recommended Health Care Decisions Law, and there is no dispute about it. (2) The characterization of staff statements is misleading and inaccurate. Probably every staff memorandum on this subject has pointed to the availability of the judicial procedure in Section 4750 *et seq.* as the final *answer* to the problem of resolving conflicts — but it should not be the first resort. The streamlined judicial procedure now in Section 4650 *et seq.*, originated in the Commission’s 1983 *Recommendation Relating to Durable Powers of Attorney for Health Care Decisions*, 17 Cal. L. Revision Comm’n Reports 101 (1984). The bill implementing the Commission’s recommendation established this procedure in Civil Code Section 2412.5. See 1983 Cal. Stat. ch. 1204, § 6 [SB 762]. We are fully aware of the origin and purpose of this procedure.

Respectfully submitted,

Stan Ulrich
Assistant Executive Secretary



September 25, 2000

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SEP 27 2000

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**Re: Family Consent in Health Care Decisionmaking for
 Adults; Commission Memorandum 2000-62;
 Meeting Scheduled for October 5, 2000 in San Francisco**

Dear Stan:

This letter discusses several issues raised in Memorandum 2000-62.

Health Care Surrogates: Opposition to Current Draft

Prior to the Commission's July 2000 meeting, it appeared that the Commission was moving towards a moderate compromise position, in which a statutory priority would generally control, although a physician would have the right to reject the priority-selected individual if (for example) that individual demonstrably was incompetent to act as a surrogate, or was estranged from the patient.

Unfortunately, however, the Commission made a dangerous change of course at the July 2000 meeting, essentially returning to a position that under certain circumstances allows a physician to select the "best qualified" individual from the priority list, even if that individual is much lower in priority than another individual willing to act as surrogate. This is the same type of provision that was pulled from the Commission's 1999 legislation at the insistence of the Assembly Judiciary Committee.

In addition, this type of provision certainly is *not* standard operating procedure in other states or in California. The Uniform Health-Care Decisions Act does not contain such a provision and, to my knowledge, only West Virginia gives a physician such wide discretion to ignore a statutory priority. Under current California law, a physician has no explicit authority to pass over one family member for another person with a lower priority; as a result, physicians generally feel bound by an uncodified priority of spouse, child, parent, sibling, etc.

The Commission's recent memoranda on this issue have argued that the physician authority will allow the "best" surrogate to be selected. But the selection of the "best" surrogate can only be made by an appropriate, objective person or entity. The Commission's current proposal improperly allows the physician to perform a function that should be performed by a court.

Physicians should not be given the authority to essentially select a patient's health care surrogate. As numerous California cases have stated, the physician's role as medical expert should not intrude on the right of the patient or patient's representative to make health care decisions.¹

As a practical matter, physicians cannot have enough information to choose one family member over another. The Commission's current proposal (*see* proposed Probate Code § 4713) assumes that a physician would be familiar with the level of family members' concern for and contact with the patient, and the family members' knowledge of the patient's personal values. This assumption is simply wrong, particularly given the size of most cities and the spread of HMO-model medicine.

If the Commission's proposal were to become law, abuses would occur. Too many physicians would take advantage of the authority in order to pick a compliant surrogate. For example, last week I encountered a physician who had refused to honor the wishes of daughter appointed as an agent under a durable power of attorney for health care; he paid attention to the daughter only after I talked to him and wrote him a stern letter. Such physicians would abuse the tremendous authority granted under the Commission's current draft.

Definitions of Capacity

We support the suggested creation of a separate definition for the "capacity" to execute an advance directive. We suggest that this definition be extended to Probate Code sections 4674(d) and 4701, relating to witness statements. If the capacity to execute an advance health care directive means "the patient's ability to understand the nature and consequences of the action," then witnesses should attest to exactly that.

¹ *See, e.g., Thor v. Superior Ct.*, 5 Cal. 4th 725, 735-36, 21 Cal. Rptr. 2d 357, 363-64 (1993) ("While the physician has the professional and ethical responsibility to provide the medical evaluation upon which informed consent is predicated, the patient still retains the sole prerogative to make the subjective treatment decision based upon an understanding of the circumstances.").

Potential Revocation of Durable Power of Attorney for Health Care Through Oral Designation of Surrogate

Designation of a surrogate should act as a revocation of a durable power of attorney for health care only during the time in which the designation of surrogate is effective. Because execution of a durable power of attorney is done with significant safeguards and process, permanent revocation should not be assumed without clear notice of an intent to revoke.

CONCLUSION

It is unfortunate that the Commission has reverted to a physician-chooses model to resolve cases in which more than one family member wishes to act as surrogate. Such a model is unworkable and inappropriate, for both legal and practical reasons.

Sincerely,



Eric M. Carlson, Esq.
Director, Nursing Home Advocacy Project

cc: Hon. Howard Wayne



California Advocates for Nursing Home Reform

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September 26, 2000

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Re: Commission Memorandum 2000-62
Family Consent in Health Care Decisionmaking for Adults

Dear Mr. Ulrich:

On behalf of California Advocates for Nursing Home Reform, I am submitting comments regarding the commission's draft proposal as attached to the above-referenced memorandum concerning family consent for adults without decisionmaking capacity.

Qualifications of Surrogate/Determination of Surrogate

We are disappointed that the Commission has chosen to disregard our and others' concerns that were expressed in response to the Commission's original proposal in 1998, and again in response to the Commission's 1999 legislation regarding a physician's discretion to select a surrogate.

The current proposal disqualifies a surrogate if the individual's "competence or motives are questionable," but fails to state who makes that determination or what these vague guidelines actually mean. The current proposal permits a primary physician to reject a surrogate if the physician believes in "good faith" that the surrogate is unable to comply with the surrogate's duties. If no one assumes authority or if there is a conflict, it allows the physician to select the "best qualified" surrogate based on a number of subjective factors, even disregarding the priority scheme.

As it is, the primary physician has the authority to determine capacity and to recommend treatment. It should not be within the physician's discretion to also select the surrogate, as this, in effect, allows the physician to substitute his or her judgment for that of the patient.

While it may have been the case in the 1950's or in old medical television shows that physicians were familiar with their patients' family members; that they could evaluate who was "familiar" with the patient's personal values or who "demonstrated care and concern for the patient," this is not the case today, particularly in urban areas and particularly in nursing homes.

In many nursing homes, the primary care physician is also the medical director, which, per se, creates a conflict of interest. Even when the physician is not the medical director, it is the rare physician who spends any time with the patient, much less with the patient's family members or friends. In short, primary physicians should not be given the discretion to select a surrogate for a patient under any circumstances.

The proposed provisions create an inherent conflict between the provider/physician's interest and the patient's best interests and are contrary to California law. California courts have repeatedly found that a patient's right to dictate his/her own medical treatment is paramount to any state or personal interest.

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

Orally Designated Surrogate

Oral designation of a surrogate for a particular course of treatment or illness should not permanently revoke an agent's authority without specific instructions to do so by the patient. One would assume that, if a patient has the capacity to orally designate a surrogate, the patient would also have the capacity to revoke an agent's authority.

Allowing an oral designation of a surrogate "during a stay in a health care institution" to revoke an agent's authority under a validly executed advance directive, is also a problem and seems to defeat the purpose of the directive.

The general purpose of an oral designation of a surrogate is for those situations where there is no agent or when the agent is otherwise unable to exercise his/her authority. This should be made clear in the statute, and, when there is a designated agent, the oral designation should only be for a particular course of treatment or illness when the agent is unable to

participate in the healthcare decisionmaking process, unless the patient has clearly revoked the agent's authority. To do otherwise is a setup for conflicts, particularly when the patient is a long term resident in a nursing home.

I plan to attend the Commission's October 5, 2000 meeting in San Francisco, and I will be available before then by phone if you have any questions.

Sincerely,

A handwritten signature in cursive script, appearing to read "Patricia L. McGinnis".

Patricia L. McGinnis
Executive Director

cc: Hon. Howard Wayne



CONGRESS OF CALIFORNIA SENIORS

CALIFORNIA'S VOICE FOR THE NATIONAL COUNCIL OF SENIOR CITIZENS



September 28, 2000

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File: _____

Re: Family Consent in Health Care Decision-Making for Adults; Opposition to Current Proposal

Dear Mr. Ulrich:

I am writing on behalf of the Congress of California Seniors to strongly protest the current proposal to come before the Commission which would give physicians the control in determining the "best qualified" individual for an incapacitated adult who, while competent, failed to appoint a decision-maker through a Durable Power of Attorney.

We do not believe that physicians should be given such authority or responsibility. Rather, we think that a priority list, the most commonly accepted method, should be followed except in extreme circumstances, for example when a surrogate is incompetent or estranged from the patient.

The current proposal grants excessive discretion to physicians. Physicians may not be objective and may only select a decision-maker based on convenience, not necessarily what is good for the patient.

We would appreciate our views being considered in your deliberations, and that you reject the current proposal. Please circulate our comments to the Commission members.

Sincerely,

William Powers
Legislative Director

WP:ef

cc: The Honorable Howard Wayne, Chair 7



October 2, 2000

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**Re: Family Consent in Health Care Decisionmaking for
Adults; Commission Memorandum 2000-62;
Meeting Scheduled for October 5, 2000 in San Francisco**

Response to Your Inquiry to Pat McGinnis

Dear Stan:

This letter is in response to your telephone discussion on September 27 with Pat McGinnis of California Advocates for Nursing Home Reform. Among other things, you asked Ms. McGinnis what system would resolve her concerns, or the concerns of others who are opposed to the Commission's current recommendation.

This letter is written on behalf of Bet Tzedek Legal Services, California Advocates for Nursing Home Reform, AARP, and the Congress of California Seniors.

I hesitate to take up this subject again because, as you know, I already have expended considerable time in the past year preparing suggested statutory revisions for the Commission on this issue. As a result, this letter attempts to highlight the signatories' position on the principal underlying dispute, without delving into other, more peripheral, issues.

Discussion

A family surrogate hierarchy is designed to formalize a family member's authority over the health care of a mentally incapacitated patient. Such a hierarchy system, if applied without exception, probably would work smoothly in more than 95 percent of the cases.

The potential problem with a hierarchy system is that on rare occasions it will select an individual who clearly should not be a surrogate. The Commission has responded to this potential problem by giving physicians

BET TZEDEK, The House of Justice, is a non-profit organization funded in part by the Jewish Federation Council of Los Angeles, United Way, the State Bar of California, the City of West Hollywood, and the City of Los Angeles.

incredibly wide discretion to reject a surrogate, or in some instances to select a surrogate who is lower in priority than another potential surrogate. We understand that you may believe that adequate safeguards exist, but we believe those safeguards to be illusory. This belief is based on our extensive experience with elderly consumers of health care, and our understanding of the appropriate role of a physician under the common and statutory law.

For practical and legal reasons, we can only accept a system in which the physician's authority to reject a surrogate is carefully circumscribed. Accordingly, we can accept the following language, which I originally submitted to the Commission in February of this year:

A supervising health care provider may refuse to accept the authority of a surrogate selected under this section, 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.*

In situations not covered by the above language, interested parties would be free to seek relief from the court, which is the appropriate body to adjudicate disputes. You in the past have cited legal authority for the proposition that courts should not be involved in health care decisionmaking. Those cases are cited out of context, because the cases involve situations in which a patient or a patient's legal representative has clear authority to make a particular decision.¹ Accordingly, current California law clearly specifies that any no-court preference applies only in the absence of a dispute: "*In the absence of controversy*, a court is normally not the proper forum in which to make health care decisions, including decisions regarding life-sustaining treatment."²

¹ See, e.g., *Conservatorship of Drabick*, 200 Cal. App. 3d 185, 194, 245 Cal. Rptr. 840, 844-45 (1988) ("Indeed, it appears that every court to have addressed the matter has concluded that judicial involvement is necessary in a decision to forego medical treatment for a persistently vegetative patient *only if the interested parties disagree*." (emphasis added)).

² Cal. Prob. Code § 4650(c) (emphasis added).

October 2, 2000

Page 3

We believe that the Commission's proposed delegation of authority to physicians is completely inconsistent with existing law; in no other context are important legal decisions simply delegated to an involved professional, with no oversight or due process. An equivalent system would allow an attorney to determine the family member "best qualified" to inherit from a deceased, or to disqualify one family member from an inheritance. Such a proposal would be categorically rejected, as should the Commission's proposed delegation of authority to physicians.

We believe that our suggested language allows physicians to reject surrogates in egregious situations, without unduly sacrificing safeguards. Please feel free to call any of us to discuss this matter further.³

Thank you.

Sincerely,



Eric M. Carlson
Attorney at Law



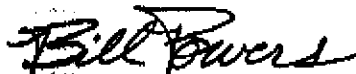
Pat McGinnis
Executive Director

California Advocates for
Nursing Home Reform



Tom Porter
California State Director

AARP



Bill Powers
Legislative Director

Congress of California Seniors

³ I will be out of town from Tuesday October 3 through Friday October 6, and thus will not be able to attend the Commission's meeting.



age and youth
in action

P.O. Box 19488
Sacramento, CA 95819
(916) 739-1540



September 28, 2000

Law Revision Commission
RECEIVED

OCT - 2 2000

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

File: _____

Re: Family Consent/Health Care Decisions
OPPOSITION to current proposal

Dear Mr. Ulrich:

Gray Panthers of Northern California wishes to join with others in the Senior Coalition in strong protest to the ~~current~~ proposal coming before you which would give the physician power to determine ~~the~~ "best qualified" individual for an incapacitated adult who, while competent, failed to appoint a decision-maker through a Durable Power of Attorney.

We feel that families should retain that authority and that, giving physicians the decision over family hierarchy is not necessarily in the best interest of the incapacitated person. Physicians do not necessarily understand the family nor the ability of the members to make wise surrogate decisions. It would be better to stay with recognized family order, ranging from spouse to children and siblings, etc.

Please place our opinion before the Commission members and consider them in your deliberations, and we trust you will reject the current proposal.

Thank you for your intelligent and forward thinking opinions and actions.

Sincerely,

A handwritten signature in black ink, appearing to read "Joan B. Lee".

Joan B. Lee
Legislative Liaison
Gray Panthers of Northern California



Older Women's League of California
926 J Street #1117, Sacramento CA 95814
+ (916) 444-2526 - Fax (916) 441-1881

VOICES OF MIDLIFE AND OLDER WOMEN

OWL-CA Council 2000

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September 30, 2000

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

Dear Mr. Ulrich,

I have been working with Eric Carlson and others about the proposed regulations for medical decisions for those incapable of making them.

To everyone's horror, when we began discussing this issue, I immediately agreed that MY doctor could make the decision. But let me briefly tell you about MY doctor. He was my uncle's doctor, and he was my mother's doctor. My mother died in 1969, and at that time he became my doctor. He has been my doctor, my confidant, and my life saver.

However, there is no one else I know who has such a long and satisfactory relationship with a medical provider. Everyone I talk with tells of their short acquaintance with their doctor. HMOs have changed the picture for patients and doctors. These decisions require an in depth knowledge of the patient, not one acquired in a few brief office visits. Then there is the whole question about how the doctor, often stranger to the family, can distinguish which is the proper family member to make the decision. Families may make mistakes, and they may disagree, but taking those rights from families is considered wrong by everyone I consulted. These are significant decisions, and not the time for expedient actions.

Allowing a doctor to decide if a family member is incapable or inappropriate as the decision maker is just going down the slippery slope which will lead to the doctor becoming the decision maker.

The Older Women's League will continue to work on increasing the use of the durable power of attorney for health. But without a durable power, in our opinion, and I have had to make this decision on three occasions, the doctor should prepare the family, if time allows, so that they can be anticipating a decision. These are very emotional times. The family needs the doctor as the person giving professional guidance, not as the partisan decision maker.

Yours truly,

Betty Perry
Betty Perry
Public Policy Director, OWL

CC: Assembly Member Howard Wayne

National Office, 666 Eleventh St., N.W., Suite 700, Washington, DC 20001