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## Nursing Home Residents and the New California Health Care Decisions Law


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# Nursing Home Residents and the New California Health Care Decisions Law

David M. English\* and Rebecca C. Morgan\*\*

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## I. INTRODUCTION

Many residents of nursing homes are frail, with disabling physical problems and degrees of diminished capacity.<sup>1</sup> Individuals are typically admitted to nursing homes because they need either skilled nursing care or nursing care beyond that available in a less restrictive setting such as an assisted living facility. Many nursing home residents also require more intense medical care, particularly during the final stages of life. While competent individuals may make their own health care decisions, nursing home residents, because of diminished capacity, may be considered incapable of deciding for themselves.<sup>2</sup> Fortunately, existing law allows individuals to plan in advance for possible future incapacity. All fifty states and the District of Columbia have statutes authorizing competent adults to make directives in advance for health care decisions.<sup>3</sup>

This article explores issues involving advance directives made by nursing home residents, both prior to and during their stay in a facility, including the frequency of making directives, the reasons why residents fail to make directives, and the reasons why facilities often fail to honor them. Specifically, this article examines these issues in light of the 1999 California Health Care Decisions Law,<sup>4</sup> effective July 1, 2000,<sup>5</sup> and focuses on how this new statute can be used to empower nursing home residents, and adults more generally, to take control of decisions regarding their own health care.

## II. HEALTH CARE DECISION MAKING IN A NURSING HOME

Few people anticipate spending time in a nursing home. However, the reality is that a significant portion of the elderly population will spend at least some time in a nursing home.<sup>6</sup> Individuals in need of skilled or recuperative therapy may be admitted for a temporary stay following their release from a hospital. Individuals

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1. Nursing home residents have the following estimated rates of impairment in activities of daily living (in percentages): eating, 40.3; dressing, 77.6; toileting, 63.2; getting in or out of bed or chair, 62.6; and bathing, 91.0. In addition, 62.6 percent of residents studied were disoriented or had suffered memory loss, and 46.9 percent had senile dementia or chronic brain syndromes. U.S. SENATE SPECIAL COMMITTEE ON AGING ET AL., *AGING AMERICA: TRENDS AND PROJECTIONS* 163, 167 (U.S. Dep't Health & Human Servs., Pub. No. 91-28001, 1991).

2. See, e.g., Eric L. Diamond et al., *Decision-Making Ability and Advance Directive Preferences in Nursing Home Patients and Proxies*, 29 *GERONTOLOGIST* 622, 624 (1989) (study finding that only 19 of 39 patients studied were perceived to be capable of making health care decisions); Jeffrey S. Janosky & Barry N. Rovner, *Prevalence of Advance Directives and Guardianship in Nursing Home Patients*, 6 *J. GERIATRIC PSYCHIATRY & NEUROLOGY* 214, 215 (1993) (finding that only 29 of 233 nursing residents were capable of making independent decisions regarding health care).

3. For a listing of the statutory provisions, see ALAN MEISEL, *THE RIGHT TO DIE* §§ 11.22, 12.52 (2d ed. Supp. 1999).

4. 1999 Cal. Stat. ch. 658, § 39 (codified at CAL. PROB. CODE §§ 4600-4805 (West Supp. 2000)).

5. *Id.* § 43.

6. See Peter Kemper & Christopher M. Murtaugh, *Lifetime Use of Nursing Home Care*, 324 *NEW ENG. J. MED.* 595 (1991) (study of likelihood those who turned age 65 in 1990 will spend time in nursing home).

entering a nursing home either from their family home or from a facility offering a level of care lower than that offered in a nursing home normally are admitted because their current caregivers are no longer able, or in some cases willing, to provide the needed level of care. For many residents, discharge is not an option; the nursing home will be their residence for the remainder of their lives.<sup>7</sup>

A. *Dependency and Autonomy in Nursing Homes*

Needless to say, nursing homes are not viewed as desirable places to live. A nursing home facility is an institution. With institutions come routines, rules and regulations, and a concomitant loss of autonomy. Although the facility is now the resident's "home," the resident does not control the routine.<sup>8</sup> The loss of control, whether real or imagined, that occurs upon entering such an undesired environment may contribute to a decline in a resident's abilities or depression, a common condition among nursing home residents.<sup>9</sup> By encouraging autonomy and independence, a facility can reduce the sense of loss of control and minimize resulting depression.<sup>10</sup>

Resident rights statutes enhance autonomy, individuality, respect and control for residents. Statutory resident rights include the right to privacy, communications, visitors, freedom of association, freedom from restraints, confidentiality of records, accommodation of needs, and participation in activities, as well as confirmation of the right to refuse treatment and the right to make an advance directive. In addition, resident rights statutes require that the facility comply with the Patient Self-Determination Act.<sup>11</sup> A facility which implements resident rights and whose

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7. Close to two-thirds of all nursing home stays terminate by reason of death. Denise A. Spence & Joshua M. Wiener, *Nursing Home Length of Stay Patterns: Results from the 1985 National Nursing Home Survey*, 30 GERONTOLOGIST 16, 18-19 (1990). Over 1.5 million people reside in nursing homes in the U.S., with a majority either dying in the nursing home or within a short time of being transferred to a hospital. Steven C. Zweig, *Cardiopulmonary Resuscitation and Do-Not-Resuscitate Orders in the Nursing Home*, 6 ARCHIVES FAMILY MED. 424, 424 (1997).

8. See Mary Marmoll Jirovec & Betty A. Maxwell, *Nursing Home Residents' Functional Ability and Perceptions of Choice*, J. GERONTOLOGICAL NURSING, Sept. 1993, at 10, 13 (describing the expectation that residents will be submissive, similar to patients in hospitals, and concluding that medical model is inappropriate if a facility is truly to become the resident's home); Linda A. O'Brien et al., *Nursing Home Residents' Preferences for Life-Sustaining Treatment*, 274 JAMA 1775, 1779 (1995) (noting that many residents believe that their position as residents compels them to give up their decision-making powers).

9. See, e.g., Barry W. Rovner et al., *Depression and Mortality in Nursing Homes*, 265 JAMA 993 (1991) (examining the prevalence of depression in nursing home residents).

10. For example, in one study, new residents were given different descriptions of their roles in the facility. To one group, autonomy and independence were emphasized, while to the other group, the focus was on the facility. The first group reported a higher level of activity, alertness, and general sense of well-being than did the second group. Ellen J. Langer & Judith Rodin, *The Effects of Choice and Enhanced Personal Responsibility for the Aged: A Field Experiment in an Institutionalized Setting*, 34 J. PERSONALITY & SOC. PSYCHOL. 191 (1976).

11. For the federal resident rights provisions, see 42 U.S.C.A. §§ 1395i-3(c), 1396r(c) (West Supp. 1999); 42 C.F.R. § 483.10 (West 1999) (listing residents' rights). For a discussion of the federal provisions, see David M. English, *The Rights of Nursing Home Patients: A Planner's Guide*, TR. & EST., July 1991, at 28. For the

operation creates a culture for honoring them will likely have residents who are less depressed and feel more in control of their lives. Residents who feel more in control are more likely to create advance directives, and a facility which respects resident rights, when presented with an advance directive, is more likely to honor it.

### B. Health Care Decisions and “Advance Directives”

At no time is autonomy and control more vividly demonstrated than when a person must make a decision about health care. Making choices regarding one’s health is a distinctly personal issue that has major ramifications for the individual—not only in terms of how long the individual will live, but also in terms of the quality of that individual’s life. Because people entering a nursing home may have significant infirmities and be near the end of their lives,<sup>12</sup> they are a group whose need for advance directives is paramount. The odds are much greater that critical health care issues will arise for nursing home residents than for “well-elders” living in the community. Further, because of their infirmities, nursing home residents on average are less likely to have the capacity to make a health care decision when one is needed.<sup>13</sup>

#### 1. The Lack of Advance Directives Among Nursing Home Residents

Despite the “ease” with which an advance directive can be made, studies show that only ten to twenty-five percent of adult Americans have made a directive,<sup>14</sup> and one study has pegged the number even lower.<sup>15</sup> While the percentage of nursing home residents who have advance directives is higher than non-nursing home residents,<sup>16</sup> the percentage is still less than a majority.

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California resident rights provisions, see CAL. CODE REGS. tit. 22, §§ 72527, 73523, 87572.

12. See *supra* note 1 (listing rates of physical and mental infirmity among nursing home residents).

13. See L. Jaime Fitten et al., *Assessing Treatment Decision-Making Capacity in Elderly Nursing Home Residents*, 38 J. AM. GERIATRIC SOC’Y 1097, 1097 (1990) (concluding that frail and dependent elderly individuals are not only more likely to be asked to make crucial health care decisions, but are also more likely to have diminished capacity for decision making).

14. See GENERAL ACCOUNTING OFFICE, GAO/HEHS-95-135, PATIENT SELF-DETERMINATION ACT—PROVIDERS OFFER INFORMATION ON ADVANCE DIRECTIVES BUT EFFECTIVENESS UNCERTAIN 8 (1995) [hereinafter “GAO Report”] (reporting the results of the implementation of advance directives under the PSDA); see also Don Colburn, *Facing Death with a Plan*, WASH. POST, Oct. 27, 1998 (Health Section), at 7 (noting a 1991 Gallup Poll that found that while 75% of Americans support the concept, only 20% of Americans have a living will).

15. See Susan M. Rubin et al., *Increasing the Completion of the Durable Power of Attorney for Health Care: A Randomized, Controlled Trial*, 271 JAMA 209, 211 (1994) (noting that only 5.8% of those surveyed had completed a written advance directive).

16. See, e.g., Melissa D. Zwahr et al., *Implementation and Impact of the Patient Self-Determination Act: A Comparison of Nursing Homes to Hospitals*, 16 J. APPLIED GERONTOLOGY 190, 203 (1997) (survey reporting that advance directives were executed by a higher percentage of Georgia nursing home residents than hospital patients).

There are numerous causes for this failure to plan and to make advance directives. Some individuals simply choose not to face their own mortality.<sup>17</sup> Others think their family members, including their spouse or children, will know what to do "when the time comes," because "they know what I want." However, family members frequently do not know what the spouse, parent or other relative wants;<sup>18</sup> many residents have never discussed with their families the topic of end-of-life care.<sup>19</sup>

Medical professionals also share responsibility for the lack of advance directives. Medical professionals routinely do *not* discuss decisions to be made with respect to life-prolonging care with nursing home residents.<sup>20</sup> Further, discussions that do occur frequently are not with the resident directly but with someone close to the resident, even in the case of residents who have capacity.<sup>21</sup> Lack of communication also occurs with respect to do-not-resuscitate (DNR) orders. DNR orders, unlike advance directives such as living wills and powers of attorney, are in some states signed by the doctor and not by the patient.<sup>22</sup> Also, DNR orders are sometimes placed in the resident's chart by the doctor without the resident's knowledge or consent.<sup>23</sup> Nursing homes can and should adopt policies and practices

17. See David Orentlicher, *The Limitations of Legislation*, 53 MD. L. REV. 1255, 1272-73 (1994) (noting natural reluctance to face mortality and unsettling nature of the subject to some people).

18. See Allison B. Seckler et al., *Substituted Judgment: How Accurate Are Proxy Predictors?* 115 ANNALS INTERNAL MED. 92, 92 (1991) (ability of family and physician to predict patient's wishes far lower than patients believed); Jiska Cohen-Mansfield et al., *The Decision to Execute a Durable Power of Attorney for Health Care and Preferences Regarding the Utilization of Life-Sustaining Treatments in Nursing Home Residents*, 151 ARCHIVES OF INTERNAL MED. 289, 291 (1991) (60% of residents surveyed had not discussed their medical care preferences).

19. See, e.g., O'Brien et al., *supra* note 8, at 1778 ("For residents able to name a family member or significant other whom they would want to act as surrogate decision maker in the event they were too ill to speak on their own behalf, 31% reported having spoken to that individual about treatment preferences.").

20. Explanations for this lack of discussion include:

- doctors are more comfortable with having, or believe it more appropriate to have, such a discussion with family members rather than with the patient;
- doctors believe they know what the patient wants, what is best for the patient, or think that life-sustaining medical treatment is futile;
- some residents may wish not to have a discussion about life-sustaining medical treatment; and
- residents may not accurately remember whether their doctors talked to them about end-of-life care or may not have understood that the discussion's outcome led to a decision on end-of-life care.

Jennifer R. Levin et al., *Life-Sustaining Treatment Decisions for Nursing Home Residents: Who Discusses, Who Decides and What is Decided?*, 47 J. AM. GERIATRICS SOC'Y 82, 85 (1999).

21. See Elizabeth Bradley et al., *Assessing Capacity to Participate in Discussions of Advance Directives in Nursing Homes: Findings from a Study of the Patient Self-Determination Act*, 45 J. AM. GERIATRIC SOC'Y 79, 81 (1997) (study of nursing home admissions finding that in a majority of cases advance directive information is given to someone other than the resident even when the resident is judged to be oriented and alert).

22. For an analysis of the state statutes, see MEISEL, *supra* note 3, §§ 9.07-9.30 (2d ed. 1995).

23. See, e.g., Levin et al., *supra* note 20, at 82 (finding that nearly half of residents with DNR orders had not discussed CPR with caregivers).

that encourage doctors to consult residents about DNR orders and other end-of-life decisions.<sup>24</sup>

## 2. *Statutory Law and the Use of Form Directives*

The federal Patient Self-Determination Act (PSDA)<sup>25</sup> was enacted in 1990 with the specific purpose of overcoming the reluctance to make advance directives. The Act requires facilities receiving Medicare and Medicaid funding to ask residents, at the time of admission, whether they have an advance directive, to document in the chart whether the resident has a directive, and if the resident does not have a directive, to ask the resident if the resident would like one.<sup>26</sup> For residents expressing an interest in having a directive, the facility will normally provide the resident with a form to complete, either its own or the state's statutory form (use of which is usually optional).<sup>27</sup> Although the Act requires facilities to inform residents of their rights, the law does not require that the resident actually understand the information provided. Experience to date suggests that patient understanding of the meaning of form directives may be superficial at best.<sup>28</sup>

Many form directives are not easy to understand or read.<sup>29</sup> In addition, standardized forms oftentimes focus more on such matters as naming an agent, giving general directions or, above all, limiting liability to those honoring the directive, rather than on emphasizing and accurately and precisely reflecting the wishes of the patient in the given circumstance. Despite this limitation, however, the making of an advance directive remains the best method for residents to make their wishes known and to put plans in place to maximize the chance their wishes will be followed.

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24. *Id.* at 86.

25. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4206, 4751, 104 Stat. 1388, 1388-115 to -117, 1388-204 to -206 (1991) (codified in scattered sections of 42 U.S.C.).

26. 42 U.S.C.A. §§ 1395cc(f), 1396a(w) (West Supp. 1999).

27. For a discussion of the statutory forms in effect in various states, see David M. English, *The UPC and the New Durable Powers*, 27 REAL PROP. PROB. & TR. J. 333, 368-404 (1992).

28. See Edward J. Larson & Thomas A. Eaton, *The Limits of Advance Directives: A History and Assessment of the Patient Self-Determination Act*, 32 WAKE FOREST L. REV. 249, 270-71 (1997) (discussing studies of effect of PSDA on patient awareness and understanding of advance directives); Thaddeus Mason Pope, *The Maladaptation of Miranda to Advance Directives: A Critique of the Implementation of the Patient Self-Determination Act*, 9 HEALTH MATRIX: J. LAW-MED. 139, 160-61 (1999) (PSDA not effective in making individuals aware of legal rights).

29. The need for easily understandable language is not limited to advance directives, but applies to all documents relating to medical treatment. A study of health care decision making at the Veterans Administration found that it is important to explain the medical treatment proposed in simple language. See Fitten, *supra* note 13, at 1102-03. The study found the VA's consent form to be complex, and likely to result in misunderstandings. "Accurate but simplified disclosures" of the information needed for consent would have benefitted the patient's understanding much more than the "currently popular legally and bureaucratically inspired forms." *Id.* at 1103.

### 3. Difficulties in Determining Capacity and Implementing Directives

Ideally, a resident should make a directive well in advance of admission to a nursing home. A resident admitted with significant cognitive impairments may lack legal capacity to execute a directive or to otherwise make a health care decision.<sup>30</sup> Errors are frequently made in determining whether a resident has the requisite capacity. Although numerous tests are available to determine capacity, the tests that are easiest to apply are often cursory and may lead to erroneous results. Those that are more accurate may be too unwieldy for routine use. There is currently no one method for measuring the capacity of nursing home residents that is used consistently and provides uniform results.<sup>31</sup>

The making of an advance directive is no guarantee that the resident's wishes will be followed. Despite the federal law intended to facilitate the making and enforcement of advance directives,<sup>32</sup> health care providers are frequently unaware that a directive exists.<sup>33</sup> A resident may have executed a directive prior to admission to the nursing home, but at the time of admission be unable to tell the facility about the directive. If the directive was not drawn by a lawyer but prepared from a "do-it-yourself" kit, no one other than the resident may have a copy of the directive or even know of its existence. To increase the chance their wishes will be followed, residents should notify others, especially their health care providers and emergency contacts, of the directive's existence and location.

The practices of health care providers also contribute to this failure to discover and implement directives. The directive, once given to the facility, may not be easy to locate, or even be contained in the medical chart. Thus, the directive frequently does not accompany the resident upon the resident's admission to a hospital or in a move to another facility.<sup>34</sup>

30. For the rates of impairment, see *supra* note 1.

31. See Fitten, *supra* note 13, at 1097, 1103. The authors note that no generally accepted method exists for assessing a patient's ability to make decisions. As a result, clinicians usually use more informal methods to make capacity determinations—for example, an abbreviated mental status exam—or may even rely on their own impressions or those of the staff to decide whether the patient is competent to make a health care decision. *Id.* at 1097. The study concludes that the more informal methods have minimal practical value in determining which nursing home residents had diminished decision making ability. These simplified "tests" were better predictors than no tests at all, but not as accurate as more extensive screening tools. *Id.* at 1103.

32. See *supra* notes 25-28 and accompanying text (setting forth the purpose and principal requirements of the Patient Self-Determination Act).

33. See Ellen H. Elpern et al., *A Preliminary Investigation of Opinions and Behaviors Regarding Advance Directives for Medical Care*, 2 AM. J. CRITICAL CARE 161, 164 (1993) (estimating that fewer than half of all patients executing advance directives have informed their physicians of their decisions); Jaya Virmani et al., *Relationship of Advance Directives to Physician-Patient Communication*, 154 ARCHIVES INTERNAL MED. 909 (1994) (study finding little evidence that directives lead to improved communication between doctors and patients about end of life treatment).

34. See GAO REPORT, *supra* note 14, at 13 (describing a study which found that only about one-third of residents' advance directives were successfully delivered to the hospital and incorporated into the hospital record); R. Sean Morrison et al., *The Inaccessibility of Advance Directives on Transfer from Ambulatory to Acute Care*



Even if the facility is aware of the directive, other factors may lead to the directive not being honored. Some health care providers treat elderly people in a paternalistic manner, frequently resulting in a resident's wishes being superseded by another course of action thought "better" for the resident.<sup>35</sup> Also, the facility may have a policy that is directly contrary to the wishes of the resident. Knowledge of this policy may be imputed to the resident, making it more difficult to enforce the resident's contrary directive.<sup>36</sup> Additionally, family members may disagree with the resident's desires regarding life-prolonging procedures and thus contest the resident's directive, threatening the facility with litigation or actually filing a petition with the court to prevent enforcement of the directive. Despite the law's emphasis on the honoring of a patient's wishes through such tenets as the doctrine of substituted judgment,<sup>37</sup> the resident may find that her wishes are thwarted no matter how careful the prior planning. It is important that the medical profession not let its perception of the patient's best interest crowd out the patient's right of self-determination.<sup>38</sup> One of the principal objectives of the 1999 California Health Care Decisions Law is to reinforce the honoring of advance directives by making it easier for residents to make their wishes known and by taking steps that increase the likelihood that those wishes will be honored.

### III. CALIFORNIA HEALTH CARE DECISIONS LAW

The California Health Care Decisions Law,<sup>39</sup> which becomes operative on July 1, 2000,<sup>40</sup> recasts California law on the making of advance directives. The new law,

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*Settings*, 274 JAMA 478 (1995) (finding that only 26% of patients who had previously executed advance directives had their directives recognized following their hospitalizations).

35. See Marion Danis et al., *A Prospective Study of Advance Directives for Life-Sustaining Care*, 324 NEW. ENG. J. MED. 882, 887 ("[T]he data suggest that in caring for incapacitated patients, physicians balance respect for autonomy with other competing ethical principles in order to make what they believe are the wisest decisions.").

36. See generally *In re Jobes*, 529 A.2d 434, 450 (N.J. 1987) (deciding that where a facility did not inform patient's family about its policy toward artificial feeding until the family requested that feeding be withdrawn, the facility could not avoid honoring family's request by discharging patient).

37. The court in *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977), described the doctrine of substituted judgment as follows:

We believe . . . [the surrogate decision maker] should have attempted (as they did) to ascertain the incompetent person's actual interests and preferences. In short, the decision in cases such as this should be that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person.

*Id.* at 431.

38. See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 271-91 (4th ed. 1994) (discussing the conflict between beneficence and autonomy).

39. 1999 Cal. Stat. ch. 658, § 39 (codified at CAL PROB. CODE §§ 4600-4805 (West Supp. 2000)).

40. *Id.* § 43.

which was drafted by the California Law Revision Commission,<sup>41</sup> replaces, with a single statute, the formerly separate provisions governing the making of living wills<sup>42</sup> and durable powers of attorney for health care.<sup>43</sup>

### A. Uniform Health-Care Decisions Act

The California law is a substantial adoption of the Uniform Health-Care Decisions Act, which was approved by the National Conference of Commissioners on Uniform State Laws in 1993.<sup>44</sup> California is the sixth state to enact the Uniform Act.<sup>45</sup> The purpose of the Uniform Health-Care Decisions Act, similar to the new California law, is to facilitate and encourage the making of advance directives.<sup>46</sup>

The California Health Care Decisions Law incorporates most, but not all, of the provisions of the Uniform Act; the California law addresses only advance directives while the Uniform Act also covers health care decision making by family and close friends, who are authorized to act on a patient's behalf if no conservator or agent has been appointed or is reasonably available.<sup>47</sup> While health care decision making by family and close friends was included in the California bill as originally introduced, these provisions were deleted by amendment in order to assure enactment.<sup>48</sup>

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41. For the official report, including the proposed bill, comments, and background memorandum, see *Health Care Decisions for Adults Without Decisionmaking Capacity*, 29 CAL. L. REVISION COMM'N REPORTS (1999) [hereinafter COMMISSION REPORT].

42. The living will provisions were codified at CAL. HEALTH & SAFETY CODE §§ 7185-7194.5 (West Supp. 1999).

43. The power of attorney provisions were codified at CAL. PROB. CODE §§ 4000-4947 (West Supp. 1999). The provisions directed exclusively at health care were codified at §§ 4600-4806.

44. UNIFORM HEALTH-CARE DECISIONS ACT, 9 U.L.A. 309 (Supp. 1999).

45. See also DEL. CODE ANN. tit. 16, §§ 2501-2517 (1998) (enacted in 1996); HAW. REV. STAT. ANN. §§ 327E-1 to -16 (Michie 1999) (enacted in 1999); ME. REV. STAT. ANN. tit. 18-A, §§ 5-801 to -817 (West 1998 & Supp. 1999) (enacted in 1995); MISS. CODE ANN. §§ 41-41-201 to -229 (Supp. 1999) (enacted in 1998); N.M. STAT. ANN. §§ 24-7A-1 to -18 (Michie 1996) (enacted in 1995).

46. UNIFORM HEALTH-CARE DECISIONS ACT prefatory note, 9 U.L.A. 309 (Supp. 1999). For analyses of the Uniform Health-Care Decisions Act, see generally David M. English, *The Health-Care Decisions Act Represents a Major Advance*, TR. & EST., May 1994, at 32; David M. English & Alan Meisel, *Uniform Health-Care Decisions Act Gives New Guidance*, 21 EST. PLAN. 355 (1994); Charles P. Sabatino, *The New Uniform Health Care Decisions Act: Paving a Health Care Decisions Superhighway*, 53 MD. L. REV. 1238 (1994).

47. For a cross-reference table, see COMMISSION REPORT, *supra* note 41, at 243. Other sections of the Uniform Act not enacted in California include Section 6 on health care decision making by conservators, and Section 14 on judicial proceedings. The new Health Care Decisions Law carries forward California's existing provisions on judicial proceedings. See CAL. PROB. CODE §§ 4900-4947 (West Supp. 2000). For the application of the standard for making decisions to decisions by conservators, see *infra* note 74 and accompanying text.

48. For the proposed provisions, which would have been codified at California Probate Code Sections 4710 to 4716, see COMMISSION REPORT, *supra* note 41, at 111-17. The provisions were deleted because of objections by the staff of the California Assembly Judiciary Committee, which described them as "controversial." See Cal. L. Revision Comm'n, Minutes of Meeting of June 24-25, at 13-14; see also Cal. L. Revision Comm'n, Staff Mem. 99-38 (discussing amendments made to the bill).

An issue not addressed in the Uniform Act is the problem of “friendless” patients; individuals who have no family or anyone else available to act on their behalf. California is one of the few states to have legislated on this subject, although not in a comprehensive way. California Probate Code section 3200 creates a judicial procedure allowing the court to direct the health care to be provided to incapacitated individuals not under conservatorship.<sup>49</sup> Also, for residents of nursing homes, nonintrusive and routine medical decisions for residents whom a physician determines lacks capacity may be made by an interdisciplinary team, which may include, where practical, a representative of the patient.<sup>50</sup> There remains a need, both in California and elsewhere, for an expanded procedure that would allow not only routine but also critical health care decisions to be made for friendless patients outside of court but with appropriate safeguards.<sup>51</sup> Further, for individuals who do have family or friends, California needs to join the substantial majority of states that recognize the right of family (and, in a number of states, close friends) to make health care decisions for patients who have failed to make advance directives.<sup>52</sup>

### B. Advance Health Care Directives Under the New Law

The California Health Care Decisions Law validates the right of an adult to give an “advance health care directive” regarding the health care to be provided should the adult later lack capacity to make health care decisions. Advance health care directives come in two forms: an “individual health care instruction” or “individual

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49. See CAL. PROB. CODE §§ 3200-3211 (West Supp. 2000). The Health Care Decisions Law leaves the section 3200 procedure unchanged except for conforming amendments.

50. For the required procedure, see CAL. HEALTH & SAFETY CODE § 1418.8 (West Supp. 2000).

51. The Commission proposal, as originally introduced, would have expanded existing law to allow any health care facility to designate an interdisciplinary team to make any health care decision for patients in facilities, including decisions to withhold or withdraw life-sustaining treatment, whether the patient was in a nursing home or hospital. Unlike the procedure authorized in California Health and Safety Code section 1418.8, the Commission’s proposal mandated the appointment of a patient or community representative to the interdisciplinary team. For the proposal, see COMMISSION REPORT, *supra* note 41, at 118-23. The proposal was deleted from the bill when it became obvious that it had no chance of enactment. See Cal. L. Revision Comm’n, Minutes of Meeting of Apr. 8, 1999, at 9-10.

The Commission proposal is subject to criticism because it failed to include a method for independent decision making or review. See David A. Lash & Eric M. Carlson, *Treatment by Committee Will Ignore Constitutional Rights of Elders*, S.F. DAILY J., Apr. 15, 1999, at 4. However, the authors’ suggestion that the section 3200 proceeding is the appropriate means for handling the problem of the friendless patient is unrealistic. The courts are ill equipped to resolve these issues as a matter of routine, a view which was expressed by the California Court of Appeals itself in upholding the constitutionality of California Health & Safety Code section 1418.8, upon which the Commission proposal was based. *Rains v. Belshe*, 32 Cal. App. 4th 157, 180-81, 38 Cal. Rptr. 2d 185, 198 (1995); see also CAL. PROB. CODE § 4650(c) (West Supp. 2000) (“In the absence of a controversy, a court is normally not the proper forum in which to make health care decisions, including decisions regarding life-sustaining treatment.”).

52. For a list of the statutory provisions, see MEISEL, *supra* note 3, § 14.10.

instruction,”<sup>53</sup> which replaces the “natural directive” or living will of former law; and a “power of attorney for health care,”<sup>54</sup> which is identical in function to the durable power of attorney for health care of former law.

Under the new California law, an individual health care instruction can relate to any aspect of health care. Unlike the former Natural Death Act,<sup>55</sup> the new law does not attempt to define and restrict application of the statute to individuals determined to be in a “terminal” or “permanently unconscious” condition,<sup>56</sup> terms which provide an appearance of precision where none is possible.<sup>57</sup> Under the new law, an individual instruction, and the authority which may be granted to an agent under a power of attorney for health care, may extend to any “health care decision,” a term that is expansively defined.<sup>58</sup>

Certain sensitive procedures are not covered by the new law, however. Subjects still controlled by other laws include: commitment to a mental health treatment facility; convulsive treatment; psychosurgery; sterilization; and abortion.<sup>59</sup> The new law also excludes from its scope the subject of physician-assisted suicide.<sup>60</sup> Finally, while an advance directive may state the patient’s wishes on DNR orders, California retains the requirement that such an order may be entered only by a physician.<sup>61</sup>

### C. Oral Instructions and Designations

In addition to unifying the law on advance directives, the law adds some new features. Although long-recognized in the case law, the new law for the first time gives statutory recognition to a patient’s oral instructions.<sup>62</sup> The new law also grants

53. For the definition of “individual health care instruction” and “individual instruction,” see CAL. PROB. CODE § 4623 (West Supp. 2000).

54. For the definition of “power of attorney for health care,” see *id.* § 4629 (West Supp. 2000).

55. CAL. HEALTH & SAFETY CODE §§ 7185-7194.5 (West Supp. 1999).

56. *Id.* § 7186 (West 1999).

57. See English, *supra* note 46, at 35:

The drafters of the Uniform Act concluded that the attempts to statutorily prescribe the circumstances when life-sustaining treatment may be withheld or withdrawn unduly restrict, are difficult to apply in a clinical setting, and provide an appearance of precision where none is possible.

*Id.*

58. For the definition of a “health care decision,” see CAL. PROB. CODE § 4617 (West Supp. 2000).

59. See *id.* § 4652 (Health Care Decisions Law does not authorize consent to any of the listed procedures); *id.* § 4722 (power of attorney may not authorize attorney-in-fact to consent to any of listed procedures).

60. *Id.* § 4653.

61. See *id.* §§ 4780-4786, which continue former California Probate Code section 4753 without substantive change.

62. See *id.* § 4670, which is drawn from section 2(a) of the Uniform Health-Care Decisions Act. The drafters of the Uniform Act in turn picked up the idea from the 1992 Virginia (VA. CODE ANN. § 54.1-2983) and 1993 Maryland (MD. HEALTH-GEN. CODE ANN. § 5-602(d)) statutes. See English, *supra* note 46, at 35-36. The validation of oral directives does not create new law. Oral directives have long been enforced by the courts. For a discussion of the case law on oral directives, see MEISEL, *supra* note 3, §10.16 (2d ed. 1995).

statutory confirmation to a patient's oral designation of a person to make health care decisions on the patient's behalf,<sup>63</sup> a practice not recognized in the case law but encountered with some frequency by health care providers. The orally designated surrogate is similar to, but does not quite have the status of, an agent appointed under a written power of attorney for health care. For example, unlike the appointment of an agent, which normally will continue for the principal's lifetime unless revoked, an oral designation of a surrogate is effective only during the course of treatment, illness, or stay in the health care institution.<sup>64</sup> The power to orally designate a surrogate should be particularly useful for couples in cohabiting relationships who have neglected to sign written advance directives and are concerned that their health care providers will automatically turn to their families to make life-altering decisions instead of relying on their companions to make the choice. While a formal power of attorney for health care is much to be preferred, the oral surrogacy provision recognizes that for many patients, orally telling their physicians whom they want to decide their fate is the most they are willing or able to do.

#### D. Enforcement Provisions

The new law contains several provisions designed to enhance the enforcement of advance directives. For the first time the law requires that a health care provider actually honor the patient's advance directive, as well as comply with the decisions made by an agent or orally designated surrogate.<sup>65</sup> This provision, if actually enforced, will do more than any other to effectuate a patient's right to self-determination. A right to self-determination is of little benefit if there is no effective way to enforce the right.

Not all provisions of an advance directive, or decisions of an agent or surrogate, are enforceable, however. Under the new law, a provider may decline to honor a directive or decision for "reasons of conscience."<sup>66</sup> For a health care institution, such a declination must be based on a formal policy of the institution which was timely communicated to the resident or person authorized to act on the resident's behalf.<sup>67</sup> Early communication will help to avoid those unfortunate situations in which the facility, upon being told of a decision to withdraw or withhold treatment, informs the resident and resident's family of its policy well after the date that a

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63. See CAL. PROB. CODE § 4711 (West Supp. 2000), which is drawn from section 5(b) of the Uniform Health-Care Decisions Act. The drafters of the Uniform Act derived the idea from the Maryland (MD. HEALTH-GEN. CODE ANN. § 5-602(d)) statute. See English, *supra* note 46, at 36-38.

64. This limitation on the authority of a designated surrogate is not found in the Uniform Act but is a useful addition, and is based on the assumption that most oral designations are not intended to be permanent in nature.

65. See CAL. PROB. CODE § 4733 (West Supp. 2000).

66. *Id.* § 4734(a).

67. *Id.* § 4734(b).

transfer to another facility could be arranged.<sup>68</sup> Any health care provider, whether an individual or an institution, may also decline a directive or decision if it requires the provision of futile treatment, which is defined as care that would be “medically ineffective,”<sup>69</sup> or care contrary to generally accepted health care standards.<sup>70</sup>

*E. Standard Forms: Aspects, New and Old*

The new law includes a statutory form.<sup>71</sup> Unlike former law, which provided separate forms for living wills and durable powers of attorney for health care, the new form combines both topics. As under former law, use of the statutory form is entirely optional. An individual choosing the form may complete it in whole or in part, and may modify any of its provisions. The form provides for the designation of an agent and two alternate agents, the nomination of the agent as conservator of the person if conservatorship becomes necessary, and the listing of any individual instructions, to be binding on the agent and anyone else who might be called upon to make health care decisions on the individual’s behalf. With respect to the subject of life-sustaining treatment, the form includes the alternatives most often selected, but does not limit the individual to only those choices. The form is designed to include all aspects of the type of advance directive signed by a well-advised client. The dilemma is that some individuals are overwhelmed by anything other than the shortest and most easily stated language.<sup>72</sup> Designing a truly universal form is probably impossible.

*F. The Decision-Maker’s Standard: A Patient-Sensitive Approach*

The new law codifies the standard for making decisions. The decision maker must comply with the individual patient’s health care instructions and other express wishes, to the extent known, whether written or oral. Otherwise, the health care decision must be made in accordance with the patient’s best interests as determined in light of the patient’s personal values, to the extent these values are known.<sup>73</sup> The

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68. For the case law on whether a facility must honor a request that is contrary to a stated policy, see MEISEL, *supra* note 3, § 17.23 (2d ed. 1995).

69. CAL. PROB. CODE § 4735 (West Supp. 2000).

70. *Id.*

71. *Id.* § 4701.

72. For a study of the consent form in use by the Veterans Administration, see *supra* note 29 and accompanying text.

73. This standard codifies but makes more explicit the test stated in *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983):

[A]ny surrogate, court appointed or otherwise, ought to be guided in his or her decisions first by his knowledge of the patient’s own desires and feelings to the extent that they were expressed before the patient became incompetent. . . . If it is not possible to ascertain the choice the patient would have made, the surrogate ought to be guided in his decision by the patient’s best interest.

*Id.* at 1021, 195 Cal. Rptr. at 493.

standard for making decisions applies not only to agents and orally designated surrogates, but also to conservators and anyone else who may be acting as the patient's surrogate,<sup>74</sup> including the patient's family and close friends. The result is that while the new law does not state when and which family members and close friends are empowered to make health care decisions on a patient's behalf, whenever they do assume this authority, they will be subject to a specified standard of care.

### G. Failure to Simplify the Witnessing Requirements

While progressive in many important ways, the new law fails to make one forward stride. The bill as originally introduced tracked the execution requirements of the Uniform Health-Care Decisions Act, which keeps execution requirements for an advance directive to an absolute minimum.<sup>75</sup> While a place for witnesses is provided in the Uniform Act's form, witnessing is not required.<sup>76</sup> The drafters of the Uniform Act concluded that the detailed execution requirements in many states have done little to deter fraud or overreaching.<sup>77</sup> While one can argue that requiring more formality protects against forgery and prevents at least some undue influence, the execution requirements of the former law, which are easily the most complicated and confusing in the country, are overkill.<sup>78</sup> Nevertheless, to eliminate a source of controversy and to assure the bill's passage, the new law carries forward the execution requirements of the former law.<sup>79</sup>

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74. CAL. PROB. CODE §§ 2355 (conservators), 4684 (agents), 4714 (surrogates) (West Supp. 2000).

75. The sole execution requirements under the Uniform Act are that a power of attorney for health care must be in writing and be signed by the principal. See UNIF. HEALTH-CARE DECISIONS ACT § 2(b), 9 U.L.A. 315 (Supp. 1999).

76. *Id.* § 4, 9 U.L.A. 318 (Supp. 1999).

77. See English, *supra* note 46, at 35:

The drafters of the Uniform Act concluded that the cumbersome execution requirements found under many state statutes have done little to deter fraud or overreaching. Rather, their primary effect is to deter the making of advance directives and invalidate defectively executed directives that otherwise would be reliable indicators of the individual's intent.

*Id.*

78. See English, *supra* note 27, at 368-76 (analyzing the execution requirements for a durable power of attorney for health care in California and elsewhere).

79. CAL. PROB. CODE §§ 4673-4675 (West Supp. 2000). The attempt to eliminate execution requirements has been the least successful aspect of the Uniform Act. Of the six states which have adopted the Uniform Act, only New Mexico has followed the Act on this point without change. For New Mexico's execution requirements, see N.M. STAT. ANN. § 24-7A-2 (Michie 1996). Delaware requires two witnesses for both an individual instruction and power of attorney for health care. DEL. CODE ANN. tit. 16, § 2503(b) (Supp. 1998). Hawaii, Maine, and Mississippi validate oral instructions but impose additional execution requirements for powers of attorney for health care; Hawaii and Maine require witnessing, Mississippi allows either witnessing or acknowledgment. HAW. REV. STAT. ANN. §§ 327E-3 (Michie 1999); ME. REV. STAT. ANN. tit. 18-A, § 5-802(b) (West 1998); MISS. CODE ANN. § 41-41-205 (Supp. 1999).

### H. Provisions of Special Importance for Nursing Homes

The new California Health Care Decisions Law contains numerous provisions of particular relevance to residents of nursing homes. While a significant portion of nursing home residents lack capacity to make their own health care decisions, this conclusion should not be too readily assumed in individual cases. For this reason, the new law provides that all adult individuals are presumed capable of making their own health care decisions.<sup>80</sup> Also, because lack of capacity is a less than precisely determinable condition, it is inappropriate for a patient to be placed totally "out of the loop" as soon as the threshold between capacity and incapacity has supposedly been crossed. To provide the resident with the peace of mind that can come from being kept informed, the new law requires that the health care provider, whenever possible, communicate to the resident the health care decision being made and the identity of the person making the decision.<sup>81</sup> Keeping the resident informed also allows the resident to communicate the resident's wishes. Lack of capacity does not imply a total inability to communicate; helpful input is often still possible.

To protect against overreaching by the facility, the new law also prohibits an owner, operator, or employee of a facility at which the resident is receiving care from acting as the resident's agent.<sup>82</sup> Owners, operators, or employees who are related to the resident are exempt from this prohibition, however.<sup>83</sup> In addition, to assure that the advance directive executed by the nursing home resident is truly the resident's independent choice, the new law also carries forward the provision that a patient advocate or ombudsman designated by the Department of Aging must witness the directive.<sup>84</sup>

## IV. CONCLUSION: THE LIMITS OF THE LEGISLATION

The new California Health Care Decisions Law has many notable features. Through its consistent philosophy of encouraging the making of and enforcement of advance directives, the new law, if properly implemented, will have a major impact on the making of health care decisions for nursing home residents. Ideally, every nursing home resident who wants an advance directive will make one prior to loss of capacity, and health care providers, in providing care, will be guided by the provisions of the directive itself or by the person whom the directive appoints.

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80. CAL. PROB. CODE § 4657 (West Supp. 2000). The presumption of capacity also applies to the making and revoking of an advance health care directive, and to the designation and disqualification of a surrogate. *Id.*

81. *Id.* § 4730.

82. *Id.* § 4659(a).

83. *Id.* § 4659(b)(1).

84. *Id.* § 4673.



But there are limits to what can be accomplished with legislation. No legislation can by itself overcome the hesitancy of individuals to make advance directives. Legislation alone cannot overcome the failure of physicians to discuss with their patients the subject of life-sustaining treatment, particularly in this era of impersonal managed care and physicians practicing medicine on a time clock. Nor will the new law alone induce individuals to discuss these issues with their families. If no matter how heroic the selling efforts only a small percentage of individuals will execute advance directives, then the enactment of even excellent advance directives legislation will do only marginal good. The focus should now shift elsewhere—to those topics addressed in the California Health Care Decisions Law as originally introduced, but which were excised from the bill as the legislation moved forward. The need remains for an effective system of health care decision making for the majority of Californians who will never make advance directives—a system that will protect rights while simultaneously assuring that the necessary decisions are made.