Date of Hearing: April 26, 2022

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 2338 (Gipson) – As Amended March 23, 2022

SUBJECT: Health care decisions: decisionmakers and surrogates.

SUMMARY: Creates a hierarchy of relatives who can make medical decisions for an incapacitated adult who does not otherwise have a legally recognized health care decision maker (LRHCDM). Specifically, **this bill**:

1) Permits that if an adult patient lacks the capacity to make health care decisions, the following LRHCDM may make health care decisions on the patient's behalf, in the following descending order of priority:
   a) The patient's surrogate chosen by the patient as provided;
   b) The patient's agent pursuant to an advance health care directive (AHCD) or a power of attorney for health care; and,
   c) The conservator or guardian of the patient having the authority to make health care decisions for the patient.

2) Allows if an adult patient lacks the capacity to make a health care decision, but does not have a LRHCDM, a surrogate to be chosen from any of the following, in the following descending order of priority:
   a) The spouse or domestic partner of the patient;
   b) An adult child of the patient, with priority given to a child with whom the patient lives, if any;
   c) A parent of the patient, with priority given to a parent with whom the patient lives, if any;
   d) An adult sibling of the patient, with priority given to an adult sibling with whom the patient lives, if any;
   e) An adult grandchild of the patient, with priority given to an adult grandchild with whom the patient lives, if any; and,
   f) An available adult relative with the closest degree of kinship to the patient, with priority given to the relative with whom the patient lives, if any.

3) Specifies that consistent with existing probate law, a patient who has capacity at the time to specifically disqualify anyone under 2) from making health care decisions on their behalf by a signed writing or personally informing the supervising health care provider of the disqualification.

EXISTING LAW:

1) Defines an "AHCD" or an "advance directive" as either an individual health care instruction or a power of attorney for health care.

2) Defines "health care" broadly as any care, treatment, services, or procedure to maintain, diagnose, or otherwise affect a patient's physical or mental condition.
3) Defines "agent" as an individual designated in a power of attorney for health care to make a health care decision for the principal, regardless of whether the person is known as an agent or attorney-of-fact, or by some other term, and includes a successor or alternate agent.

4) Defines "individual health care instruction" or "individual instruction" as a patient's written or oral direction concerning a health care decision for the patient.

5) Defines "health care decision" as a decision made by a patient, or a patient's agent, conservator, or surrogate, regarding the patient's health care, including:
   a) Selection and discharge of health care providers and institutions;
   b) Approval or disapproval of diagnostic tests, surgical procedures, and programs of medication; and,
   c) Directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

6) Permits an adult having capacity to execute a power of attorney for health care, authorizing an agent to make health care decisions and which can include individual instructions. Sets forth the powers of a principal in a power of attorney for health care.

7) Provides that the authority of an agent under a power of attorney for health care becomes effective only on a determination that the principal lacks capacity, and ceases to be effective on a determination that the principal has recovered capacity, unless provided otherwise.

8) Institutes specified requirements for the legal sufficiency of a written AHCD, which can be electronic, including that the advance directive is either acknowledged before a notary public or signed by at least two witnesses who meet specified requirements.

9) Creates a statutory AHCD form that includes instructions for completion, allowing an individual to choose an agent with power of attorney for health care, provide instructions for end-of-life decisions, and specify preferences related to donations of organs at death.

10) Requires an agent to make health care decisions in accordance with the patient's individual health care instructions, and other wishes to the extent known to the agent, or otherwise to make a decision in accordance with the agent's determination of the patient's best interest, which must consider the patient's personal values to the extent known by the agent.

11) Requires, unless provided otherwise in the power of attorney for health care, the agent designated in a power of attorney, who is known to the health care provider and is reasonably available and willing to make health care decisions, to be given priority over any other person in making health care decisions for the principal.

12) Defines "surrogate" as an adult, other than a patient's agent or conservator, authorized to make a health care decision for the patient.

13) Provides that a patient may designate an adult as a surrogate to make health care decisions by personally informing the supervising health care provider, and requires the designation to be promptly recorded in the patient's health care record. Provides that the designation only lasts during the course of treatment or 60 days, whichever is shorter, unless the patient specifies a shorter period. Specifies that if the patient has designated an agent under a power of attorney for health care, the surrogate has priority over the agent for the effective period of the surrogate designation.

14) Requires a surrogate to make health care decisions in accordance with the patient's individual health care instructions, and other wishes to the extent known to the surrogate, or

otherwise make decisions in accordance with the surrogate's determination of the patient's best interest, which must consider the patient's personal values to the extent known by the surrogate.

15) Allows a patient having capacity to disqualify, at any time, another person, including a member of the patient's family, from acting as the patient's surrogate by a signed writing or by personally informing the supervising health care provider of the disqualification.

16) Defines "request regarding resuscitative measures" as a written document, signed by both an individual with capacity, or a LRHCDM, and the individual's physician, that directs a health care provider regarding resuscitative measures. Provides that a request regarding resuscitative measures is not an AHCD. Provides that a "request regarding resuscitative measures" includes one, or both of, the following:
    a) A pre-hospital "do not resuscitate" form as developed by the Emergency Medical Services Authority (EMSA) or other substantially similar form; and,
    b) A Physician Orders for Life Sustaining Treatment (POLST) form, as approved by the EMSA, which directs a health care provider regarding the resuscitative and life-sustaining measures.

17) Requires a health care provider to treat an individual in accordance with a POLST form, which directs a health care provider regarding resuscitative and life-sustaining measures.

18) Requires that if the POLST or pre-hospital resuscitation orders in an individual's request regarding resuscitative measures directly conflict with their individual health care instruction, then, to the extent of the conflict, the most recent order or instruction is effective.

19) Except as provided, requires a health care provider or health care institution providing care to: a) comply with an individual health care instruction of the patient and with a reasonable interpretation of that instruction made by a person then authorized to make health care decisions for the patient; and, b) comply with a health care decision for the patient made by a person then authorized to make health care decisions for the patient to the same extent as if the decision had been made by the patient while having capacity.

20) Requires a hospital, within 24 hours of the arrival of a patient in the emergency department who is unconscious or otherwise incapable of communication, to make reasonable efforts to contact the patient's agent, surrogate, or a family member or other person the hospital reasonably believes has the authority to make health care decisions on behalf of the patient. Sets forth activities deemed to be reasonable efforts on the hospital's part.

21) Allows a statutorily prescribed surrogate to make decisions with respect to medical experiments if the person to be experimented on is unable to consent and does not express dissent or resistance to participation. The list of surrogates, in order of priority, is the person's agent, conservator, spouse, domestic partner, adult child, custodial parent, adult sibling, adult grandchild, or adult relative with the closest degree of kinship.

22) Requires a hospital to make reasonable efforts to accommodate religious and culture practices and concerns, if the patient's LRHCDM, family, or next of kin voices any special religious or cultural practices and concerns.

FISCAL EFFECT: None.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, 46 of 51 states including the District of Columbia have "next of kin" or similar language in their state laws. California does not. Existing law allows "a patient to designate an adult as a surrogate to make health care decision by personally informing" the healthcare provider. Should an ill patient (18 or older) not have a signed AHCD on hospital admission, and cannot "personally" designate a medical decision-maker (if they are unconscious or obtunded), there is a threat hospital administrators or healthcare organizations will usurp this responsibility and make decisions for these vulnerable patients. This bill seeks to prevent one of the biggest threats to patients. This threat is how present law allows other entities to control medical decision-making. Since only 30% of the population presently have an AHCD, there will be many ill patients susceptible to decision-making not made by "next of kin" or family members. This threatens the family and loved ones of patients who might be seriously ill. Most citizens and even healthcare professional believe "next of kin" is part of the decision-making dynamics. This is not true in California. This bill would aligns our state with others to preserve and protect a patient's healthcare.

2) **BACKGROUND.**

   a) **Who can make health care decisions on behalf of an incapacitated adult?** When an adult is incapacitated, a third party may make health care decisions on that individual's behalf. The third party may include a court-appointed conservator or a person specifically designated by the individual through an AHCD, a power of attorney for health care, or a written or oral designation, including a designation as a surrogate. These designees are commonly referred to as LRHCDM, though that term is not well defined in statute.

   b) **Surrogate.** A surrogate is an adult, other than an individual's agent or conservator, authorized to make health care decisions for the individual. An individual designates a surrogate to make health care decisions by personally informing a supervising health care provider of the surrogate. A surrogate designation is only effective for the course of treatment or illness or during the stay at a health care institution, or for a period of 60 days, whichever is shorter. During that time, a surrogate has authority over all other decision makers designated by the patient while making health care decisions for the patient, including an agent under a power of attorney for health care. A surrogate is limited in health care decision-making in that any health care decision must be made in accordance with the individual's health care instruction to the extent known to the surrogate. In absence of that health care instruction, the surrogate is required to make health care decisions in accordance with the best interest of the individual, which must include consideration of the individual's personal values to the extent known.

   c) **Agent under an AHCD or power of attorney for health care.** An agent is a person designated in a power of attorney for health care or an AHCD to make health care decisions for the individual who executes the directive, regardless of whether the person is known as an agent or attorney in fact, or by some other term. The agent effectively makes health care decisions with the same authority as the individual when the individual becomes incapacitated, unless otherwise specified. Identical to the limitations on health care decision making by a surrogate, an agent must make health care decisions in accordance with the individual's health care instructions and other wishes to the extent

known by the agent. Otherwise, the agent is to make health care decisions in accordance with the individual's best interests in mind, which must include consideration of the individual's personal values to the extent known by the agent. An agent's authority in health care decision-making has priority over any other person making health care decisions for the patient, though a surrogate has priority over an agent during the surrogate's period of authority. This is because whichever instruction is most recent in time takes precedence.

To make things easier for individuals to state their health care wishes while they have capacity, the Legislature has created a statutory form known as the AHCD for individuals to give instructions for their health care decisions. The AHCD form, created by AB 891 (Alquist), Chapter 658, Statutes of 1991, allows an individual, with capacity to make health care decisions, to select an agent to make those decisions in the event the individual is not able to do so. The directive also allows the individual to make end-of-life health care choices, including the choice to prolong, or not prolong, life and to seek relief from pain.

A surrogate and an agent act on behalf of a patient based on the patient's action of appointing them. As a result, there is little controversy about having them make health care decisions for the patient when the patient is incapacitated. Likewise, if a conservator is authorized by a court to make health care decisions on behalf of their conservatee because the court has determined that the conservatee lacks the capacity to give informed consent to medical treatment, the authority to make health care decisions is clear. The surrogate, agent, and conservator are all considered LRHCDMs.

d) Legally recognized health care decision makers under a POLST. A POLST form, which is supposed to complement an AHCD, is different in that it is generally filled out (or at least signed) by a health care provider, often near the end of a person's life, and is usually used to guide actions by emergency medical personnel or other health care providers near the end of the patient's life. POLST forms indicate the patient's preferences for end-of-life care, including resuscitative measures and other life-sustaining treatment. It is signed by the health care provider and either the patient or a LRHCDM. Thus, unlike a designated surrogate or an agent under an AHCD or a power of attorney, a POLST can be established without the consent and agreement of the patient.

POLST forms are bright pink -- thus easy to locate in a medical file or in an individual's home -- and since they are completed by heath care professionals, they are generally available when health care decisions need to be made. POLST forms have been an effective tool in guiding health care providers, particularly emergency medical personnel, when rendering services.

A surrogate, agent, and conservator have statutory authority to be a LRHCDM on behalf of an individual. A POLST form, however, is more expansive and additionally allows a spouse, registered domestic partner, closest available relative, or person whom the patient's medical professional signing the order believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known, to serve as a LRHCDM. The broader group of LRHCDMs recognized by the POLST form has the same ability as the statutorily

designated LRHCDMs to make potentially life altering health care decisions on behalf of an incapacitated individual.

e) What happens if an incapacitated adult has not designated a LRHCDM to make health care decisions on their behalf? Today, despite all of the above-described options, many patients will not have designated someone to make those decisions for them, will not have a conservator, and will not have a POLST in the event they become incapacitated. In these situations, 24 hours after the arrival at an emergency room of an unconscious patient or one incapable of communication, the hospital is required to make "reasonable efforts" to contact the patient's agent, surrogate, family member, or other person the hospital reasonably believes has the authority to make health care decisions on behalf of the patient. Under existing the law, the hospital does not need informed consent to perform life-saving procedures in the event of an emergency. Should the hospital be unsuccessful in identifying an appropriate surrogate after a emergency, the hospital will continue to provide life-sustaining services under the assumption the individual would want their life saved. The law sets forth activities deemed to be reasonable efforts on the hospital's part and suspends the requirement during disasters. However, this practice does not provide direction on whom the hospital should rely on for instruction.

f) Policy for Selection of Surrogate for Patient without Decision-Making Capacity who Lacks an Appointed Surrogate. The California Medical Association, the California Hospital Association (CHA) an the California Coalition for Compassionate Care (CCCC) considered the ethical, medical, and legal issues in the process of selecting a surrogate for incapacitated individuals. It is their belief that patients, physicians and health care institutions benefit when a uniform process is agreed upon by which such designations will be made. As such they developed the following written policy they recommend physicians, clinics, long-term health care facilities, medical centers, hospitals, and other health care professionals to adopt.

"If the patient has not appointed a surrogate or agent through a valid written or oral directive and if there is no court appointed conservator for health care decision making; or if the designated surrogate, agent, or conservator is not reasonably available, the primary physician may identify an individual (surrogate) to make health care decisions on behalf of the patient. This surrogate shall be the individual who appears, after a good faith inquiry, to be best able to function in this capacity. In identifying a surrogate, input from any or all of the following may be used as appropriate:

i) Family and friends of the patient;
ii) Other health care professionals;
iii) Institutional committees;
iv) Social workers; and,
v) Chaplains

In determining the individual best able to serve as the surrogate, all relevant factors may be considered, among them:

i) Familiarity with the patient's personal values;
ii) Demonstrated care and concern for the patient;
iii) Degree of regular contact with the patient before and during the patient's illness;
iv) Availability to visit the patient;

v) Availability to engage in meaningful contact with health care professionals for the purpose of fully participating in the health care decision making process;
vi) Ability to understand the medical condition and treatment options as explained by physicians or other health care professionals;
vii) Ability to assume the duties of a surrogate detailed below; and,
viii) Previous designation as a surrogate, whose authority has expired.

The written policy went on to state that an agreement by a potential surrogate with the treatment recommendations of the physician or other health care professionals should not be a criterion used in the selection of a surrogate.

3) **SUPPORT.** The California Senior Legislature, sponsor of this bill, states that existing law requires a patient to "only orally" designate a surrogate. Should a patient be mentally incapacitated and unable to orally make a surrogate decision, and does not have legal documentation designating a surrogate, healthcare professionals lack adequate direction in the medical care of the patient. This bill will bring California into alignment with 46 other states that have statutes prioritizing "next of kin".

   California Advocates for Nursing Home Reform (CANHR) in a support position states that California has long-needed a default health care surrogate law. When patients in the health care system lack capacity to make health decisions and have no agent in an AHCD (most Californians do not have an AHCD), health care providers have very little legal guidance as to who can the make decisions for that patient. In conclusion, CANHR states that this bill ensures that next of kin have the legal authority to make health care decision for patients who do not have the capacity to do so and have not named a surrogate.

4) **OPPOSE UNLESS AMENDED.** The CHA, in an opposed unless amended position, states that everyday California hospitals care for patients who are unable to make their own health care decisions due to unconsciousness or another medical condition. In the absence of an AHCD or other formalized directions, doctors and nurses strive to contact a family member or other loved one who has demonstrated special care and concern for the patient and is familiar with their values and beliefs to make decisions on behalf of the patient. This bill would remove the very personal option and instead requires health care providers to strictly follow the laws of intestate succession. In concluding CHA, states that while the laws of intestate succession may identify an appropriate surrogate decision maker in some families, in many families they do not.

   The CCCC states in an oppose unless amended position, that the problems with applying a cookie-cutter family tree approach to medical decision making are numerous, including:

   a) Many people are estranged from some members of their family. Estrangement does not follow a family tree hierarchy;
   b) Just because someone is closer on the family tree to the person does not mean that they share the same values as the person or have the person's best interests in mind;
   c) How much effort needs to be made to find distant or estranged family members? How are decisions made while a healthcare provider is searching for distance relatives?
   d) If a healthcare provider starts working with who they believe is the right person only to find out that there is a relative in a higher priority that exists, what are they to do?

e) If a class has multiple people in the class, how does the healthcare provider chose who to serve as the spokesperson? and,
f) The proposed hierarchy fails to recognize close relationships that do not involve blood or are not legally recognized. For example, many people live together for years without getting married or filing for domestic partnership.

Moreover, the hierarchy set forth in this bill is based on white, middle-class values, and assumptions. It is not culturally sensitive or appropriate for many populations. For example, in some cultures the oldest adult male child is the person who is expected to make medical decisions for an elderly parent, rather than the elderly parent's spouse. In other cultures, it may be a spiritual or community leader that takes on the role of making medical decisions for members of their community, alleviating the family of the psychological or emotional burden that can accompany such role. CCCC concludes that applying a rigid hierarchy to these highly personal decisions will create untold emotional, psychological, spiritual, and cultural harm for many people, families, and communities. It will perpetuate generations of systemic racism and healthcare trauma that have been imposed on many people.

5) **DOUBLE REFERRAL.** This bill has been double referred. It passed the Assembly Judiciary Committee with a vote of 9-0 on March 29, 2022.

6) **RELATED LEGISLATION.** AB 2288 (Choi) clarifies that the provisions in the Health Care Decision Law also include mental health conditions. Revises the statutory AHCD form to clarify that a person may include instructions relating to mental health conditions. AB 2288 is pending in the Assembly Health Committee.

7) **PREVIOUS LEGISLATION.** AB 1234 (Arambula) of 2021 would have established provisions that POLSTs executed in another state or jurisdiction are valid and enforceable to the same extent as a POLST executed in this state. Would have allowed an electronic signature to be used for the purposes of AHCD and POLST forms. Due to the shortened legislative session brought on by the COVID-19 Pandemic, AB 1234 was not heard in Assembly Health Committee.

8) **COMMITTEE AMENDMENTS.** Responding to those entities that have taken an oppose unless amended position to this bill, the Committee recommends the following amendments that would provide health care professionals and institutions more latitude and that allows for the those circumstances when either individuals higher in a priority are not available or when the surrogate selection process breaks down over disagreements about whom is "best able" to make medical decisions on a patient's behalf::

(c) Notwithstanding (b) or the prioritization listed in (b) a person who has demonstrated special care and concern for the patient, is familiar with the patient's personal values and beliefs to the extent known, and is reasonably available and willing to serve, may take precedence in making health care decisions on the patient's behalf.

REGISTERED SUPPORT / OPPOSITION:

Support

California Senior Legislature (sponsor)
California Advocates for Nursing Home Reform

Opposition

None on file.

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