By Marshall S. Zolla and Deborah Elizabeth Zolla

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# Lasting Wishes

## California's new Health Care Decisions Law smooths the procedural path for those who wish to control their medical treatment in their last days

End-of-life issues and concerns are as ancient as biblical sources and commentaries[1] and as modern as the new California Health Care Decisions Law, effective July 1, 2000.[2] These dramatic issues have affected the American consciousness since 1976, when *In re Quinlan*,[3] a well-publicized and watershed case, brought the age-old and critical issue of decision making at the end of life into contemporary society. In *Quinlan*, Karen Ann Quinlan's father sought a court order to have his daughter, who had long been in a persistent vegetative state, removed from a respirator. The New Jersey Supreme Court held that Karen had a right of privacy that encompassed the right to decline medical treatment under both the U.S. and New Jersey Constitutions and that could be asserted on her behalf by her guardian.[4]

When Karen Quinlan became comatose in 1975, no state recognized a patient's right to set limits on life-prolonging medical efforts. Since then, all 50 states have enacted legislation governing the requirements for some type of advanced healthcare directive.[5]

The California Health Care Decisions Law is codified in Sections 4600 through 4805 of the Probate Code.[6] The Legislative Findings contained in Probate Code Section 4650 set forth the new law's public policy,[7] which recognizes a patient's right to control decisions relating to his or her own healthcare. A patient's right of individual autonomy, privacy, and dignity includes the right to exercise control over healthcare decisions when modern medical technology has made possible the prolongation of life beyond natural limits.[8]

Before the passage of the Health Care Decisions Law, there were five statutorily recognized ways in California in which a patient could make his or her treatment preferences known in case of subsequent incompetency: 1) advanced directives pursuant to the Natural Death Act,[9] 2) durable powers of attorney for healthcare,[10] 3) statutory surrogacy,[11] 4) a court-appointed conservator,[12] and 5) other judicial intervention.[13] The first two have been superceded by the new law.[14]

Similarly, before this year, there were three primary kinds of documents that addressed the healthcare of incompetent patients: 1) advance directives pursuant to the Natural Death Act, which allowed a patient in good health to authorize his or her doctor to forego life-sustaining treatment in the event of terminal illness; 2) durable powers of attorney for healthcare, which appointed an agent to make appropriate decisions for an incompetent patient; and 3) statutory surrogacy provisions. Conflicts existed among the different forms. Realizing that

*Marshall S. Zolla is a certified family law specialist who practices in Century City. Deborah Elizabeth Zolla is a second-year law student at Loyola Law School in Los Angeles.*

California law did not adequately address numerous important issues concerning healthcare decisions for adults who lack capacity, the California Legislature decided to provide procedures and standards in this area and adopt consistent rules governing healthcare decision making by surrogates.

The Health Care Decisions Law[15] makes numerous revisions to prior law in order to promote the use and recognition of advance directives and improves the effectiveness of directives in the realization of patients' wishes once they become incapable of making decisions for themselves. The Health Care Decisions Law applies to all powers of attorney for healthcare no matter when they were executed.[16] A durable power of attorney for healthcare that was valid under prior law remains valid under the new law.[17] The new law allows patients to execute a directive about the use of life-sustaining treatment and to appoint a third party to carry out their wishes. Appointed individuals are given the authority to act in the principal's best interests when the healthcare wishes of the principal are unknown or unclear in his or her directive.[18]

Included in the new law is a statutory form Advance Health Care Directive[19] that improves on earlier forms by using simpler, more modern terminology that will make the directive easier to use and understand. The new form will help people focus on the decisions that ultimately involve soul-searching questions, such as whether or not to prolong life, whether or not to withhold or withdraw artificial nutrition and hydration, instructions concerning cardiopulmonary resuscitation, relief from pain, and donation of organs at death. The use of the statutory form is not mandatory for an enforceable advance healthcare directive in California,[20] and an individual who chooses to use the form may complete or modify all or any part of it.[21] The form can be found in Probate Code Section 4701.

A patient can still make his or her treatment preferences known by statutory surrogacy.[22] This approach is used when the patient, despite having executed an advance directive, may be faced with unforeseen changes, such as new medical treatments and procedures, that would substantially alter the person's choice of treatment.[23] This approach is commonly used when the patient does not execute a living will and does not appoint a surrogate decision maker pursuant to the durable power of attorney for healthcare law. Surrogate decision makers are also effective when something unexpected happens, such as the expiration of an executed durable power of attorney.[24] Judging from statistics that indicate that only approximately 10 to 20 percent of adults have advance directives, surrogate decision makers are frequently used.[25]

How does a surrogate decision maker elect a choice when none has been made? Who are the individuals or family members charged with the responsibility to make such decisions? There exists a significant gap in the new Health Care Decisions Law because the proposed statutory provision listing possible adult surrogates with a relationship to the patient to be selected by the primary physician was deleted from the proposed legislation and was not enacted as part of the new law.[26] Courts have responded by looking for what the patient would have chosen.[27] A judgment based on a search of the patient's competent life for his or her preferences, values, and commitments is appropriate—not because it is required by the patient's right of autonomy but because it is in the patient's best interests to achieve a treatment plan that the patient would have wanted if the patient had been able to so designate.[28]

The doctrine of "substituted judgment" focuses on the patient's treatment preferences to the extent they are discoverable. This decision-making standard considers factors such as statements made by the patient while competent regarding medical decisions and the religious, moral, and philosophical convictions of the patient. When the patient's wishes are unexpressed or unclear, it becomes harder to justify third-party treatment decisions because there is too little information to ensure that the decision reflects the patient's own preferences. In such a case, the surrogate decision maker's own standards and philosophy exert a substantial influence on the treatment decision. In effect, the surrogate decision maker makes the treatment decision rather than giving voice to the patient's decision. This situation is one in which the surrogate decision maker evaluates the patient's then-existing status and makes a treatment decision based on what he or she concludes is in the patient's best interests.[29]

There is no simple solution to the complex problem of determining future medical decisions. It requires balancing the interests of many different parties and concerns. Patients and their families have an interest in being treated with respect and dignity. The state has an interest in protecting its citizens from premature death. The medical profession has an interest in protecting its integrity and ensuring that scarce medical resources are put to the best uses. Finally, the judicial system, in the absence of direct legislative guidance, has an interest in ensuring that existing legal standards are not violated in the pursuit of these conflicting interests.[30]

Attorneys drafting advance healthcare directives should be aware of potential ethical pitfalls. The client is the person for whom the document is being drafted, not the spouse, adult child, or friend who may have first contacted the attorney.[31] One of the main decisions for the principal is naming his or her agent. The issue of capacity raises another ethical dilemma. The Due Process Incompetents Determin-

## In Honor and Memory

Theodore Zolla, father and grandfather of the authors, completed and signed a durable power of attorney for healthcare on June 1, 1992. The directive was signed as part of his estate plan after careful financial planning and discussions with his family. He was 87 years old.

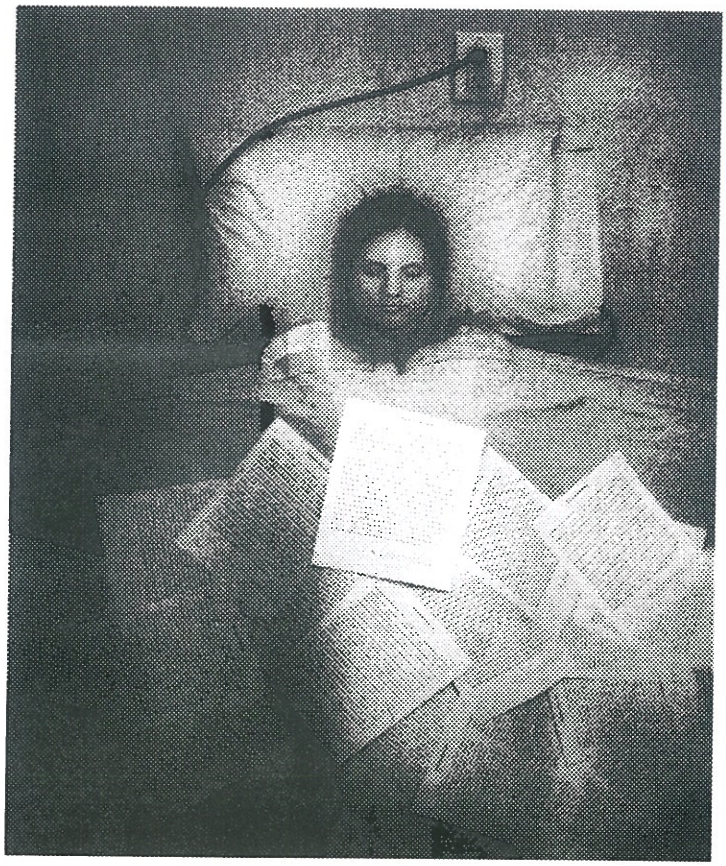
In May 2000, at age 95 and still active playing bridge, golf, and traveling, he fell ill. After being admitted to the hospital, the family was asked to obtain his advance healthcare directive so that his medical wishes could be known and carried out. In reviewing his directive, in the midst of his deteriorating health condition, the authors noticed that the seven-year time limitation in the directive had expired. That sparked an inquiry into the California statutes governing advance healthcare directives, in which the authors discovered that the seven-year limitation of former Civil Code Section 2436.5 was continued in 1994 in Probate Code Section 4654 and then repealed in 1999. In addition, state, federal, and case law had changed to cope with evolving medical technology. In particular, California had enacted its new Health Care Decisions Law, which became effective on July 1, 2000.

As he slipped into unconsciousness, end-of-life decisions had to be faced, discussed, and resolved with family, attending physicians, and rabbis. The authors decided to research and write this article in honor and memory of their father and grandfather.

Theodore Zolla died on July 5, 2000, at the age of 95.—**M.S.Z. & D.E.Z.**

ations Act[32] sets forth standards for determining if a person has the capacity to perform particular acts, including the capacity to give medical consent.[33]

For 15 years following *Quinlan*, various state courts struggled with the right-to-die issue and arrived at conflicting decisions. More than 100 cases covering some aspect of right-to-die issues and dilemmas were litigated throughout the country, with withdrawals of medical care permitted in some instances and denied in others. Each case contributed its own special nuance to the ongoing debate.



## Evolution of California Statutory and Case Law

With the enactment of the 1976 Natural Death Act, California became a pioneer in the area of healthcare decision making for adults without decision-making capacity.[34] Durable power of attorney statutes had been in effect since 1979,[35] and durable power of attorney for healthcare statutes were enacted in 1983.[36] In 1990, the federal Patient Self-Determination Act was codified.[37] However, not until 1994 were a diverse number of statutes consolidated and expanded into the California Power of Attorney Law.[38] As indicated in the 1994 recommendation report from the California Law Revision Commission,[39] placement of the Power of Attorney Law in the Probate Code reinforced its nature as an estate planning device.

The years between the the enactment of the durable power of attorney statutes in 1979 and the Power of Attorney Law in 1994 saw a number of groundbreaking and widely cited judicial decisions dealing with these practical and increasingly difficult medical, ethical, and legal issues. In 1983, in *Barber* v. *Superior Court*,[40] two physicians were charged with murder and conspiracy to commit murder after life support measures were terminated for a deeply comatose patient in accordance with the wishes of the patient's immediate family.[41] The doctors petitioned the court of appeal for a writ of prohibition to dismiss the charges. The court of appeal granted the writ, holding that cessation of heroic life support measures was not an affirmative act but rather a withdrawal or omission of further treatment.

The *Barber* court emphasized that the physicians' omission to continue life support procedures, although intentional and with the knowledge that the patient would die, was not an unlawful act. The doctors had no legal duty to continue medical treatment when the patient had virtually no chance of recovering and when the family consented to the termination. Further, the court underscored that the failure to institute formal guardianship proceedings did not render the physicians' conduct unlawful. There was no such statutory requirement for guardianship and, under the circumstances, the wife was the proper person to act as surrogate decision maker for the patient.

The court also held that there was no legal requirement for prior judicial approval of a decision to withdraw treatment.[42] Moreover, the opinion stated, "Although there may be a duty to provide life-sustaining machinery in the aftermath of a cardio-respiratory arrest, there is no duty to continue its use once it has become futile in the opinion of qualified medical personnel." Despite the breadth of its language, however, *Barber* did not dispose of the issue of who can consent to treatment because the issue arose as part of a defense to a charge of murder—specifically, whether the doctors could rely on requests from the family of the patient. Indeed, the court was aware of the difficulty of determining who should be included in the patient's "family" for the purpose of decision making by surrogate.[43]

The *Bartling* v. *Superior Court* decision[44] came one year after *Barber*. William Bartling had executed a living will and a durable power of attorney for healthcare evidencing his wish to discontinue ventilator life support. The Glendale Adventist Medical Center refused to withdraw the ventilator. The trial court denied Bartling's request for an injunction against further treatment; the court of appeal reversed, holding that his expressed wishes in his advance directive should have been honored. The appellate court held that the right of a competent adult patient to refuse medical treatment is a constitutionally guaranteed right that must not be abridged[45] and "if the right of the patient to self-determination as to his own medical treatment is to have any meaning at all, it must be paramount to the interests of the patient's hospital and doctors."[46]

In 1986, the *Bouvia* v. *Superior Court* case, which involved a patient's desire to refuse nutrition and hydration, generated a great deal of controversy.[47] In *Bouvia*, the trial court denied the patient's request to have her feeding tube removed. The court of appeal issued a writ of mandate reversing the trial court order and holding that a competent patient had the right to remove a feeding tube even though she might be kept alive for 15 or 20 years if it were left in place. The language of the court majority is as direct as its ruling: "[The] [p]etitioner sought to enforce only a right which was exclusively hers and over which neither the medical profession nor the judiciary have any veto power."[48]

The divided opinion in the *Bouvia* case was not without dissension and controversy. The majority concluded that the patient's decision to allow nature to take its course was not equivalent to an election to commit suicide.[49] A concurring opinion struggled with the suicide issue and poignantly observed, "Whatever choice Elizabeth Bouvia may ultimately make, I can only hope that her courage, persistence and example will cause our society to deal realistically with the plight of those unfortunate individuals to whom death beckons as a welcome respite from suffering."[50] The Health Care Decisions Law is a signif-



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icant step in that direction.

*Conservatorship of Drabick*[51] is another influential case. In *Drabick*, the conservator sought court approval to remove the nasogastric feeding tube of the conservatee, who was in a persistent vegetative state. No one opposed the action; the conservator simply wanted a court order to protect the healthcare providers.[52] A county public defender appointed to represent the conservatee-patient agreed with the proposed termination of treatment. Nevertheless, the probate court denied the conservator's petition on the ground that continued feeding was in the patient's best interests. The conservator appealed. The court of appeal reversed the probate court and allowed removal of the feeding tube. The court held that, in California, each adult has a right to determine the scope of his or her own medical treatment, which includes the legal right to refuse medical treatment such as artificial nutrition and hydration. Further, incompetent patients retain the right to have appropriate medical decisions made on their behalf. An "appropriate medical decision" was defined as one that is made in the patient's best interests, as distinct from one made in the interests of the hospital, the physicians, the legal system, or anyone else.[53]

The *Drabick* court observed that under Probate Code Section 2355, which provides that the conservator need not obtain judicial approval of its decision absent disagreement among interested parties, the probate court will review a conservator's proposed decision only if there is a dispute among interested parties or if the conservator seeks confirmation of a proposed action.[54] Thus, as a practical matter, the court will become involved only if, for example, there is a family dispute, a doctor demands judicial confirmation, or a conservator seeks judicial confirmation as a precaution.

In 1990, the U.S. Supreme Court decided its first right-to-die case, *Cruzan* v. *Director, Missouri Department of Health*.[55] In *Cruzan*, the existence of a constitutionally protected right to refuse treatment was affirmed on a national level. The *Cruzan* opinion upheld a constitutional right to die and recognized a constitutionally protected liberty interest to refuse treatment—but the Court left to the individual states the task of establishing their own guidelines on life or death treatment decisions for incapacitated persons. The Supreme Court's opinion opened the door to enactment of advance directive statutes like those enacted in California by holding that an appointed surrogate decision maker would have the right to refuse treatment on behalf of an incapacitated individual. But the *Cruzan* Court also made it clear that a patient's rights are jeopardized if he or she fails to leave explicit advance instructions.

## Conflicts between Healthcare Providers and Patients

In our society, sensitive services such as termination of life support create potential conflicts between healthcare providers and patients. Tension arises when healthcare providers insist on providing care in accordance with their own beliefs and refuse to grant patients access to medical care that the providers find objectionable.[56]

The constitutional complication inherent in this provider-patient conflict emerges in an analysis of the interaction between the free exercise and establishment clauses of the First Amendment and patients' right to privacy.[57] If religious healthcare providers, institutions, and health plans are allowed to refuse to provide services on religious or moral grounds, patient access to healthcare may be significantly curtailed.[58] Although the right to refuse life-sustaining medical treatment is constitutionally protected, patients may experience difficulty in getting religious providers to implement their advance directives.[59] No federal or state law has established a fundamental right to healthcare. Thus, in conflicts between religious beliefs and healthcare choices, it is not surprising that religious beliefs have received more statutory and legal protection. However, consistent with the constitutional protections that prevent both the imposition of religious beliefs as well as limitations on individuals to refuse life-sustaining treatment, patient rights to services must not be compromised. Policymakers should devise alternative means to ensure that patients can go to providers willing to honor their treatment requests.[60]

The fact that a patient has the right to refuse continued medical treatment, however, does not give rise to a concomitant physician duty to discontinue care upon request. This principle is illustrated by *Conservatorship of Morrison* v. *Abramovice*.[61] In that case, the conservator-daughter of a 90-year-old woman in a persistent vegetative state sought removal of a nasogastric feeding tube from her mother. The hospital physicians refused the daughter's request due to "personal moral objections."[62] At issue was whether a conservator can require a physician to comply with a treatment request against the physician's personal moral objections. The court answered this question by basing its holding on the prevailing view among medical ethicists that a physician has the right to refuse to follow a conservator's direction to withhold life-sustaining treatment on personal moral grounds, but must be willing to transfer the patient to another physician who will follow the conservator's direction.[63]

Physicians not only have the right to refuse to follow a patient's direction to withhold life-sustaining treatment but customarily are not punished for ignoring a patient's preferences about life-sustaining care. Accumulated evidence indicates that physicians and healthcare providers often ignore patient preferences about life-sustaining care.[64] But the likelihood of wrongfully treated patients recovering compensatory damages has been placed in doubt. Courts and commentators alike have suggested that actions for life support not consented to by the patient are analogous to actions for wrongful life and should, for that reason, be rejected.[65]

End-of-life issues continue to be presented to the judicial system for resolution, as evidenced by the recent grant of review by the California Supreme Court in *In re Conservatorship of Wendland*.[66] The *Wendland* case involves a struggle between the wife, mother, and sister of a 42-year-old man who was brain damaged and cognitively impaired in a motor vehicle accident but is conscious and sometimes able to respond to simple commands. The patient's wife sought permission to remove the feeding tube and to allow her husband to die; the mother and sister objected. The trial court refused permission to remove the feeding tube. The court of appeal reversed with directions in a lengthy and detailed opinion that has now been superseded by the supreme court's grant of review.

The debate over adequate and affordable healthcare and ethical decision making at the end of life has permeated political, medical, legal, religious, and bioethics discourse during most of the past decade[67] and continues to command widespread national and international attention.[68] Technological advances in the medical field persist in outpacing the ability of society to accommodate them.[69] Because no one knows when tragedy or illness may strike, adults of all ages would best be served by considering, completing, and signing an advance directive under the new Health Care Decisions Law. Upon signing an advance directive, adults should give a copy to their doctor and their family and should keep a duplicate original or copy in a safety deposit box.

The values the patient and physician bring to the bedside are not similarly constituted. A patient's values and considerations may comprise religious, sociological, economic, and psychological influences.[70] A physician's values may be similarly derived but may be tempered by experiences and training in the medical field.[71] The legal counselor can help by providing focus and well-reasoned advice. Mere technical expertise is not enough; concern for the overall well-being of the client requires consideration of the client's financial, moral, religious, family, and personal set of values.

If clients, patients, or attorneys need inspiration beyond medical

technology and legal technicalities, perhaps they can look to the wise words from the book of Ecclesiastes, which serve as a reminder that dying has been part of life since time immemorial:

> Remember then thy Creator in the days of thy youth,
> Before the evil days come,
> And the years draw nigh, when thou shalt say:
> "I have no pleasure in them";...
> Before the silver cord is snapped asunder,
> And the golden bowl is shattered,
> And the pitcher is broken at the fountain,
> And the wheel falleth shattered, into the pit;
> And the dust returneth to the earth as it was....[72]

And in the end, from the same source, there are further words of comfort: "[T]o everything there is a season, a time to be born and a time to die...."[73] ■

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[1] 2 *Kings* 4:8-37; *Psalms* 23, 41:4; *Isaiah* 38:1-8; *Jeremiah* 17:14; TALMUD (*Shabbat* 151b); JOSEPH CARO, SHULCAN ARUCH, YOREH DE'AH 339.

[2] PROB. CODE §§4600 *et seq.* (effective July 1, 2000).

[3] In re Quinlan, 355 A. 2d 647 (N.J. 1976), *cert. denied*, 429 U.S. 922 (1976). Chief Justice Rehnquist described Quinlan as a "seminal decision" on the issue of the right to refuse treatment.

[4] *Id.*

[5] Bretton J. Horttor, *A Survey of Living Will and Advanced Healthcare Directives*, 74 N.D. L. REV. 233 (1998). This article surveys selective state statutes concerning end-of-life treatment decisions, living wills, healthcare agent designation laws, and surrogate decision-maker laws. *See also* Rachel Pergament & Brian Raphael, *Gerontology and the Law: A Selected Annotated Bibliography: 1995-1998 Update*, 72 S. CAL. L. REV. 1461, 1502-03 (1999); Ernle W. D. Young, *Ethical Issues at the End of Life*, 9 STAN. L. & POL'Y REV. 267 (1998). Young's article discusses ethical issues related to end-of-life decisions and the challenge facing "courts, legislatures, healthcare professionals and bioethicists to discern humane and morally acceptable ways of assisting patients and their families as death approaches."

[6] The provisions of the Power of Attorney Law governing powers of attorney for healthcare and the Natural Death Act were repealed, and the Power of Attorney Law no longer applies to powers of attorney for healthcare. PROB. CODE §§4010-4310, 4600-4805; HEALTH & SAFETY CODE §§7185-7194.5; PROB. CODE §4050(a).

[7] PROB. CODE §4650:

> The Legislature finds the following: (a) In recognition of the dignity and privacy a person has a right to expect, the law recognizes that an adult has the fundamental right to control the decisions relating to his or her own health care, including the decision to have life-sustaining treatment withheld or withdrawn. (b) Modern medical technology has made possible the artificial prolongation of human life beyond natural limits. In the interest of protecting individual autonomy, this prolongation of the process of dying for a person for whom continued health care does not improve the prognosis for recovery may violate patient dignity and cause unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the person. (c) 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.

[8] *Id.*

[9] 1976 Cal. Stat. ch. 1439.

[10] 1983 Cal. Stat. ch. 1204; former PROB. CODE §§4600 *et seq.*

[11] 2000 Health Care Decisions Law and Revised Power of Attorney Law, 30 Cal. L. Rev. Comm'n Rep. 1, at 26-30 (2000).

[12] PROB. CODE §§1400 *et seq.*

[13] PROB. CODE §§3200 *et seq.*

[14] *See* 2000 Health Care Decisions Law and Revised Power of Attorney Law, 30 Cal. L. Rev. Comm'n Rep. 1, at 7-12 (2000).

[15] PROB. CODE §§4600 *et seq.*

[16] PROB. CODE §4665(a).

[17] PROB. CODE §4665(e); *see* 2000 Health Care Decisions Law and Revised Power of Attorney Law, 30 Cal. L. Rev. Comm'n Rep. 1, at 43 (2000).

[18] *Id.*

[19] 2000 Health Care Decisions Law and Revised Power of Attorney Law, 30 Cal. L. Rev. Comm'n Rep. 1, at 12-32 (2000).

[20] PROB. CODE §4700.

[21] *Id.* For an example of a medical directive based upon religious precepts, *see* Elliot N. Dorff, *A Time to Be Born and a Time to Die, A Jewish Medical Directive for Health Care, reprinted in* RON WOLFSON, A TIME TO MOURN, A TIME TO COMFORT 285 (1993).

[22] 2000 Health Care Decisions Law and Revised Power of Attorney Law, 30 Cal. L. Rev. Comm'n Rep. 1, at 10 (2000).

[23] Sanford H. Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 CAL. L. REV. 857 (July 1992).

[24] Former CIV. CODE §2436.5, continued in 1994 in PROB. CODE §2436.5, repealed by 1999 Cal. Stats. ch. 658 (A.B. 891), 2000 Health Care Decisions Law and Revised Power of Attorney, PROB. CODE §§4600 *et seq.*

[25] 2000 Health Care Decisions Law and Revised Power of Attorney Law, 30 Cal. L. Rev. Comm'n Rep. 1, at 10 n.10 (2000).

[26] Proposed PROB. CODE §4712 and the Law Revision Commission's surrogate committee provisions were removed from A.B. 891 and not enacted into the new Health Care Decisions Law; *see* 30 Cal. L. Rev. Comm'n Rep. 1, at 10-11, 26-30 (2000).

[27] Kadish, *supra* note 23, at 878 n.91.

[28] *Id.* at 888.

[29] Michele Yuen, *Letting Daddy Die: Adopting New Standards for Surrogate Decision Making*, 39 UCLA L. REV. 581 (Feb. 1992).

[30] *Id.* at 617.

[31] CALIFORNIA DURABLE POWERS OF ATTORNEY §5.3 (CEB, Mar. 2000 update).

[32] Due Process Incompetents Determinations Act, PROB. CODE §§810-813, 1801, 1881, 3201, 3204.

[33] *See* note 31, *supra*.

[34] 1976 Cal. Stat. ch. 1439. The California Natural Death Act was first enacted in 1976, then repealed in 1991. A new Natural Death Act was enacted and codified at HEALTH & SAFETY CODE §§7185-7195.

[35] Former CIV. CODE §2307.1; 1979 Stats ch. 234.

[36] 1983 Cal. Stat. 1204, former PROB. CODE §§4600 *et seq.*, enacted on recommendation of the Cal. L. Rev. Comm'n; *see* 2000 Health Care Decision and Revised Power of Attorney Law, 30 Cal. L. Rev. Comm'n Rep. 1, at 9 n.8 (2000).

[37] Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§4206, 4751, 104 Stat. 1388, 1388-115 to 1388-117, 1388-204 to 1388-206. *See particularly* 42 U.S.C.A. §§1395cc(a), 1396a(w)(1)(1998).

[38] Former PROB. CODE §§4000-4947 (repealed effective July 1, 2000).

[39] 24 Cal. L. Rev. Comm'n Rep. 323, 333 (1994).

[40] Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484, 491 (1983).

[41] *Id.* at 1010.

[42] *Id.* at 1021.

[43] *Id.*; 2000 Health Care Decisions Law and Revised Power of Attorney Law, 30 Cal. L. Rev. Comm'n Rep. 1, at 20-21 (2000).

[44] Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984).

[45] *Id.* at 195.

[46] *Id.*

[47] Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986), *rev. denied* (June 5, 1986).

[48] *Id.* at 1135.

[49] *Id.* at 1144.

[50] *Id.* at 1147.

[51] Conservatorship of Drabick, 200 Cal. App. 3d 185, 198, 245 Cal. Rptr. 840 (1998).

[52] *Id.* at 202.

[53] *Id.* at 205.

[54] *Id.* at 204.

[55] Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 100 S. Ct. 2841, 111 L. Ed. 224 (1990).

[56] Katherine A. White, *Crisis of Conscience: Reconciling Religious Healthcare Providers' Beliefs and Patients' Rights*, 51 STAN. L. REV. 1703 (July 1999).

[57] *Id.* at 1703.

[58] *Id.* at 1748.

[59] *Id.*

[60] *Id.* at 1749.

[61] Conservatorship of Morrison v. Abramovice, 206 Cal. App. 3d 304, 253 Cal. Rptr. 530 (1988).

[62] *Id.* at 306-07.

[63] *Id.* at 310. *See* COMMITTEE ON BIO-MEDICAL ETHICS OF THE LOS ANGELES COUNTY MEDICAL ASSOCIATION & LOS ANGELES COUNTY BAR ASSOCIATION, GUIDELINES FOR FOREGOING LIFE-SUSTAINING TREATMENT FOR ADULT PATIENTS 4-5 (1990). The joint committee, in its revised 1990 guidelines, removed some of the burden of transferring a patient from the attending physician. Instead of requiring the declining physician to transfer the patient to another qualified physician, the committee urged the withdrawing physician to simply "cooperate" in the transfer to a new physician.

[64] Phillip G. Peters Jr., *The Illusion of Autonomy at the End of Life: Unconsented Life Support and the Wrongful Life Analogy*, 45 UCLA L. REV. 673 (Feb. 1998).

[65] *Id.* at 674.

[66] In re Conservatorship of Wendland, 78 Cal. App. 4th 517, 93 Cal. Rptr. 2d 550 (2000), *review granted* (June 21, 2000).

[67] ALAN MEISEL, THE RIGHT TO DIE (2d ed. 1995).

[68] *When Living Is a Fate Worse than Death*, NEWSWEEK, Aug. 28, 2000, at 12; *Dying on Our Own Terms*, TIME, Sept. 18, 2000; *New Guidelines Issued by British Government to Deal with Controversial "Do Not Resuscitate" Instructions in National Health Service Hospitals*, LONDON DAILY TELEGRAPH, Sept. 5, 2000.

[69] *Mapping of the Human Genome*, LOS ANGELES TIMES, June 26, 2000; TIME, July 3, 2000, at 19.

[70] *See, e.g.*, ELLIOT N. DORFF, MATTERS OF LIFE AND DEATH, A JEWISH APPROACH TO MODERN MEDICAL ETHICS (1998).

[71] *See* Judith F. Darr, *A Clash at the Bedside: Patient Autonomy v. a Physician's Professional Conscience*, 44 HASTINGS L. J. 1241 n.97 (1993); for a discussion of the role personal values play in a physician's decision making, *see* SAMUEL GOROVITZ, DOCTOR'S DILEMMAS: MORAL CONFLICT AND MEDICAL CARE 98-111 (1982).

[72] *Ecclesiastes* 12:1-7.

[73] *Id.* at 3:1-2.