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SUPERIOR COURT OF CALIFORNIA,
COUNTY OF ALAMEDA

CALIFORNIA ADVOCATES FOR NURSING HOME REFORM (CANHR); and GLORIA A.; Petitioners vs. RONALD CHAPMAN, MD., as Director of the California Department of Public health Respondent.	No. VERIFIED PETITION FOR WRIT OF MANDATE, DECLARATORY RELIEF AND INJUNCTION Date: Time: Dept: Judge: Action filed: Trial Date: None Set

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INTRODUCTION

1. Californians have a fundamental right, even as prisoners and if mentally ill, to refuse medical treatment (*Thor v. Superior Court* (1993) 5 Cal 4th 725, 731) unless adjudicated legally incompetent (*In re Qawi*, (2004) 323 Cal 4th 1.) Section 1418.8, Health & Safety Code (hereafter Section 1418.8, Exhibit 1 Compendium) denies infirm residents of skilled nursing (snfs) and intermediate care facilities (icfs) fundamental rights to refuse treatment upon a medical determination of a legal issue, incapacity, made by an interested person, the same physician who recommended the treatment. The statute requires no notice whatsoever, whether of the allegation of incapacity, the decision, the treatment, or the right to challenge both decisions. It requires no representation and no hearing. Section 1418.8 then permits snf/icf staff and the same physician to act both as surrogates, in consenting to, and practitioners, in administering, the treatment. The treatment may include highly intrusive actions such as mind-altering drugs, physical restraints, loss of freedom to leave the snf, loss of financial control, intra-snf surgery (such as the debridement of Mark H, Exhibit 3-A Compendium) and treatment discontinuation resulting in death.

2. Examples of the misuse are found as to the now deceased Mark H. (paragraph 47 herein): "RNNP [registered nurse, nurse practitioner] and ADON [assistant director of nursing] approached resident with Ombudsman asking simply: 'Do you want to live or die?' Resident did not respond to direct question, even with a change in facial expression." As a result, the "EPPLE Act [Section 1418.8] Committee finds that change of POLST to DNR [do not resuscitate] is warranted…" and "the committee agrees with admission to hospice for end-of-life care." His feeding tube was then withdrawn and he died. A POLST [Physicians Order for Life Sustaining Treatment] is a form of advance directive and may only be legal if signed by the resident or representative of an incompetent person (Probate Code sections 4780-6), but the staff, through 1418.8, acted as that representative in deciding on his death.

3. Before his death, this double amputee was at times tied by his arms to his bed although less intrusive measures were available and eventually used, and he was constantly given antipsychotic drugs, and although Psychiatrist Kulsant Singh stated that Mr. H. was "very sedated" on Remeron and "d/c [discontinue] Seroquel for same reason" nevertheless was administered these drugs, and particularly Seroquel, which carries FDA black box warnings of death, until his transfer of care to a hospice, and his subsequent death. (See para 52-53, infra) As to his decisional capacity, the "Epple Committee", using Section 1418.8 in July, 2012, declared him to lack decisional capacity in that "Resident is *not competent enough* to make medical decisions." (emphasis added) (See para 46, infra). Just before his death, on February 7, 2013, a progress note states: "Able to make some basic needs known but he is very particular about when he talks and who he talks to." (para 45, infra)

4. Other individual examples of this use of the statute include Petitioner GLORIA A. Ms. A., a nursing home resident, was determined medically incompetent upon admission to the facility, but

has never been adjudicated decisionally incapacitated and in fact had scored 13 out of 15 on a Section 3 "Cognition" section of the required Minimum Data Set (MDS) (Decl para 12 of Ombudsman Patsy Pence). In May, 2013, her physician sought a psychiatric determination of her capacity which was not then performed, however, in September, 2013, nine months after admission, a psychiatrist examined her and stated: "Patient seen and evaluated. Patient has capacity to make decision about her finances, accommodation, medical issues etc." (para 41 herein). Thus, although legally presumed capable, due to application of Section 1418.8, she lost her right to refuse drugs, and her liberty for a period of nine months and had not been legally informed of the loss, nor that they have been restored, nor has she received information as to her current drug regime. She too was given Seroquel non-consensually and said in her declaration para 12 thereto:

> I am informed that I was given something called Seroquel, but I don't know what that is and don't know that I was given it. There was one drug I hated and maybe that was it. They told me I had to take it, and that I had no choice.

5. As to her liberty, when she tried to go on a picnic with the family of another resident on April 12, 2013, a social work progress note states:

> Resident was trying to leave and go to a bbq with 25c we let her know she could not leave without a CNA present….MD stated she was not competent to go on her own.

(para 36 herein)

6. Medical directors often serve as attending physicians and thus have significant potential for conflict:

> It must be understood that the physician for about a third to 50% of the residents is the medical director of the facility. The medical director is also responsible for the other physicians and can override their decisions. This means that the director-physician, as well as the staff, is concerned for the entire patient group at the facility, and for the staff, as well as for the individual patient. The result is that antipsychotics and antidepressants will often be used in order to assure that the facility's staff is in control and the facility has the fewest possible problems.

Declaration of Ombudsman Geneva Carroll para 26 thereto

7. Competence decision error is rampant as stated in the Declarations. For example, Margaret (Peggy) Main, a consultant for over 50 nursing homes, stated that medical determinations of capacity are usually made in the first three days of care, and then stated, in para 8, 9 of her declaration:

> I have never seen policies and procedures or any written guidelines for determining capacity.
>
> Although it is possible for the Doctor to revisit and re-determine the resident's capacity this does not appear to be the norm. The H&P [History & Physical] shows the capacity is done on an annual basis. From what I have observed, once a resident has been determined to lack capacity that generally continues. There is generally not much accommodation for recovery from delirium, effects of pain medication and adjustment to a new environment. Other staff, particularly nursing and social service, who have daily on-going contact with the residents will sometimes feel that capacity needs to be re-evaluated. They are left in the position of presenting their case to the MD and hoping they will be listened to. Recently a resident was admitted from the acute hospital. Both the RN on the floor and the social service designee talked to her at length regarding her wishes for end of life care. Both felt she understood and was very clear that she did not want life sustaining treatment. She reiterated this on more than one occasion. However, the primary physician determined she lacked capacity and the POLST had to be CPR and full code, thus negating the resident's wishes. Fortunately, after much searching the social service worker was able to identify and contact a cousin who, after talking in depth with the resident, was willing to sign the POLST reflecting the resident's wishes. Without the work of the social worker the resident could have been subjected to various life sustaining interventions including CPR (with possible broken ribs from chest compressions, burns from defibrillation) and various tubes for feeding.

8. Section 1418.8 is unconstitutional as a denial of autonomy privacy, equal protection, and due process. It is *facially* unconstitutional for the following reasons:

A. It gives to the resident no notice or opportunity to oppose as to the determination of incapacity, or the determination or application of treatment (Point One);

B. It permits a medical decision as to the legal determination of decisional incapacity (Point Two A.);

C. It permits that legal decision to be made by a non-neutral, the very physician who has already decided on the treatment (Point Two B.);

D. It permits medical decision making without requiring any representation as to the loss of a fundamental right to decide for the highly vulnerable and frail nursing home person at risk (Point Two C);

E. It permits the attending physician who has decided on the treatment, on the person's incapacity and the absence of a surrogate to be one of those reviewing and approving their own treatment decisions (Point Three);

9. Section 1418.8 is unconstitutional *as applied* in that Respondent does not require that a patient representative be involved in the treatment decision review although the statute has been judicially interpreted to require a patient representative at the treatment review in order to save its constitutionality, and respondent has failed to require such representative (Point Four).

10. Section 1418.8 is unconstitutional *as applied* in that, as interpreted by respondent, it permits all of the above as to the administration of highly intrusive antipsychotic drugs which, if used on a prisoner or a mentally ill person without consent would require a judicial determination of incapacity, representation, and a clear and convincing showing of incapacity before loss of the right to refuse (Point Five A). It is unconstitutional *as applied* in that, it has been and is being interpreted and applied by snfs without statutorily required prohibition by respondent as to activities including removal of feeding tubes and other forms of cessation of medical treatment leading to the death of the elderly nursing home resident (Point Five B.)

11. One case has previously held Section 1418.8 constitutional as interpreted and limited therein. In *Rains v. Belshe* (1995) 32 Cal App 4th 157, a taxpayer action was brought attacking the facial constitutionality of the statute on privacy and due process grounds, the due process grounds including absence of notice, that representatives were required both at the capacity and treatment decisional stages, and that a treating physician could not make a competency decision. The *Rains* court, without reaching the issue of notice, or a representative at the capacity determination, held

that, but only as properly interpreted and limited, the statute was facially constitutional in that incompetence was a medical decision and that nursing home residents had severe limitations on their privacy rights. The interpretations included that the statute was limited to "relatively non-intrusive treatment", that a patient representative was required at the determination of the proposed treatment for the person previously found incompetent by the treating physician, and that the treatment could not occur if the patient representative did not agree.

12. Since the *Rains*, supra, decision, the California Supreme Court has held that competence is not a medical decision but is a legal matter. *In re Qawi*, (2004) 323 Cal 4th 1, and in 2012 the California Court of Appeal, in *K.G. v. Meredith* (2012) 204 Cal App 4th 164, reiterated that the holding in *Qawi* supra, was a constitutional one as a matter of privacy.

13. In 2012, Respondent Department of Public Health issued a survey tool (Antipsychotic Drug Survey Tool, Exhibit 14 hereto) to its inspecting surveyors concerning the use of highly intrusive antipsychotic drugs in skilled nursing facilities with attention to the requirements of informed consent. In so doing, it included Section 1418.8 in the process of determining consent to the use of such drugs, bypassing the limitation of "relatively nonintrusive" treatment placed by the *Rains* court in that such drugs are highly intrusive for the elderly, even more so than for prisoners and the mentally ill. (Exhibit 6)

14. Further, the 2012 Survey Tool (Exhibit 14) issued by Respondent herein failed to include the requirement of a patient representative ordered by the *Rains* court at the treatment review without which that court indicated the statute was unconstitutional, instead merely quoting the statutory language of a patient representative if "practicable."

15. In addition, and again without the limitation of "relatively nonintrusive treatment" found by the *Rains* court, supra, and the statutory introduction language limiting the statute to "day-to-day"

treatments, Respondent has failed in its statutory duty to assure compliance with the law in that the statute is currently applied by nursing homes so as to permit the highly intrusive activities set forth above. In point of fact, Respondent has never enforced the statute, whether as interpreted or as written, and has never, not once in the over 20 years of the statute's existence, issued a citation for its violation. The result is widespread disobedience, and that snfs/icfs and physicians have final authority regarding patient rights for those deemed incapacitated and without surrogates (See declaration of Anthony Chicotel).

16. Petitioners seek the following relief herein: A. To have the statute declared facially unconstitutional based on absence of notice, absence of a required adjudication of legal incapacity, absence of a neutral decisionmaker as to both incapacity and the treatment decision, and absence of a representative as to determinations of incapacity; and B. in the event the Court does not hold the statute facially unconstitutional, to have the application of the statute declared violative of *Rains* and the Constitution as to the absence of a representative with refusal power at the statutory treatment review, and the use of the statute for antipsychotic drugs and treatments resulting in death. Petitioners further seek mandate and injunctive relief as to the above, and that, for residents claimed to be without capacity and a surrogate, there be judicial determinations of incapacity and the appointment of a surrogate with refusal power within a reasonable time after such claim.

II.

PARTIES

A. PETITIONERS

17. California Advocates for Nursing Home Reform (CANHR), is and has been since 1983, a statewide nonprofit 501(c)(3) advocacy organization, and has been dedicated to improving the

choices, care and quality of life for California's nursing home residents. Through direct advocacy, community education, legislation and litigation it has been CANHR's goal to educate and support nursing home residents and advocates regarding the rights and remedies under the law, and to create a united voice for long term care reform and humane alternatives to institutionalization. In particular, CANHR has litigated and won rights of informed consent in medical treatment for nursing home residents. As such it has a direct as well as indirect interest in the rights of residents in skilled nursing and intermediate care facilities including those under Section 1418.8.

18. Petitioner GLORIA A. (hereinafter referred to as "Petitioner") is a 63-year-old former driver of "semi" trucks who expects to return to driving smaller trucks, and is a current resident of a skilled nursing facility in Santa Cruz County. As such, as is further stated herein, she has been determined decisionally incapacitated by her treating physician, and has been denied informed consent as to her medical treatment, denied her physical freedom as a result of that determination, and denied access to her medical chart as a result of that determination.

B. Respondent

19. RONALD CHAPMAN, MD., Respondent (hereinafter referred to as "Respondent") is Director of the California Department of Public Health and is responsible for licensing, certification, oversight, inspection and surveying of all skilled nursing and intermediate care facilities in California, and, as such, the adherence of such facilities to California laws.

III.

STATUTORY FRAMEWORK

20. As a result of an earlier law suit brought by Petitioner CANHR, then Bay Area Advocates for Nursing Home Reform, claiming that residents in nursing homes were denied

informed consent as to medical treatment, Section 72528 was added to the California Administrative Code (CAC) giving a minimal informed consent process to such individuals. What was absent from the CAC was a process for decisionmaking as to those who lacked both capacity and a surrogate. The initial legislative response to this problem was a bill (AB 3209), which would use the same process as to the mentally ill and others in similar situations, and permit engagement of public guardians through conservatorships. However, public guardians objected to this solution and the legislature capitulated to their objections with the result that Section 1418.8 (Exhibit 1 hereto) was enacted permitting treating physicians and nursing home staff to obtain a default process whereby they would make all decisions, those of legal capacity, of absence of legal surrogates, and of the treatment itself.

21. Section 1418.8, Health & Safety Code permits treating physicians with patients in skilled nursing or intermediate care facilities who have decided to treat their patients with interventions requiring informed consent to determine that the patient lacks the capacity to give such consent and further lacks any legal surrogate. (1418.8(a)). It then permits the physician, together with at least a nurse from the facility, and perhaps others, termed an "interdisciplinary team", to review the treatment and administer it thereafter.

22. The statute requires no notice to the resident of the incapacity process nor that the resident has been determined incapacitated, nor does it require notice of the treatment decision, that both the incapacity and treatment decisions may be challenged in court, nor even notice of the treatment administration. Although a patient interview is required in order to determine incapacity, (1418.8(b)), nothing prevents it from occurring at the same time as the physician decides on the treatment.

23. In fact what usually occurs is that incapacity is decided when the patient is first admitted to the facility, and not revisited thereafter even if the patient recovers as many do (See Declarations of Ombudsmen Patsy Pence, Geneva Carroll, Cheryl Wilcox, and Consultant Peggy Main) nor is there an interview before each treatment as is statutorily required (1418.8(b)), see Ombudsmen, consultant, Gloria A. Declarations).

24. As to any representation at any point, the statute requires only that there be a representative for the resident at the treatment review "if practicable".

25. Other than to state that the legislative intent concerns treatments requiring informed consent and "day to day medical treatment decisions" (Legislative Findings, Section 1(b)) no definition of the types of treatments is present in the Section 1418.8 Findings or statute itself. Additionally, the Findings indicate that one legislative purpose is to assure providers are not subject to inappropriate liability for delivering appropriate care. (Section 1418,8(c)).

26. Section 1418.8 further provides that if the attending physician prescribes or orders a medical intervention requiring informed consent, and the physician determines the resident lacks decisional capacity and there is no person with legal authority to make such decisions, the physician is to inform the facility. In that event, there shall be an inter-disciplinary team (hereafter IDT) review of the physician's determination whose purpose is to "oversee the care of the resident" prior to the administration of the intervention (1418.8(e)). The review is to include consideration of, inter alia, the reason for the intervention, its impact, alternatives, the resident's condition and a discussion of the desires of the patient including an interview with the patient and review of the records (1418.8(e, 1-6)). No mention is made in the statute of the right to refuse the treatment in that since the resident has been found incompetent, neither the desires nor the interview is determinative since

there is no longer a right of refusal. Again nothing in the statute requires that the resident be told that they have been found incapacitated, nor the decision after review.

27. The reviewing body, the IDT is made up of the physician who first decided on the treatment, a nurse with responsibility for the resident, other appropriate staff and, if practicable, a patient representative (1418.8(e). In short, under the statute, the reviewing team must include the physician who first decided to order the treatment, and a nurse, and may include others such as the patient representative where "practicable" most of whom have institutional interests regarding care decisions, particularly where the attending physician is also the institutional medical director (See Para 60, herein)

28. Nothing is stated in the statute as to how the treatment decision will be made in terms of voting other than that it will be "reviewed" (1418.8(e)).

29. The statute specifies that nothing therein shall affect the resident's right to seek judicial review, (1418.8(j)), but nothing in the statute requires that the resident be informed of the: 1. Nature of the treatment; 2. The side effects to the treatment; 3. The right to refuse the treatment; 3. That s/he is alleged or has been found to lack capacity; 4. That the physician will determine decisional capacity; 5. That the resident may obtain a substitute decision maker; 6. That there will be a committee review; 7. The decision of the committee; or 8. That there is a right to seek judicial review. Notice to the resident is not mentioned anywhere or at any stage of the proceeding.

30. There is no right in the statute to the appointment of a representative for the resident for purposes of the determination of capacity, the availability of a surrogate, the necessity of the treatment, opposing the treatment, or obtaining judicial review.

31. Although the legislative purpose was to deal with "day to day" treatment, the statute contains no limitations as to types of treatment other than that requiring informed consent, and is thus currently used, as permitted by Respondent, for severely intrusive activities[1]

IV.

STATEMENT OF FACTS

A. FACTS AS TO PETITIONER GLORIA A.

[All facts as to Petitioner GLORIA A. are found in the declarations of Petitioner GLORIA A and PATSY PENCE, and exhibits 4-1 through 4-21 of the Compendium]

32. Petitioner Gloria A. is a 63 year-old resident of Country Villa Skilled Nursing Facility in Santa Cruz, California, where she has resided since January, 2013. She has been employed as a driver of "semi" trucks, and intends to return to work as a driver of smaller trucks in the near future.

33. Ms. A. was found by her treating physician, upon her entry to the snf, to lack decisional capacity. No notice was ever given to her of any claim of incapacity, finding thereof, or opportunity to challenge such finding (See declaration of Gloria A. para therein) She had no one appearing for her to challenge the finding. Petitioner Gloria A. did not learn she was found incompetent until months later in April of 2013 when she tried to leave the facility on a picnic with the family of another resident and she was informed she could not since she had been found incompetent.

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[1] In an article in the December 2011 News of the The California Association of Long Term Care Medicine it was stated that "[S]ince the statute was designed for "snf" decisions, these might be a restraint, a device, a minor or major medical procedure or even code status and psychotropic consents.", *CALTCM* supra. The article further suggested that the statute was reasonably applied to creating Physician Orders for Life Sustaining Treatments, which are often used to order cessation of life support *CALTCM* supra. The long term care industry article as well legitimized the use of the statute "to refusal or the withholding or withdrawal of treatment" *CALTCM* supra.. As will be pointed out in the Statement of Facts herein, the statute is being used currently for each and every application set forth above, and has been expressly approved by Respondent herein for use as to antipsychotic drugs. (Exhibit 2 herein)

34. On the day of her admission to the facility, the request for admission and consent to treat was signed, not by her, but by the facility's IDT since she was incompetent (exhibit 4-1 hereto).

35. Thereafter, Petitioner was administered, without informed consent, numerous psychoactive drugs, including antipsychotic drugs such as Seroquel, which has a black box warning as to a risk of death, as well as trazadone, ambien, ativan, and lexapro. She was given Seroquel non-consensually and said in her declaration, para 12 therein:

> I am informed that I was given something called Seroquel, but I don't know what that is and don't know that I was given it. There was one drug I hated and maybe that was it. They told me I had to take it, and that I had no choice.

36. As to the loss of her liberty through decisions by the IDT and her physician, based upon her decisional incapacity, on April 12, 2013, a social work progress note states:

> Resident was trying to leave and go to a bbq with 25c we let her know she could not leave without a CNN present…. *MD stated she was not competent to go on her own*. (emphasis added, Exhibit 4-19 hereto)

37. On April 17, 2013, an IDT meeting was held without the physician and stated: "IDT is the Resp Party and does not have the capacity per MD. Res cont to refuses care, tx, [treatment] meds and gets verbal to staff." (Exhibit 4-16 hereto)

38. On April 25, 2013 an IDT meeting note states:

> At this time the IDT will exercise the medical decision making on a case-by-case basis and meet as a team to exercise professional, medical, and nursing judgment as needed. Social services will assist the patient with the finances follow up such as appointments with social security and psychosocial needs. (Exhibit 4-15 hereto)

38A. In June, 2013, when access was sought to her medical chart, the snf denied her access as she had been determined incompetent (See declaration of Patsy Pence. Para 25 therein).

39. The most recent drug addition to her regimen is trazadone. The "consent", given on June 11, 2013, was by members of the IDT. The facility chart entry as to trazadone states, as to the side

effects: "trazadone risks: sedation, constipation, dry mouth, blurred vision, urinary retention, rash, fever, increased risk of suicidal thinking in adults with MDD…[major depressive disorder]" (Exhibit 4-11).

40. Nevertheless, numerous facts reveal that Ms. A. had and has decisional capacity. For example, a representative of the Respondent DPH, stated to ombudsman Patsy Pence, that Petitioner had cognition and had scored 13 out of 15 on a Section 3 "Cognition" section of the required Minimum Data Set. (Declaration of Patsy Pence).

41. On May 9, 2013, in determining whether Ms. A. might live on her own as she wished to do, the attending physician stated, in the Progress Notes "pt. believes yr is 2000, most answers other questions, ok…" (See Exhibit 4-7 herein). On the same day, the physician ordered a psychiatric exam for purposes of determining her capacity to live on her own, but none was performed at that time. On May 20, 2013, an IDT conference note states: "Res is alert and able to make her needs known." (Exhibit 4-14 hereto). It further states: "will educate on risks and benefits of smoking." On July 23, 2013, Petitioner Gloria A. received a letter as to a notice of intent to evict for non-payment as a result of her representative payee having failed to make payments. (Exhibit 4-20). On September 5, 2013, four months after requested and nine months after admission, she was seen by a psychiatrist and a note from the psychiatrist (Exhibit 4-21) states:

> Patient seen and evaluated. Patient has capacity to make decision about her finances, accommodation, medical issues etc. Full dictated report will follow

Thus, although capable, due to application of Section 1418.8, Petitioner Gloria A. lost her right to refuse drugs, and her liberty. To this date she has received no notice of restoration of decisional capacity, just as she never received notice of decisional incapacity, or of allegations or findings thereof.

42. PETITIONER GLORIA A. has been denied, from the first date of admission to the skilled nursing facility, the right to make personal decisions as to the administration of psychoactive drugs including antipsychotic drugs, the right to decide her personal finances, the right to decide her health care, access to her chart, and the right to determine her personal liberty, all as the result of decisions by the facility's IDT (IDT) and her attending physician. Such denials have occurred without notice or opportunity to oppose them, without notice of the determination or of the right to challenge, without a judicial adjudication of her decisional incapacity, without a representative to assist her at either the determination of incapacity or the determination of the deprivation, and without a neutral decision maker at either the determination of incapacity or the determination of the deprivation.

B. Facts as to the Deceased Mark H. (Facts as to the deceased Mark H. are in Exhibit 3A through Exhibit 3-P and in the Declaration of Petitioner GENEVA CARROLL

History and demographics

43. Mark H. was a 62 year old double amputee resident of a California skilled nursing facility located in Placer County, for whom Section 1418.8 was used to create an IDT to make treatment decisions, including a Physician Order for Life Sustaining Treatment (POLST)[2] used to change his status from full treatment ("full code") to comfort care only and a do not resuscitate order. (Exhibit 3- A, B, C, and Carroll Declaration).

44. As a result of the decision of the IDT through Section 1418.8, Mr. H. died through an order of "comfort care only", expiring on February 14 , 2013 (Exhibit 3-D). This although the

[2] A POLST, unlike an advance directive which informs the physician of the patient's wishes, is an actual order by a physician as to end of life decisions. (Probate Code sections 4780-6)

statute had been judicially interpreted to be solely for "relatively unintrusive" treatments (*Rains v. Belshe*). An article in a nursing home industry periodical stated that Section 1418.8 could be used for death-related decisions (see fn 1 herein).

Competence

45. In April, 2012, Mr H. while treated at the Mercy San Juan Medical Center, his chart stated that: "Patient/representative has Capacity…to understand and sign admission contract…or make healthcare decisions…" (Ex. 3-E). On July 8, 2012, at the snf, Nurse Ray entered "Res A/O [alert/oriented] to person and place. Able to make needs known with staff and answer all questions approp." (Ex. 3-F) On January 2, 2013, a progress note states: "Resident has also been more verbal in the past week. He says thank you after dressing changes and good morning when we go into his room." (Ex 3-G). On February 7, 2013, a progress note states: "Able to make some basic needs known but he is very particular about when he talks and who he talks to." (Ex 3-H). On February 13, 2013 a note says: "Verbally responsive with hospice cna." (Ex 3-I).

46. On July 24, 2012, while receiving antipsychotics, Mr. H. was declared to lack decisional capacity by his physician in that "Resident is *not competent enough* to make medical decisions." (Ex. 3-J, emphasis added) according to an "Epple Committee" report. At no time is there any evidence that Mr. H. was given notice of his alleged incapacity, nor a representative or other opportunity to oppose this determination.

Decisions under Section 1418.8 as to Death of Mark H.

47. On December 5, 2012, the Section 1418.8 IDT team, (termed the "Eppel Committee" after the author of the Act) met, with the ombudsman present, but not the physician and not Mr. H. No patient representative was present as ombudsmen are prohibited from acting as patient representatives. (Ex 3-B). The "topic of discussion" was withdrawal of life support systems.

(Report of Eppel Committee). The report stated that the "Ombudsman attempted to ask resident's wishes with respect to changing POLST to DNR; resident did not respond. RNNP [registered nurse, nurse practitioner] and ADON [assistant director of nursing] approached resident with Ombudsman asking simply: Do you want to live or die?" Resident did not respond to direct question, even with a change in facial expression." (Ex 3-B).

48. As a result, the "EPPLE Act Committee finds that change of POLST to DNR is warranted…" and "the committee agrees with admission to hospice for end-of-life care." (Ex3-B).

49. According to a progress note on December 5, 2012, as to the "EPPLE ACT Committee", the Ombudsman did not sign the report as "Ombudsman stated she was not permitted to sign document although she attended the meeting." (Ex 3-K).

Chemical And Physical Restraints

50. Mr. H. never consented to the use of chemical or physical restraints nor any psychotherapeutic drugs, having, on April 21, 2012, and again on April 26, 2012 signed a form stating, "I decline the use of the psychotherapeutic drug". (Ex 3-L, M). Nevertheless, Mr. H. was repeatedly administered those drugs, including antipsychotic drugs.(Ex 3-N)

51. Mr. H. was administered such drugs for "agitation" (Ex 3-N) which is not a clinical indication for using an antipsychotic (see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf - F329).

52. When he allegedly attempted to pull out his g [gastric] tube, he was put in physical restraints which tied his arms to the sides of his bed, spread-eagled. (Ex 3-O) Neither he nor any representative consented.

53. On September 1, 2012, in an "individual psych education session" by Psychiatrist Kulsant Singh, it was stated that Mr. H. was "very sedated" on Remeron which was to be

discontinued and "d/c Seroquel for same reason." (Ex 3-P). Nevertheless, and although sedation is a significant side effect for antipsychotic drugs, and the form reads "Antipsycotics (sic) are not approved for the treatment of dementia related psychosis", Mr. H. was administered these drugs, and particularly Seroquel, (Ex. 3-N) until his transfer of care to a hospice and his subsequent death. Neither he nor any representative consented other than the IDT. On information and belief, when transferred to the hospice and antipsychotics ceased, Mr. H. became less sedated and more coherent.

C. Capacity Determinations in California Skilled Nursing Facilities

54. Although required by Section 1418.8, capacity determinations are not made before each treatment requiring informed consent (See Declarations of ombudsmen affixed hereto). Instead, such determinations are routinely made upon entry to the snf, usually after admission from acute care facilities (See Decl of Consultant Peggy Main para 6). The result is significant errors as to capacity determinations for reasons including merely checking a box (See declaration of Consultant Peggy Main para 6 - 10), temporary conditions such as placement anger, placement bewilderment, delirium, pain, and various sedating medications (See declarations of ombudsmen herein). Rarely are subsequent examinations for regained capacity made, although required by Section 1418.8.

55. The determination also may involve bias on the part of the clinician (See *Are clinician's (sic) ever biased in their judgments of the capacity of elder adults's (sic) to make medical decisions?* Generations 2009 Spring 33(1) 78 – 91) (study showing "some clinicians tending to rate capacity more liberally and some more stringently…") A large percentage of snf physicians are either also medical directors of the snf or have large numbers of patients at the snf. The American Medical Association recognizes the presence of bias in physician/institutional settings due to multiple allegiances and it has, at its 2012 Interim Meeting of the AMA House of Delegates, recognized some

of the problems of conflicts of interest in its newly adopted AMA Principles for Physician Employment saying:

> A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.

AMA Principles for Physician Employment,
Addressing Conflicts of Interest (1) (a),
Adopted 2012, Interim Meeting of the AMA House of Delegates,
(Board of Trustees Report 6)

56. Additionally there is significant inconsistency in capacity judgments by physicians. (see *Consistency of physician judgments of capacity to consent in mild Alzheimer's disease* (J of the American Geriatrics Society 45/4 453 – 457 ("only 56% judgment agreement for the mild AD patients")

57. As to the limited nature of exams as to cognition, the declaration of Elizabeth (Tippy) Irwin, ombudsman for San Mateo County states, at para 12 therein:

> Determinations of medical treatment decisional incapacity are usually made when the resident arrives at a facility. When residents first enter nursing facilities, they are often on medications which affect them, such as numerous types of drugs, including sedation or pain killers. They are often distraught and disoriented after being placed in the nursing home. As a result the resident might seem to be incapable of making decisions, which frequently results in a determination of incapacity on the part of the client. Given time to orient themselves to their new situation, or to recover from whatever trauma may have been the cause for their placement in the nursing home in the first place, many of the residents regain their capacity to make their own decisions, but often the change is not documented. It is uncommon for that determination to be reversed, even when it becomes evident that the resident has regained capacity to make his/her decisions.

58. In para. 9. of her Declaration, nursing home consultant Peggy Main stated, as to a snf:

> Recently a resident was admitted from the acute hospital. Both the RN on the floor and the social service designee talked to her at length regarding her wishes for end of life care. Both felt she understood and was very clear that she did not want life sustaining treatment. She reiterated this on more than one occasion. However, the primary physician determined she lacked capacity and the POLST had to be CPR and full code, thus negating the resident's wishes. Fortunately, after much searching the social service worker was able to identify and contact a cousin who, after talking in depth with the resident, was willing to sign the POLST reflecting the resident's wishes. Without the work of the social worker the resident could have been subjected to various life sustaining interventions including CPR (with possible broken ribs from chest compressions, burns from defibrillation) and various tubes for feeding.

59. Ombudsman Elizabeth Irwin, ombudsman for San Mateo County, experienced a situation in which an elderly nursing home resident apparently had decisional capacity, but was determined incapacitated by her physician who refused to change her determination. The resident had been placed in the snf by a "friend" who had previously changed the resident's will, (Irwin declaration at Para 6, 7, 8) and the resident had been refused visits from her granddaughter. Believing the resident capable, and after visits from two Regional Ombudsman Coordinators confirming this belief, the ombudsman witnessed a new advance directive, naming the granddaughter as agent. The "friend" brought suit in Sacramento Superior Court and:

> During the court proceedings, the judge on the case took the elderly woman, the resident, into chambers for about forty five minutes, and emerged, stating that she was of the opinion that the elderly woman, our client, was perfectly capable of making her own decisions in this matter.

Irwin declaration at Para 11

60. Erroneous capacity decisions have additional effects. In the declaration of Sacramento Ombudsman Cheryl Simcox, at para 11 – 14, it is stated:

> In one instance, a woman was said to lack capacity and as a result, she was forced to give up her section 8 housing, the apartment she lived in and wanted to return to. She lost the apartment because it was said she was mentally incapacitated,

> In my many conversations with this resident she consistently presented as alert and oriented to time, place, and person and showed no evidence of lacking the ability to make decisions for herself.
>
> In another situation a physician documented that a patient lacked capacity, and I had seen him 6 or 8 times and spoken with him.
>
> He consistently was able to express his wishes, was alert and oriented times three, and was working independently building his strength so he could return home.

61. Ombudsman Geneva Carroll, from Placer County, stated, in para 12, 13 of her declaration, as to capacity errors in skilled nursing facilities:

> My own mother in law had a similar experience – she was upset because she thought she had a heart attack, and instead of working with her to reassure her, she was given an antipsychotic drug, Haldol, and determined to be incapacitated, but she wasn't incompetent, she was upset and frightened.
>
> Many people in nursing homes are found to be incompetent, and denied the right to make their own decisions even though they are quite capable to decide for themselves. Much of this is really a matter of staff convenience.

62. Courts have drawn factual conclusions from the Alaska Supreme Court, as to physician and institutional conflict in determinations of incapacity in hospitals and nursing homes:

> Many cases describe the unavoidable tensions between institutional pressures and individual best interests that can arise in this setting. The doctors who are attempting to treat as well as to maintain order in a hospital have interests in conflict with those of their patients who may wish to avoid medication. Economic considerations may also create conflicts.

Myers., v. Alaska Psychiatric Institute (2006) 138 P.3d 238, 250

D. Use of Section 1418.8 as to Highly Intrusive Treatment

63. As with Petitioner Gloria A., and Mark H., although Section 1418.8 is to be limited to "relatively nonintrusive treatment" *(Rains v. Belshe*), it is often used for highly intrusive treatment, such as anti-psychotics, physical restraints and death. As was said by Sacramento Ombudsman Simcox, at para 10 of her declaration:

> At the "Epple" meetings I've attended, the discussion had to do with highly intrusive decisions such as hospice care, DNR, or the choice as to whether a resident be given liquids with the chance of aspiration and possible death.

64. Death is highly intrusive. Antipsychotic drugs are also highly intrusive, especially as to the elderly. Antipsychotic drugs are often used in nursing homes as forms of behavior control of the population. The antipsychotic drug given to both Petitioner Gloria A. and Mark H., seroquel, carries the following warning:

> **BOXED WARNING**
>
> **WARNING**
>
> - Increased Mortality in Elderly Patients with Dementia-Related Psychosis
> - Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Seroquel is not approved for the treatment of patients with dementia-related psychosis (see BOXED WARNING).

(Exhibit 6 hereto).

65. With particular application in the for-profit operation of nursing homes which often are understaffed, in analyzing the effects of antipsychotic drugs, the court in *Keyhea v. Rushen* (1987) 178 Cal. App. 3d 526, 540 [223 Cal. Rptr. 746] cited in *Qawi,* stated:

> They "also possess a remarkable potential for undermining individual will and self-direction, thereby producing a psychological state of unusual receptiveness to the directions of custodians." (*Mental Hospital Drugs, supra*, at p. 1751.)

66. Thus, such drugs are often used, as they were for Petitioner Gloria A., and for Mark H., not as treatment for psychosis, but to control behaviors which are not desired in the snf, such as crying or yelling, and thus chemical restraints.

67. The Office of the Inspector General of the Department of Health and Human Services has concluded, in a Report issued May, 2011 that over 50 percent of the use of atypical antipsychotic drugs for elderly nursing home residents involved these drugs "not used for medically accepted

indications". (see Exhibit 7 Compendium). The same report found that "some nursing homes that failed to comply with CMS standards regarding unnecessary drugs may not adequately ensure nursing home residents health and safety." (exhibit 7, Table 4, page 18). It cited, as an example, a situation where the drug was used for agitation where the patient had infection and pain which caused the agitation, and "more efforts could have been placed on treating these conditions."

68. Further, the Office of the Inspector General of the Department of Health and Human Services has concluded, in the Report issued May, 2011 that 88 percent of the use of atypical antipsychotic drugs for elderly nursing home residents "were associated with the condition specified in the FDA boxed warning (See exhibit 7). It further found that "twenty-two percent of the atypical antipsychotic drugs claimed (for Medicare reimbursement) "were not administered in accordance with CMS standards regarding unnecessary drug use in nursing homes." (exhibit 7 hereto).

69. The Office of the Inspector General of the Department of Health and Human Services as well concluded, in a Report issued July, 2012 that, as to records of patients in nursing homes receiving atypical antipsychotic drugs: "Nearly all records reviewed (90 percent) of the use of atypical antipsychotic drugs for elderly nursing home residents failed to meet one or more Federal requirements for resident assessments and/or care plans." (exhibit 8), although: "Elderly nursing facility residents (residents) receiving atypical antipsychotic drugs are a particularly vulnerable population because of an increased risk of death associated with these drugs." (exhibit 8).

70. In a Task Force White Paper published by the American Council on Neuropsychopharmacology in 2007, it was stated that these drugs have other numerous risks as to the elderly, including "excessive sedation, postural hypotension, and falls". The White Paper then set forth alternatives to antipsychotics, which included psychosocial and psychotherapeutic interventions. The White Paper concluded that there should be shared decision-making including

provision, to patients as well as surrogates, "all relevant information (including risks and benefits of no treatment and of possible environmental/psychosocial interventions) along with opportunities to participate in decisions to the extent they are comfortable." [Exhibit 9] Both the American Geriatrics Society and the American Psychiatric Association have cautioned both physicians and patients against using antipsychotics for treatment of behavioral symptoms including agitation, (Exhibit 10, *Choosing Wisely*, 2013, American Psychiatric Association; Exhibit 11, *Choosing Wisely,* 2011, American Geriatrics Society.) This was the basis for their use as to Mark H., and as well as to Petitioner Gloria A.

71. The most recent judicial statement as to antipsychotic medications was made by the California Supreme Court in 2004 in *In re Qawi* (32 C4th 1) in the course of granting relief as to sexually violent predators. Such individuals are significantly less vulnerable, and less fragile and less innocent than those herein, and the side effects less harmful, but the list of effects would be included in those potentially suffered by the elderly. It is as follows:

> No doubt such commonly used drugs, the phenothiazines, have been of considerable benefit to many mentally ill patients. Use of these drugs has greatly reduced the number of mentally ill individuals requiring hospitalization, and the frequency and length of hospitalizations. (See Cichon, The Right to "Just Say No": A History and Analysis of the Right to Refuse Antipsychotic Drugs (1992) 53 La. L. Rev. 283, 293.) But they also have been the cause of considerable side effects. Reversible side effects include akathesia (a distressing urge to move), akinesia (a reduced capacity for spontaneity), pseudo-Parkinsonism (causing retarded muscle movements, masked facial expression, body rigidity, tremor, and a shuffling gait), and various other complications such as muscle spasms, blurred vision, dry mouth, sexual dysfunction, drug-induced mental disorders. (Keyhea, supra, 178 CaL. App. 3d at p. 531.) A potentially permanent side effect of long-term exposure to phenothiazines is tardive dyskinesia, a neurological disorder manifested by involuntary, rhythmic, and grotesque movements of the face, mouth, tongue, jaw, and extremities, for which there is no cure. (Ibid.) On rare occasions, use of these drugs has caused sudden death. (Ibid.)
>
> Although a new generation of antipsychotic drugs, the so-called atypicals, have been regarded as being more benign and effective, considerable controversy remains over

> both their efficacy and the extent and nature of their side effects. (See Goode, Leading Drugs for Psychosis Come Under New Scrutiny, N.Y. Times (May 20, 2003) p. 1.) Moreover, most atypical antipsychotics are difficult to administer without a patient's cooperation, because unlike the older generation of medications, the newer drugs are generally not available in forms that can be injected. (See Mossman, Unbuckling the "Chemical Straitjacket": The Legal Significance of Recent Advances in the Pharmacological Treatment of Psychosis (2002) 39 San Diego L. Rev. 1033, 1078, fn. 214.) Also, phenothiazines are cheaper than atypicals and are still the most widely used class of drugs to treat psychosis. (See Julien, A Primer of Drug Action (9th ed. 2001) p. 339.)

E. Implementation of Section 1418.8 by California Department of Public Health

72. Although a California Court of Appeal decision has recognized that Section 1418.8 is limited to "relatively nonintrusive and routine" treatment, the California Department of Public Health (hereafter CDPH) has explicitly permitted the use of Section 1418.8 as to antipsychotic drugs (See exhibit 14 hereto), instructing its surveyors that Section 1418.8 may be so used.

73. Although a California Court of Appeal decision has mandated that there shall be a patient representative at Section 1418.8 treatment reviews, CDPH continues to inform skilled nursing facilities that a patient representative is necessary only where it is "practicable" as the statute stated before judicial interpretation and limitation. This results in widespread disregard for the limiting requirements of the judicial decision. For example in one facility, the policy is:

> "The IDT shall include the resident's Attending Physician, a Registered Nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident's needs, and *when applicable* [sic], a resident's personal representative."

Policy – SS – 08, p. 1., Operational Manual, Roseville Point Skilled Nursing Facility, emphasis added, Exhibit 12 to petition

73A. In another, the physician is merely invited as is any family/responsible party:

> The composition of the IDT members varies…Suggested IDT members include facility representatives from the following departments: Activities; Rehabilitation; Nursing…In addition the resident, *resident family/responsible party and physician are invited to attend*

Exhibit 13 to petition, Country Villa Health Services Operations Manual, emphasis added

74. Although CDPH has the statutory responsibility to inspect California skilled nursing and intermediate care facilities (snf/icfs) for failure to comply with California laws ("Notwithstanding any other provision of law, the department *shall inspect for compliance with provisions of state law and regulations* during a state or federal periodic inspection..." Section 1279.9(g) Calif. Health & Safety Code (emphasis added)), and although numerous errors exist, CDPH has never issued a citation even as to improper determinations of incapacity (See Declaration of Anthony Chicotel).

75. Numerous failures of implementation of Section 1418.8 exist in that: 1. physicians do not determine capacity on each occasion that treatment requiring informed consent occurs: 2. physicians do not use the statutory standard for such determination; 3. IDT meetings seldom include physicians; 4. Section 1418.8 is not used on all occasions when treatment requiring informed consent is involved; 5. physicians do not investigate as to existence of surrogates; 6. antipsychotic drugs are often prescribed based on phone calls and emails; 7. IDTs do not contain patient representatives even if practicable and not as a mandate; and 8. skilled nursing facilities make no effort to assure physicians or the homes comply with Section 1418.8. 9. The statute is used to deprive snf and icf residents of far more than medical decision rights, such as liberty, finances, chart access and life itself.

F. Residents of Skilled Nursing Facilities

76. By their very nature, skilled nursing and intermediate care facilities are residences for persons who are ill, frail, sometimes disabled, usually elderly, and often suffering from depression, loneliness, loss of homes, loss of control over their lives, possibly looking forward to no future other than slow death, and trying to maintain life.

77. As the New Jersey Supreme Court held, there is a "special vulnerability of mentally and physically impaired, elderly persons in nursing homes and the potential for abuse with unsupervised institutional decision-making in such homes…" In *In re Conroy*, (1985) 486 A2d 1209, at 1240-1241 Such facilities and the physicians treating patients therein have had and continue to have significant problems in the delivery of medical treatment.

V.

CAUSES OF ACTION

FIRST CAUSE OF ACTION

(DUE PROCESS UNDER THE CALIFORNIA CONSTITUTION)

(Right to Notice and Opportunity to oppose)
(This cause of action is brought by all Petitioners against Respondent.)

78. Petitioners reallege and incorporate every allegation and paragraph set forth above.

79 Section 1418.8, Health & Safety Code violates the constitutional right to due process as to adequate notice and opportunity to oppose: A, the determination of decisional incapacity; B. the determination of the absence of a legal substitute decision maker; C. the hearing (statutorily termed a review) as to medical treatment; and D. the administration or withdrawal of medical treatment.

SECOND CAUSE OF ACTION

(Right to Due Process under the California Constitution)
(This cause of action is brought by all Petitioners against Respondent.)

80. Petitioners reallege and incorporate every allegation and paragraph set forth above.

81. Section 1418.8, Health & Safety Code violates the right to due process under the California Constitution by failing to require adequate representation at the determination of incapacity.

THIRD CAUSE OF ACTION

(RIGHT TO PRIVACY UNDER THE CALIFORNIA CONSTITUTION)
(Right to an adjudication of incapacity and absence of substitute decision maker)
(This cause of action is brought by all Petitioners against Respondent.)

82 Petitioners reallege and incorporate every allegation and paragraph set forth above.

83. **.**Section 1418.8, Health & Safety Code violates the right to privacy under the California Constitution by permitting physicians to make legal adjudications as to decisional incapacity.

FOURTH CAUSE OF ACTION

(Right to Due Process under the California Constitution)
(This cause of action is brought by all Petitioners against Respondent.)

84. Petitioners reallege and incorporate every allegation and paragraph set forth above.

85. Section 1418.8, Health & Safety Code violates the right to due process under the California Constitution by failing to require neutral decision makers at the adjudications as to decisional incapacity.

FIFTH CAUSE OF ACTION

(Right to Due Process under the United States and California Constitutions)
(This cause of action is brought by all Petitioners against Respondent.)

86. Petitioners reallege and incorporate every allegation and paragraph set forth above.

87. Section 1418.8, Health & Safety Code violates the right due process under the United States and California Constitutions by failing to require a neutral decision maker at the review and approval or rejection of treatment.

SIXTH CAUSE OF ACTION

(Failure to comply with judicial precedent as to section 1418.8 Health & Safety Code)

(This cause of action is brought by all Petitioners against Respondent.)

88. Petitioners reallege and incorporate every allegation and paragraph set forth above.

89. Respondent has violated Petitioners' right to a review with representation under Section 1418.8, Health & Safety Code by failing to require a patient representative at the review to determine treatment, absent exigent circumstances, as set forth in judicial precedent.

SEVENTH CAUSE OF ACTION

(Failure to comply with judicial precedent as to section 1418.8 Health & Safety Code)

(This cause of action is brought by all Petitioners against Respondent.)

90. Petitioners reallege and incorporate every allegation and paragraph set forth above.

91.Respondent has violated Petitioners' right to a Limiting Judicial Interpretation under Section 1418.8, Health & Safety Code precluding its use as to antipsychotic drugs, or in the alternative, providing adequate notice, counsel, evidence and a judicial hearing as to incapacity, necessity and the least intrusive alternative.

EIGHTH CAUSE OF ACTION

(Failure to comply with judicial precedent as to section 1418.8 Health & Safety Code)

(This cause of action is brought by all Petitioners against Respondent.)

92. Petitioners reallege and incorporate every allegation and paragraph set forth above.

93. Respondent has violated Petitioners' right to a Limiting Judicial Interpretation under Section 1418.8, Health & Safety Code precluding his use of the statute for treatments or discontinuation thereof which would result in death, such as, but not limited to do not resuscitate, comfort care, or discontinuation of treatment, or for POLST orders.

VI.

APPLICATION FOR EXTRAORDINARY RELIEF

94. As set forth above, this action concerns the constitutionality of and application by Respondent herein of Section 1418.8. The claim requires no evidentiary hearing as to the facial claims herein, and no evidentiary hearing as to the applied claims herein as all necessary papers are appended to this petition.

95. A Writ of Mandate is to be issued "to compel the performance of an act which the law specially enjoins…in all cases where there is not a plain, speedy and adequate remedy, in the ordinary course of law…" (Code of Civil Procedure, secs. 1085, 1086.) Courts have held that a Writ is to be issued when a question of first impression is presented (*Cianci v. Superior court* (1985) 40 Cal. 3d 903, 908 fn. 2, 221 Cal. Rptr. 575). Courts have further held that a Writ may be issued where constitutional issues are presented (*McHugh v. Santa Monica Rent Control Board* (1989) 49 Cal. 3d 348, 261 Cal Rptr 318; *Aden v. Younger* (1976) 57 Cal App 3d 662, 670, 129 Cal; Rptr 535). Further, Courts may issue a Writ when important questions of public interest are involved (*Richard P. v. Superior Court* (1988) 202 Cal. App. 3d 1089, 249 Cal. Rptr 245). Courts have also held a

Writ appropriate when the issue is of widespread interest, as well as where petitioner may suffer harm absent the issuance of the Writ (*Omaha Indemnity v. Superior Court* (1989) 209 Cal. App. 3d 1266, 1275, 257 Cal Rptr 66).

96. In the instant matter all of the considerations set forth above are present. No court in California has ever determined whether notice or opportunity to oppose the determination of decisional incapacity under Section 1418.8 is required, and the one appellate decision denying a right to a judicial determination of incapacity as a medical decision before losing decisional rights under Section 1418.8 occurred before a decision by the Supreme Court holding that the determination was not medical but legal.

97. The action concerns persons and statewide there are and will be thousands of such persons. Thus, the matter is of widespread interest. Given that Section 1418.8 may result in loss of fundamental health decisional autonomy, the matter is of considerable public interest. Further significant constitutional questions of privacy, equal protection and due process are presented. Therefore a Writ of Mandate is appropriate.

98. Such petitions as well have resulted in the extraordinary writs regarding such nonconsensual treatment without judicial determinations of incapacity. Such writs have been granted in a number of recent cases involving nonconsensual use of antipsychotic medications and the need for a judicial determination of incapacity. Thus, *In re Qawi*, 32 C4th 1 (2004), resulted from an original writ of habeas corpus. In that matter, the California Supreme Court granted, to a Mentally Disordered Offender detained under under the Penal Code, and based upon the Supreme Court's interpretation of LPS statutory rights of autonomy as to antipsychotic drug treatment, the right to a judicial determination of incapacity prior to nonconsensual treatment. Similarly, in *In re Calhoun*, 121 CA4th 1315 (2004), the Court of Appeal granted a similar right to a judicial

determination of incapacity prior to nonconsensual treatment with antipsychotic drugs as to a Sexually Violent Predator. That case also resulted from an original Writ in the Court of Appeal.

99. Respondent has the clear present and ministerial duty to act in accordance with state and federal law and the United States and California Constitutions, as set forth below.

100. The responsibilities and duties of Respondent which are subject to mandamus relief herein include inspecting, surveying, and insuring compliance with and enforcement of Section 1418.8. Although Respondent has had and currently has the capacity and ability to discharge his duties, as set forth above, in a manner consistent with all applicable state and federal laws and the California Constitution, he has failed and refused to do so and/or abused his discretion under an improper interpretation of the law.

101. Petitioners have no plain, speedy and adequate remedy in the ordinary course of law.

102. This action presents a case of first impression because no court in California has ever directly determined whether Section 1418.8 is unconstitutional as a denial of notice and opportunity to oppose, whether treating physicians are neutral in deciding incapacity and treatment for nonconsenting and unrepresented patients in a non-emergency, and whether such patients are entitled to representation in a determination of incapacity. Further, no court has determined whether the decision of the Supreme Court in *Qawi,* supra, reverses the decision of the Court of Appeal in *Rains,* supra in holding that incapacity is a medical decision.

103. The individually named petitioners herein have a beneficial interest in that Petitioner GLORIA A.is now deemed incapacitated based solely on a physician's determination, and Petitioner CANHR's mission will be thwarted as set forth below… (Code of Civil Procedure §§ 1085, 1086.)

104. Petitioners and each of them are beneficially interested in Respondent's discharge of his obligations as set forth herein, and suffer irreparable injury from Respondent's failure to discharge his obligations.

105. The Action is equally appropriate as to the issuance of a declaratory judgment (See *KG v. Meredith,* supra..

VII.

ALLEGATIONS CONCERNING INJUNCTIVE AND DECLARATORY RELIEF

106. Respondent's actions, as alleged herein, have resulted in and will continue to result in irreparable injury to Petitioners and others caused by non-consensual medical treatment without adequate notice or opportunity to oppose, without a judicial determination of incapacity to consent to or refuse that treatment, or of the absence of a legal substitute decisionmaker, without a neutral decisionmaker, and without a representative at the treatment hearing. Petitioners have no plain, speedy or adequate remedy at law.

107. An actual controversy exists between Petitioners and Respondent, in the Petitioners claim that Respondent, through Section 1418.8 has violated their rights of privacy, and due process, under the California constitution, and Respondent denies all such contentions.

108. Unless the requested relief is granted, Petitioner CANHR's mission will be thwarted as set forth above, and Petitioners and others will continue to suffer the negative effects and loss of personal autonomy that result from their loss of the right to refuse unwanted and nonconsensual treatment, and the risk that they will be subject to such involuntary treatment again in the future.

109. This action seeks to declare and mandate that Section 1418.8 is unconstitutional and that persons affected thereby have a right to a judicial determination of their incapacity to make

treatment decisions, a right to a judicial determination of the absence of a substitute decisionmaker, a neutral adjudicator as to both rights as well as at the hearing to decide treatment, and a representative at such hearing, as well as adequate notice and opportunity to oppose the loss of the right to oppose medical treatment.

110. The legal basis of this action includes California constitutional rights of privacy and due process under the California Constitution.

VIII

RELIEF REQUESTED

WHEREFORE, petitioners respectfully request that this Court grant the following relief:

1. Assume jurisdiction over this action and maintain continuing jurisdiction until Respondent is in full compliance with every order of the Court.

2. Issue an Order declaring that:

A. Section 1418.8 facially violates the privacy and due process provisions of the California Constitution in that:

i. Section 1418.8 fails to assure adequate notice and opportunity to oppose both the determination of incapacity and the decision to treat

ii. Section 1418.8 fails to require adequate representation at the determination of incapacity

iii. Section 1418.8 permits a medical determination of a legal right, capacity to make treatment decisions

iv. Section 1418.8 permits a person interested in the outcome to determine legal incapacity

v. Section 1418.8 permits a person interested in the outcome to review and determine medical treatment

B. Section 1418.8 as applied by Respondent violates the privacy and due process provisions of the California Constitution and, in the alternative, Respondent violates Section 1418.8 in that:

i. Nonconsensual administration of antipsychotic drugs is highly intrusive and requires a judicial adjudication of decisional incapacity

ii. Nonconsensual withdrawal of medical treatments necessary to support life requires a judicial adjudication of decisional incapacity and appointment of a surrogate

iii. a patient representative with power of refusal of treatment is required for treatment review and approval

3. Issue a peremptory writ of mandate, pursuant to Code of Civil Procedure Section 1085 mandating that:

A. Section 1418.8 facially violates the privacy and due process provisions of the California Constitution in that:

i. Section 1418.8 fails to assure adequate notice and opportunity to oppose both the determination of incapacity and the decision to treat

ii. Section 1418.8 fails to require adequate representation at the determination of incapacity

iii. Section 1418.8 permits a medical determination of a legal right, capacity to make treatment decisions

iv. Section 1418.8 permits a person interested in the outcome to determine legal incapacity

v. Section 1418.8 permits a person interested in the outcome to review and determine medical treatment

B. Section 1418.8 as applied by Respondent violates the privacy and due process provisions of the California Constitution and, in the alternative, Respondent violates Section 1418.8 in that:

i. Nonconsensual administration of antipsychotic drugs is highly intrusive and requires a judicial adjudication of decisional incapacity

ii. Nonconsensual withdrawal of medical treatments necessary to support life requires a judicial adjudication of decisional incapacity and appointment of a surrogate

iii. a patient representative with power of refusal of treatment is required for treatment review and approval

4. Issue a peremptory writ of mandate, commanding as follows:

Respondent shall prohibit the use of Section 1418.8 by all California skilled nursing and intermediate care facilities

5. Enjoin Respondent from permitting the use of Section 1418.8 by all California skilled nursing and intermediate care facilities and from failing to survey as to the use of Section 1418.8 by all California skilled nursing and intermediate care facilities

6. Order that there be payment to petitioners of the costs and fees herein, including reasonable attorneys' fees, as the Court deems just;

7. And Grant such other and further relief as the Court deems just and proper.

Respectfully submitted,

_____
Morton P. Cohen,
Petitioners' Attorney

Dated:_____
San Francisco, CA.