IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA
FIRST APPELLATE DISTRICT
DIVISION FOUR

CALIFORNIA ADVOCATES FOR NURSING HOME REFORM, et al. Plaintiffs and Appellants, vs. KAREN SMITH, MD., MPH, as Director of the California Department of Public Health, Defendants and Appellants.	Case No. A147987 Alameda County Superior Court, Case No. RG13700100

ON APPEAL FROM THE JUDGMENT OF THE SUPERIOR COURT

COUNTY OF ALAMEDA

Hon. Evelio M. Grillo, Presiding

ANSWER TO AMICI CURIAE BRIEF OF CALIFORNIA MEDICAL ASSOCIATION, CALIFORNIA DENTAL ASSOCIATION, AND CALIFORNIA HOSPITAL ASSOCIATION

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Plaintiffs and Appellants, California Advocates for Nursing Home Reform, et al., answer the amicus brief of the California Medical Association, the California Hospital Association and the California Dental Association as follows:

I. *The Result of this Action Will Not Cause Delay or Deprivation Of Medical Treatment for Nursing Home Residents*

Amici claim that the result of this action is likely to be that nursing home residents will: (1) be refused admission to nursing homes ("Patients will have to be treated in *acute care* hospitals …"); Amicus Curiae Brief of California Medical Association [hereafter ACB/CMA], at 11 (emphasis in original); (2) be denied necessary care once in the nursing home, saying residents with *"treatable chronic conditions will deteriorate*" (*Id*. at 11 (emphasis in original)); and (3) require decisions by courts in order to find decisional incapacity ("[I]t Will Be Necessary for Courts To Decide for These Patients" (*Id.* at 17 (capitals in original)).

As to the first argument, similar alarmist claims have been made in similar litigation as to the legal rights of, unlike the physically frail, vulnerable and elderly residents of nursing homes, mentally ill individuals and prisoners, but no such results have occurred. *See, e.g.*, *Riese v. St. Mary's Hospital* (1987) 209 Cal. App. 3d 1303. Such processes as are sought in this case exist in both private and public hospitals which admit the mentally ill with the protections sought here. St. Mary's Hospital, wherein Eleanor Riese was hospitalized was and is a private hospital, and Amici have cited to no references that the result of such protections was that admission was or currently is, refused. Thus, were it not in a skilled nursing home for the elderly as to day to day treatment, a conservator or public guardian would today be necessary, with a concomitant court order of decisional incapacity and requirements of notice. The highly likely result of the lower court's order in this case is that doctors and nursing homes will adjust to the order here as they have historically. *See eg, Cobbs v. Grant* (1972) 8 Cal 3d 229 (as to informed consent);

Bartling v. Superior Court (1984) 163 Cal.App.3d 186 (as to ending life); *In re Qawi* (2004) 323 Cal 4th 1 (as to antipsychotic drugs).

As to the second argument, it was decided years ago, in *Matter of Conroy* (1985) 98 NJ 321[1]:

> [N]ursing homes generally are not faced with the need to make decisions about a patient's medical care with the same speed that is necessary in hospitals. Hospitals are called upon for urgent care, and treatment decisions in that context must be made quickly. Nursing homes, in contrast, care for individuals whose lives are slowly declining and for whom treatment issues arise more gradually and are foreseeable longer in advance.

Matter of Conroy at 376 - 377.

Assuming immediate care is necessary without informed consent, the laws of California permit such care in an emergency. For example, a conservator may

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[1] Non-California cases have often been cited as to factual findings particularly as to issues of competence. For example, the *Riese* case cited to New York and Massachusetts cases as to the ability of the mentally ill to be competent (*Riese* at 1315). See also *Bartling,* 163 Cal. App. 3d at 194*,* citing to an out-of-state case.

Matter of Conroy, although not a California case, has been cited many times by the California Supreme Court. For example, it was cited with approval nine times in *Thor v. Superior Court* (1993) 5 Cal 4th 725 and *Conservatorship of Wendland* (2001) 26 Cal 4th 519 cited it as to the requirement of clear and convincing evidence before a conservator could withdraw life supports for a conscious person. Citing to other out of state cases the Court said, in language appropriate here:

> While we place no great emphasis on the out-of-state cases, they nevertheless support the fundamental principles that underlie our conclusions*,* including the imposition of a high standard of proof.

26 Cal. 4th at 550.

permit some medical acts without consent from the conservatee or a court in the event of an emergency under Welfare and Institutions Code §5358.2:

> If a conservatee requires medical treatment and the conservator has not been specifically authorized by the court to require the conservatee to receive medical treatment, the conservator shall, after notice to the conservatee, obtain a court order for that medical treatment, *except in emergency cases in which the conservatee faces loss of life or serious bodily injury*.

Scott S. v. Superior Court (2014) 204 Cal. App. 4th 326, 337 (emphasis added). *See also* 9 Cal. Code Regs. §853: "Nothing in this article is intended to prohibit the physician from taking appropriate action in an emergency."

As to the third argument regarding the need to go to court for findings of decisional incapacity, there is no such need now as to either the mentally ill or prisoners. Instead, an administrative system exists wherein decisions may be rapidly rendered at the facility within 24 hours. This system exists in all counties within California. *See, e.g.*, Welf. & Inst. §5334.

Section 1418.8 already includes a requirement to go to Superior Court, but that burden is put on the elderly, ill, now determined incapacitated, and frail, patient, who without notice as to the treatment has to go to court. Or if the patient is deemed incapacitated and has no surrogate acceptable to the physician, or other representation, the patient must commence an action in a Superior Court, and immediately obtain a temporary restraining order in order to obtain fundamental constitutional rights as to due process and autonomy. If ever there were a reversal of legal rights and duties, this is it.

II. *The Superior Court's Order as to the Requirement of Notice Is Supported by California Law*

The essence of Amici's objections as to notice is that there is no constitutional need for "formalistic" notice and the statute is a "good solution" to the problem. ACB/CMA at 29. Amici then contend without evidence that the

notice required by the superior court would result in its excessive exercise: "Physicians know that many (if not most) of these patients, upon receiving the formalistic written notice the Superior Court claims to be constitutionally necessary will immediately disagree (if not completely reject) their physicians' assessments of health-care decision-making incapacity." ACB/CMA at 18. They fail to show how physicians "know" this, and that the assertion is accurate as to the ill and non-litigious elderly residents of nursing homes.

Amici argue that the statutory process was a good solution as to the problem of informed consent particularly assuming incapacity: "When the patient is incapacitated and unfriended." ACB/CMA at 31-41. In so arguing, Amici cite to no case law on point as to notice, and further they conclusively assume (like the Court in *Rains v. Belshe* (1995) 32 Cal. App. 4th 157) that the resident is decisionally incapable because the physician has so decided: "Section 1418.8 was an effective solution to the problem that arose when a physician realized his or her patient lacked capacity …" ACB/CMA at 31. Recognizing that nothing in 1418.8 requires any notice of any sort to the person about to lose a fundamental right of autonomy as well as liberty (see JA, 14 - 17 (Gloria A.,)) and the right to make property decisions and possibly lose life, Amici cite only to a different statute not involving, as here, treatment decisions by interdisciplinary teams. Prob. Code §4732.

Section 4732,[2] which is unrelated to Heath & Saf. Code §1418.8, requires none of the procedures involved in §1418.8, does not involve issues of surrogacy, nor that an interdisciplinary team will review the treatment recommendation, that the same physician will be part of the team that consents to or refuses the treatment, nor does it provide a standard to be used by the physician in determining incapacity, nor that the treatment may occur without consent by the resident or a surrogate, and that the opposing resident might go to court and obtain a temporary restraining order. Thus, Probate Code §4732, and its oral notice to the patient and the surrogate, is without application in this matter.

Perhaps as important is that Amici is both condoning and promoting a process which itself is violative of §1418.8. Amici state that physician determinations of incapacity are made at intake to the nursing facility. "…[P]hysician determinations of decision-making capacity are made soon at (sic) the outset of residency at the skilled nursing or intermediate care facility and, thereafter, are regularly reevaluated." ACB/CMA at 20. The rationale is: "a clinical assessment that a physician makes for purposes of diagnosis and treatment." ACB/CMA at 62. As a result, Amici communicate what does occur, and that is that any time a physician initially examines a resident at intake, the physician should as well and does decide on capacity and surrogacy. Even if subsequently complying with the statute, a physician has thus previously at intake,

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[2] Probate Code §4732 provides: "A primary physician who makes or is informed of a determination that a patient lacks or has recovered capacity, or that another condition exists affecting an individual health care instruction or the authority of an agent, conservator of the person, or surrogate, shall promptly record the determination in the patient's health care record and communicate the determination to the patient, if possible, and to *a person* then authorized to make health care decisions for the patient." (Emphasis added.)

as with Gloria A., formed an opinion as to the decisional (in)capacity of the resident which affects subsequent decisions, if any.

This is utterly violative of the law, and section 1418.8 itself, which requires the physician to apply the statutory criteria not at intake, but only after deciding that a medical intervention is involved which requires informed consent. *See* §1418.8 (a).

The result is that elderly persons often in pain, under sedatives and pain killers, and possibly suffering from delirium, disorientation and depression at finding themselves in an unfamiliar setting, are found incapable. Numerous declarations have been submitted by petitioners to the superior court that support this conclusion, despite Amici's characterization of them as "anecdotal." ACB/CMA at 52.[3]

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[3] Amici also claim "Petitioners misstate the evidence" as to the absence of attempts to have Gloria A's nephew become her surrogate. ACB/CMA at 20. This accusation is incorrect. Dr. McDaniel's declaration as to the nephew's involvement concerns *only* the period *after* Gloria A. had been found, by a psychiatrist, to *have* capacity as of September 5, 2014, and thus should have been making all her own medical decisions and those imposed by a surrogate. As Dr. McDaniel said in his declaration:

> *After Gloria A. was determined to have capacity* and wanted to live outside the facility, her nephew expressed concern to me that Gloria A. would not be able to care for herself living on her own and would likely fail to take her lactulose. Her nephew, who spent the most time with her *during the latter part of her stay* in the nursing facility and acted as her surrogate decision-maker *at that time*….

Declaration of Dr. McDaniel, JA 470 (emphasis added).

Further, physicians are only intermittently available to residents in that, after initial visits, 42 CFR §483.30(c) requires a physician visit only every 120 days since the resident need only be seen once every 60 days and every other visit can be delegated to a nurse practitioner or physician assistant. As was elucidated in *Matter of Conroy*, physicians in nursing homes are usually not the long-term family physicians with knowledge of the patient and the patient's history, but instead are assigned to the patient, and thus, meeting the patient for the first time upon entry to the home. As was said in *Conroy*:

> (P)hysicians play a much more limited role in nursing homes than in hospitals. The Subcommittee on Long-Term Care of the Senate Special Committee on Aging states that physicians visit their patients in nursing homes infrequently, and then for only brief periods of time. Senate Report on Aging, supra, Supporting Paper No. 3, Doctors in Nursing Homes: The Shunned Responsibility 323-24 (1975)…. Moreover, physicians caring for nursing home residents generally are not chosen by the residents and are not familiar with their personalities and preferences. Besdine, "Decisions to Withhold Treatment from Nursing Home Residents," 31 J.Am. Geriatrics Soc'y 602, 603 (1983).

Conroy at 375-376.

Additionally, Amici cite to no standards that are to be used by a physician at intake in determining the loss of this fundamental right of choice, resulting in significant opportunity for error. While Amici claim that the determination of decisional incapacity as to this fundamental right of choice is "regularly reevaluated," Amici point to nothing, whether statutory, regulatory, or customary, as to such reevaluations. Indeed, the declarations show otherwise: ombudsmen are often unable to get physicians to revise conclusions.

Amici make no claim that the notice required by section 1418.8 is constitutionally compliant with existing case law. Indeed, they cite, in ten pages of argument, to only two cases, *Rains* and *Conservatorship of Wendland,* neither one

of which spoke to notice requirements, under either due process or privacy. ACB/CMA at 31-41.

Amici's argument, as to notice, is essentially that anything more than having doctors inform residents orally that they have been found incapacitated will interfere with needed treatment. They assert that the superior court mistrusted doctors. Amici never suggest a recognition of the vulnerable nature of the residents in nursing homes, or the significant potential abuses or the residents' fundamental rights. As was stated in a congressional report concerning nursing homes in Los Angeles, after speaking to the vulnerable nature of nursing home residents:

> This report finds that there continue to be serious deficiencies in many of the nursing homes in Los Angeles County. A total of 382 of the 419 nursing homes (91%) in the county violated federal standards during recent state inspections. Moreover, 14 of the nursing homes had violations that caused actual harm to residents or worse.

Nursing Home Conditions in Los Angeles County: Many Homes Fail to Meet Federal Standards for Adequate Care, Prepared for Rep. Henry A. Waxman, Minority Staff, Special Investigations Division, Committee on Government Reform, U.S. House of Representatives, February 4, 2003. See also *Matter of Conroy*:

> (R)esidents of nursing homes are a particularly vulnerable population. Nursing-home residents are often quite elderly, with an average age of eighty-two nation-wide. Subcomm. on Long-Term Care of the Special Comm. on Aging, United States Senate Nursing Home Care in the United States: Failure in Public Policy, Introductory Report, S.Rep. No. 1420, 93d Cong., 2d Sess. 16 (1974) [hereinafter cited as Senate Report on Aging]. Most suffer from chronic or crippling disabilities and mental impairments, and need assistance in activities of daily living. *Id*. at 17.

Conroy at 375.

To add to this vulnerability is the fact of insufficient oversight for this population. For example, a 2012 report from the Office of Inspector General of the Department of Health and Human Services found as to the California Department of Public Health, Licensing and Certification Division, in its Summary of Findings:

> From 2006 through 2008, the Division did not always determine deficiency ratings, ensure the adequacy of correction plans, and verify nursing homes' correction of identified deficiencies in accordance with Federal requirements. For 3 nursing homes that we judgmentally selected, the Division:
> • understated the deficiency ratings for 23 of 178 deficiencies (13 percent), including 9 deficiencies that involved actual harm to resident health and safety;
> • did not ensure that 40 of 52 correction plans (77 percent) contained specific information addressing the 5 corrective action elements for the deficiencies identified; and
> • did not verify the nursing homes' correction of identified deficiencies by obtaining evidence of correction for 4 of 9 standard surveys (44 percent) before certifying substantial compliance with Federal participation requirements when followup surveys were not conducted.

Federal Survey Requirements Not Always Met for Three California Nursing Homes Participating in the Medicare and Medicaid, Department of Health and Human Services, Office of Inspector General Programs, Daniel R. Levinson, Inspector General, February 2012.

Further, Amici grant no recognition to the rights at stake, which have been held as follows:

> No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law. As well said by Judge Cooley, "The right to one's person may be said to be *a right of complete immunity: to be let alone." Cooley on Torts, 29.*

Union Pac. Ry. Co. v. Botsford (1891) 141 U.S. 250, 251.

As well, Amici say nothing of the classic cases involving due process and notice, such as *Mullane v. Central Hanover Bank & Trust Co.* (1950) 339 U.S. 306, or *Goldberg v. Kelly* (1970) 397 U.S. 254, which did not involve, as here, fundamental rights as to a person's control over his or her body, or liberty, but instead, in *Goldberg*, the privilege of welfare benefits. Nor did Amici consider that prisoners have constitutional rights as to notice even as to a mere transfer from a prison to a mental hospital for medical treatment. *Vitek v. Jones* (1980) 445 U.S. 480.

To have the physician who has made at least an initial medical decision to treat, then notify the patient of the finding of incapacity is to have an interested person inform an affected person regarding a right that the interested person does not want the affected person to exercise. As set forth above, Amici has said as much in its brief – that if the person were informed in writing, they might disagree with the finding of incapacity, and challenge it. ACB/CMA at 18.

Amici accuse Petitioners and the superior court of improper and unfounded beliefs as to physicians and do so without proof. For Amici, citing to *Rains*, Petitioners claim physicians are improperly determining incapacity for financial reasons. ACB/ CMA P. 57. No such claim is made here, nor was it made in *Rains*, nor did *Rains* cite to anything in the record saying otherwise. Petitioners' claim of lack of neutrality is the same as in *Goldberg* and *Washington v. Harper* (1990) 494 U.S. 210 – that persons involved in an incident have insufficient neutrality to be the judge of that incident.

Indeed, Amici's rationale as to why the treating physician should orally give the notices, rather than as required by the superior court, is, as set forth above, the fear that residents would disagree with the finding of incapacity, and thereafter

seek to exercise their constitutional rights. That very conclusion is a valid reason as to why the physician should not orally or otherwise give the notices.

The nursing home resident is in a highly vulnerable position being ill, fragile, displaced from home, often post-surgical, and usually elderly. That person is in a strange location in the nursing home. Further, the physician is generally assigned, and needs to visit the ill resident only on an intermittent basis. Lastly, the physician has made at least an initial medical decision to treat, and particularly has decided to treat with the treatments recommended for this resident, and thus is likely desirous of not wanting the resident to refuse, whether temporarily or permanently.

III. *Amici's Brief Evidences the Risk of Error in Capacity Decisions Made by Treating Physicians*

Amici have presented a process statement as to the current customary procedures used by physicians to determine capacity which itself is in violation of the statute. As set forth by Amici, as to "medical reality" (ACB/CMA at 19), "physician determinations of decision-making capacity are made soon at (sic) the outset of residency at the skilled nursing or intermediate care facility and, thereafter, are regularly reevaluated." ACB/CMA at 20. Thus, Amici have misstated the statutory requirements and instead applied customary nursing home procedures regarding intake information (see, eg, Declaration of Margaret Main, ¶6, JA 97). The specific statutory requirements have nothing to do with the outset of residency, but instead are dependent on particular treatments which require informed consent as is the informed consent direction mandated by *Cobbs v. Grant* (1972) 8 Cal 3d 229. The statute reads:

> If the attending physician and surgeon of a resident in a skilled nursing facility or intermediate care facility prescribes or orders a medical intervention that requires that informed consent be obtained prior to administration of the medical intervention, but is unable to

> obtain informed consent because the physician and surgeon determines that the resident lacks capacity to make decisions concerning his or her health care and that there is no person with legal authority to make those decisions on behalf of the resident, the physician and surgeon shall inform the skilled nursing facility or intermediate care facility.

Health & Saf. Code § 1418.8 (a).

The capacity and surrogacy decisions are coordinated with a particular recommended treatment which requires informed consent, and assume that the physician will examine the resident as to capacity when informed consent treatments are prescribed or ordered. The statutory requirement assumes a physician prescription or order which requires informed consent and not simply a decision made at the time of admission to the facility. Further, the statute then engages the interdisciplinary team, which includes the same physician, for purposes of review as to the recommended treatment, and consent thereto, substituting that body for, in the event of such findings, the consensual processes of conservators or public guardians for whom the statute was created as a reduced substitute in snfs and intermediate care facilities. The *Rains* court limited the statute, as to the IDT review and consent, mandating that the patient representative on the IDT make the treatment decision, and the medical staff on the IDT make the decision only in exigent circumstances when the patient representative is unavailable:

> [W]e deal with a statutory procedure by which the *equivalent of informed consent may be provided, by a patient representative* if practicable, and in exigent circumstances by health professionals…

Rains at 185-186 (emphasis added).

The practice, wherein a box is checked at admission, and remains with the resident unless changed, or merely continuation of the current practice prior to adherence to the statutorily mandated process, has the result that the physician has

formed an opinion as to capacity prior to making the statutorily mandated decision. This opinion is not dependent on the definition of capacity set forth in the statute. This is a routinized determination, made for all residents, including those, unlike in §1418.8, who have a known, available surrogate. Finally, this determination is made while the resident may be undergoing pain, depression at being placed in an unfamiliar nursing home, and the effects of medication and treatment.

Nothing in the statute requires the revisitation of the intake processes stated by Amici. Certainly neither Amici nor Respondent have pointed to any such requirement. Of equal importance is that at the stage Amici refers to, that of intake to the facility, and the "History" Intake Form, the considerations are merely as to all residents and the general and medical background of all of the residents, without consideration of involvement of an interdisciplinary team as a substitute for personal decisions by the patient, or the patient's legal surrogate.

The result is that whatever standards are used by the physician to determine decisional capacity do not require use of the standards found in §1418.8, but whatever are the self-imposed determinations of that physician. The further result is that the physician has formed and will continue to use those standards as to that patient. For example, Gloria A.'s physician was concerned with her depression, and applied a standard as to his concerns for her best interests, and for what he thought was "prudent" for her, including loss of her liberty. (See Declaration of Clayton McDaniel, MD, JA 470.) There was no consideration of a presumption of decisional capacity. These incapacity decisions were the opposite of, as to Gloria A., the capacity determinations of other physicians made at the time of her nursing home institutionalization, test scores, the opinion of lay people, and that of a psychiatrist, all of whom determined she had capacity. See Facts as to Gloria A., JA 14-17.

Although belittled by Amici as being merely "anecdotes"(ACB/CMA at 52) the evidence, in the form of sworn declarations by ombudsmen and others, instead evidences that significant error occurs, and while such changes are requested given that such problems as post surgical pain, pain medications, depression at nursing home placement, delirium, and others, may resolve, physicians are reluctant to change their initial determinations if made upon intake, as with the custom and procedure of physicians as presented by Amici. The whole purpose of obtaining informed consent is to get the patient to consent to what the physician wants to perform on the patient's body. And that is the basis of the fundamental constitutional and common law right to refuse. *See Thor v. Superior Court* (1993) 5 Cal 4th 725(common law fundamental right to refuse); *Bartling v. Superior Court* (1984) 163 Cal.App.3d 186, 194 ("The fact that Mr. Bartling periodically wavered from this posture because of severe depression or for any other reason does not justify the conclusion of Glendale Adventist and his treating physicians that his capacity to make such a decision was impaired to the point of legal incompetency. *See also Lane v. Candura* (Mass. 1978) 376 N.E.2d 1232, 1234, fn. 3") As in *Bartling* and *Lane*, courts find that medical conclusions as to incapacity often do not comport with legal conclusions as to incapacity.

With Gloria A., even with a reexamination as to capacity, rather than a determination that she lacked decisional capacity whether clearly and convincingly or even to a preponderance, the physician merely found it was "prudent" to conclude she lacked capacity. See Declaration of Clayton McDaniel, MD, JA 470. This although other physicians had concluded not that it was "prudent" to find she lacked capacity, but simply that she had capacity. Similarly, as to Mark H., the determination (as to competence, and not decisional capacity) was "not competent enough to make medical decisions." JA124 (emphasis added). Thus, and with no consideration of the statutory requirements, nor of how "competent" a patient must

be, Mark H. lost his fundamental right of autonomy based on the vague application of the phrase "not competent enough."

IV. *Section 1418.8 Constitutes Governmental Action*

Amici argue that §1418.8 is a non-governmental solution to a problem (ACB/CMA at 39). It requires little response to demonstrate that §1418.8 is a governmental solution. The fact that the statute is effectuated by non-governmental actors does not change this result. For example, laws that require landlords to have fire escapes to protect tenants (Cal. Code of Regs, title 24, Part 9) or that require certain packaging of foods or drugs (*see, eg*, Health and Saf. Code Division 104, Part 7) are carried out by private manufacturers and nonetheless constitute governmental actions. Indeed, all of the activities of the U.S. Food & Drug Administration (Federal Food, Drug and Cosmetics Act, 21 USC, Chap 9, sections 301 *et seq*) while eventually affecting private activity, nevertheless are governmental actions.

This case involves issues as to the constitutionality of a statute, and thus involves governmental action. Section 1418.8 permits nursing homes to take action that denies fundamental rights of autonomy, and that otherwise would be considered battery. *Cf. Cobbs v. Grant* (1972) 8 Cal 3d 229. In the absence of an emergency, there is no authority to nonconsensually treat a patient without this grant from the state. Were it not for §1418.8, in nursing homes, and absent an emergency, medical treatment would require either consent from the individual, from a power of attorney, from a legal surrogate such as a family member or from a court through a decision of the court itself, or a court appointed conservator or guardian.

V. *An Interdisciplinary Team Derives its Authority from the Parens Patriae Power of the State and Is Neither Selected Nor Accepted by the Nursing Home Resident*

Another point made by amici, in their argument as to notice, again has nothing to do with notice, but instead is that this matter does not involve the "'parens patriae' power of the State to protect incompetent persons." ACB/CMA at 40. According to Amici, the interdisciplinary team does not derive its power from the government, but acts because, as to the interdisciplinary team, "the patient either has selected or at least accepted [them] to be his or her caregivers." ACB/CMA at 41. According to Amici, the interdisciplinary team is far more like a voluntarily appointed surrogate than like a conservator. But this claim, made with no factual, statutory, nor legal support, is utterly unfounded. To begin with, the statutory introduction specifies that, because of considerations of cost, speed and supposedly inconsistent results, the use of the interdisciplinary team is a substitute for conservatorships and public guardianships, and not that it is a substitute for patient-chosen surrogacy. If a legal surrogate can be located, interdisciplinary teams lose their statutory power.

In addition, Amici point to nothing whatsoever in the record indicating that residents have "selected" or even accepted the interdisciplinary team. Not only are residents not involved in the selection of the team, or given an opportunity to reject the team, they are not even notified as to the identity or positions of the members of the team, virtually all being employed by the facility. Indeed, the most important member, the physician, is usually assigned at the outset to the patient (*See Conroy* at 376), who has no right to refuse that physician's assignment. As well, it must be remembered that the resident seldom chooses the facility itself, but instead is transferred by decisions made by hospital discharge planners, not by choice of the patient. As was found in *Conservatorship of Sanderson* (1980) 106

Cal. App. 3d 611, 619-620, in the context of loss of liberty, even where there is a judicial conservatorship:

> The potential for deprivation of liberty under probate conservatorship is illustrated by the facts of this case. Appellant had lived much of her life in Palo Alto and wished to obtain an apartment in Palo Alto. However, she was placed in a rest home in San Jose.

Amici also misinterpret *Conservatorship of Wendland*, in saying that an interdisciplinary team is "far more like a voluntarily appointed surrogate than like a conservator.'" ACB/CMA at 40. *Wendland*, after discussing personal decisions by competent individuals, and those of surrogates voluntarily selected by persons while competent, as well as laws permitting competent persons to give treatment instructions in the form of advance directives, then recognized that all these possibilities depended, unlike those involving conservators and by extension Interdisciplinary Teams, upon personal choice. 26 Cal. 4th at 534-535. *Wendland* then went on to distinguish these personal choices from those of the conservator, wherein the appointment is not based on choice or selection by the affected person:

> In contrast, decisions made by conservators typically derive their authority from a different basis--the parens patriae power of the state to protect incompetent persons. Unlike an agent or a surrogate for health care, who is voluntarily appointed by a competent person, a conservator is appointed by the court because the conservatee "has been adjudicated to lack the capacity to make health care decisions." (§ 2355, subd. (a).) In 1988, the court in Drabick, supra, 200 Cal.App.3d 185, confused these two distinct concepts--the voluntary act of a competent person and the state's parens patriae power--and on that questionable basis took to a novel conclusion the idea that a person's right to refuse treatment survives incompetence.

26 Cal. 4th at 536.

As with conservatorships and guardianships, for which §1418.8 is a statutorily designed substitute in nursing facilities, it is only by virtue of the State's creation of the §1418.8 statutory process with the finding of incapacity and the use

of the interdisciplinary team, that that team is given power to approve the recommendation of the physician and provide the treatment. Absent that statutory power, through parens patriae, the patient retains the fundamental right to refuse. The fact that the process is performed by private individuals does not change the conclusion that it is only by means of the governmental parens patriae power that residents of nursing homes may, absent an emergency, be so treated without their consent or that of those they have chosen, as with surrogates, whether it be through conservator, public guardian or interdisciplinary team.

The result is that Amici can point to nothing, and in fact point to nothing, to show that residents have "selected or at least accepted" interdisciplinary teams to be their caregivers. Nothing in the statute so requires, and nothing in the statute permits residents to reject any member of, nor the entirety of the team. Unlike surrogates, such teams are not chosen, and indeed the attending physician need not be chosen, by the resident affected.

VI. *The Decisions of the Superior Court as to Antipsychotic Drugs and Ending Life Should Be Affirmed*

Amici, in their Second Point, would have this Court reverse the lower court not based on the constitutional rights of Petitioners, but because the statute was "the best way to reconcile" conflicting "policy considerations." ACB/CMA at 42.

A. *Antipsychotic Drugs*

As to the antipsychotic drug decision of the superior court, Amici assert that the purpose of §1418.8 is to give interdisciplinary teams the power to "veto treatment" (ACB/CMA at 45) which has been consented to by incompetent patients. They contend "[t]hat is what Section 1418.8 provides." ACB/CMA at 45. But neither Amici nor Respondent presented any evidence whatsoever as to that, nor is there any in case law. Instead, as found by California (*Qawi* and *Riese v. St. Mary's Hospital* (1987) 209 Cal App 3d 1303), the Supreme Court in *Washington*

v. Harper (1990) 494 U.S. 210), and as with Gloria A., as well as many of the Petitioners' declarations, such drugs have significant side effects not desired by their recipients. Indeed, as to the elderly, and not mentioned by Amici, the drugs are not approved by the FDA as to "dementia" psychosis, and carry a black box warning of death as to use on the elderly. "Antipsychotic drugs are not approved for the treatment of dementia-related psychosis." *Information for Healthcare Professionals: Conventional Antipsychotics*, FDA ALERT [6/16/2008] (Food & Drug Administration Bulletin informing Healthcare Professionals as to dangers of both conventional and atypical antipsychotics.) They also carry a black box warning as to death: "Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death." JA 160, Exh. 6; JA 255.

Second, Amici claim that the result of the superior court order will be that "[S]uch drugs no longer can be prescribed by physicians for these patients." ACB/CMA at 47. Such alarmist assertions are unfounded, and indeed Amici provide no citation to any authority, nor to the superior court order itself saying the result will be preclusion of these drugs. The fact is that there has been no elimination of the drugs in mental hospitals, where the treatment is for such diseases as schizophrenia and not "dementia" psychosis through aging, or prisons *See Riese v. St. Mary's Hospital, supra; In re Qawi*, *supra*.

Third, Amici point to considerations of combative and self-destructive behavior as to which there may be a need for these drugs without consent by competent residents or their surrogates. ACB/CMA at 46. But Amici point to no case law whereby the constitutional rights of individuals are precluded in the event of such behavior. However, there is case law supporting the superior court's order. In the federal courts, and involving dangerous prisoners, the US Supreme Court has upheld the liberty interests of such prisoners to refuse antipsychotic drugs absent a determination, with notice and hearing, by an independent tribunal,

excluding the physician, as to the necessity of such drugs. *Washington v. Harper*, *supra*. The California Supreme Court has gone even further, and, in *Qawi*, has held that prisoners have a right to refuse absent either a determination by a court of decisional incapacity, or a determination by a court regarding dangerousness, even as to mentally disordered offenders:

> an MDO can be compelled to take antipsychotic medication in a nonemergency situation only if a court, at the time the MDO is committed or recommitted, or in a separate proceeding, makes one of two findings: (1) that the MDO is incompetent or incapable of making decisions about his medical treatment; or (2) that the MDO is dangerous within the meaning of Welfare and Institutions Code section 5300. As explained below, someone committed or recommitted as an MDO may not necessarily fit in either of these categories; such MDO's would have the right to refuse medication in nonemergency circumstances. The rights of MDO's to refuse medication can be further limited by State Department of Mental Health regulations necessary to provide security for inpatient facilities.

32 Cal.4th at 10.

Under §1418.8, the only authority for the nonconsensual use of antipsychotic drugs is as to those deemed incompetent, and so found by the physician who has prescribed the drugs. In fact, Amici have pointed to no evidence in the record of use to prevent violence. However, any such use does present the very conclusion Amici deny, which is that the drugs are being used as chemical restraints, and thus support the superior court's order, requiring, for non-consensual, non-emergency use, in nursing homes, judicial determinations by administrative tribunals of decisional incapacity. In a recent study performed by the federal Government Accounting Office, it was found that not violence, but patient agitation, delusions, and low staffing levels were involved in the use of antipsychotic drugs in nursing homes:

> Experts and research identified patient agitation or delusions, as well as certain setting-specific characteristics, as factors contributing to the prescribing of antipsychotics to older adults. For example, experts GAO spoke with noted that antipsychotic drugs are often initiated in hospital settings and carried over when older adults are admitted to a nursing home. In addition, experts and research have reported that nursing home staff levels, particularly low staff levels, lead to higher antipsychotic drug use.

Antipsychotic Drug Use, Report to Congressional Requesters, GAO-15-211 (January 2015), United States Government Accountability Office, Highlights Page.

The combination of these federal findings together with the fact that antipsychotic drugs carry a warning of death for elderly users makes them immensely dangerous as well as subject to significant misuse in nursing homes, even more than for the mentally ill, a consideration never mentioned by Amici.

B. *End-of-life Decisions*

Amici misstate the holding of the superior court by saying that the result would require full treatment if the patient insists on it. ACB/CMA at 49. Amici state that analysis of the issue solely in terms of informed consent may be misleading, and quote from an article that the law should "distinguish those situations in which an elderly person's decisions should be implemented and those in which paternalistic intervention is justified." ACB/CMA at 49-50. This, they claim, is particularly applicable in ending the lives of the elderly. ACB/CMA at 49-50. Amici assert that elderly persons, if found incompetent by their physicians, are entitled to fewer constitutional and common law rights than younger persons. In other words, doctors may decide who is competent, and then decide, paternalistically, who shall live and who shall die

VII. *Determinations of Incapacity under 1418.8 Require a Legal Adjudication of Decisional Incompetence as to the Particular Medical Treatment*

Amici argue that this statute does not concern legal competence, but only a determination of capacity, which Amici claim may be decided by a physician. ACB/CMA at 61-67. And, without case citation, Amici claim that capacity is merely "a clinical assessment that a physician makes for purposes of diagnosis and treatment" (ACB/CMA at 62) and that the Legislature has given physicians the power to make medical decisions as to capacity whereas competence decisions are legal. However, that is not the law.

Courts have recognized that medical treatment decisional capacity concerns sufficient ability to act competently when affected by such diseases as mental illness, or mental or physical deterioration, and the presumption is that adults have that capacity and therefore competence, unless proven otherwise. *Qawi* at 23-24; *Riese* at 1320-1324.

An application of this conclusion is found in the area of capacity to decide as to treatment with antipsychotic drugs. In *Qawi*, the Supreme Court held, citing to *Riese v. St. Mary's Hospital*, 209 Cal. App. 3d at 1321:

> The presumption that LPS patients are competent to refuse antipsychotic medication unless proven otherwise is based on a recognition that "mental illness 'often strikes only limited areas of functioning, leaving other areas unimpaired, and consequently … many mentally ill persons retain the *capacity to function in a competent manner*.'"

Qawi at 23-24 (emphasis added).

In *Riese*, the court spoke to capacity to consent, and to the resultant competence of the individual. In reaching its holding, the court discussed competence and capacity to decide, citing to a similar New York statute, saying:

> The act accepts the proposition that, as stated by the highest court of New York, mental illness "often strikes only limited areas of functioning, leaving other areas unimpaired, and consequently . . . many mentally ill persons retain the *capacity to function in a competent manner*." (Rivers v. Katz, supra, 495 N.E.2d at p. 342;

> Rogers v. Okin, supra, 478 F.Supp. at p. 1361; Davis v. Hubbard, supra, 506 F.Supp. 915, 927 ["roughly 85% of the patients (of a state mental hospital) are capable of rationally deciding whether to consent to (use of psychotropic drugs)."]; Brooks, The Constitutional Right to Refuse Antipsychotic Medications (1980) 8 Bull. of Am.Acad.Psychiatry & L.Bull. 179, 191.)

Riese at 1322 (emphasis added).

The result is that the determination as to whether an individual might lose the fundamental right to refuse requires deciding whether the individual has the capacity to decide and is therefore competent. The *Riese* court's statement as to the processes required for the mentally ill regarding capacity to decide and therefore maintain competence, as to antipsychotics is as follows:

> [T]he task for the court is simply to determine whether a patient refusing medication is *competent to do so* despite his or her mental illness. The determination of *this capacity* "is uniquely a judicial, not a medical function." *Rivers v. Katz*, *supra*, 495 N.E.2d at p. 343.

Riese at 1321 (emphasis added).

Amici would have a fundamental constitutional right lost through a "clinical assessment" made by a physician at intake to a nursing facility. But this is not the law. *Qawi* distinctly held:

> Competence is not a clinical, medical, or psychiatric concept. It does not derive from our understanding of health, sickness, treatment, or persons as patients. Rather, it relates to the world of law, to society's interest in deciding whether an individual should have certain rights (and obligations) relating to person, property and relationships. . . .

Qawi at 17.

The statute that resulted from the holding in *Riese* explicitly reflects that court's holding, and is similar to §1418.8 in that it too uses the term 'capacity' to determine whether the individual retains or loses the right to refuse. *See* Welf. & Inst. Code §5332 (b) ("…a determination of that person's incapacity to refuse the treatment…").

In determining whether medical patients have or lack decisional capacity as to a particular treatment, the courts look to the competence of the individual as to that ability. This is not limited to mental illness or antipsychotic drugs, but is applicable as to any effect, whether mental or physical, whenever issues of decisional capacity and resultant competence arise as to medical treatment. Thus, in *Bartling v. Superior Court* (1984) 163 Cal.App.3d 186, a case involving decisional capacity and competence as to the choice of discontinuing life support systems, the hospital physicians had decided that the individual lacked capacity, because he was at times inconsistent in his wishes to end life support. The Court of Appeal opined that that was not sufficient as to the required legal incompetence, holding:

> The fact that Mr. Bartling periodically wavered from this posture because of severe depression or for any other reason does not justify the conclusion of Glendale Adventist and his treating physicians that *his capacity to make such a decision was impaired to the point of legal incompetency*. (See Lane v. Candura, supra, 376 N.E.2d 1232, 1234, fn. 3.)

163 Cal. App. 3d at 194 (emphasis added).

In rejecting what Amici would have this court hold, that a physician's determination of decisional incapacity as to a condition, and therefore incompetence as to that condition, would suffice, the *Riese* court went on to say that this was not a scientific determination. The court held:

> The determination by a physician that an individual is mentally incompetent to refuse drug treatment cannot be exempted from judicial evaluation on the ground that the medical determination rests upon an unimpeachable scientific foundation. "[Because] of the imprecision of the criteria and difficulty inherent in any attempt to compass the human mind" (People v. Burnett, supra, 188 Cal.App.3d 1314, 1329, citing Gould, The Mismeasure of Man (1981)), determinations of mental competence simply cannot achieve scientific certainty.

Riese at 41-42.

To conclude that, as Amici claim, capacity is merely "a clinical assessment that a physician makes for purposes of diagnosis and treatment" (ACB/CMA at 62) and that the legislature has given physicians the power to make medical decisions as to capacity whereas competence decisions are legal, is not a conclusion found in §1418.8 and would, if so found, be a substantial departure from existing law. Given that such a conclusion would involve a deprivation of a fundamental constitutional right, it would first require that such "clinical assessments" have an objective, scientific base as with a diagnosis of a disease, which, as stated above is not the case.

Second, it would require an explicit statement in the statute that capacity as used therein is completely different from its use by courts and in statutes elsewhere (*cf*. *Riese, Qawi, Bartling*, Welf. & Inst. Code §5332). And third, it would require a compelling reason why, based on a clinical assessment, residents of nursing homes are to be denied fundamental rights of autonomy foundational to all medical treatment that competent persons have a right to refuse whether in physicians' offices or surgery (*Cobbs v. Grant* (1972) 8 Cal 3d 229), prisons (*Thor v. Superior Court*, *supra*) or even in mental hospitals (*Riese*). That such occurs in a nursing home where treatment is the purpose would not suffice as treatment is the purpose in all of the above settings.

These conclusions as argued by Amici, cannot be drawn, and therefore determinations of incapacity under §1418.8 require a legal adjudication of decisional incompetence as to the particular medical treatment.

CONCLUSION

The court should affirm the Judgment of the Superior Court in part, and reverse it in part, as requested in Appellants' Opening Brief.

Dated: September 14, 2017

Respectfully submitted,
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CERTIFICATE OF WORD COUNT

(Cal. Rules of Court, Rule 8.204(c))

The text of the foregoing brief consists of 7,827 words as counted by the Corel WordPerfect X8 word-processing program used to generate the brief.

Dated: September 15, 2017

/s/ Amitai Schwartz
Amitai Schwartz
Attorney for Petitioners and Appellants

PROOF OF SERVICE BY MAIL

Re: California Advocates for Nursing Home Reform v. Smith
California Court of Appeal, First Appellate District
Case No. A147987

I, Amitai Schwartz, declare that I am over 18 years of age, and not a party to the within cause; my business address is 2000 Powell Street, Suite 1286, Emeryville, CA 94608. I served a true copy of the

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on the following, by placing a copy in an envelope addressed to the party listed below, which envelope was then sealed by me and deposited in United States Mail, postage prepaid at Emeryville, California, on September 15, 2017.

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1225 Fallon Street
Oakland, CA 94612

I declare under penalty of perjury that the foregoing is true and correct.

Executed on September 15, 2017

/s/ Amitai Schwartz
Amitai Schwartz

STATE OF CALIFORNIA
Court of Appeal, First Appellate District

PROOF OF SERVICE

(Court of Appeal)

Case Name: **California Advocates For Nursing Home Reform(CANHR) v. Chapman**
Court of Appeal Case Number: **A147987**
Superior Court Case Number: **RG13700100**

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/s/Amitai Schwartz

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