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

COMBINED RESPONDENTS' AND CROSS APPELLANTS' OPENING BRIEF

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CERTIFICATE OF INTERESTED ENTITIES OR PERSONS

There are no interested entities or persons to list in this certificate. See Cal. Rules of Court, Rule 8.208(e)(3).

Dated: January 17, 2017

Respectfully submitted,

/s/ Morton P. Cohen
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STATEMENT OF THE CASE

I. *Nature of the Action, Relief Sought, and Orders of the Superior Court*

This is an appeal from a judgment granting, in part, and denying, in part, a petition for a writ of mandate. JA 152. Defendants appealed and plaintiffs cross appealed. JA 864-865, 867.

II. *Finality and Appealability of the Orders*

Judgment was entered on January 27, 2016. JA 852. Notice of entry of judgment was served on February 2, 2016. JA 857-863.

Defendants filed a timely notice of appeal on March 24, 2016, within 60 days of notice of entry of Judgment. Cal. Rules of Court, Rule 8.104 (a)(1)(B). Plaintiffs filed a timely notice of cross-appeal on March 25, 2016. JA 867, 893.

The judgment is appealable pursuant to Code Civ. Proc. §904.1(a)(1).

III. *Introduction*

All competent Californians, including prisoners and the mentally ill, have a fundamental right to refuse medical treatment. *Thor v. Superior Court* (1993) 5 Cal. 4th 725, 731. That right may be lost if a patient is adjudicated legally incompetent in a conservatorship proceeding (*see Conservatorship of Wendland* (2001) 26 Cal.4th 519) or a court ordered treatment under Probate Code §§ 3200 *et seq.* (*see also In re Qawi* (2004) 32 Cal. 4th 1). The determination may also be transferred to a legal surrogate such as a family member who does not dispute the patient's legal incompetence. *Barber v. Superior Court* (1983) 147 Cal.App.3d 1006.

Health & Safety Code §1418.8 (JA106-107) deprives elderly, infirm residents of skilled nursing facilities (SNFS) of that fundamental right, without legal adjudication or a surrogate decision by permitting a physician to decide the treatment, the patient's incompetence to refuse treatment, and the absence of a

legal surrogate. The physician may then commence treatment after review by a team which includes that same physician. §1418.8.

Section 1418.8 requires no prior or subsequent notice to the affected patient of the physician's decisions, grants no prior opportunity for opposition to any of the three decisions, and provides no advocate for the elderly patient. Section 1418.8 is used to impose or withdraw treatment on frail, infirm, elderly nursing home residents with virtually no privacy or due process protections, including notice or opportunity to oppose. JA106-107.

In contrast, the United States Supreme Court has held that the mere recommendation of transfer of a prisoner to a mental hospital for medical treatment, although solely a medical decision and not one as to fundamental autonomy and privacy rights, implicates due process rights of notice, opportunity for a prior meaningful hearing, an advocate for the prisoner-patient, and a neutral decisionmaker (*Vitek v. Jones* (1980) 445 U.S. 480, 496-497), which cannot include the physician.

Adding to the limitations on the ill, elderly person, as found by the superior court, and also lost resulting from a statutory finding of incapacity, are both liberty and property. JA730. "Incompetent" residents such as Appellant Gloria A. (discussed below) are prohibited from leaving a facility absent an order from the physician who found her incompetent. She is also prohibited from controlling her own finances. As the superior court recognized, life may be lost due to §1418.8 decisions as the treatments for which the statute is currently used include discontinuing treatment, which may result in death. JA737-748. This is the case although the legislative findings behind §1418.8 state that its statutory purpose is limited to "day to day medical treatment decisions [which] must be made on an ongoing basis." Stats. 1992, Chap. 1303, §1. The treatments covered by the statute may also include other highly intrusive actions such as mind-altering drugs and physical restraints.

The deciding physician under §1418.8 is usually one assigned to and not chosen by the patient (*see In re Conroy* (1985) 98 N.J. 321) and also is often the medical director of the SNF (see Declaration of Carl Steinberg, M.D. (JA552-561)), making the physician a staff member of the nursing home responsible for many of the patients in the SNF. Having decided on the need for treatment before making the incompetence and surrogacy decisions, the physician lacks neutrality.

Another United States Supreme Court opinion has held that prisoner-patients are entitled to a neutral decisionmaker before nonconsensual administration of treatment with antipsychotic drugs. *Washington v. Harper* (1990) 494 U.S. 210.

Under §1418.8, a review of the treatment decision occurs before its administration, but it is the same physician, together with a nurse, other nursing home staff, and possibly but not necessarily a patient representative (both staff and representative selected, if at all, by the first two or by the nursing home), who review the treatment previously decided on by the now reviewing physician. The result is the denial of the fundamental right to refuse treatment based upon a medical determination of legal incapacity and legal surrogacy made by the same physician who has recommended and then reviewed, the treatment.

The elderly, infirm, and "incompetent" patient's only recourse, under the statute, without any notice or advocate as to anything, is somehow to learn about the decisions, and immediately, from the nursing home obtain and retain counsel or act pro per and, immediately commence a superior court action and obtain a temporary restraining order, with the burden on the infirm and now deemed incompetent patient to rapidly reverse all the medical and legal determinations, before the treatment starts.

IV. *Summary of Significant Facts*

A. *Statutory Framework*

As a result of an earlier law suit brought by Petitioner California Advocates for Nursing Home Reform (CANHR), then known as 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 Title 22 of the California Code of Regulations giving a minimal informed consent process to such individuals. (New section filed 5-27-92; operative 5-27-92 (Register 92, No. 22.)) What was absent from the regulations was a process for decisionmaking for persons who might lack both capacity and a surrogate.

Health & Safety Code §1418.8 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).[1] 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.

The statute does not require any 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. 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."

Other than to state that the legislative intent concerns treatments requiring informed consent and "day to day medical treatment decisions" no definition of the types of treatments is present in the legislative findings or statute itself.

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[1] A copy of Section 1418.8 is attached to this Brief as an appendix.

Stats 1992 ch 1303 provides, in part, as to legislative findings:

SECTION 1. The Legislature finds and declares as follows:

(a) . . . .

(b) The current system is not adequate to deal with the legal, ethical, and practical issues that are involved in making health care decisions for incapacitated skilled nursing facility or intermediate care facility residents who lack surrogate decisionmakers. Existing Probate Code procedures, including public conservatorship, are inconsistently interpreted and applied, cumbersome, and sometimes unavailable for use in situations in which day-to-day medical treatment decisions must be made on an on-going basis.

(c) . . . .

Section 1418.8 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 the decision, the physician is to inform the facility.

In that event, there must 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 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. Once the resident has been found incompetent, neither the desires nor the interview is determinative, since there is no longer a personal right of refusal. Nothing in the statute requires that the resident be told that he or she has been found incapacitated, nor that the decision is subject to review.

The IDT is made up of the physician who first decided on the treatment, incompetence and lack of a surrogate, a nurse with responsibility for the resident,

other appropriate staff and, if practicable, a patient representative. §1418.8(e). Most of these team members have institutional interests regarding care decisions, particularly where the attending physician is also the institutional medical director.

The statute specifies that nothing affects the resident's right to seek judicial review §1418.8(j), but nothing in the statute requires that the resident be informed of the right to seek review or to be informed of anything else.

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

B. *Background of this Case*

In 2012, the Department of Public Health issued an Antipsychotic Drug Survey Tool (JA288-300)) to its inspecting surveyors concerning the use of highly intrusive antipsychotic drugs in SNF's. It was directed to the requirements of informed consent. It included §1418.8 in the process of determining consent to the use of such drugs, in that such drugs are highly intrusive for the elderly, even more so than for prisoners and the mentally ill. JA288-300.

The case was filed in 2013. It challenges §1418.8 on its face and as applied, alleging eight causes of action:

1. The absence of prior notice and the opportunity for a meaningful hearing;

2. The absence of representation for the ill, elderly resident at the incompetence and surrogate determinations;

3. The requirement of an adjudication of incompetence;

4. The need for a neutral person or body to decide all issues of incapacity, surrogacy and treatment.

5. The need for neutrals to review and give consent to the treatment;

6. The need for and absence of enforcement as to the statutory requirement of a patient representative at the review and that that patient representative consent to the treatment;

7. The need for full due process rights as to the applied use of the statute for antipsychotic drugs; and,

8. The need for full due process rights as to the applied use of the statute to withdraw treatment and cause death.

In 2015, the superior court issued its order granting, in part, and denying, in part, a writ of mandate (JA705-748), and subsequently entered Judgment. JA854-855. The superior court held that adequate written notice is required: (1) After a treating physician prescribes or orders a medical intervention requiring informed consent; (2) after a treating physician has determined that the resident lacks capacity; and, (3) after a treating physician has determined that there is no person with legal authority to act on behalf of the resident. Additionally, the court required notice that an interdisciplinary team including that same treating physician and others will review all of that physician's three determinations to determine if the treatment may occur, and notice to the patient that further prescribed treatment will be overseen by the team unless or until a legal surrogate is identified or the team, the physician or a court determines that the resident has or has regained decisional capacity. Lastly, the court required notice that the resident may challenge the three determinations in a judicial proceeding.

The superior court order requires notice, not prior to, but after the fact of the physician's determinations as to the need for the treatment, decisional incapacity, and absence of surrogate. Notice is to be given before the review by the reviewing team, but that team includes the physician who has previously made the three determinations. The superior court also permitted the interdisciplinary team (which includes the physician) and a court to decide that the "resident has, or has regained capacity…" Judgment, I (A) (3); JA852. Further, the court, after making its

determination as to notice, made no determination as to denial of the opportunity for meaningful opposition to the decisions of either the physician or the committee. The superior court denied the request for an advocate as to the three determinations as well as the claim that the physician was not a neutral decisionmaker, either in the original decisions or as to the review of the physician's own determinations.

The superior court further held that the use of the statute is prohibited for the administration of antipsychotic drugs absent a determination under Probate Code §3200. And the court prohibited the use of the statute to make end of life decisions regarding the withholding or withdrawal of life-sustaining treatment for residents, except to the extent consistent with the resident's individual health care instructions, if any, and other wishes, to the extent known, with two provisos: one, that physicians could decline to comply with instructions or decisions requiring medically ineffective health care or health care contrary to generally accepted standards, pursuant to Probate Code §§ 4735 and 4636, and, two, that the statute can be used to initiate hospice care.

As to the need for adjudication of incapacity, the absence of neutrality both at the determination and review stages, and the absence of an advocate at the determination and review stages, the court found itself bound by the decision in *Rains*, and therefore denied relief on those issues.

Both parties appealed.

C. *Rains V. Belshe*

Rains v. Belshe (1995) 32 Cal.App.4th 157 held §1418.8 facially constitutional. The Court of Appeal held that capacity determinations are purely medical decisions and there was no need for an adjudication. The court never reached the notice issues. The court interpreted the statute to apply only to "relatively nonintrusive and routine" treatment, and that for such decisions as surgery, the Probate Code requirements of a judicial determination of incapacity

and the need for the treatment were must be met. 32 Cal.App.4th at 186. The court then found, as to procedural due process, that the absence of neutrality by the treating physician as to the determinations of incompetence and absence of a surrogate did not deny due process because the patient had the opportunity to start a court proceeding and obtain a temporary restraining order. As to the right of privacy, the court found it was not violated since, in a nursing home, the right of privacy including that of medical treatment, was negated based on social norms as to low expectations of privacy in nursing homes. The question of an advocate for the patient as to any of the decisions including incompetence and a surrogate was not raised in *Rains.* Further, since the case was a facial challenge, the use of the statute to discontinue life support systems or administer antipsychotic drugs was neither raised nor decided.

Since *Rains* was decided, the California Supreme Court has held that competence is not a medical matter. It is a legal matter. *In re Qawi* (2004) 32 Cal. 4th 1. In 2012 the California Court of Appeal, in *K.G. v. Meredith* (2012) 204 Cal.App.4th 164, followed the holding in *Qawi* that competence is a legal matter and a judicial finding of incompetence is required by the constitutional right to privacy.

D. *The Superior Court Record*

1. *Gloria A*.

During the pendency of this case in the superior court, petitioner Gloria A. died. Her medical chart (JA 134-154) showed that: on December 22, 2012, upon entry to the nursing home, her assigned treating physician checked a box on a form, finding she lacked capacity. JA 348. This finding continued for nine months, until September 2013 although, only 20 days after the December finding, on January 11, 2013, she was examined by another physician who found: "*This resident has the capacity to understand and make decisions*." JA 390 (emphasis added). During her stay, she took a capacity exam and answered 13 of the 15

questions correctly and was determined by one of the Department of Public Health's examiners to have capacity. JA091, ¶12. As a result of the physician's findings, the IDT assumed control over all treatment, financial and liberty decisions for her (JA 139).

On May 9, 2013, the treating physician who had first found Gloria A. incompetent, again examined her for capacity as a result of her request for discharge and stated in the Progress Notes "pt. believes yr is 2000, most answers other questions, ok. Still concern re *ability to make decisions in her best interest* (emphasis added)…rec psych eval. I don't believe pt's thought is organized enough to d/c to self." JA380 The physician continued the incapacity finding. JA 380. Finally, on September 5, 2013, four months after requested and nine months after admission, she was seen by a psychiatrist. A note from the psychiatrist simply stated: "Patient seen and evaluated. Patient has capacity to make decision about her finances, accommodation, medical issues etc." JA154.

Throughout, a nephew continued to visit Gloria A, and speak with the physician, but no attempt was made to have her nephew become her surrogate. JA472. In addition to losing her right to make treatment decisions, and to control her finances, she lost her liberty to come and go from the facility. JA 090. Gloria A. was denied her liberty to leave the nursing home when she sought to go on a picnic with the family of another resident. She was threatened with police action should she try, discovering then, for the first time that her doctor had determined her to be incompetent and had ordered that she could not leave the facility. JA092-093. Gloria A. received no notice she had been found incompetent until she tried to leave the facility. Decl. Gloria A. (JA721).

As to Gloria A.'s facility policy regarding the liberty of all residents deemed incompetent, the policy stated "It is facility policy to not allow a resident to go out on pass if the resident has been deemed incapable by a doctor." (JA399).

At no time did any Interdisciplinary Team (IDT) consider Gloria A's capacity, nor did facility policy permit such consideration. Determinations of capacity are the province of the physician. This is the same as other facilities: if nurses believe patients have regained capacity, they must seek a change from a physician. (JA96-102)(Declaration of Margaret Main).

On January 12, 2013, Gloria A. was ordered to take Seroquel, an antipsychotic drug and did take Seroquel, carrying a black box warning of death (JA160-161) for "psychosis amb aggression." JA396, 473:

> 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.

JA66 (¶ 12).

As to her finances, the facility administrator wrote to creditors that they "bill our facility" and that "The IDT team is responsibility [sic] for the care of Gloria A…" JA139. They effectively took over her money.

Doubt was resolved in favor of finding incapacity. For example Gloria A's physician stated in his declaration that although he had doubts as to her incapacity, "it was prudent" to find she lacked capacity. JA473, ¶ 9.

What happened to Gloria A. is not unusual. Studies as to determinations of incapacity by physicians regarding persons with mild Alzheimer's disease have found virtually a coin-toss as to whether persons were competent or incompetent. In *Consistency of Physician Judgments of Capacity to Consent in Mild Alzheimer's Disease*, Journal of the American Geriatrics Society (2000) 48/8:911-1853-457 as to determinations of incompetence by physicians "only 56% judgment agreement for the mild AD patients." In an article concerning the determination of capacity of those with mild to moderate dementia (which estimated decisional incapacity to be only 9.4% when first evaluated, and only 26.4% when re-evaluated after nine months), the authors stated:

> Evaluating decisional capacity can be challenging, especially among older adults with mild-to-moderate dementia. Even within-study samples, rates of decisional incapacity in demented patients vary widely depending on the clinician (from 0% to 90%) and the legal standard (from 0% to 67%) used. *Interrater agreement for capacity is no better than chance (56%),* possibly because physicians focus on different cognitive tasks to assess capacity.

Neuropsychological Predictors of Decision-Making Capacity over 9 Months in Mild-to-Moderate Dementia, Moye, Karel, Gurrera, Azar, J Gen Intrern Med, Jan 2006, 21(1) 78-83 (Emphasis added).

The declarations submitted by petitioners below, some of which were cited by the superior court below, abound with similar instances of error. For example, Geneva Carroll, an ombudsman in Placer County declared:

> 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.

JA 68-79.[2]

Margaret Main, a Licensed Clinical Social Worker, who for ten years has been a Social work/social service consultant in skilled nursing homes, and whose duties include reviewing charts for statements of capacity, appropriateness of healthcare decision makers signing consents, consistency of information and provision of medically related social services declared that:

> In my doing consulting work in these facilities, determinations of resident capacity for medical decisions are theoretically made within the first three days.

JA98. Of particular importance, she said:

> I have never seen policies and procedures or any written guidelines for determining capacity.

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[2] An ombudsman is a government official employed by the State to receive and investigate complaints. 42 U.S.C. §3001.

Id. As to liberty, Ms. Main submitted a second declaration stating:

> Most residents who are determined incapacitated are precluded from leaving the facility by physicians' orders absent accompaniment by an approved individual, which means they cannot go shopping, or take a walk, or go to church, unless meeting the physician's constraints. Further, as elderly and infirm people, most do not complain about this limitation on their liberty, but simply accept it.

JA 346. See also, declaration of Cheryl Simcox, an Ombudsman in Sacramento County, as to determinations of incapacity being made while patient is "in a drugged state from pain killers, or other drugs that sedate the individual, and as well they are distraught at being in a nursing home, and perhaps still in surgical pain, or even angry at their situation." JA 80-84. She went on to say that "in my experience, the intake determination remains with the person and they will thereafter retain an incapacitated status as to their decisional abilities."

> 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.

JA82. Ms. Simcox also declared:

> The facility often attempts to get me to agree to the decisions of the physician or of the IDT, but I won't, and I can't. The result is that there is no patient representative.

JA83.

> Another concern, What happens is that, if the doctor says the person lacks capacity, and there is no surrogate, no one signs for the individual, but the POLST form is filled out, signed by the doctor, and possibly by the IDT, and becomes an order affecting life and death.

JA84.[3]

2. *Mark H.*

Mark H. also died during the preparation of this case as a result of transfer to hospice consented to by an IDT resulting from a Physician's Order for Life Sustaining Treatment (POLST) created and signed by the IDT and not Mark H. or a surrogate. He was found in July 2012, while sedated with antipsychotic drugs, by the "Epple Committee" (for the Legislator introducing §1418.8) "*not competent enough* to make medical decisions." JA124 (emphasis added). There is no evidence that Mark H. was given notice by the SNF of his alleged incapacity, nor a representative or other opportunity to oppose this determination. Three months earlier in April 2012, his chart stated that: "Patient/representative has Capacity…to understand and sign admission contract…or make healthcare decisions…" JA19. On February 7, 2013, a progress note stated: "Able to make some basic needs known but he is very particular about when he talks and who he talks to." JA122. On February 13, 2013, a note said: "Verbally responsive with hospice cna." JA122.

Nevertheless, the Epple Committee and the physician created a Physician's Order for Life Sustaining Treatment (POLST) for him saying that life sustaining treatment was to be given (JA 116), and then, in December 2012, that same Epple Committee changed the form to deny life sustaining treatment. JA117. As a result, in reliance on §1418.8, Mark H. was transferred to a hospice and died through an order of "comfort care only," by the Eppel Committee. JA117. He died on February 14, 2013. JA118.

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[3] In fact what usually occurs is that incapacity is decided when the patient is first admitted to the facility, when they are likely only days removed from a serious medical crisis, and not revisited, even if the patient recovers as many do. See Declarations of Ombudsmen Patsy Pence, Geneva Carroll, Cheryl Wilcox, and Consultant Peggy Main).

Other nursing homes as well use Section 1418.8 to determine Do Not Resuscitate (DNR) orders and create POLSTS. See Decls. of Cheryl Simcox, Margaret Main, resident parent and resident council president Jane Doe. JA80-84, 96-102, 344, 346.

As to antipsychotic drugs, approved by Mark H's IDT, on September 1, 2012, psychiatrist Kulsant Singh, stated in a note that Mark H. was "very sedated" on Remeron which was to be discontinued and "d/c Seroquel for same reason." JA129-130.

Nevertheless, Mark H. was administered these antipsychotic drugs, particularly Seroquel, until his transfer of care to a hospice, and his subsequent death. JA129. Neither he nor any representative consented. Subsequently, he was put in physical restraints which tied his arms to the sides of his bed, spread-eagled. JA130. Neither he nor any representative consented.

There is ample evidence of failure to follow, and indeed staff creation and revisions of patient legal documents as to end of life instructions and wishes. The most egregious undoubtedly, as contained in the declaration of ombudsman Geneva Carroll (JA 68-79) and referred to in the superior court's order was that of Mark "A." [sic "H."] "Mark A.s' POLST was changed from full code to comfort care only meaning Mark A. would receive no life sustaining treatment although he would receive nutrition…Mark A. passed away at the facility while in the care of hospice….". JA745.

The superior court recognized several examples of the misuse of the POLST, which may result in the withdrawal or withholding of life support systems. It cited to the examples of Jane Doe, Geneva Carroll and Mark H., Cheryl Simcox and, Margaret Main. JA744-745. In the instance of Jane Doe, not only was a POLST placed in her daughter's chart without permission and without a patient signature, "[T]his practice occurs with many residents of the facilities where a POLST instruction is placed in a patient's chart without any patient or surrogate signature."

JA744-745. Social Worker Margaret Main described a case where the patient wished not to have life sustaining treatment, "but the primary physician determined that the patient lacked capacity and changed the POLST to CPR and full code." JA745.

As to forms of treatment in nursing homes, many often thought of as routine and even straightforward in fact have significant risk. For example, in its amicus brief in the superior court, the California Association of Health Facilities (CAHF) referenced several drugs, including insulin and Coumadin, an anticoagulant, as being among the "countless instances of straightforward medical treatments that are implemented using the section 1418.8 provisions." JA757. Yet the declaration submitted in support of the Department's position in this case by Karl Steinberg, M.D., a medical director at many nursing facilities, and the Chief Medical Officer at a group which includes eight nursing facilities, said in comparison to antipsychotics, "…[c]ommonly used medications like insulin or the blood thinner Wayfarin (Coumadin) are *much more risky and associated with many more serious adverse events and deaths*." JA557- 558 (emphasis added).

3. *Facts Found by the Superior Court*

a. *End of Life*

The Superior Court found:

(1) "Petitioners' evidence supports that physicians and IDT's are making end of life decisions without consulting patients and without considering the patient's wishes as to end of life decisions." JA744.

(2)"Mark A.s' (sic) POLST was changed from full code to comfort care only meaning Mark A. would receive no life sustaining treatment although he would receive nutrition…Mark A. passed away at the facility while in the care of hospice…." JA 745.

(3) "[T]he declaration of ombudsman Cheryl Simcox describes being at IDT meetings that discuss decisions such as hospice care, DNR [do not resuscitate… .] JA745.

(4) “Perhaps the most telling evidence though, is the Department’s own position that neither section 1418.8 nor Rains [Rains v. Belshe] precludes the statute’s application to all end of life decisions…” JA746.

(5) “Section 1418.8, as applied, is being construed as allowing physicians to make end of life decisions, such as creating or changing POLSTS, and also permitting IDTs to make end of life decisions such as withdrawing life sustaining measures.” JA746.

(6) “The Department provides no evidence that it has required facilities to limit end of life decisions to those instances that the Department contends may be constitutionally permitted.” JA746.

(7) “Section 1418.8 does not require a judicial determination of the patient’s Lack of capacity to make such decisions for himself or herself.” JA746.

(8) “The statute further does not require that a patient’s wishes be taken into account in making health care decisions, but only requires the IDT to discuss the patient’s wishes.”JA746.

(9) “Also, the statute, as applied by the Department is not being limited to IDT’s making end of life decisions for those patients who are terminally ill, comatose or in a persistent vegetative state and have not left form instructions for such health care decisions. Rather, the statute is being applied to permit physicians and IDTs to make such end of life decisions for the patients, irrespective of the patient’s instructions on such health care decisions without demonstrating that such treatment would be medically ineffective or contrary to generally accepted standards.” JA746.

b. *Gloria A.*

> Gloria A., a sixty-three year old woman residing in a skilled nursing facility in California describes how she wanted to attend a picnic with another resident and her sister, and was told by the nurse that it would be okay. …On the day of the picnic though, she was told by the administrator that she did not have permission from her doctor who had determined that she was incompetent, and had ordered that she could not leave the facility…Gloria A. then describes how the nurses were going to call the police after she attempted to leave. Gloria A. stated that her doctor found her incompetent, but her social worker said that she was not incompetent. Gloria A. further stated that she knew that she was not incompetent. Thus Gloria A. did not learn she had been found incompetent by her physician until she tried to leave the facility. Had Gloria A. been advised at the time her physician declared her incompetent and provided with notice of her right to

challenge this determination under section 1418.8(j), then she may have been able to retain the right to make her own medical care decisions instead of feeling like a prisoner, being forced to take drugs with a choice, and losing control over her finances.

JA720-721.

c. *Mark H.*

A POLST was signed by a physician, but not by Mark A., that stated "full code" when Mark A. entered the nursing facility. Prior to a meeting by the IDT, Ombudsman Geneva Carroll visited Mark A., and asked if he wanted to live or die, but he did not respond nor did his facial expression change, although when Carroll left, he stated "come back any time."…At a meeting of the IDT, Carroll discovered that no one had asked Mark A. what he wanted so the IDT went to talk to him, but all he said to the nurse practitioner that spoke to him was "Do you know what I am?" Thereafter, the meeting resumed and Mark A's POLST was changed from full code to comfort care only, meaning Mark A. would receive no life sustaining treatment although he would receive nutrition…Mark A. passed away at the facility while in the care of hospice in February 2013.

JA745.

d. *Patient Representatives*

Petitioners …point to two facility's plans accepted by the Department that do not mandate a patient representative as part of the IDT. The Roseville Point Skilled Nursing Facility states that the IDT shall include "when applicable, a resident's personal representatives."… The Country Villa Health Services Operations Manual states that the suggested IDT members include facility representatives from the following departments: Activities, Rehabilitation, Nursing…; Nutritional Care; Social Services. In addition, the resident, resident family/responsible party and physician are invited to attend.:…Further, Petitioners provide declarations from ombudsmen to support that patient representatives are rarely, if ever, part of the IDT.

JA726-727.

e. *Facts Set Forth in Memorandum of California Association of Health Facilities*

A memorandum submitted to the superior court by the California Association of Health Facilities stated:

(1) "CAHF is a non-profit association representing approximately 1300 licensed skilled nursing and intermediate care facilities serving individuals with developmental disabilities in the State of California. Of these facilities, CAHF represents 800 skilled nursing facilities out of a total number of 11,244 such facilities operating statewide." JA756

(2) "[T]he majority of the residents receiving end of life care through the Section 1418.8 process are individuals suffering from severe to profound dementia." JA764. "CAHF estimates that approximately 15% of the residents covered by section 1418.8 currently receive hospice or palliative care through the section 1418.8 process. This means… 900 to 1800 residents…." JA766.

SUMMARY OF ARGUMENT

I. *Response to The Department of Public Health's Appeal*

Fundamental due process requires legal notice in that residents affected by §1418.8 may lose autonomy, liberty, property, and even life. Further such notice is required as to the determinations of incapacity, its effects, the treatment, and the determination of the absence of a surrogate, as well as the right to go to court, as ordered by the superior court.

The California Supreme Court has held that constitutional rights of privacy require a judicial determination of incapacity before nonconsensual administration of antipsychotic drugs. Petitioner Gloria A.' s rights were violated when she tried to refuse, and was told, based on her physician's incapacity decision, that she had no right to refuse.

As to nonconsensual administration of antipsychotic drugs the California Supreme Court has held that constitutional rights of privacy require a judicial

determination of incapacity. These drugs are more intrusive for the elderly than prisoners and the mentally ill since they may result in death. Thus, Petitioner Gloria A.'s rights were violated when she tried to refuse, and was told, based on her physician's incapacity decision, that she had no right to refuse.

The Department's ripeness and advisory opinion contentions were not presented to the superior court and therefore should not be considered on appeal. However, if this court does consider these contentions, this matter is clearly ripe because the Department has a statutory duty to act, and cannot pick and choose which §1418.8 activities or failures it will evaluate, survey, and investigate. The superior court did not render an advisory opinion because this case concerns the constitutionality of a state statute.

II. *Petitioner's Cross-Appeal*

First, as to notice and opportunity to oppose, due process requires that there be notice prior to the physician's determinations, and a meaningful opportunity to oppose. *See Mullane v. Hanover Bank* (1950) 339 U.S. 306. The superior court did not require that the notice as to the factual interview of the patient or findings by the physician be given prior to the determinations of incapacity, of the absence of a surrogate and of the need for treatment. This violates due process because the patient need not be informed of, aware of, and be able to oppose any of those determinations. There is no meaningful opportunity to oppose whatsoever.

Second, competence is not a medical decision, but a legal one, requiring a judicial adjudication, particularly since §1418.8 is an exercise in parens patriae. *In re Qawi, supra; K.G. v. Meredith, supra*. However, the adjudication may be by an administrative legal officer. Therefore, neither the physician nor the interdisciplinary team may decide decisional incapacity. Third, loss of fundamental rights such as loss of autonomy requires the involvement of *neutral* decision makers. Decisions by those factually involved in the underlying events denies due process. *See Washington v. Harper* (1990) 494 U.S. 210; *Goldberg v. Kelly* (1970)

397 U.S. 254. Fourth, persons such as ill, elderly nursing home residents are entitled to legal assistance before loss of fundamental legal rights such as privacy and autonomy. *See Vitek v. Jones* (1980) 445 U.S. 480, 496-497.

Lastly, the superior court allowed four exceptions to its holding precluding the use the use of §1418.8 to end lives, despite lack of judicially determined incapacity and the absence of a surrogate as well as the absence of an explicit legislative authorization in permitting an interdisciplinary team to decide on patient wishes and instructions to end life, to cease curative care and transfer the resident to hospice for death, and to grant a physician the right of treatment refusal, all in opposition to the statutory limitations of §1418.8 as to "day to day medical treatment decisions [which] must be made on an ongoing basis" and the *Rains* limitation of the statute to "relatively nonintrusive and routine treatment." Should §1418.8 be used to end lives, it requires far greater procedural protections. *See Conservatorship of Wendland* (2001) 26 Cal.4th 519; *Barber v. Superior Court* (1983) 147 Cal.App.3d 1006; *Bartling v. Superior Court* (1984) 163 Cal.App.3d 186; *Cruzan v. Missouri* (1990) 497 U.S. 261.

ARGUMENT

I. *RESPONSE TO THE DEPARTMENT'S OPENING BRIEF*

A. *The Superior Court Correctly Held that Notice Is Required Under §1418.8*

A fundamental right of due process is that no life, liberty or property interest shall be denied by government absent prior notice and an opportunity to oppose the loss. *Conservatorship of Moore* (1986) 185 Cal.App.3d 718, 725, quoting *Mullane v. Central Hanover Bank Tr. Co*. (1950) 339 U.S. 306. The California Supreme Court has found this right fundamental, even as to persons previously declared insane. It predates the due process clause and is as old as the Magna Carta itself. See *Julie Grinbaum (an insane person) v. Superior Court* (1923) 192 Cal. 528.

These points have since been reiterated by the United States Supreme Court in matters involving mere privileges (*see Goldberg v. Kelly* (1970) 397 U.S. 254, unlike here where there are fundamental personal rights at stake (*cf. Thor v. Superior Court* (1993) 5 Cal. 4th 725), and even matters involving the mere transfer of convicted felons from prisons to mental hospitals for treatment. *Vitek v. Jones*, *supra*.

In *Vitek*, where the issues concerned the procedural due process entitlements of a convicted felon before transfer from a prison to a mental hospital, the Court held that to afford sufficient protection to the liberty interest it had identified, the State was required to observe the following minimum procedures before transferring a prisoner to a mental hospital: Written notice to the prisoner that a transfer to a mental hospital *is being considered*. *Vitek*, at 494-495 (emphasis added).

The California courts have applied these rules in many cases, including loss of property rights and suspension from school. In *Beaudreau v. Superior Court* (1975) 14 Cal. 3d 448, a case involving merely the loss of property, the Court held notice was necessary. See also *Braxton v. Municipal Court* (1973) 10 Cal. 3d 138 (requiring a due process hearing as to a school suspension).

The principle has also been applied in cases where issues of personal autonomy and consent to medical treatment have been present. *Thor,* 5 Cal. 4th at 733, n. 2, the Court held:

> The unnecessary exclusion of *the* critical party from meaningful participation in a determination of his right to direct the course of medical treatment contravenes the basic tenets of our judicial system and affronts the principles of individual integrity that sustain it. Accordingly, except in cases of imminent danger to the life or health of the patient or a similar exigency, we disapprove any procedure that denies or limits any relevant party *access to the proceedings and the opportunity to be heard.*

(Emphasis added).

As to the conclusion that notice is not required due to the availability of court review, the Ninth Circuit has held, regarding a statute conditioning a court hearing upon the request of the individual affected by governmental action, in *Doe v. Gallinot* (9th Cir. 1981) 657 F.2d 1017, 1022, that "conditioning a probable cause hearing on the request of the individual reverses the usual due process analysis in cases where potential deprivation is severe and the risk of error is great. It is inconceivable that a person could be arrested on criminal charges and held for up to 17 days without a hearing unless he requested it. Even in civil cases where the deprivation is of property rather than liberty, the State must initiate the hearing and justify the deprivation…."

In *Edward W. v. Lamkins* (2002) 99 Cal.App.4th 516, 537, this court held, as to issues of notice as to availability of habeas review:

> As for respondent's argument that the risk of error in ex parte temporary conservatorship decisions is minimal because of the opportunity for immediate judicial review by writ of habeas corpus, as discussed above, the availability of "immediate" review is a farce if the conservatee is not informed of it.

Rains never discussed, nor ruled on notice. Without any discussion of the fundamental rights at stake it cannot be said that notice was specifically rejected. "A decision is not even authority except upon the point *actually passed upon by the Court* and directly involved in the case. But even then, the mere reasoning of the Court is not authority. The point decided by the Court*, and which the reasoning illustrates and explains,* constitutes a judicial precedent." *Hart v. Burnett* (1860) 15 Cal. 530, 598 (emphasis added).

Hart was cited and quoted with approval as recently as 2013 in *Andreini & Co. v. MacCorkle Ins. Co.* (2013) 219 Cal.App.4th 1396, 1402. "Language used in any opinion is of course to be understood in the light of the facts and the issue then before the court, and *an opinion is not authority for a proposition not therein considered." Ginns v. Savage* (1964) 61 Cal.2d 520, 524, fn. 2 (emphasis added).

Other than saying in an early part of the decision that the issue of notice was raised (*Rains* at 178), there is not a holding as to this fundamental right.

The *Rains* analysis, as to due process, concerned first, the "Determination of Incompetency by Physician" (*Rains* at 180-182), and second, the right to a "Patient Representative" (*Rains* at 182-184). The court closed its discussion as to due process, with an analysis of the patient's opportunity to obtain a neutral decision, after the initial decision, in which it discussed, in an analysis highly appropriate to, but failing in, the need for notice, the opportunity for the patient to go to court, but neglected to require that the patient be notified of this opportunity. *Rains* at 186.

It is for that reason that the superior court found, after concluding that *Rains* did not address notice, that:

> Indeed *Rains* seems to presume that the patient would receive notice of these determinations, as such notice to the patient would be required in order for a patient to invoke review of such a decision by a court under section 1418.8(j) which the *Rains* court found afforded a patient due process.

JA 727. *Rains,* therefore*,* did not address notice as required for stare decisis.

Further, *Rains* holds that the physician's decision is merely an "initial decision" and that there is still an opportunity for a resident to challenge it in court. However it is as much a final decision as any from an administrative tribunal which may be appealed to a court. As in *Washington v. Harper*, *Vitek*, or *Goldberg*, while there may be recourse to a court, the decision of the administrative agency may be acted upon absent a stay or a TRO. Similarly here, absent a judicial stay or TRO, the treatment may be immediately administered, and there is no requirement that the affected resident be notified.

Another of the Department's positions as to notice is that there is no right to notice since "These decisions are medical decisions." *Rains* at 180. But the issue is not whether these are medical decisions or school decisions or welfare decisions.

The due process question is whether the result is a governmental deprivation of life, liberty or property, including merely a "liberty interest" as in *Washington v. Harper*, involving a far more medically based decision than that of competence, that of ordering antipsychotic drugs, than here where §1418.8 gives a purely legal definition of competence and nothing within that issue regarding medical diagnosis, prognosis or cure.

Nevertheless, *Rains* never cited to cases holding that competence decisions are medical decisions. For example, *Rains* cited to *Barber v. Superior Court* (1983) 147 Cal.App.3d 1006, where the Court considered the plight of a person then in a persistent vegetative state, as to the matter, not of competence, but of whether life support systems should be continued and who should decide. *Matter of Quinlan* (1976) 70 N.J. 10, involved an individual in a persistent vegetative state, and the issue of who should decide whether to end life. There was no issue of incompetence. Indeed, in New Jersey, as to the competence of a conscious nursing home resident, *In re Conroy* (1985) 98 N.J. 321, explicitly requires a *judicial* determination of incompetence with the physician merely giving medical evidence, and does so given the "special vulnerability" of nursing home residents and the "potential for abuse with institutional decision-making. " 98 N.J. at 381-382.

Similarly, neither *Youngberg v. Romeo* (1982) 457 U.S. 307, nor *Parham v. J. R.* (1979) 442 U.S. 584, 609, were concerned with issues of competence, but instead with purely medical decisions as to treatment. Likewise *Washington v. Harper* did not decide competence.

The end result is that *Rains* cited to no case holding that competence was a medical rather than a legal decision.

The fact is that competence is not a medical decision; it is a legal one, as found by the California Supreme Court in decisions subsequent to *Rains*. The California Supreme Court held *in In re Qawi:*

> ‘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.’

32 Cal. 4th at 17.

In finding that competence is a legal decision, the *Qawi* court concluded that an adjudication was necessary under the California constitutional right of privacy in order to find decisional incapacity. It reached this conclusion after citing to *Conservatorship of Wendland* (2001) 26 Cal.4th 519, where the Court found that individuals had rights to refuse medical treatment, but that the state had a parens patriae interest in assuring treatment for those who lacked decisional capacity and the reconciliation of the two interests required an adjudication:

> The right to refuse antipsychotic medication is not, however, absolute, but is limited by countervailing state interests. One such interest is parens patriae, the state's interest “in providing care to its citizens who are unable … to care for themselves.” (Addington v. Texas (1979) 441 U.S. 418, 426 [60 L. Ed. 2d 323, 99 S. Ct. 1804].) *In California, parens patriae may be used only to impose unwanted medical treatment on an adult when that adult has been adjudged incompetent. (See Wendland, supra, 26 Cal.4th at p. 535.)*

In re Qawi, 32 Cal. 4th at 18 (emphasis added).

Wendland distinguished between medical decision makers chosen by the patient, and those imposed by the State, speaking first to the decisions of competent persons, and then contrasting that with the state’s rights under parens patriae, to appoint a substitute, saying:

> 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).

26 Cal. 4th at 534-535.

Determinations of capacity are legal decisions, requiring an adjudication of incapacity before the State may, as through §1418.8, determine incapacity. The Department also argues that *Rains* found notice unnecessary because of the many protections given to residents of nursing homes, and further argues that "In light of such protections, a resident capable of understanding his or her rights will be put on notice that a facility is not giving effect to his or her right to refuse treatment if it seeks to initiate treatment under section1418.8 contrary to the resident's desires or belief that he or she has capacity to give or refuse consent." Dept AOB at 30-31.

The Department cites no case supporting this proposition, and indeed, in numerous areas there are significant regulatory protections for persons receiving medical care, and nevertheless, courts have found the need for constitutional due process. Thus, as to certain mentally ill persons, for whom there are significant regulatory protections, *Qawi* requires notice and a judicial hearing prior to determinations of incapacity. For mentally ill prisoners*, Vitek* requires a due process notice and hearing. As to even dangerous prisoners, *Washington v. Harper* requires due process notice and a hearing. As for the many protections given to residents of nursing homes, that is equally true of involuntary mental patients. *Conservatorship of Roulet* (1979) 23 Cal. 3d 219. Yet notice is constitutionally required independent of all the protections.

Thus, *Edward W. Jr. v. Lamkins* (2002) 99 Cal.App.4th 516, 529, does not hold that the many rights afforded mental patients precludes a need for notice. Instead, it held: "'An elementary and fundamental requirement of due process in any proceeding which is to be accorded finality is notice reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections. [Citations.].'" *See also K.G. v. Meredith* (2012) 204 Cal.App.4th 164.

The Department's claim that notice is unnecessary because a resident should somehow know when his or her rights are being trampled, and take some action, so that notice is unnecessary, if successful, would eliminate altogether the need for notice absent an emergency, and place the burden on the resident. Dept AOB at 30-31.

The Department also argues that patient's rights rules, are sufficient to protect the patient in that physicians "should" inform residents of the §1418.8 determination, and all nursing home residents "should" have been advised of these rights and therefore "will" be put on notice that they are being denied constitutional rights. Dept AOB at 29-30. But that is not what *Mullane* requires, or *Goldberg*, or *Vitek*.

The Department additionally would preclude consideration of the due process factors addressed in *People v. Ramirez* (1975) 25 Cal. 3d 260, 275 because it contends that *Ramirez* only applies after there has been a determination of failure of due process in order to determine what process is in fact due. Dept AOB at 31. This was not the case in *Ramirez*, where the Court held:

> We therefore hold that the due process safeguards required for protection of an individual's statutory interests must be analyzed in the context of the principle that freedom from arbitrary adjudicative procedures is a substantive element of one's liberty. (See Van Alstyne, Cracks in the New Property (1977) supra, 62 Cornell L. Rev. at p. 487.) This approach presumes that when an individual is subjected to deprivatory governmental action, he always has a due process liberty interest both in fair and unprejudiced decision-making and in being treated with respect and dignity. Accordingly, it places front and center the issue of critical concern, i.e., what procedural protections are warranted in light of governmental and private interests.

Id. at 275.

Nevertheless, the Department goes on to contend there is no governmental action here sufficient for the application of the *Ramirez* factors. However, as

pointed out in the superior court's order (JA710), the Department has a statutory duty to oversee and assure compliance with state law, and §1418.8 is unconstitutional in its denial of due process, which is what *Ramirez* contemplates.

The Department cites to several cases to claim that the statute is not unconstitutional as to notice and should not be voided. But as the Department recognizes this depends on the ability to interpret a statute to avoid constitutional issues and the need for rewriting. In this case, there is nothing in the statute requiring notice. Therefore, the statute has to be rewritten and cannot be interpreted to contain the necessary notice requirements. To construe the statute to require notice would be insufficient.

As the superior court has found, given the several steps as to when notice is necessary, a specific set of legislative mandates is required at different times in the statutory process. Thus, redrafting is necessary. As was said in *Fort v. Civil Service Commission* (1964) 61 Cal. 2d 331:

> Where a provision encompasses both valid and invalid restrictions on free speech and its language is such that a court cannot reasonably undertake to eliminate its invalid operation by severance or construction, the provision is void in its entirety regardless of whether the particular conduct before the court could be constitutionally regulated and whether there is a severability clause applicable to the provision. (See, e.g., Thornhill v. Alabama, supra, 310 U.S. 88, 96-99 [60 S.Ct. 736, 84 L.Ed. 1093, 1098-1100]; In re Blaney, supra, 30 Cal.2d 643, 655-656.

The superior court found both facial validity of the statute and, as to notice, facial invalidity. JA720.

As to notice, the superior court ordered adequate written notice: 1. After a treating physician prescribes or orders a medical intervention requiring informed consent; and 2. After a treating physician has determined that the resident lacks capacity therefor, and 3. After a treating physician has determined that there is no person with legal authority to act on behalf of the resident. JA 853. Additionally,

the court required notice that an interdisciplinary team including the same treating physician and others will review all of that physician's three determinations to determine if the treatment may occur, and notice that further prescribed treatment will be overseen by the team unless or until a legal surrogate is identified or the team, the physician, or a court determine that the resident has or has regained decisional capacity. JA852. Lastly, the court required notice that the resident may challenge the three determinations in a judicial proceeding. *Id.*

These requirements, necessary to satisfy due process, cannot simply be read into the statute by interpretation, but instead require a "wholesale rewriting" of the statute as to the requirements of notice in order to assure that the elderly in nursing homes receive due process.

B. *The Superior Court Judgment as to the Use of Antipsychotic Drugs Is Correct*

The superior court prohibited the use of §1418.8 for the administration of antipsychotic drugs to SNF residents unless authorized pursuant to the procedures set forth in Probate Code §§3200 et seq., except in emergency situations as emergencies are defined under California law. Judgment, JA 852.

The Department raises several defenses, such as that §1418.8 expressly permits the use of antipsychotics as treatment (Dept AOB at 37) and that while prisoners may have certain rights as to these drugs, the elderly in nursing homes do not. Dept AOB at 43. The Department also claims regulations adequately protect (Dept AOB at 39) and eliminate the need for a judicial determination of incompetence as to the right to refuse. The most important of the Department's arguments is that existant law as to the right to refuse is only of a statutory and not constitutional nature. Dept AOB at 43.

The Department claims that the Legislature expressly authorized the general approval by interdisciplinary teams as to the use of antipsychotic drugs in §1418.8(h). Dept AOB at 35. Section 1418.8(h) provides:

> (h) In case of an *emergency,* after obtaining a physician and surgeon's order as necessary, a skilled nursing or intermediate care facility may administer a medical intervention that requires informed consent prior to the facility convening an interdisciplinary team review. If the *emergency* results in the application of physical or *chemical restraints*, the interdisciplinary team shall meet within one week of the *emergency* for an evaluation of the medical intervention.

Emphasis added.

This subsection speaks solely to an emergency, whereby if use of physical or chemical restraints during the emergency continues, requires the interdisciplinary team to meet within one week of the emergency for an evaluation of the medical intervention. The sole purpose of the intervention is for the team to decide if the emergency continues. Further, the subsection speaks not to the general use of antipsychotic drugs, which have not been approved by the FDA for use as to the elderly,[4] but the limited use of "physical or chemical restraints." §1418.8(h).

Chemical restraints are restraints and not medical treatment. Thus, a White Paper on chemical restraint use entitled *Chemical Restraint Use for The California Department of Public Health*, July 2012, issued for the Department by the Health Services Advisory Group as part of the legislative requirements under AB 19, 2011, states:

> The SOM provides the following definitions related to chemical restraints:
> Chemical Restraints – refers to <u>any</u> drug that is used for *discipline or convenience and not required to treat medical symptoms*

Page 1-2 Chemical Restraint Use for The California Department of Public Health, July 2012, at p. i. (emphasis added).

In speaking to the emergency use of chemical restraints, the Legislature did not give approval to the general use of antipsychotics as treatment, as consented to

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[4] United States Food & Drug Administration Safety Bulletin, August 2008, Seroquel (quetiapine fumarate) Tablets.

by interdisciplinary teams, but instead gave the IDT power to review to determine whether the emergency continued, and if the use was proper. This reference in the statute is the only mention of chemical restraints and there is no mention of antipsychotics for use in medical treatment at all. Furthermore, the statute has been judicially interpreted to be limited.

> Section 1418.8 by its own terms applies only to the relatively nonintrusive and routine, ongoing medical intervention, which may be afforded by physicians in nursing homes; it does not purport to grant blanket authority for more severe medical interventions such as medically necessary, one-time procedures which would be carried out at a hospital or other acute care facility, as to which compliance with Probate Code section 3200 et seq. would still be required, except in emergency situations.

Rains, 32 Cal.App.4th at 186.

Federal courts (*Washington v. Harper*) as well as California courts (*In re Qawi*) have found the side effects of such drugs highly intrusive. Of determinative importance is the effect these drugs have on the elderly. They have never been approved by the Federal Food & Drug Administration for use as to the elderly, but are currently being used in an unapproved status. United States Food & Drug Administration Safety Bulletin, August 2008, Seroquel (quetiapine fumarate) Tablets).

As to the elderly, these drugs have what is termed a "black box warning" in that they have the propensity to cause death. The "black box" warning as to Seroquel, similar to other such drugs, states:

> 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).

JA160-161. *See* USDA Safety Bulletin, Seroquel.

As to other side effects *In re Qawi* pointed out that:

> 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, and 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.*)

With particular application in the for-profit operation of nursing homes in analyzing the effects of antipsychotic drugs, the court in *Keyhea v. Rushen* (1987) 178 Cal.App.3d 526, 540 said:

> 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.)

Petitioner Gloria A. was administered an antipsychotic drug, Seroquel. JA141-142. Her medical notes recognize that "Elderly patients …treated with antipsychotic drugs may be at an increased risk of death." JA 142. But Petitioner Gloria A. never even knew she was forced to take the drug. She described her experience with Seroquel and her failed attempt to exercise her constitutional right to refuse:

> 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.

Declaration of Gloria A. JA66.

Mark H. was nonconsensually given such drugs for "agitation" (JA129) which is not a clinical indication for an antipsychotic, but instead a restraint. Further, after several months a psychiatrist examined him and stated that Mr. H.

was "very sedated" on Remeron, an antidepressant which was to be discontinued and also on an antipsychotic, Seroquel, which was ordered "d/c Seroquel for same reason." JA129-130.

The result of the misuse of antipsychotics in nursing homes has been described by the Department as leading to action toward assuring improved use. But, the Department fails to cite any cases saying that improved use mitigates the violation of constitutional rights. Furthermore, the same arguments were made as to the mentally ill in *Riese v. St. Mary's Hospital & Medical Center* (1987) 209 Cal.App.3d 1303, but the case holds that mental patients do not lose their rights due to improved medical treatment. Indeed, voluntary patients, such as the mentally ill, have rights of refusal. 22 Cal. Code. Regs. § 853.

The superior court was correct in its conclusion that although dangerous prisoners (*Washington v. Harper*), mentally disordered offenders (*In re Qawi*), and involuntarily institutionalized mentally ill persons under LPS had statutory and constitutional rights to a judicial determination of incapacity before losing the right to refuse, whereas elderly residents of nursing homes did not, "the Legislature must not have intended for section 1418.8 to apply to the administration of antipsychotic drugs." JA734.

The Department cites *In re Qawi* as being merely a statutory interpretation Dept AOB at 44. But *Qawi* expressly held:

> The starting point of the analysis is the "relatively certain principle that a competent adult has the right to refuse medical treatment, even treatment necessary to sustain life." (Conservatorship of Wendland (2001) 26 Cal.4th 519, 530 [110 Cal. Rptr. 2d 412, 28 P.3d 151] (Wendland); see also Riese v. St. Mary's Hospital & Medical Center (1987) 209 Cal.App.3d 1303, 1317 [271 Cal. Rptr. 199] (Riese).) This right is grounded both in state constitutional and common law. (Wendland, supra, 26 Cal.4th at p. 531.).

Qawi at 14.

After delineating the intrusiveness of these drugs, the *Qawi* opinion stated:

> The right to refuse antipsychotic medication is not, however, absolute, but is limited by countervailing state interests. One such interest is parens patriae, the state's interest "in providing care to its citizens who are unable … to care for themselves." (Addington v. Texas (1979) 441 U.S. 418, 426 [60 L. Ed. 2d 323, 99 S. Ct. 1804].) In California parens patriae may be used only to impose unwanted medical treatment on an adult when that adult has been adjudged incompetent. (See Wendland, supra, 26 Cal.4th at p. 535.)

Qawi at 15-16.

The right of privacy guaranteed by the California Constitution, article I, section 1 "guarantees to the individual the freedom to choose to reject, or refuse to consent to, intrusions of his bodily integrity." *Qawi* at 14.

In interpreting *Qawi*, this court has held, in a case involving a condition of probation that a defendant take antipsychotic drugs:

> We agree with defendant that adults have a state constitutional privacy right and a fundamental due process freedom to refuse to take antipsychotic medications. (See, e.g., Williams, supra, 356 F.3d at pp. 1053–1054; In re Qawi (2004) 32 Cal.4th 1, 14 [7 Cal. Rptr. 3d 780, 81 P.3d 224].)

People v. Petty (2013) 213 Cal.App.4th 1410, 1417.

In another case decided by this court, *Qawi* was held to set out a constitutional right of privacy as to the use of nonconsensual antipsychotics, citing to *Riese v. St. Mary's Hospital,* was based on statutory interpretation:

> The *Riese* court expressly declined to address constitutional arguments, but our Supreme Court has since held that the right of a competent adult to refuse medical treatment, including the right to refuse antipsychotic drugs, is not only statutorily recognized in the LPS Act, but is grounded as well in both state constitutional and common law rights of privacy and personal autonomy. (In re Qawi (2004) 32 Cal.4th 1, 14, 16–19 [7 Cal. Rptr. 3d 780, 81 P.3d 224].

K.G. v. Meredith, 204 Cal.App.4th at 170-171.

Other states have held that decisions as to incapacity regarding antipsychotic drugs are judicial and not medical: "Such a determination is uniquely a judicial, not a medical function…." *Rivers v. Katz* (1986) 67 N.Y.2d 485, 496-497.

The erroneous result in *Rains* was that the court assumed that since an individual was in a nursing home for treatment, their expectations of privacy were significantly reduced:

> While persons residing in nursing homes obviously have a reasonable expectation of privacy relating to aspects of their lives which are not connected to the medical purposes of the facility, it can hardly be doubted that the reasonable expectation of privacy as it relates to medical care must be diminished.

Rains at 173-174.

If *Rains* is correct, that would apply to medical treatment in a hospital, or a physician's office, or wherever non-emergency medical care occurs, and would result in the elimination of personal autonomy as to medical care. It does not, and is antithetical to basic California law as to medical autonomy that competent people are entitled to material information as to medical treatment and to consent to or refuse such treatment. *Cobbs v. Grant* (1972) 8 Cal. 3d 229 (right to decide medical treatment). That right is protected in mental hospitals, prisons and, as to antipsychotics, for persons in hospitals, clinics and, as here, nursing homes.

Under California constitutional law residents of nursing homes are entitled, as to issues of decisional incapacity regarding administration of antipsychotics, to the privacy and due process protections by petitioners, including a judicial determination of incapacity, notice, opportunity for a hearing, an advocate, an independent decisionmaker, and that therefore that §1418.8 is unconstitutional as to the administration of antipsychotic drugs.

The result, in *Qawi*, was its conclusion that:

> [I]n MDO can be compelled to be treated with antipsychotic medication under the following nonemergency circumstances: (1) he

> is determined by a court to be incompetent to refuse medical treatment…;

Qawi at 27.

The Department claims that prisoners, but not the infirm elderly in nursing homes, have a right to a judicial determination of decisional incapacity, citing to *Rains*. But California courts, including this one, have not so limited the application. *Wendland* speaks to the rights of all competent adults as to all medical treatment: "One relatively certain principle is that a competent adult has the right to refuse medical treatment, even treatment necessary to sustain life." 26 Cal.4th at 530. *Qawi*, as to antipsychotics held the right of privacy guaranteed by the California Constitution, article I, section 1 "guarantees to the individual the freedom to choose to reject, or refuse to consent to, intrusions of his bodily integrity." *Qawi* at 14.

Petitioner Gloria A. was administered an antipsychotic drug, Seroquel. JA141-142. Her medical notes recognize that "Elderly patients …treated with antipsychotic drugs may be at an increased risk of death." JA 142. Although she was unaware she was receiving an antipsychotic drug, Seroquel, and thus had no information as to any of its effects, since she had been determined incompetent by her physician, and had no right to refuse, Petitioner Gloria A. was forced to take the drug she hated. JA66. The Department would have §1418.8 explicitly apply to antipsychotics as treatment where it only speaks to temporary emergency use as a chemical restraint. The Department avoids recognition that antipsychotics are more dangerous for the elderly than prisoners or the mentally ill given that they carry a warning of death. And, the Department would have this court believe that, as to antipsychotic drug consent, dangerous, felons have greater constitutional rights than vulnerable, ill innocent elderly residents of nursing homes which is an unsupportable premise. Most important, the Department, unlike this court, would have *Qawi* given only a statutory application and not its actual holding of constitutional application.

Residents of nursing homes have a constitutional right to an adjudication by a court as to their decisional incompetence before losing their rights to refuse antipsychotic drugs.

In order to give the nursing home resident at least the same privacy and due process rights as to the nonconsensual use of antipsychotics, as with the involuntary mentally ill (*Riese*), mentally disordered offenders (*Qawi*), and prisoners generally (*Keyhea*), an independent administrative tribunal would suffice constitutionally and reduce both time and expense for the facilities.

C. *The Superior Court Correctly Held the Department Responsible for Insuring that §1418.8 is Not Used for End of Life Decisions*

1. *This Issue is Ripe for Decision*

The Department contends that determining the use of §1418.8 to make end of life decisions is not ripe and would result in an advisory opinion by this court. Dept. AOB 47-48.

A party is not permitted to change its position and adopt a new and different theory on appeal. To permit him or her to do so would not only be unfair to the superior court, but manifestly unjust to the opposing litigant. *Ernst v. Searle (1933)* 218 Cal. 233, 240-241*; see also Zito v. Firemen's Ins. Co*. (1973) 36 Cal.App.3d 277, 283 [111 Cal. Rptr. 392] (Zito) [" ' "a party cannot, after trying a case on a well-defined theory accepted by all the parties and the court, raise for the first time in the appellate court the question of the correctness of that theory" ' "]. *In re Marriage of Eben-King & King* (2000) 80 Cal.App.4th 92, 110 - 111.

Nowhere in the Department's submission to the superior court is there mention of a failure of "ripeness" or of an "advisory opinion" being sought. See Dept Answer, JA 540-550.

A similar argument, with application to a mandate action and, in relation to standing, contending the absence of governmental action, was made in *Connerly v. State Personnel Bd.* (2001) 92 Cal.App.4th 16. It was rejected for three reasons.

First, it was made for the first time on appeal. Second, mandate can be used to test the constitutionality of a statute. And, third, agencies cannot ignore statutory directives.

> At oral argument, respondents added to their argument on the issue of standing. They assert that this proceeding is in mandate, that mandate addresses conduct rather than the validity of legislation, and that plaintiff cannot proceed in mandate without introducing proof that respondents are in fact engaging in unconstitutional behavior. We reject this contention for three separate reasons. First, it was raised for the first time at oral argument. (Rebney v. Wells Fargo Bank (1990) 220 Cal.App.3d 1117, 1138, fn. 6 [269 Cal. Rptr. 844].) Second, mandate can be used to test the constitutional validity of a legislative enactment. . . .Third, to the extent respondents suggest that we should deny plaintiff standing to challenge the statutory schemes because agencies subject to those schemes may perform their duties in a constitutional manner by either ignoring the statutory directives or by engaging in a strained interpretation thereof, the argument overlooks a critical principle of law. As we will explain more fully in subsequent portions of this opinion, an administrative agency lacks the authority to cure a facially unconstitutional statute by refusing to enforce it as written.

92 Cal.App.4th at 30-31 (citations omitted).

Further, given that the Department has a duty to act but claims not to have acted, a plaintiff may successfully sue that agency, obtain an interpretation of the law, and obligate a defendant to take action by way of mandate. *Hollman v. Warren* (1948) 32 Cal. 2d 351, 357.

But even if the court considers the merits of this new argument, the Department argues, for the first time, that an attack against it cannot be successfully mounted since it is not the Department which effectuates §1418.8, but the nursing homes. Dept. AOB 47. It further argues that *Tobe v. City of Santa Ana* (1995) 9 Cal. 4th 1069 requires, for an applied attack, that there be some form of conduct in order to satisfy the requirements for such an attack. Dept. AOB 47. The Department claims this violates the newly argued concept of ripeness; but the Department is

wrong. As the Court stated in *Pacific Legal Foundation v. California Coastal Com.* (1980) 33 Cal. 3d 158:

> A logical starting point for a discussion of the concept of ripeness is the following general statement from Aetna Life Ins. Co. v. Haworth (1937) 300 U.S. 227, 240-241 [81 L.Ed. 617, 621, 57 S.Ct. 461, 108 A.L.R. 1000]: HN16 "The controversy must be definite and concrete, touching the legal relations of parties having adverse legal interests. [Citation.] It must be a real and substantial controversy admitting of specific relief through a decree of a conclusive character, as distinguished from an opinion advising what the law would be upon a hypothetical state of facts."

33 Cal. 3d 158, 170-171.

Tobe does not require conduct by a defendant, as the Department argues, which would then limit the ability of courts to order mandatory injunctions, or mandate itself. But that is not what *Tobe* held. Instead, *Tobe* holds, in part:

> An as applied challenge may seek (1) relief from a specific application of a facially valid statute or ordinance to an individual or class of individuals who are under allegedly impermissible present restraint or disability as a result of the manner or circumstances in which the statute or ordinance has been applied, *or (2) an injunction against future application of the statute or ordinance in the allegedly impermissible manner it is shown to have been applied in the past.* It contemplates analysis of the facts of a particular case or cases to determine the circumstances in which the statute or ordinance has been applied and to consider whether in those particular circumstances the application deprived the individual to whom it was applied of a protected right.

9 Cal. 4th 170-171 (emphasis added).

The Department's claim that, absent "application" of the statute to prove conduct as to the use of the statute to end lives, this case is not ripe for adjudication against the Department, is simply unsupported by the law.

As to taxpayer actions, the courts have held that petitioners, such as petitioner Anthony Chicotel, may sue as taxpayers: "'A taxpayer may sue a governmental body in a representative capacity in cases involving [its] . . . failure . .

. to perform a duty specifically enjoined.' [Citation.].” *Vasquez v. State of California* (2003) 105 Cal.App.4th 849, 854.

Here, the Department has a statutory duty to inspect skilled nursing facilities: "for compliance with provisions of state law and regulations…" Health & Safety Code §1279, including §1418.8, and to do so in a constitutional manner. By its own admission the Department adopted a policy in 1993 prohibiting the use of §1418.8 to end lives. JA503, 506-507. But the Department argues it recently superceded those actions in 2013, when this action commenced. JA 697. Today, in abrogation of its statutory duty, the Department now claims that, having withdrawn the policy, it has not regulated use of the statute to cause death.

A governmental agency has no right to pick and choose what it will enforce within a statute nor to supercede an existant policy to avoid its legal duty to enforce the law. *See Connerly*, *supra*. Petitioners, therefore, sought mandate to assure that the Department enforces its duty by prohibiting, through survey and inspection for non-compliance, use of §1418.8 to end lives. This is authorized by *Tobe.*

In the superior court, there was proof of the unconstitutional application of the statute as to Mark H. (JA116- 118, 124), as well as of the numbers of nursing home residents, 900 to 1600, now affected by the permissive failure of the Department to act according to its statutory duty. JA766. Further, the superior court found that the Department has taken positions resulting in its failure to act to prevent withdrawal of life support, leading to death. *See Tobe* at 1084 (“If a plaintiff seeks to enjoin future, allegedly impermissible, types of applications of a facially valid statute or ordinance, the plaintiff must demonstrate that such application is occurring or has occurred in the past.”).

Petitioners have demonstrated that use of §1418.8 to end lives of nursing home residents is precluded (1) by the statute, which only applies to day to day treatments, (2) by *Rains*, which interprets the statute as applying to “minimally invasive” matters, and (3) by the Department’s own policy which it previously

enforced, and which it claims to have superceded during, or just before, the pendency of this action.

In fact, the Department itself determined that §1418.8 did not apply to such end of life decisions. In 1993, a departmental memo was written by its Licensing and Certification branch and sent to District Administrators. It posed, in question seven, whether §1418.8 could be used to withdraw or withhold life sustaining treatment. It then stated in answer to question seven:

> No. H & S Code, Section 1418.8, authorizes the IDT to make decisions regarding medical interventions. Since withdrawing or withholding life sustaining treatments are not medical interventions, this statute does not authorize the IDT to make these decisions or behalf of residents.

JA503, 506-507

The Department claims to have "superceded" that position in an All Facilities Letter 13-38 (JA697), the same year in which this action was commenced. First, AFL 13-38 never even mentions §1418.8, nor ending lives, and does not rescind in any way its position of 1993. It is an instruction on informed consent with particular attention to psychoactive drugs. Instead, of "superceding" the earlier position in 1993 (JA503), AFL 13-38 specifically states it "supercedes" AFL 11-31, which is an instruction on informed consent for the use of psychoactive drugs and physical restraints. AFL 11-31 says nothing as to §1418.8 or ending life.

Further, the Department acted, in accord with its 1993 policy on March 1, 2011 when one of its surveyors found §1418.8 violated as to a patient who had been diagnosed with terminal prostate cancer and for whom a POLST was filled out by the IDT with no patient representative, saying Do Not Resuscitate, comfort care only, and not to transfer to a hospital. JA382-388. The surveyor said:

> The Statute is not met as evidenced by: Based on staff interview and clinical record review the facility failed to ensure Patients without capacity to make informed consent did not have end of life decisions

> made for them by the interdisciplinary /team without prior instructions from the patient or responsible party.

JA385.

Of equal importance, as to the risk of error in ending lives, the Department's Inspector further determined:

> Administrative Staff stated the physician had documented Patient A had prostate cancer, *however testing results had been inconclusive if Patient A had cancer at all.*

JA388 (emphasis added). The inspector then said:

> Administrative Staff acknowledged the statute addresses the authority for facility staff to make decisions regarding "medical interventions." It does not address authority to make end of lie decisions.

Id.

The 1993 policy (JA503) was followed until at least 2011, and, although neither it nor §1418.8 were referred to in either the 2011 or in the 2013 AFL (JA697), the Department now takes the position that it has not acted, and "superceded" the 1993 policy.

This statute is being construed, without regulations, inspections or surveys, by the Department, to permit ending the life of frail, ill, elderly residents of nursing homes without notice of any sort, without an advocate, without an opportunity for a fair hearing, without a judicial determination of incapacity, or detached decision maker as to incapacity. The only recourse for the ill resident is to bring a legal action and obtain a temporary restraining order, the ill, elderly person, now also deemed incompetent, has never been informed that he or she has been found incompetent nor to have their life ended, and given no assistance in starting an action rapidly to obtain a TRO.

Nor are such actions by nursing homes merely occasional or intermittent so as to escape inspection by the Department in performing its duties. In its memorandum to the superior court the California Association of Health Facilities (CAHF) stated that it represents "1,300 licensed skilled nursing and intermediate

care facilities…in California" and 800 skilled nursing facilities out of a total number of 1,244 such facilities operating statewide." JA756. "CAHF estimates that approximately 15% of the residents covered by section 1418.8 currently receive hospice or palliative care through the section 1418.8 process. This means… between 900 to 1,800 residents…" JA766.

Section 1418.8 provides no explicit legal permission to end lives. Indeed the statutory limitation set forth by the Legislature is to the contrary. When statutes permit ending life, they explicitly say so. In *Conservatorship of Wendland* (2001) 26 Cal.4th 519, involving the Health Care Decisions Law, Probate Code 2355, the Court found the Legislature had spoken explicitly to such end of life withdrawal of treatment in the Act itself.

> The last sentence of section 2355, subdivision (a), set out above, incorporates definitional provisions of the Health Care Decisions Law… Section 4617 defines " '[h]ealth care decision' " as " a decision made by a patient or the patient's agent, conservator, or surrogate, regarding the patient's health care, including the following:… (c) Directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation."

Wendland at 540.

Rather than explicitly permitting ending nursing home lives§1418.8 limits its use to day to day treatments made on an ongoing basis. In *Wendland* the Court found the Legislature had spoken explicitly to such end of life withdrawal of treatment in the Act itself. Here,

> The Legislature finds and declares as follows: (b) Existing Probate Code procedures, including public conservatorship, are inconsistently interpreted and applied, cumbersome, and sometimes unavailable for use in situations in which day-to-day medical treatment decisions must be made on an on-going basis.

Statutes 1992, Chapter 1303, Section 1: Legislative Findings. *See also Rains* (1995) 32 Cal.App.4th at 187 (emphasis added):[5]

> …[S]ection 1418.8 by its own terms applies *only to the relatively nonintrusive and routine, ongoing medical intervention*, which may be afforded by physicians in nursing homes; it does not purport to grant blanket authority for more severe medical interventions such as medically necessary, one-time procedures which would be carried out at a hospital or other acute care facility, as to which compliance with Probate Code section 3200 et seq. would still be required, except in emergency situations.

There is no more intrusive action which can be taken than ending a life. However, the Department argues that it bears no responsibility since it has taken no action to apply the statute, in that it is the nursing homes which end the lives of residents. See Dept AOB 48-51. But the superior court held, as to an argument not of ripeness but of standing to sue as a taxpayer, that the Department has a duty to act as it is the overseeing agency for nursing homes, and is charged with ensuring that such facilities adhere to California laws:

> [T]he Department in this case has direct oversight of all skilled nursing facilities and intermediate care facilities in California and is charged with ensuring that such facilities adhere to California laws.

JA710.

The Department has a statutory duty to inspect skilled nursing facilities: "for compliance with provisions of state law and regulations…" Health & Saf. Code §1279. No law currently exists, nor is cited by the Department, explicitly permitting the use of §1418.8 to end lives.

The superior court additionally made other finding concerning the Department's failure to carry out its statutory duties, saying:

> Section 1418.8, *as applied, is being construed as allowing* physicians to make end of life decisions, such as creating or changing POLSTS [Physician's Orders for Life Sustaining Treatment], and *also*

---

[5] Indeed, the director of the Department was a party to the *Rains* case.

> *permitting IDTs to make end of life decisions* such as withdrawing life sustaining measures.
>
> Also, the statute, *as applied by the Department is not being limited to IDT's* making end of life decisions for those patients who are terminally ill, comatose or in a persistent vegetative state and have not left form instructions for such health care decisions. Rather, the statute is *being applied to permit* physicians and IDTs to make such end of life decisions for the patients, irrespective of the patient's instructions on such health care decisions without demonstrating that such treatment would be medically ineffective or contrary to generally accepted standards.
>
> The Department provides *no evidence that it has required facilities to limit* end of life decisions to those instances that the Department contends may be constitutionally permitted.
>
> Perhaps the most telling evidence though, is the Department's own position that neither section 1418.8 nor *Rains* precludes the statute's application to all end of life decisions… (citing to *Rains v. Belshe*….)

JA737-747 (emphasis added).

The Department argues, specifically as to Mark H., that an ombudsman served to satisfy the statutory requirement of a patient representative. Dept AOB at 49. But the ombudsman did not serve as a representative (see Decl. of Geneva Carroll, JA68-79) as she could not be a substitute for a surrogate by federal law. See Decl. of Cheryl Simcox, JA80-81. As with Gloria A., and many others, there is no patient representative. Decisions to end life are made solely by representatives of nursing homes. See Decl. of Cheryl Simcox, JA80-84). In contrast, *Rains* mandated patient representatives, even for minimally invasive treatment, and would have them make the informed consent decisions absent exigent circumstances where staff might give the consent:

> [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, so

> as to allow necessary medical treatment to be afforded to already admitted patients of nursing homes on a routine, ongoing basis.

32 Cal.App.4th at 185-186.

The conclusion is that the Department is currently failing as to its statutory duty.

2. *There Is Sufficient State Action to Support the Judgment*

The Department further argues the absence of state action based solely on one case which is inapposite. Dept AOB at 47. In *Deutsch v. Masonic Homes of California, Inc*., (2008) 164 Cal.App.4th 748, the plaintiffs argued the denial of due process based on delay in enforcing a state statute. But *Deutsch* is a delay case.

> The civil cases cited by appellant involving violations of due process on the grounds of delay are distinguishable from the case before us because all involve delay on the part of a government actor. (See Consolidation Coal Co. v. Borda (4th Cir. 1999) 171 F.3d 175 [coal mine operator denied due process by government's delay and failure to notify it of claim....

164 Cal.App.4th at 762.

This case is concerned with failure to enforce the law. In this case, the superior court specifically concluded: "[T]he Department in this case has direct oversight of all skilled nursing facilities and intermediate care facilities in California and is charged with ensuring that such facilities adhere to California laws." JA710. The Department has a statutory duty to inspect skilled nursing facilities: "for compliance with provisions of state law and regulations…" Health & Saf. Code §1279. No law is cited by the Department, which permits the use of §1418.8 to end lives.

The Department has long taken a position against the use of §1418.8 to end lives, publicly set it forth as its position, enforced that position, and now seeks in this litigation to withdraw that position through an unrelated statement to nursing homes having nothing to do with ending lives. Section 1418.8 has no connection to ending lives of residents, and was not for that purpose. The Department has a

statutory duty under Health & Saf. Code §1279 to prohibit the use of §1418.8 to end lives. The Department's failure to act is sufficient to support an "as applied" attack on the use of the statute to end lives.

By eliminating Department monitoring and inspections regarding use of §1418.8 to support end of life decisions, the Department has taken specific action warranting judicial intervention.

3. *The Judgment Is Not an Advisory Opinion*

The superior court found that the Department has a duty to inspect facilities for violations of law. JA710. Insofar as ending life is concerned, the Department is not currently performing that duty. The superior court found that, as to decisions to end lives, §1418.8 is violative of the constitutional rights of nursing home residents, with certain exceptions. JA737-747. As a result, the Department has the duty to inform nursing homes of the court's decision, and then to assure compliance with the judgment. JA852-855. If the Department officials fail to do so, they can be held in contempt in order to assure compliance. None of this could occur if the Judgment was an advisory opinion.

In a recent case involving a dispute as to the meaning of a state regulation as to education, *California Charter Schools Assn. v. Los Angeles Unified School Dist.* (2015) 60 Cal. 4th 1221, the Supreme Court first set forth the nature of the case, saying:

> The controversy here is not over whether a particular charter school was offered the right number of classrooms. Rather, CCSA requests declaratory relief with respect to the meaning of the pertinent regulations. The question before us is whether the District's use of norming ratios complies with Proposition 39 (§ 47614) and the implementing regulations (§ 11969.3).

60 Cal. 4th 1221, 1234. The Court held that resolution of the case did not require an advisory opinion because, as here, there was an actual controversy and that declaratory relief might be afforded. Resolution of the case did not require an

advisory opinion because, as here, there was an actual controversy and that declaratory relief might be afforded.

In *Hunt v. Superior Court* (1999) 21 Cal. 4th 98, for example, a case concerning a county financial policy as to indigents' eligibility for medical treatment, the Supreme Court rejected the argument that it was being asked to render an advisory opinion.

> The ripeness requirement does not prevent us from resolving a concrete dispute if the consequence of a deferred decision will be lingering uncertainty in the law, especially when there is widespread public interest in the answer to a particular legal question. (Id. at p. 170.) Postponing review of the revised and contingent standards would leave uncertain the County's health care obligations and undoubtedly result in additional, lengthy appellate proceedings.

This appeal involves the potential deaths of nursing home residents, which deaths may be hastened by physicians and nursing homes, through a unique statute which permits such action based upon a treating physician's determination of decisional incapacity and the absence of a legal surrogate. This is not merely a rehashing or "mirroring" of existant law, as argued by the Department.

This is not like a conservatorship proceeding where a court decides incompetence, and the statute (unlike §1418.8) explicitly permits a conservator to make end of life decisions for conscious persons if there is clear and convincing evidence a conscious conservatee's wishes. See *Conservatorship of Wendland* at 545-546. This is also unlike use of a legally valid advance directive to be effectuated by a person chosen by the patient. As the superior court recognized, the Department is in no way limiting the ending of lives to the wishes of the patient. JA737-747.

When, as in this case, the Department has a duty to act, and nursing home residents may die without the protections offered in conservatorship and other court proceedings, petitioners have the legal right to test the constitutionality of the

statute and hold accountable the agency with a duty to oversee and enforce that statute.

II. *PETITIONER'S OPENING BRIEF* ON THEIR CROSS-APPEAL

A. *Elderly and Infirm Nursing Home Residents are Entitled to Notice and a Meaningful Opportunity to Oppose Before Losing their Fundamental Rights*

Although the superior court found some notice necessary prior to the deprivation of rights, it did not require adequate notice prior to the physician's determination of competence and surrogacy, nor did it require a hearing. Further, it found that adequate review of both incapacity and absence of a surrogate could be made by the Interdisciplinary Team which involved the same physician who made the original decision. JA718. But such a review is not supported by §1418.8 or by the decision in Rains.

1. *Absence of Prior Notice*

The superior court found that the only notice requirement is to tell the patient he or she had already been determined incompetent. The court found notice necessary only as to the fact that there was failure to notify that the patient had already been found incapacitated. The court found only that Petitioners are entitled to notice *after* the determinations have been made by the physician and only before a review of those determinations by a group including the physician who made the determinations, a nurse and a patient representative, if one is practicable. JA852. The court did not require an opportunity to oppose, except for the illusory opportunity for the patient to initiate a proceeding. The superior court required that the notice include: 1. Notice that the Interdisciplinary Team will review those determinations by the physician to determine if the medical intervention may be initiated and that further prescribed interventions will continue to be overseen using this team approach unless or until a person with legal authority is identified or the physician, interdisciplinary team or a court determines that the resident has, or has

regained, capacity to make decisions…and 2. that the resident may only challenge the above determinations in court. Judgment, ¶I.A. (3) (4), JA852.

Given that, under the statute, treatment or other acts may commence after the review by the Interdisciplinary Team, which includes the physician in reviewing his/her previous decisions, the fact that the resident is notified that treatment may commence after the IDT review, but that the person may thereafter go to court and seek reversal, is insufficient to give adequate notice to oppose prior to treatment or other intrusive occurring.

2. *Absence of Meaningful Opportunity to Oppose*

Petitioners clearly sought notice as to, and the opportunity to oppose, the physician's determination of incapacity. JA58-59. The superior court, however, characterized petitioners' challenge to the absence of notice alone, without affording meaningful opportunity to oppose.

Fundamentally, prior to loss of life, liberty or property, there must be both notice and a meaningful opportunity to oppose. In *Goldberg v. Kelly,* 397 U.S. at 267- 270 the Supreme Court held:

> "The fundamental requisite of due process of law is the opportunity to be heard." Grannis v. Ordean, 234 U.S. 385, 394 (1914). The hearing must be "at a meaningful time and in a meaningful manner." Armstrong v. Manzo, 380 U.S. 545, 552 (1965). In the present context these principles require that a recipient have timely and adequate notice detailing the reasons for a proposed termination, and an effective opportunity to defend by confronting any adverse witnesses and by presenting his own arguments and evidence orally.

In *Vitek v. Jones*, 445 U.S. 494-495, where the issues concerned a convicted felon's entitlement to procedural due process before transfer for *medical treatment* from a prison to a mental hospital – unlike, as here, the fundamental constitutional rights of autonomy of an innocent, ill and fragile elderly person – the Court affirmed the district and stated that:

> The District Court held that to afford sufficient protection to the liberty interest it had identified, the State was required to observe the following minimum procedures before transferring a prisoner to a mental hospital:
> "B. A hearing, *sufficiently after the notice to permit the prisoner to prepare,* at which disclosure to the prisoner is made of the evidence being relied upon for the transfer and at which an opportunity to be heard in person and to present documentary evidence is given;

(Emphasis added.)

In *Washington v. Harper* (1990) 494 U.S. 210, 235-236 as to the nonconsensual administration of antipsychotic drugs to dangerous convicted felons in a prison setting the Supreme Court held:

> The procedures established by the Center are sufficient to meet the requirements of due process … The Policy provides for notice, the right to be present at an adversary hearing, and the right to present and cross-examine witnesses. See *Vitek, supra*, at 494-496.

The California courts have applied these rules in a variety of contexts. In *Beaudreau v. Superior Court* (1975) 14 Cal. 3d 448, 458, a case involving merely the loss of property, the Court held:

> [I]n every case involving a deprivation of property within the purview of the due process clause, the Constitution *requires* some form of notice and *a hearing* (citations omitted). Absent extraordinary circumstances justifying resort to summary procedures, this hearing must take place *before* an individual is deprived of a significant property interest.

Citations omitted, emphasis added. See also *Braxton v. Municipal Court* (1973) 10 Cal. 3d 138 (involving need for due process hearing as to a school suspension).

The principle has been applied also in cases where issues of personal autonomy and consent to medical treatment have been present. In *Thor v. Superior Court*, 5 Cal. 4th 725, 733 n.2, involving issues of forced feeding, the Court held:

> The unnecessary exclusion of *the* critical party from meaningful participation in a determination of his right to direct the course of medical treatment contravenes the basic tenets of our judicial system and affronts the principles of individual integrity that sustain it.

> Accordingly, except in cases of imminent danger to the life or health of the patient or a similar exigency, we disapprove any procedure that denies or limits any relevant party access to the proceedings and the opportunity to be heard.

Here, because the notice occurs after the loss, the burden as to the loss of autonomy is on the patient. The meaningful opportunity to oppose is also absent, with the sole opportunity being to initiate judicial review.

Relying on *Rains*, the superior court ruled that the due process requirements were satisfied by the opportunity of the nursing home patient to bring an action in the superior court and obtain a "neutral" temporary restraining order before the treatment occurred, finding that the physician's findings were merely "initial." JA721. However, those findings and the review are not merely "initial" in that, with the burden on the ailing patient, if the patient fails to seek or obtain the TRO immediately, the treatment of the "incompetent" and surrogate-less patient occurs.

This process, acceptable in *Rains* over twenty-one years ago has not been found acceptable by the federal courts. In *Doe v. Gallinot*, *supra,* the Ninth Circuit found unconstitutional a process even more protective of the patient than is present in §1418.8. In *Doe*, which involved hospitalizing mentally ill persons for up to fourteen days based on a physician's assessment, the patient was given the opportunity to initiate a habeas corpus hearing within two days, unlike here, by a mere verbal request, with appointed counsel. This process was far more extensive than the one provided by §1418.8, but the court found it unconstitutional, holding, after a discussion of procedural due process:

> The district court, however, found this procedure deficient because "the heavy burden of contesting the 14-day certification rests entirely with the patient." 486 F. Supp. at 988. The person on whom this burden rested would often be "under the effects of tranquilizing medication," leaving him to "rely on the hospital treatment staff or other hospital employees for an explanation of his rights and for access to the superior court." Id. While some procedural safeguards did exist in the Act, its provisions for notice and explanation of a detainee's right to counsel and a habeas corpus hearing [did] not

> assure that a person will not be certified without probable cause. The State's determination may still be unreviewed. Habeas corpus is difficult to understand. The individual may not request a hearing because of the influence of drugs or great emotional distress.
>
> Conditioning a probable cause hearing on the request of the individual reverses the usual due process analysis in cases where potential deprivation is severe and the risk of error is great. It is inconceivable that a person could be arrested on criminal charges and held for up to 17 days without a hearing unless he requested it. *Even in civil cases where the deprivation is of property rather than liberty, the State must initiate the hearing and justify the deprivatio*n….

Emphasis added.

In *Vitek, Harper, Goldberg*, and *Doe,* judicial review could have been obtained if initiated by the affected individual. But this fact did not validate the unconstitutional absence of prior notice and opportunity for a meaningful hearing with the burden on the party seeking to effect the loss of life, liberty or property. The holding in *Rains* that the determination of incapacity and absence of surrogate are merely initial does not vitiate the need for prior notice and opportunity for a meaningful hearing, with the burden on the State.

B. *Section 1418.8 Facially Violates the California Constitutional Right to Personal Autonomy In Denying, a Judicial Determination of Incapacity to Make Medical Decisions*

The California constitutional right to privacy (Cal. Const., Art. 1, § 1) protects the right of competent adults as to choice in medical treatment. This was succinctly stated in *Conservatorship of Wendland*: "One relatively certain principle is that a competent adult has the right to refuse medical treatment, even treatment necessary to sustain life." 26 Cal.4th at 530.

Wendland recognizes that the right to refuse medical treatment may be involuntarily transferred to another person based on "the parens patriae power of the state to protect incompetent persons." *Wendland* at 535. However, such loss to

the individual requires that there be an adjudication of incapacity. *Id*. In *Wendland* that loss resulted in appointment of a conservator. The Court stated that the conservator was appointed "because the conservatee 'has been adjudicated to lack the capacity to make health care decisions.'" *Id*.

The *Wendland* holding as to the requirement of a judicial determination of incapacity to effectuate the State's parens patriae interest in treating persons without their consent has since been upheld in another Supreme Court case on the basis of the constitutional right of privacy. In *Qawi*, the Court held, quoting from *Wendland*, held, as to the right to refuse:

> This right is grounded both in state constitutional and common law. (*Wendland*, *supra*, 26 Cal.4th at p. 531.) The right of privacy guaranteed by the California Constitution, article I, section 1 "guarantees to the individual the freedom to choose to reject, or refuse to consent to, intrusions of his bodily integrity." (*Wendland*, *supra*, 26 Cal.4th at pp. 531–532.)

The *Qawi* case, which did not involve a conservatorship, but instead mentally ill prisoners' right to refuse treatment, then went on to recognize that in the context of antipsychotic drugs, unlike decisions to end life as in *Wendland*, the personal right to refuse might be overcome based on the state's parens patriae interest, saying:

> The right to refuse antipsychotic medication is not, however, absolute, but is limited by countervailing state interests. One such interest is *parens patrie*, the state's interest "in providing care to its citizens who are unable … to care for themselves." (*Addington v. Texas* (1979) 441 U.S. 418, 426 [60 L. Ed. 2d 323, 99 S. Ct. 1804].

The Court then reiterated the *Wendland* holding, saying: "In California, parens patrie may be used only to impose unwanted medical treatment on an adult when that adult has been adjudged incompetent. (*See Wendland, supra*, 26 Cal.4th at p. 535.)" *Qawi* at 15-16. *Qawi* then concluded by holding:

> We therefore hold that an MDO can be compelled to be treated with antipsychotic medication under the following nonemergency

> circumstances: (1) he is determined by a court to be incompetent to refuse medical treatment; …

Qawi at 27.

Other courts have reached the same conclusions as to the need for a judicial determination of incapacity in order to permit the use of parens patriae to deprive an individual of his or her constitutional right of privacy.

In *Edward W. v. Lamkins* (2002) 99 Cal.App.4th 516, 533 the court held:

> "[T]he right of persons not adjudicated incompetent to give or withhold consent to medical treatment is protected by the common law of this state [citations] and by the constitutional right to privacy. [Citations.]" (*Riese v. St. Mary's Hospital & Medical Center, supra,* 209 Cal.App.3d at p. 1317; *Conservatorship of Wendland* (2001) 26 Cal. 4th 519, 530, [110 Cal. Rptr. 2d 412, 28 P.3d 151].)

Further:

> "Unless the incompetence of a person refusing drug treatment has been judicially established, 'it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure that the greatest possible protection is accorded his autonomy and freedom from unwanted interference with the furtherance of his own desires.'] *Rivers v. Katz* [(1986) 67 N.Y.2d 485, [504 N.Y.S.2d 74, 495 N.E.2d 337].)

Id. at 533.

Rains concluded that elderly infirm residents of nursing homes have no constitutional right to make their own health decisions if their physician decides they are incompetent, stating "These decisions are medical decisions." *Rains* at 180. In so doing, and without citation, Rains says that, based on the physician's finding of incompetence, the patient's expectation of privacy is "greatly lessened" and goes so far as to say that, as to all persons residing in nursing homes "While persons residing in nursing homes obviously have a reasonable expectation of privacy relating to aspects of their lives which are not connected to the medical purposes of the facility it can hardly be doubted that the reasonable expectation of privacy as it relates to medical care must be diminished." *Rains* at 174.

Rains' conclusion flies in the face of case law involving the right of privacy. No other California case has permitted a physician to disable nursing home residents of their fundamental right to make their own medical decisions. In fact, none of the cases cited by the *Rains* court permit such a result. The *Rains* court cites to several cases where consent to testing, but not where medical treatment was involved. *See, e.g. Heller v. Norcal Mutual Ins. Co.*(1994) 8 Cal. 4th 30 (no privacy invasion as to sharing of medical information). Instead, the California cases constantly point to a right of privacy absent a judicial determination of incapacity, and do so with particular attention to the need for a judicial determination of incompetence before that right of privacy as to consent to medical privacy is lost.

Rains cites a New Jersey case, *In re Conroy (1985) 98 N.J. 321,* to state that legislative decisions are useful, but the New Jersey Supreme Court made many conclusions as to nursing home settings not mentioned in *Rains*. To begin with, and unlike *Rains*, the Conroy court said: "residents of nursing homes are a particularly vulnerable population." *Conroy* at 375. Further, "[P]hysicians play a much more limited role in nursing homes than in hospitals." In so concluding it cites to a U.S. Senate Report in finding that "… physicians visit their patients in nursing homes infrequently, and then only for brief periods of time." The *Conroy* court went on to state: "Moreover, physicians caring for nursing home residents generally are not chosen by the residents and are not familiar with their personalities and preferences." *Id.* at 376. The court then required that: "A necessary prerequisite to surrogate decisionmaking is a *judicial* determination that the patient is incompetent…" *Id*. at 381 (emphasis added).

As to the role of physicians in disabling people of their fundamental rights to make medical decisions, unlike §1418.8 and *Rains*, the court relied on the usual methods of determining incompetence: "Medical evidence bearing on these capabilities should be furnished to a court by at least two doctors…" The *Conroy* court's conclusion as to the proof requirements was the same as that in *Wendland*,

and absent from §1418.8: "The proof must be clear and convincing that the patient does not have and will not regain the capability of making the decision for himself." *Conroy* at 382.

In finding that there was no infringement of a right to privacy in nursing homes under §1418.8, *Rains* did not have the benefit of many of the cases set forth above, and particularly the decisions by the Supreme Court in *Wendland* and *Qawi*. Instead, the *Rains* court presumed that nursing home residents were incompetent (*Rains* at 173) because a physician had said so. It likened the residents' interests to those of persons who had to disrobe or take a urine test as athletes. *Rains* at 175. It further concluded that, without consideration of a parens patriae requirement: "[T]he providing of necessary medical care to patients on a timely basis is in very close 'proximity' to the central functions of a nursing home and is, in fact, a compelling state interest." *Id.* at 174. It denied both privacy and due process considerations and said, as to determinations of incapacity by treating physicians: "These decisions are medical decisions." *Id.* at 180. Its citations as to this conclusion were *Barber v. Superior Court* (1983) 147 §Cal.App.3d 1006) (right of physician with informed consent by spouse to end life of patient in persistent vegetative state) and *Washington v. Harper* (issue of procedural due process as medical necessity as to antipsychotic drugs.) Neither of these cases concerned or raised issues as to the parens patriae interest of the state as to judicial hearings in determining privacy and autonomy of competent individuals.

The analysis by the *Rains* court as to the rights of privacy of residents in nursing homes as to medical treatment did not have the currently available considerations found in the cases cited above.

Wendland, and such as *Qawi,* recognized, that unlike *Rains*, the determination of incompetence, whereby a patient might lose the personal right to refuse treatment, absent a patient-chosen surrogate, was dependent on the State's

parens patriae interest, and that the exercise of that interest required a judicial determination of incapacity.

Absent a judicial determination of incompetence, the right at stake for a resident in a nursing home is at least the same as it is in a prison (*Thor, Keyhea*), in a MDO treatment center *(Qawi*), in a mental hospital (*Riese, K.G.*), or in an acute care hospital (*Cobbs v. Grant (1972)* 8 Cal. 3d 229). Because of the limitations of the parens patriae state interest, as with all other Californians, due their fundamental rights of privacy and autonomy absent an emergency or a judicial determination of incompetence, nursing home residents have personal rights of refusal, including a judicial finding of incapacity.

C. *Section 1418.8 Denies Due Process in That It: 1. Permits An Interested Person to Make Legal Decisions; 2. Denies an Advocate to the Affected Person, and 3; Permits an Interested Person to Review Their Own Decisions*

1. *A Treating Physician May Not Act As the Decision Maker Required for Legal Adjudication Of Incapacity*

The Supreme Court has repeatedly prohibited interested persons from participating as arbiters of those areas in which they have been involved. The classic case for determining minimum procedural due process requirements is *Goldberg v. Kelly*, 397 U.S. 254 (1970), a case involving deprivation of welfare benefits. The Court held, as to the use of non-neutrals:

> [O]f course, an impartial decision maker is essential. Cf. In re Murchison, 349 U.S. 133 (1955); Wong Yang Sung v. McGrath, 339 U.S. 33, 45-46 (1950). We agree with the District Court that prior involvement in some aspects of a case will not necessarily bar a welfare official from acting as a decision maker. He should not, however, have participated in making the determination under review.

397 U.S. at 271. *See also Morrissey v. Brewer* (1972) 408 U.S. 471, 485-486; *Vitek v. Jones, supra.*

Preclusion of a participating person as an arbiter of rights was particularly addressed in *Washington v. Harper*, where, in a matter involving a purely medical determination rather than, as here, legal issues of capacity and surrogacy, the court nevertheless held: "In particular, independence of the decisionmaker is addressed to our satisfaction by these procedures. None of the hearing committee members may be involved in the inmate's current treatment or diagnosis." 494 U.S. at 233.

2. *An Advocate for The Resident Is Required for Fair Adjudication Of Incapacity*

The right and power of a competent person to refuse any interference with the body is, absent an emergency, fundamental, particularly as to medical intrusions. (*See*, e.g., *Cobbs v. Grant* (1972) 8 Cal. 3d 229) (right of competent adult to informed consent before medical treatment). Alternatively, the right and power of an incompetent person without a surrogate or advance directive to determine treatment is virtually non-existent – it is, at best to have a guardian determine what is best, and at worst, as in §1418.8, to default to the medical staff by the elimination of the fundamental right to refuse. The statutory fact is that the only mandated members of the team are the attending physician and the resident's assigned nurse. Section 1418.8 (e)("The interdisciplinary team… shall include the resident's attending physician, a registered professional nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident's needs, and, where practicable, a patient representative…"). It will be for the doctor and nurse to decide if other appropriate staff are needed, and the representative, only if "practicable."

At least three reasons exist why §1418.8 is unconstitutional absent an appointed representative. First, loss of physical liberty ordinarily requires appointment of counsel or at least a counsel substitute. *County of Santa Clara v. Superior Court* (1992) 2 Cal.App.4th 1686, 1693, held:

> The clearest predicate for a conclusion that an indigent litigant will be entitled to appointed counsel as a matter of due process will be a determination that the litigant may lose his or her physical liberty if he or she loses the litigation.

Liberty is clearly at stake here in that a determination of incapacity results in loss of liberty, such as occurred when Gloria A. was told she could not attend a picnic (JA724-26) Further, numerous devices and medications exist to restrain individuals of their liberty. Mark H. was tied to his bed by authority of the IDT. JA130.

Second, courts have mandated counsel to protect a liberty interest in the right to make medical decisions, even if physical liberty is not at stake. In *Keyhea v. Rushen* (1986) 178 Cal.App.3d 526, the court required among other procedural protections, such as a neutral decisionmaker, counsel to be appointed in any hearing to determine incapacity, stating:

> But these protections are to be implied from the right to a judicial determination of competency and are a necessary and integral part of that right. To divorce these protections from the right to a court determination of competency would deprive that right of any meaningful significance.

178 Cal.App.3d at 542, n. 14.

In a case involving California prisoners' right to counsel in a determination of capacity as to decisions regarding antipsychotic drugs, the court in *Department of Corrections v. Office of Administrative Hearings* (1997) 53 Cal.App.4th 780, 786, held:

> …under California law a competent, informed adult has a fundamental right of self-determination to refuse or demand the withdrawal of medical treatment of any form irrespective of the personal consequences.' (*Thor v. Superior court* 5 Cal.4th 725, 732). This right is rendered meaningless if a person cannot adequately and through competent assistance of counsel and necessary experts challenge a psychiatric determination that he or she is incompetent to refuse antipsychotic medication.

Third, courts have also mandated counsel, or a counsel substitute, when, as here, the individual is unable to represent themselves due to physical or mental limitations. The Supreme Court has held, even in the context of prisoners:

> "[W]e have recognized that prisoners who are illiterate and uneducated have a greater need for assistance in exercising their rights. (citations omitted) A prisoner thought to be suffering from a mental disease or defect requiring involuntary treatment probably has an even greater need for legal assistance, for such a prisoner is more likely to be unable to understand or exercise his rights. In these circumstances, it is appropriate that counsel be provided to indigent prisoners whom the State seeks to treat as mentally ill.

Vitek v. Jones, at 496-497. *See also In re Roger S* (1977) 19 Cal. 3d 921 (due process rights of minors whose parents seek to institutionalize them).

The requirement of a representative before the loss of a fundamental right is necessary both because of the possibility of rampant error, and because elderly, infirm, and intimidated residents cannot be expected to represent themselves, nor to file legal proceedings in California courts.

Petitioners are not seeking appointed counsel, but some sort of representative, a counsel substitute, available to the mentally ill as to capacity decisions (see Welf. & Inst. Code §5332), and even to prisoners for mere limitations on already limited physical liberty by placement in administrative segregation. *See Inmates Of Sybil Brand Institute For Women V. County Of Los Angeles* (1982) 130 Cal.App.3d 89, 109 (right to counsel substitute for transfer to administrative segregation).

3. Section *1418.8 Violates Due Process at The Treatment Review in Permitting the Treating Physician to Decide Treatment for A Nonconsenting Patient*

For the reasons set forth in Point Two A., a treating physician may not participate in the review and approval of the very treatment that that physician has recommended at the outset. The purpose of patient autonomy as to the inviolability of the person is to protect against nonconsensual invasions by medical caregivers.

Cobbs v. Grant, supra. Numerous state and federal cases preclude persons directly involved with the facts of the issues in question from determining the outcome of those issues (*Goldberg v. Kelly*, *Morrissey v. Brewer*, *Washington v. Harper*). *Washington v. Harper*, concerned, as here, the due process requirement of decisionmaker independence in making purely medical decisions whereby only those independent from the particular incident at issue might make such decisions. *See Washington v. Harper*, 494 U.S. at 233:

> In particular, independence of the decisionmaker is addressed to our satisfaction by these procedures. None of the hearing committee members may be involved in the inmate's current treatment or diagnosis.

D. *Review Of Capacity and Surrogacy Decisions by Interdisciplinary Team are Not Permitted Under §1418.8*

The superior court relied on the Departments's interpretation of the statute, which is different from the court in *Rains*. In its order, granting and denying the writ, the court said, as to notice "[T]o the extent that IDT's currently review a physician's determination of lack of capacity as claimed by the Department, there was no contention or evidence that this has resulted in any backlog to the courts. This court sees no reason why also informing patients of these determinations and permitting them to seek judicial review is likely to result in any significant financial and administrative burdens." JA719. Nonetheless, in relying on the Department's contentions, the court erroneously expanded the statute requiring notice that an interdisciplinary team would review the above three determinations (failure of notice that an interdisciplinary team: "…will review the physician's determinations and prescribed medical interventions…)." Judgment, I.(A) (3), JA853-854.

Section 1418.8 does not empower the IDT to review the physician's decisions as to incapacity or surrogacy. It only requires review of treatment intervention as to the patient's medical condition, making the physician's determination as to incapacity and absence of a surrogate final, unless a court, or

the physician himself reverses it. See Simcox Decl. (JA80-84) ("we have to try to get the physician to change his mind.").

The statute specifically states that there is to be "an interdisciplinary team review of the *prescribed medical intervention*" (emphasis added), and not of the legal status as to incompetence and adequacy of a surrogate. In fact, there is a specific definition of the "prescribed medical intervention" which is a medical treatment requiring the informed consent of the patient. §1418.8(e). Nothing in the statute speaks to the review so as to include consideration of the patient's capacity to make treatment decisions, nor the patient's surrogate decision-makers. Were it otherwise, as has been ordered by the superior court, it would mean that a nurse and a patient representative, if one is "practicable," would make legal decisions as to capacity and surrogacy and that the physician would review his/her own decisions.

The statute is quite specific in stating that the purpose of the IDT is solely to "oversee the care of the resident." §1418.8(e). It provides that the interdisciplinary team "conduct an interdisciplinary team review of the prescribed medical intervention which shall include: (e)(1) A review of the physician's assessment of the resident's condition, (e)(5), the probable impact on the resident's condition, with and without the use of the medical intervention, and (g) the interdisciplinary team shall periodically evaluate the use of the prescribed medical intervention at least quarterly or upon a significant change in the resident's medical condition.

The interdisciplinary team reviews the *medical* condition as to the medical intervention, and not the *legal* decision as to the absence of a surrogate nor the absence of decisional capacity. As *Rains* explained, it is the responsibility of the "physician to determine whether the patient lacks the capacity to make medical decisions, subject to court review if any," whereas "the interdisciplinary team assess[es] the reasons for the treatment under section 1418.8." 32 Cal.App.4th at 186. The same conclusion was reached by the Departments's expert, who has served on many interdisciplinary teams. Dr. Karl Steinberg stated in his declaration

that "Section 1418.8 appropriately leaves capacity determinations to the resident's attending physician…" and not the IDT. ¶ 9; JA555.

The result of the superior court's erroneous interpretation of the statute is to empower the IDT to review, not merely the patient's condition medically, as to the treatment itself, but as well the patient's legal status, both as to decisional capacity, and presence of a surrogate.

The fact of notice to the patient that the IDT would review the three predicate determinations made by the physician is of no value to the patient since the patient is afforded no opportunity to oppose the determinations made by the physician, either before those determinations are made by the physician, nor at the review by the IDT. The sole involvement of the patient at the IDT is

> (3) A discussion of the desires of the patient, where known. To determine the desires of the resident, the interdisciplinary team shall interview the patient, review the patient's medical records, and consult with family members or friends, if any have been identified.

§1418.8.

An interview concerning a patient's desires does not satisfy the requirements of a meaningful opportunity to oppose the determinations of incapacity, especially since the same physician who has made the determinations is reviewing those determinations, and since the determinations have already been made and require the patient to bear the burden of reversal of those determinations in a court proceeding.

In order to determine what process is due, California law requires an analysis under *People v.Ramirez* (1979) 25 Cal. 3d 260, 268. The superior court performed this analysis (see order p.13-14, JA717), finding the *Ramirez* factors were satisfied. However, these factors were analyzed as to notice being given after the physician and IDT actions and without a meaningful opportunity for a hearing, although before recourse to a court.

If notice is given before action is taken and a meaningful opportunity to oppose is provided, the *Ramirez* factors are satisfied. First, the private interest affected remains the same. Second, the risk of erroneous deprivation is considerably less given prior notice and a fair hearing so that the probable value of the additional safeguards is greater. Third, the dignitary interest in enabling fragile elderly nursing home residents to tell their story is far superior. Fourth, the governmental interest is enhanced through protection of the rights of California's elderly and, assuming a simple process before an independent decision maker such as an administrative law officer (ALO) as with the mentally ill (*see Qawi, Riese*, *Keyhea, Washington v. Harper, Vitek v. Jones*), no loss of needed medical care greater than that occurring as to the current statutory referral to an IDT for review, need occur. The *Ramirez* factors continue to be satisfied with prior notice and a meaningful opportunity for a hearing.

The end result is that procedural due process is denied both as to notice and a meaningful opportunity to be heard by giving the IDT the power to review the legal findings of incapacity and absence of a surrogate.

E. *As Written, Section 1418.8 Does Not Permit Nor May It Constitutionally Authorize End of Life Decisions*

The superior court prohibited the use of §1418.8 with four exceptions. Petitioners would preclude its use entirely, including to all of the exceptions carved out by the superior court. Thus, §1418.8 may not be used to forgo curative treatment and life support systems and end a nursing home resident's life as: 1. It explicitly was intended not to be so used, 2. By its terms it may not be so used, 3. it has been judicially interpreted to prevent its being so used, 4. It has been interpreted by the Department so as to prohibit such use; 5. It has been applied by the Department to bar such use; and 6. if so used, as with lesser intrusions such as surgery or antipsychotic drugs, it constitutionally requires far greater resident protections against risk of error and harm than are provided.

The fact is, as set forth below, that numerous sources including the statute, the legislature, *Rains*, the Department and the Department's investigators have determined the statute does not apply to end of life decisions. In enacting the statute, the Legislature stated its limited purpose:

> The Legislature finds and declares as follows: (b) Existing Probate Code procedures, including public conservatorship, are inconsistently interpreted and applied, cumbersome, and sometimes unavailable for use in *situations in which day-to-day medical treatment decisions must be made on an on-going basis.*

(Statutes 1992, Chapter 1303, Section 1: Legislative Findings at §1(b) (emphasis added).

The Legislature found, declared, and intended that the statute be used only as to "day-to-day" decisions, of which death is certainly not one, and that it involve only those medical treatment decisions which "must be made on an on-going basis" and again, death, or the discontinuation of treatment is not one "made on an on-going basis."

Further, the statute speaks to the interdisciplinary team's responsibility to "periodically evaluate the use of the prescribed medical intervention at least quarterly or upon a significant change in the resident's medical condition. " §1418.8 (g). This directive reflects "day to day medical treatment decisions [which] must be made on an on-going basis." This does not demonstrate legislative intent to permit using the statute to end the life of the resident, but instead, as the Legislative findings state: "to make health care decisions" for the resident, not to end them.

Still, further, as *Rains* said:

> section 1418.8 by its own terms applies only to the relatively nonintrusive and routine, ongoing medical intervention, which may be afforded by physicians in nursing homes; it does not purport to grant blanket authority for more severe medical interventions such as medically necessary, one-time procedures which would be carried out at a hospital or other acute care facility, as to which compliance with

> Probate Code section 3200 et seq. would still be required, except in emergency situations.

Rains at 186.

If §1418.8 cannot be used for one time procedures and those which are not relatively nonintrusive and those which are not routine and ongoing, and it is statutorily necessary to use the Probate Code procedures for such procedures, §1418.8 cannot possibly be used to discontinue treatment and end life, a one-time procedure which is the most intrusive, the least routine, and the least ongoing of any medical decision.

The superior court rejected §1418.8 as a basis for nonconsensual administration of antipsychotic drugs. The judgment requires judicial proceedings under Probate Code Section 3201 for an intrusion far less intrusive than loss of life. JA852-855.

In fact, the Department previously determined that §1418.8 did not apply to such end of life decisions. JA506-507.

When statutes permit ending life, they say so explicitly. In *Wendland*, the Court found the Legislature had spoken explicitly to such end of life withdrawal of treatment in the Act itself.

> The last sentence of section 2355, subdivision (a), set out above, incorporates definitional provisions of the Health Care Decisions Law… Section 4617 defines " '[h]ealth care decision' " as " a decision made by a patient or the patient's agent, conservator, or surrogate, regarding the patient's health care, including the following:… (c) Directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation."

Wendland at 540. Earlier in *Wendland*, the Court referred to another statute, since repealed, where the Legislature had made express findings as to the withdrawal of life support systems, saying:

> The former Natural Death Act (Health & Saf. Code, former § 7185 et seq., added by Stats. 1976, ch. 1439, § 1, p. 6478, and repealed by Stats. 1991, ch. 895, § 1, p. 3973), as first enacted in 1976, authorized competent adults to direct health care providers to withhold or withdraw life-sustaining procedures under very narrow circumstances only: specifically, in the event of an incurable condition that would cause death regardless of such procedures and where such procedures would serve only to postpone the moment of death.

Wendland at 533.

These explicit statutes, as well as the Legislative findings and intent as to §1418.8, are in keeping with the case law discussing those determinations where ending life is involved. In *Wendland,* involving the power of a conservator to end life by withdrawing life supports, the Court spoke not to the provision of treatment, but to the withdrawal of such treatment. Each of the California judicial decisions discussing ending of life, whether as to a competent patient (*Bartling*), an incompetent patient's family (*Barber*) or a court appointed conservator (*Wendland*), speak not to the provision of treatment, as does §1418.8, but instead to the withdrawal or forgoing of life support systems. *See Barber*, 147 Cal.App.3d at 102; *Bartling*, 163 Cal.App.3d 186, 197 (involving a person found incompetent by his physicians but legally competent by the court and the court spoke not to the provision of treatment as in §1418.8 but to the decision to withdraw treatment).

If section 1418.8 did, far greater constitutional protections would be required to cause death, or other highly intrusive medical decisions, than are present in the statute given that its result is not curative treatment as was its intent, but final, unappealable death.

1. *Section 1418.8 Can Not Be Used to Assess and Act on a Resident's Wish to End Life*

The use of §1418.8 as a basis to assess patient wishes would mean that the interpretation of those wishes is left to an assigned physician and reviewed by that same physician and the rest of the IDT, which may only include a nurse. The

physician would initially decide that the patient is incompetent and without surrogate, and as well that their wish is to end life. Federal and California case law require far greater protections than to permit a treating physician to decide the wishes of the patient and then act to end life. Nor does the case law permit a physician to decide initially on patient incapacity, absence of a surrogate, and then that the patient wishes to end life. There is no case law that limits review of the physician's determination to a court proceeding initiated by the ill, fragile, elderly patient.

The primary California case is *Wendland*. There are at least six differences between the statute in *Wendland* and §1418.8 with respect to ending a life. First, in *Wendland* the statute expressly permitted end of life decisions. Second, there was a judicial determination of the patient's incapacity. Third, there was an independent substitute decisionmaker – the conservator. Fourth, the decisionmaker was court appointed. Fifth, for conscious patients, which is the majority of the patients for whom end of life decisions are made under §1418.8 JA764-765. *Wendland* requires a higher standard of proof as to patient wishes than mere preponderance of the evidence, clear and convincing evidence. Sixth, the burden of proving clear and convincing evidence in a subsequent judicial action was put on those who claimed to have such evidence. *Wendland* at 545-546.

Wendland recognizes the stark nature of the rights at stake as to end of life, the risk of error and the result of that risk:

> In this case, the importance of the ultimate decision and the risk of error are manifest. So too should be the degree of confidence required in the necessary findings of fact. The ultimate decision is whether a conservatee lives or dies, and the risk is that a conservator, claiming statutory authority to end a conscious conservatee's life "in accordance with the conservatee's . . . wishes" (§ 2355, subd. (a)) by withdrawing artificial nutrition and hydration, will make a decision with which the conservatee subjectively disagrees and which subjects the conservatee to starvation, dehydration and death. This would represent the gravest possible affront to a conservatee's state

> constitutional right to privacy, in the sense of freedom from unwanted bodily intrusions, and to life. While the practical ability to make autonomous health care decisions does not survive incompetence, the ability to perceive unwanted intrusions may. Certainly it is possible, as the conservator here urges, that an incompetent and uncommunicative but conscious conservatee might perceive the efforts to keep him alive as unwanted intrusion and the withdrawal of those efforts as welcome release. But the decision to treat is reversible. The decision to withdraw treatment is not.

Wendland at 547.

Wendland cites to the Supreme Court's decision in, *Cruzan v. Missouri* (1990) 497 U.S. 261 a case involving an unconscious person, but which rested on the same constitutional requirements of reliability and objectivity as those in *Wendland*. In *Cruzan*, the Court upheld Missouri's statute requiring clear and convincing evidence of patient wishes before withdrawal of life support systems, saying: "An erroneous decision to withdraw life-sustaining treatment, however, is not susceptible of correction." *Cruzan* at 283, *quoted* in *Wendland* at 547.

2. *Section 1418.8 Can Not be Used in As a Means to Carry Out A Patient's Instructions*

The superior court permitted the use of the statute to end residents' lives after a determination of incapacity and the absence of a surrogate where the IDT concluded it was following the resident's instructions, without a judicial determination of incapacity, without an advocate for the resident and without limiting the "instructions" to those permitted under California law. JA854-855.

Californians, in skilled nursing facilities or not, have statutory rights to determine whether life support systems will be used or withdrawn after loss of capacity. But these statutory rights, unlike the process sanctioned by §1418.8, are quite precise. They are not so open-ended as to apply without more to "patient instructions." For example, there may be an advance directive under California law. *See* Prob. Code §§ 4700-4701. But an advance directive created for a patient in a skilled nursing facility must be witnessed by a patient advocate or ombudsman to

be lawful. *Id*. Further, the Probate Code requires designation of an agent to carry out the advance directive and it prohibits "a supervising health care provider or employee of the health care institution"from being the agent. Prob. Code §4701.

Another end of life "instruction" is the Physician's Order for Life Sustaining Treatment (POLST). But as found by the superior court as to its use under §1418.8 (JA 745), as with Mark H. (JA 745) and as shown in the declarations of Jane Doe and others (JA 744-745), use of a POLST is prohibited absent a signature by a patient or a legal agent JA738-739). Further, as found by the superior court, significant errors are present as to the use of §1418.8 to end life. While competent Californians have significant rights to determine end of life, the exception permitted by the superior court as to using the statute to end life upon undefined "instructions" is prohibited by Section §1418.8, and if permitted would violate both California statutory and constitutional law.

Section 1418.8 does not permit end of life determinations based on instructions any more than it permits physician determinations of patient wishes, unless instructions are limited to the form and process permitted under Probate Code §§ 4700-4701, or a valid health care directive. Alternatively, the risk of error, whether by omission or commission, and the absence of patient protection through mandated judicial review and adequate legal representation, is excessively great. The superior court reached this conclusion as to a number of examples, including that of a POLST which is to be considered such an "individual health care instruction" and thus requires the consent of a competent patient or representative of such as it was intended to be. The court recognized the requirements as to a POLST:

> The purpose of the POLST is for patients to identify their advance care wishes regarding life sustaining treatment. (See Probate Code Sections 4780-4786).) A patient or the patient's legal surrogate and a physician must sign the POLST in order for it to be enforceable. (Prob. Code Section 4780 (c).). A patient's legal surrogate may

> execute the POLST only if the patient lacks capacity, or the individual has designated that the decisionmaker's authority is effective pursuant to Probate Code Section 4682. (Prob Code Section 4780(b).).

JA738-739.

However, numerous examples show misuse of the POLST in conjunction with §1418.8 because §1418.8 permits a physician to determine patient incompetence, absence of a surrogate, patient treatment, and eliminates meaningful initial opportunity for hearing and reduces fair opportunities for judicial review prior to removal of life support systems. JA50-68. The superior court recognized misuse of the POLST by citing to the examples of Jane Doe, of Geneva Carroll and Mark H., of Cheryl Simcox, and of Margaret Main, all of whom described misuses of POLSTS. JA68-110. In the instance of Jane Doe, not only was a POLST placed in her daughter's chart without permission and without a patient signature, "[T]his practice occurs with many residents of the facilities where a instruction is placed in a patient's chart without any patient or surrogate signature." JA744. Social worker Margaret Main described a case where the patient wished not to have life sustaining treatment, "but the primary physician determined that the patient lacked capacity and changed the POLST to CPR and full code." JA744. The most egregious undoubtedly, as contained in the declaration of ombudsman Geneva Carroll was that of Mark H. as to whom the superior found:

> A POLST was signed by a physician, but not by Mark A.[sic], that stated "full code" when Mark A. entered the nursing facility. Prior to a meeting by the IDT, Carroll visited Mark A., and asked if he wanted to live or die, but he did not respond nor did his facial expression change, although when Carroll left, he stated "come back any time."…At a meeting of the IDT, Carroll discovered that no one had asked Mark A. what he wanted so the IDT went to talk to him, but all he said to the nurse practitioner that spoke to him was "Do you know what I am?" Thereafter the meeting resumed and Mark A's POLST was changed from full code to comfort care only, meaning

> Mark A. would receive no life sustaining treatment although he would receive nutrition…Mark A. passed away at the facility while in the care of hospice in February 2013.

JA745.

The simple conclusion from this evidence is that, while instructions, that is legal written ones as in living wills, durable powers of attorney for health care, and legal POLSTs are enforceable, the superior court merely allowed "instructions" (JA854-855). As to end of life decisions the statute is being used for unintended purposes, including the misuse of other statutes such as POLST. As a result, even in those situations where there are legally valid instructions, §1418.8 was not intended to provide, and does not provide, independent protection against terminal error through death.

3. *Section 1418.8 Can Not be Used by a Physician to Decline Patient Instructions*

In ordering, in its Judgment that §1418.8 may be used to decline instructions or decisions requiring ineffective care, or that which is contrary to generally accepted medical standards, the superior court cited Probate Code §§ 4735, 4736, which do not refer to, nor are found in, Health &Saf. Code §1418.8. Sections 4735 and 4736 are part of the Uniform Health Care Decisions Act (HCDA). Using §4735 in conjunction with §1418.8 may result in the physician and IDT deciding that the now allegedly incompetent patient who has previously while competent given instructions to maintain life, may have life ended by the same physician deciding to cease life support systems in contravention of instructions found in legal POLSTS and durable powers of attorney for health care.

As the Supreme Court stated in *Wendland,* the HCDA, as to issues of death, permits a competent person, or, in the case of incompetency that person's agent or surrogate to make decisions for that individual. As well, a conservator, appointed after a judicial determination of incompetence is permitted to act for the incompetent patient. The HCDA defines each of the three substitutes for the

incompetent person. "'Agent' means an individual designated in a power of attorney for health care to make a health care decision for the principal, regardless of whether the person is known as an agent or attorney-in-fact, or by some other term." Prob. Code §4607. "'Conservator' means a court-appointed conservator having authority to make a health care decision for a patient." Prob. Code §4613. "'Surrogate' means an adult, other than a patient's agent or conservator, authorized under this division to make a health care decision for the patient." Prob. Code §4643. None of these includes the medical treatment providers themselves, and indeed this would be antithetical to the purposes of the HCDA.

There is no authority for health care decisions to be made by any but the patient, agent, conservator or surrogate and this would include ending life. Nowhere is an Interdisciplinary Team, including the attending physician, given authority by the HCDA. Indeed, skilled nursing facilities are defined and covered in HCDA. Prob. Code §4639. Section 1418.8 was enacted several years before the HCDA so that the Legislature was fully aware of §1418.8. It could have included interdisciplinary teams or physicians in its scope, if it had chosen to do so. But, it did not.

The result of the superior court's judgment is that if there are legal and binding instructions or decisions, such as a valid POLST or valid Durable Power of Attorney for Health Care, whereby the patient has expressed a desire for life sustaining treatment, the attending physician may decide, using §1418.8, that the patient is now decisionally incompetent, lacks a surrogate, and contravene the patient's instructions or decisions by withholding or discontinuing life-sustaining treatment contrary to the resident's wishes.

These are not day-to-day medical treatment decisions [which] must be made on an on-going basis. *See* Stats 1992, Chapter 1303, §1: Legislative Findings.[§1418.8] (emphasis added)). At most §1418.8 authorizes consideration of a patient's "desires," not contravention of them. Section 1418.8(e)(3), only

immunizes the physician from sanctions if he or she believed that "…the action is consistent with this section and the desires of the resident... *"* §1418.8(k).

That §1418.8 cannot be used to contravene the decisions or instructions of the patient is also evident from Probate Code §4736. This section requires that, where a physician refuses such decision or instruction, he or she shall "(a) Promptly so inform the patient, if possible, and any person then authorized to make health care decisions for the patient." Under §1418.8, that physician has already decided that the patient is incompetent, and it is the physician, together with the team members who are authorized to make some, but only "relatively nonintrusive and routine" decisions for the patient. It cannot be the intent of the legislature that the physician who decides not to obey the legal instructions of the patient then gives notice to him or herself.

The superior court has permitted use of §1418.8 in conjunction with Prob. Code §§ 4735 and 4736, where the physician empowering the physician to refuse life sustaining treatment, and as the deciding authority, to then give notice to him or herself and decide to refuse transfer to a treating facility, with the only recourse for the patient to initiate a court proceeding. Minimally, this cannot be the intent of §1418.8 or §4735 and §4736.

Under HCDA, there must be an agent, conservator or surrogate for the adjudicated incompetent patient, which would prohibit the physician from using 4735 and 4736 absent notice to any of those three persons. As well, §4736(b) requires that efforts be made for transfer to another institution willing to comply with the instruction or decision, and gives the patient, or "person authorized to make health care decisions for the patient" the right to refuse transfer. The result of applying §1418.8 would then mean that the physician and others in the IDT could decide not to make reasonable efforts at transfer.

Neither the Health Care Decisions Law nor §1418.8 is authority for using an Interdisciplinary Team to make the decision to decline compliance with such

instructions as a POLST or a Durable Power of Attorney for Health Care or to revise a "Full Code" order to a "No Code" order. Further, to the extent that §4735 permits a health care provider to decline under the HCDA, immediate notice is required to be given to the person authorized to make decisions. Given that the Interdisciplinary Team must include the treating physician and the attending nurse it cannot be notice to themselves.

If it were otherwise, significant and determinative problems of due process would arise. Section 1418.8, if read together with § 4735 and §4736, would permit the treating physician to decide that the patient is incompetent, that there is no surrogate, that there is no need for a meaningful hearing nor a patient advocate, and that a POLST or DPAHC may be changed so as to result in death, and thereby to fail to comply with patient wishes and legal instructions, and then to review his or her decisions together with the nurse. The physician and nurse would then inform themselves that they can refuse to transfer the patient, and then notify the fragile patient that he or she can go to court and try to get a temporary restraining order.

Giving a medical team the right to both determine incapacity and then disobey the legal instructions of an ill, elderly person and then end that person's life because the physician decides those instructions or decisions require "ineffective care, or that which is contrary to generally accepted standards" without more than permitting that ill, elderly person to try to challenge that decision in court, is inconsistent with the right of privacy, with due process, and with both §1418.8 and the HCDA.

4. *Section 1418.8 Can Not be Used to Initiate Hospice Care*

Hospice is not permitted under §1418.8 alone, or through the federal regulations governing hospice. If §1418.8 permitted such a use, it would be an unconstitutional denial of privacy and due process.

Section 1418.8 is limited to day-to-day curative treatments and not that which must result in discontinuation of treatment and death. Alternatively, hospice

itself is only appropriate if *curative* treatment is ended and only *palliative* treatment and death is intended.

Hospice care is controlled by federal law and federal regulations. 42 CFR Chap. IV, Subchap. B, Part 418. Significant aspects of the federal regulations are either inconsistent with the use of §1418.8, or, for purposes of any application, would require far greater procedural protections than are now available under §1418.8.

Federal regulations require that the individual, or the individual's representative, recognize that there will be no curative care in hospice, which is the antithesis of the purpose of §1418.8, that is, providing medical treatment either to cure, maintain or treat the person's underlying injury or disease. *See* 42 CFR §418.24(b)(1) (2)). In hospice, the regulations require that the patient or their representative understand that that treatment will no longer be the objective, but instead the purpose will be to make the person comfortable as he or she is dying. Section 418.24(b)(1)(2) requires that an election which must include, inter alia, the following: "The individual's or representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal illness."

Should there be any doubt that curative care is not permitted under hospice, the regulations define palliative care to treat, not the underlying disease or injury, but only the suffering resulting from the disease or injury. Palliative care is defined by 42 CFR 418.3 as follows:

> Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

Patient's rights as conditions of participation in hospice are set forth in 42 CFR 418.52. They include either through an adjudication of incompetence by a court, or through a legal representative designated by the patient, neither of which includes an interdisciplinary team under §1418.8. Title 42 CFR 418.52(b)(iv) states, in part:

> (2) If a patient has been adjudged incompetent under state law by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed pursuant to state law to act on the patient's behalf.
>
> (3) If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law.

Unlike, §1418.8, which does not require a judicial determination or a patient representative, hospice requires, for incompetent patients, that there must be a representative, and limits that representative to those who are authorized under state law. A "representative" is defined by 42 CFR 418.3 as:

> An individual who has the authority under State law (whether by statute or pursuant to an appointment by the courts of the State) to authorize or terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill patient who is mentally or physically incapacitated. This may include a legal guardian.

In addition, although under §1418.8 the attending physician may be assigned and need not be the choice of the patient, the hospice regulations require otherwise. The hospice regulations require that the individual or representative acknowledge that the physician was his or her choice, and it cannot be that the physicians under §1418.8 choose him or her as the hospice representative. Both concepts would be inconsistent with 42 CFR 418.24(b)(1) which requires that there be an election statement which must include:

> Identification of the particular hospice and of the attending physician that will provide care to the individual. The individual or

> representative must acknowledge that the identified attending physician was his or her choice.

The federal regulations prohibit transfer to hospice absent the physician's determination that the person is terminally ill and will die within six months. In order to be eligible for hospice care, "an individual must be '(b) certified as being terminally ill in accordance with [Section] 418.22.'" 42 CFR 418.20. Title 42 CFR 418.22 states that:

> (b) Certification will be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness. The certification must conform to the following requirements:
>
> (1) The certification must specify that the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course.

The primary consideration as to the transfer from curative care in a skilled nursing home to hospice care is the diagnosis that the resident will soon die and should be given palliative care rather than care whose purpose is to treat and cure disease.

In the Judgment, the superior court permitted a treating physician to determine that a resident is decisionally incompetent, has no legal surrogate, is terminally ill, and then without consent from the patient, a surrogate, or any source independent from the providers of curative care, to transfer that resident to a hospice where the resident will receive no curative care, but only palliative care, and then to require that the same physician review, as a member of the interdisciplinary team, that physician's previous recommendation. Further, under the lower court's judgment, the resident will have no meaningful hearing as to this fatal decision, no neutral decision maker, no advocate, no opportunity to oppose the finding of terminal illness nor of transfer to hospice care, no judicial determination of incapacity and their only recourse regarding this travesty is to somehow start a

proceeding in superior court where the burden of proving error is on a sick, elderly, vulnerable unrepresented person.

The Department's own records show instances of erroneous diagnoses of such terminal illnesses, such as cancer. JA382-388. Should this court find a statutory interpretation whereby the statute could be used to make life ending decisions regarding terminal illnesses and have the interdisciplinary team transfer the resident to a hospice for palliative care only, due process would require greater protections. In fact, the superior court afforded far greater protections for a far lesser intrusion than death, the decision to administer antipsychotic drugs. Due process and privacy protections cannot only require court orders for the nonconsensual use of antipsychotic drugs, but none for determinations of incapacity, of terminal illness, of cessation of curative care, and transfer to a hospice for resultant death.

For the far less intrusive activity of transfer of a felon from a prison to mental hospital, unlike transfer of an ill elderly person to a hospice to die, the Court has required the full panoply of legal rights in *Vitek v. Jones*. For the far less intrusive determination of the use of antipsychotic drugs on a dangerous prisoner, where there has been no determination of the fundamental right of autonomy as is required in California, the Court again required a full panoply of legal rights including a neutral decision maker. *Vitek* at 494-496. In California, as to the much less intrusive determination of the nonconsensual use of antipsychotics, as to a prisoner, the California Supreme Court required a judicial determination of incapacity. *See Qawi*. Although on a somewhat different point, the power of a conservator to terminate treatment, *Wendland* came to the same conclusion. Due process, as well as protection of the fundamental autonomy rights of the nursing home resident, demand greater protections than from a statute never intended for that purpose.

CONCLUSION

The court should affirm the Judgment with respect to:

1. The notice requirements set forth in the Judgment;

2. The procedures for the administration of antipsychotic drugs to skilled nursing and intermediate care facility residents as set forth in the Judgment;

3. The prohibition against the use of Health & Saf. Code §1418.8 for end of life decisions as set forth in the Judgment, without any exceptions, including (a) the wishes of the resident; (b) instructions from the resident; (c) Prob. Code §4735; or (d) hospice.

The court should reverse the Judgment with respect to:

1. The requirements that there be notice and a meaningful opportunity to be heard prior to: (a) determination of incapacity; and (b) the need for treatment;

2. The need for a judicial determination of incapacity to make medical decisions;

3. That the treating physician may not be the decisionmaker as to incapacity of the resident;

4. That the resident is entitled to an advocate as to issues of issues of decisional incapacity;

5. That the treating physician is prohibited from reviewing his or her own decisions as to incapacity, surrogacy, or treatment;

6. That the interdisciplinary team is prohibited from reviewing decisions as to capacity and surrogacy; and,

7. That, as to ending the life of the resident, §1418.8 may not be used for any purpose, including (a) consideration of the wishes of the resident; (b) consideration of the instructions of the resident; (c) in conjunction with Prob. Code §4735; and, (d) as support for transfer to hospice.

The court should remand for entry of a peremptory writ consistent with the court's opinion.

Dated: January 17, 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 26,604 words as counted by the Corel WordPerfect X8 word-processing program used to generate the brief.

Dated: January 17, 2017

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

Health and Safety Code Section 1418.8

HEALTH AND SAFETY CODE - HSC

DIVISION 2. LICENSING PROVISIONS [1200 - 1796.63] *(Division 2 enacted by Stats. 1939, Ch. 60.)*

CHAPTER 2.4. Quality of Long-Term Health Facilities [1417 - 1439.8] *(Chapter 2.4 added by Stats. 1973, Ch. 1057.)*

1418.8. (a) 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.

(b) For purposes of subdivision (a), a resident lacks capacity to make a decision regarding his or her health care if the resident is unable to understand the nature and consequences of the proposed medical intervention, including its risks and benefits, or is unable to express a preference regarding the intervention. To make the determination regarding capacity, the physician shall interview the patient, review the patient's medical records, and consult with skilled nursing or intermediate care facility staff, as appropriate, and family members and friends of the resident, if any have been identified.

(c) For purposes of subdivision (a), a person with legal authority to make medical treatment decisions on behalf of a patient is a person designated under a valid Durable Power of Attorney for Health Care, a guardian, a conservator, or next of kin. To determine the existence of a person with legal authority, the physician shall interview the patient, review the medical records of the patient, and consult with skilled nursing or intermediate care facility staff, as appropriate, and with family members and friends of the resident, if any have been identified.

(d) The attending physician and the skilled nursing facility or intermediate care facility may initiate a medical intervention that requires informed consent pursuant to subdivision (e) in accordance with acceptable standards of practice.

(e) Where a resident of a skilled nursing facility or intermediate care facility has been prescribed a medical intervention by a physician and surgeon that requires informed consent and the physician has determined that the resident lacks capacity to make health care decisions and there is no person with legal authority to make those decisions on behalf of the resident, the facility shall, except as provided in subdivision (h), conduct an interdisciplinary team review of the prescribed medical intervention prior to the administration of the medical intervention. The interdisciplinary team shall oversee the care of the resident utilizing a team approach to assessment and care planning, and shall include the resident's attending physician, a registered professional nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident's needs, and, where practicable, a patient representative, in accordance with applicable federal and state requirements. The review shall include all of the following:

(1) A review of the physician's assessment of the resident's condition.

(2) The reason for the proposed use of the medical intervention.

(3) A discussion of the desires of the patient, where known. To determine the desires of the resident, the interdisciplinary team shall interview the patient, review the patient's medical records, and consult with family members or friends, if any have been identified.

(4) The type of medical intervention to be used in the resident's care, including its probable frequency and duration.

(5) The probable impact on the resident's condition, with and without the use of the medical intervention.

(6) Reasonable alternative medical interventions considered or utilized and reasons for their discontinuance or inappropriateness.

(f) A patient representative may include a family member or friend of the resident who is unable to take full responsibility for the health care decisions of the resident, but who has agreed to serve on the interdisciplinary team, or other person authorized by state or federal law.

(g) The interdisciplinary team shall periodically evaluate the use of the prescribed medical intervention at least quarterly

or upon a significant change in the resident's medical condition.

(h) In case of an emergency, after obtaining a physician and surgeon's order as necessary, a skilled nursing or intermediate care facility may administer a medical intervention that requires informed consent prior to the facility convening an interdisciplinary team review. If the emergency results in the application of physical or chemical restraints, the interdisciplinary team shall meet within one week of the emergency for an evaluation of the medical intervention.

(i) Physicians and surgeons and skilled nursing facilities and intermediate care facilities shall not be required to obtain a court order pursuant to Section 3201 of the Probate Code prior to administering a medical intervention which requires informed consent if the requirements of this section are met.

(j) Nothing in this section shall in any way affect the right of a resident of a skilled nursing facility or intermediate care facility for whom medical intervention has been prescribed, ordered, or administered pursuant to this section to seek appropriate judicial relief to review the decision to provide the medical intervention.

(k) No physician or other health care provider, whose action under this section is in accordance with reasonable medical standards, is subject to administrative sanction if the physician or health care provider believes in good faith that the action is consistent with this section and the desires of the resident, or if unknown, the best interests of the resident.

(l) The determinations required to be made pursuant to subdivisions (a), (e), and (g), and the basis for those determinations shall be documented in the patient's medical record and shall be made available to the patient's representative for review.

(Amended by Stats. 2006, Ch. 538, Sec. 355. Effective January 1, 2007.)

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

Combined Respondents' and Cross-Appellants' Opening Brief

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 January 17, 2017.

Clerk, Alameda County Superior Court
400 McAllister Street
San Francisco, CA 94612

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

Executed on January 17, 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**

1. At the time of service I was at least 18 years of age and not a party to this legal action.

2. My email address used to e-serve: **amitai@schwartzlaw.com**

3. I served by email a copy of the following document(s) indicated below:

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

01-17-2017

Date

/s/Amitai Schwartz

Signature

Schwartz, Amitai (55187)

Last Name, First Name (PNum)

Law Offices of Amitai Schwartz

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