SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF ALAMEDA

CALIFORNIA ADVOCATES FOR NURSING HOME REFORM (CANHR); GLORIA A.; and ANTHONY CHICOTEL, AS TAXPAYER, Petitioners, v. RONALD CHAPMAN, M.D., as Director of the California Department of Public Health, Respondent.	Case No. RG13700100 **ORDER GRANTING PETITION FOR WRIT OF MANDATE IN PART AND DENYING IN PART**

The Petition of California Advocates for Nursing Home Reform (CANHR), Gloria A. and Anthony Chicotel, as taxpayer, ("Petitioners") for Writ of Mandate, Declaratory Relief and Injunction, came on regularly for hearing on February 19, 2015, March 20, 2015, and March 27, 2015, in Department 14 of the above-entitled court, the Honorable Evelio Grillo presiding. Petitioners appeared by counsel Morton Cohen and Amitai Schwartz. Respondent Ronald Chapman, M.D., as Director of the California Department of Public Health ("Department"), appeared by counsel Joshua Sondheimer.

Following the March 27, 2015 hearing, the court took the matter under submission. The court has considered all of the papers filed in connection with the petition, and the arguments at the hearings and, good cause appearing, hereby rules as follows:

BACKGROUND

Petitioners bring this petition challenging Health and Safety Code section 1418.8 as unconstitutional. The Legislature enacted Health and Safety Code section 1418.8 to allow certain incompetent patients residing in skilled nursing facilities or intermediate care facilities to receive medical treatment after a physician has determined that a patient is incapable of giving informed consent to such treatment and there is no person with legal authority to make such decisions on behalf of that patient.

Petitioners allege eight causes of action in their petition. The first five causes of action allege that the statute is facially unconstitutional. The remaining three causes of action allege that the statute is unconstitutional as-applied by the Department. These claims are:

(1) Health and Safety Code section 1418.8 – violation of California Constitution right to due process re: right to notice and opportunity to oppose: (a) determination of decisional incapacity, (b) the determination of the absence of a legal substitute decision maker, (c) the hearing or review as to medical treatment, and (d) the administration or withdrawal of medical treatment.

(2) Health and Safety Code section 1418.8 – violation of California Constitution right to due process by failing to require adequate representation at the determination of incapacity

(3) Health and Safety Code section 1418.8 – violation of California Constitution right to privacy by permitting physicians to make legal adjudications as to decisional incapacity

(4) Health and Safety Code section 1418.8 – violation of California Constitution right to due process by failing to require neutral decision makers at the adjudications as to decisional incapacity

(5) Health and Safety Code section 1418.8 – violation of US and California Constitutions right to due process by failing to require a neutral decision maker at the review and approval or rejection of the treatment

(6) Health and Safety Code section 1418.8 – failure to comply with judicial precedent by failing to require a patient representative at the review to determine treatment, absent exigent circumstances

(7) Health and Safety Code section 1418.8 – failure to comply with judicial precedent precluding use as to antipsychotic drugs, or in the alternative, providing adequate notice, counsel, evidence and a judicial hearing as to incapacity, necessity and the least intrusive alternative

(8) Health and Safety Code section 1418.8 – failure to comply with judicial precedent precluding use of statute for treatments or discontinuation thereof which would result in death, such as, but not limited to, do not resuscitate, comfort care or discontinuation of treatment or for Physician Order for Life Sustaining Treatment (POLST) orders.

Based on these claims, Petitioners seek declaratory and injunctive relief that section 1418.8 is unconstitutional, as well as a peremptory writ of mandate prohibiting use of section 1418.8 by all California skilled nursing and intermediate care facilities. The Department opposes the petition on substantive grounds, and also challenges whether Petitioners have standing to bring this taxpayer action.

STANDARD OF REVIEW

Code of Civil Procedure section 1085 provides that "[a] writ of mandate may be issued by any court to any inferior tribunal, corporation, board, or person, to compel the performance of an act which the law specially enjoins, as a duty resulting from an office, trust, or station, or to compel the admission of a party to the use and enjoyment of a right or office to which the party is entitled, and from which the party is unlawfully precluded by that inferior tribunal, corporation, board, or person." (Civ. Proc. Code § 1085.) To obtain such relief, petitioner must demonstrate there is no other plain, speedy and adequate remedy, the public official or entity had a ministerial duty to perform, and the petitioner had a clear and beneficial right to performance. (*Pomona Police Officers' Assn. v. City of Pomona* (1997) 58 Cal.App.4th 578, 584.)

"A ministerial act is an act that a public officer is required to perform in a prescribed manner in obedience to the mandate of legal authority and without regard to his own judgment or opinion concerning such act's propriety or impropriety, when a given state of facts exists." (*Id.*) Thus, the trial

court's role in such a writ proceeding is limited to determination of whether the agency's action was arbitrary, capricious, or without evidentiary support, or whether the agency failed to follow the procedure and give the notices required by law. (*Id.*) The trial court may not substitute its judgment for that of the agency or force the agency to exercise its discretion in a certain way. (*Ass'n of Irritated Residents v. San Joaquin Valley Unified Air Pollution Control Dist.* (2008) 168 Cal.App.4th 535, 543.)

LEGAL ANALYSIS

I. WHETHER PETITIONER CHICOTEL FAILS TO STATE A TAXPAYER CLAIM

Petitioners' initial petition in this action, filed on October 22, 2013, named CANHR and Gloria A. as Petitioners. Approximately four months later, on February 24, 2014, Petitioner Gloria A. passed away. The Department initially opposed this writ in part, on the ground that Gloria A.'s action does not survive her passing and that CANHR lacked any direct interest in the outcome of this action.

Petitioners then sought leave to amend the petition to add Anthony Chicotel as a petitioner to support a taxpayer action. The court granted Petitioners' motion to amend on January 14, 2015. Petitioner filed a First Amended Petition including Anthony Chicotel as a petitioner. The Department then filed a supplemental opposition contending that Petitioner Chicotel fails to state a taxpayer claim under Code of Civil Procedure section 526a.

Generally, a writ of mandate must be brought by a party that is beneficially interested. (See C.C.P. § 1086.) An exception has been found to this general rule though "where the question is one of public right and the object of the mandamus is to procure the enforcement of a public duty...." (*Bd. of Soc. Welfare v. County of L.A.* (1945) 27 Cal.2d 98, 100-101.) In such cases, the petitioner need not have a legal or special interest in the result, but rather it is sufficient that the petitioner, as a citizen, has an interest in having the laws executed and the duty in question enforced. (*Id.*) The rationale behind this exception is that it enables citizens the opportunity to ensure that no governmental body impairs or

defeats the purpose of legislation establishing a public right. (*Green v. Obledo* (1981) 29 Cal.3d 126, 144.)

In *Connerly v. State Pers. Bd.* (2001) 92 Cal.App.4th 16, 30, the court found that plaintiff's taxpayer action challenging affirmative action programs was consistent with the purpose of a standing requirement, which is to ensure that courts address actual controversies between parties who have sufficient adverse interests to press their case with vigor. "[T]axpayer suits provide a general citizen remedy for controlling illegal governmental activity." (*Id.* at 29.) This includes relief from the improper expenditure of governmental time. (See *Blair v. Pitchess* (1971) 5 Cal.3d 258, 268.)

In this case, Petitioner Chicotel, as a taxpayer, objects to expenditures of time and money by the Department in enforcing this claimed unconstitutional statute. (See First Amended Petition, ¶ 18A.) The Department contends that the allegations fail to state a claim because they are directed not to improper conduct by the Department, but rather to the physicians and nursing facilities to whom section 1418.8 is directed. A taxpayer claim seeking injunctive relief pursuant to Code of Civil Procedure section 526a may be properly rejected where the wrongful allegations involved were not directed to the actions of public officials regarding that statute, but rather some of the alleged beneficiaries of the statute that were provided tax relief. (See *Humane Society of the United States v. State Board of Equalization* (2007) 152 Cal.App.4th 349.)

In *Humane Society*, the State Board of Equalization was charged with implementing an exemption to sales and use taxes, passed by the Legislature for "Farm Equipment and Machinery." (*Id.* at 352.) The Humane Society and four individual taxpayers then brought an action alleging that the State Board of Equalization and the State Controller alleging in part, that the implementation of this exemption, Revenue and Taxation Code section 6356.5, violated Penal Code sections 597(b) and 597t by allowing tax exemptions to poultry producers who kept egg-laying hens in cages with inadequate exercise areas. (*Id.* at 353.) The court found that the attempt to stop the improper use of cages by seeking injunctive relief under section 526a was a significant step removed from any implicated

governmental action in the passage, implementation and administration of section 6356.5. (*Id.* at 360-361.) The court found that section 526a is properly used where some illegal expenditure or where the complaint endeavors to control illegal governmental activity. (*Id.* at 361.) Because the court found that the Humane Society and the taxpayers failed to state a claim for relief under section 526a, the Court of Appeal did not reach the trial court's alternative holding that they also lacked standing to sue. (*Id.* at 360, fn.6.)

Humane Society however, did not challenge the constitutionality of either section 6356.5 or the State Board of Equalization's implementing regulation. (*Id.* at 360.) In contrast, Petitioners here specifically challenge the constitutionality of section 1418.8 and the Department's implementation of section 1418.8. Moreover, whereas the State Board of Equalization's role was only to implement and administer the tax exemption to the poultry producers accused of the wrongful conduct, the Department in this case has direct oversight of all skilled nursing facilities and intermediate care facilities in California and thus is charged with ensuring that such facilities adhere to California laws. (First Amended Petition, ¶ 19.) Thus, the facts in this case are distinguishable from those in *Humane Society,* and the court finds that Petitioner Chicotel sufficiently states facts to support a taxpayer claim.

II. WHETHER CANHR HAS STANDING TO BRING THESE CLAIMS

Petitioner CANHR is a statewide, nonprofit 501(c)(3) advocacy organization operating since 1983, that is dedicated to improving the quality of care for California's nursing home residents. (See First Amended Petition, ¶ 17.)

"[W]hen a nonhuman entity claims the right to pursue a citizen suit, the issue must be resolved in light of the particular circumstances presented, including the strength of the nexus between the artificial entity and human beings and the context in which the dispute arises." (*Save the Plastic Bag Coal. v. City of Manhattan Beach* (2011) 52 Cal.4th 155, 167.) The factors to be considered are whether the corporation has shown a continuing interest in or commitment to the public right being

asserted, whether it represents individuals who would be beneficially interested in the action, whether individuals who are beneficially interested would find it difficult or impossible to seek vindication of their own rights, and whether prosecution of the action as a citizen suit by a corporation would conflict with other competing legislative policies. (*Id.*) A nonprofit corporation was found to have standing in a citizen suit challenging housing regulations. (See *Urban Habitat Program v. City of Pleasanton* (2008) 164 Cal.App.4th 1561, 1581.)

All of the factors to be examined clearly support that Petitioner has standing to bring a citizen action here. Petitioner is a nonprofit organization that is dedicated to advocating for and protecting the interest of nursing home residents, whom this statute directly impacts. There is no dispute that it would be difficult or impossible for any beneficially interested individuals, i.e. nursing home residents who have been found incompetent and have no one designated to make determinations as to their care, to otherwise obtain relief. No conflict with other legislative policies has been identified by the Department in allowing CANHR to proceed with this action as a citizen action. Accordingly, the court finds that CANHR has standing to bring this action.[1]

III. THE PETITION CHALLENGING SECTION 1418.8 AS FACIALLY UNCONSTITUTIONAL

Petitioners' first five causes of action challenge section 1418.8 on the ground that it is facially unconstitutional. "A facial challenge to the constitutional validity of a statute or ordinance considers only the text of the measure itself, not its application to the particular circumstances of an individual." (*Dillon v. Municipal Court* (1971) 4 Cal.3d 860, 865.) To support that a statute is facially unconstitutional, "petitioners cannot prevail by suggesting that in some future hypothetical situation constitutional problems may possibly arise as to the particular application of the statute....Rather,

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[1] In light of this court's finding that Petitioners Chicotel and CANHR have standing to pursue these claims, the court need not reach the issue raised by the parties of whether these claims may still be brought on behalf of Petitioner Gloria A., who passed away after this action was filed.

petitioners must demonstrate that the act's provisions inevitably pose a present total and fatal conflict with applicable constitutional prohibitions." (*Tobe v. City of Santa Ana* (1995) 9 Cal.4th 1069, 1084, citing *Arcadia Unified School Dist. v. State Dept. of Education* (1992) 2 Cal.4th 251, 267.) However, while a statute may not be invalidated as facially unconstitutional because unconstitutional problems may arise in some future hypothetical situation, a court also may not ignore the actual standards contained in a procedural scheme and uphold the law simply because in some hypothetical situation it may lead to a permissible result. (*California Teachers Ass'n v. State of California* (1999) 20 Cal.4th 327, 347.)

In contrast, an as applied challenge is based on 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. (*Tobe, supra* at 1084.) "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." (*Id.*)

A. First Cause of Action: Health and Safety Code section 1418.8 – violation of California Constitution right to due process re: right to notice and opportunity to oppose: (a) determination of decisional incapacity, (b) the determination of the absence of a legal substitute decision maker, (c) the hearing or review as to medical treatment, and (d) the administration or withdrawal of medical treatment.

The court begins with the premise 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.) As an expert, a medical doctor's role is to appreciate the risks inherent in the procedure being prescribed, the risks of a decision not to undergo the treatment, and the probability of a successful outcome of the treatment. (*Cobbs v. Grant* (1972) 8 Cal.3d 229, 243.) Once the doctor has disclosed this information, the evaluation and decision whether to undergo the procedure or treatment is then up to the patient alone. (*Id.*) "A patient should be denied the opportunity to weigh the risks only where it is evident he cannot evaluate the data, as for example, where there is an emergency or the patient is a child or incompetent." (*Id.*) Thus, the law provides that a patient's consent is implied in an emergency. (*Id.*) In a situation where a patient is incompetent though, consent is still needed and is usually transferred to the patient's legal guardian or closest available relative. (*Id.* at 244.) If the incompetent patient has no legal guardian or designated person to make such decisions for the patient, then a petition may be brought pursuant to Probate Code section 3201(b) to designate such a person. (See Prob. Code § 3201(b) ["A petition may be filed to determine that a patient lacks the capacity to make a health care decision concerning specified treatment for an existing or continuing condition, and further for an order authorizing a designated person to make a health care decision on behalf of the patient."].)

In 1992, the Legislature enacted Health and Safety Code section 1418.8 specifically to deal with the issue of how to provide nonemergency but necessary and appropriate medical treatment to nursing home patients that were incompetent and therefore lacked capacity to consent, and also did not have anyone to provide consent for them. (*Rains v. Belshe* (1995) 32 Cal.App.4th 157, 166.) The Legislature recognized the need to provide such medical treatment without the delay of securing a ruling on a petition authorizing treatment under Probate Code section 3201, which the Legislature found frequently took from two to six months to obtain. (*Id.*)

Section 1418.8(a) provides that if the attending physician and surgeon of a resident in a skilled nursing facility or intermediate facility prescribes or orders a medical intervention that requires informed

consent be obtained but is unable to obtain such consent because the physician and surgeon have determined that the resident lacks capacity to make healthcare decisions and there is no other person to make such decisions on behalf of the resident, then the physician and surgeon shall inform the skilled nursing facility or intermediate care facility. A resident lacks capacity to make a healthcare decision 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 preference regarding the intervention. (Health & Safety Code § 1418.8(b).) A person with legal authority to make medical treatment decisions on behalf of a patient is defined, for purposes of section 1418.8(a), as a person designated under a valid Durable Power of Attorney for Health Care, a guardian, a conservator or next of kin. (Health & Safety Code § 1418.8(c).) In making both the capacity determination and the determination that the patient has no one available to make medical treatment decisions for that patient, the physician is required to interview the patient, review the patient's medical records, and consult with staff at the facility, as appropriate, and family and friends of the patient, if any have been identified. (Health & Safety Code § 1418.8(b) & (c).) If the physician determines the patient lacks capacity to make health care decisions, there is no person with legal authority to make those decisions on behalf of the patient, and the physician has prescribed a medical intervention, the facility shall, except in cases of emergency as explained in section 1418.8(h), conduct an interdisciplinary team review of the prescribed medical intervention prior to the administration of the medical intervention. (Health & Safety Code § 1418.8(e).)

Petitioners challenge section 1418.8 as facially unconstitutional because it violates a patient's due process rights by: (1) failing to require that the patient be notified that the patient has been determined incapacitated, (2) failing to require that the patient be notified that it has been determined that the patient lacks a surrogate decisionmaker, (3) failing to require that the patient be notified of the prescribed medical intervention, and (4) of the opportunity to seek judicial review of these

determinations. Petitioners cite to Gloria A. as an example of such a situation where the patient did not find out until she tried to leave the facility with another patient, that she had been declared incompetent, and therefore should have been told at the time of the incapacity determination that she was found incompetent. (See Gloria A. Decl.)

The Department contends that this issue was already addressed in *Rains, supra*, and was rejected because section 1418.8(j) allows any interested person to seek judicial review of the physician's determination of incapacity, thereby meeting the requirements of due process. (See The Department's Opposition, 11:8-14, citing to *Rains, supra*, 32 Cal.App.4th at 185.) Additionally, at the hearing, the Department asserted that notice to the interdisciplinary team ("IDT team") is provided once the physician determines incapacity, and thus the IDT team may seek review of the capacity determination.

After reviewing *Rains, supra*, the court is not persuaded that *Rains* addressed the specific issues presented by Petitioners here. In *Rains*, the Court of Appeal found that an adversarial hearing was not required following a physician's determination of lack of capacity to consent to medical treatment, reasoning that to do would not only be cumbersome to thousands of patients and courts, but it would presume the bias, if not dishonesty, of physician's opining as to patient's capacity, which the court rejected. (*Id.* at 181-182.) The court further found that "[n]ursing home patients are not denied due process because their incapacity to give consent to medical intervention is initially determined by a physician and surgeon, rather than by a judicial or quasi-judicial hearing." (*Id* at 182.) Instead, in light of section 1418.8(j), "due process is assured because there is also the right to secure judicial review of a physician's determination of the patient's *incapacity* to give informed consent to that medical intervention, which is the predicate condition for the application of section 1418.8." (*Id.*) Thus, *Rains* found that no adversarial hearing was required following a physician's determination of lack of capacity, but it did not address the issue here of whether a patient's due process rights are violated by failing to

notify *the patient* that he or she has been determined by the attending physician or surgeon to lack capacity.

Further, *Rains* found that even though section 1418.8 allows the patient's physician to determine initially whether the patient lacks the capacity to make medical decisions, and the IDT team assessing the reasons for the treatment under section 1418.8 would often include the physician who had initially prescribed the treatment under review, this initial decision is not final. (*Id.* at 186.) "Parties seeking to object to such a decision, including the patient, the patient's representative, or a public agency which supervises or investigates the care provided by nursing homes, still retain full access to a neutral determination by a court under subdivision (j) of section 1418.8." (*Id.*) Thus, the court held that this comports with due process principles. (*Id.*)

Accordingly, this court sees nothing in *Rains* that addresses the issue presented by Petitioners as to whether a patient's due process rights under the California Constitution is violated by failing to provide notice and opportunity to the patient to oppose the determination of lack of capacity, absence of a legal substitute decision maker and the prescribed medical intervention. 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. (*Rains, supra* at 186.)

Since this issue was not determined in *Rains*, the court turns now to whether the statute, on its face, violates due process under the California Constitution. Article I, section 7, subdivision (a) of the California Constitution provides in part that "A person may not be deprived of life, liberty, or property without due process of law...." Health and Safety Code section 1418.8(a) states:

> (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.*

(Health & Safety Code § 1418.8(a) (emphasis added).)

"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.]" (*Conservatorship of Moore* (1986) 185 Cal.App.3d 718, 725, quoting *Mullane v. Central Hanover Bank Tr. Co.* (1950) 339 U.S. 306.) Where a prison physician brought an ex parte proceeding seeking to forcibly treat an inmate, the California Supreme Court has indicated its disapproval of "any procedure that denies or limits any relevant party access to the proceedings and the opportunity to be heard," except "in cases of imminent danger to the life or health of the patient or a similar exigency." (*Edward W. v. Lamkins* (2002) 99 Cal.App.4th 516, 529, citing *Thor v. Superior Court* (1993) 5 Cal.4th 725, 733, fn. 2.) "The unnecessary exclusion of the critical party from meaningful participation in a determination of this 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." (*Id.*)

People v. Ramirez (1979) 25 Cal.3d 260, 268, established the test that has since been used by courts to evaluate due process claims under the California Constitution. This test for evaluating due process rights under the California Constitution generally requires the court to consider: "(1) the private interest that will be affected by the official action, (2) the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards, (3) the dignitary interest in informing individuals of the nature, grounds and consequences of the action and in enabling them to present their side of the story before a responsible governmental official, and (4) the governmental interest, including the function involved and the fiscal

and administrative burdens that the additional or substitute procedural requirement would entail." (*Id.* at 269.)

Considering these factors, the private interest to be affected by the official action is significant and serious as a physician's determination under section 1418.8 takes away a patient's ability to both make the patient's own health care decisions and to designate a person on the patient's behalf to make such decisions. A competent adult has the right to refuse medical treatment, which is grounded both in state constitutional and common law. (*In re Qawi* (2004) 32 Cal.4th 1, 14, citing *Wendland, supra*, 26 Cal.4th at 530.) The right of privacy guaranteed by 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. (*Id.*) Thus, deprivation of such rights is clearly of the utmost importance.[2]

Further, section 1418.8(a) on its face only requires the physician to inform the skilled nursing facility or intermediate care facility of these determinations, but it does not also require that the patient be notified. Thus, the risk of an erroneous deprivation of such liberty and privacy interest are substantial, as such a finding results in the patient no longer being able to make decisions about health care treatment for himself or herself as well as designate a surrogate. Additionally, the probable value of additional procedural safeguards of notifying the patient that such determinations have been made, i.e., that the patient has been determined to lack capacity, that the physician has determined there is no surrogate available to make such decisions for the patient, that a medical treatment has been recommended for the patient, and that the patient may challenge these determinations under section 1418.8(j), is high. To the extent that any of these patients are competent enough to want to challenge

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[2] It appears that a physician's determination of lack of capacity may also deprive a patient thereafter from being able to control that patient's own finances, and places the patient's finances into the hands of the facility caring for the patient, including allowing the facility to cash the patient's checks. (See Pence Decl.) A patient's visitors, excursions, telephone calls and mail may also be limited based on a physician's determination of lack of capacity. (See e.g., Petitioners' Supplement, Jones Decl., Thompson Decl.)

these determinations, such notice and opportunity may allow them to keep their decision-making capacity, or designate someone of their own choosing, instead of placing such decisions in the hands of a team of strangers.[3] There is also an important dignitary interest in informing patients of the nature, grounds and consequences of these determinations by the physician so that they may seek judicial review, if they choose to do so.

The fiscal and administrative burdens of notifying patients of these determinations is also minimal. The physician is already required to inform the skilled nursing facility or intermediate care facility of these determinations, and therefore simply needs to also provide notification to the patient. The only burden on the Department would appear to be adopting standards for how physicians are to provide these patients with such notice, including the right to seek review. The burden on the courts would also appear to be insignificant because if, in fact, these patients are incompetent, then they are unlikely to seek review of these determinations. Indeed, to the extent that IDTs 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. Thus, 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.

In sum, the court fails to see how a patient is afforded due process if it is not required that a patient be provided with notice that these determinations have been made as well as advised of the patient's right to seek court review. *Rains* found that section 1418.8 comported with due process because "there is also the right to secure judicial review of a physician's determination of the patient's incapacity to give informed consent to that medical intervention, which is the predicate condition for the

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[3] If in fact, the patient lacks capacity, then the patient will likely be unable to understand the nature of these determinations or to seek review, but at least the patient will have been afforded his or her due process rights.

application of section 1418.8." (*Rains, supra* at 182.) Thus, without notice to a patient that he or she has been declared incompetent, notice that the patient has been determined to have no surrogate decision maker, notice that an IDT has reviewed the physician's prescribed medical intervention and the medical treatment determined to be administered or withdrawn, and notice of a patient's right to challenge these determinations, it is impossible to see how a patient could ever seek such judicial review pursuant to section 1418.8(j). Furthermore, as to the Department's contention that the IDT reviews the determination of incapacity, or moreover to the extent that section 1418.8(l) provides for such determination to be documented in the patient's chart and made available to the patient's representative for review, such review is insufficient to comply with due process requirements that a patient himself or herself has a right to notice of such determinations and the right to seek his or her own review, rather than relying on the patient representative or IDT to seek such review, particularly in light of the significant deprivation of liberty interest that results to the patient alone. (See *Vitek, supra* at 496 [written notice to prisoner facing involuntary transfer to a mental hospital is essential to afford prisoner an opportunity to challenge the contemplated action and to understand the nature of what is happening to him].)

For example, 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. (See Petitioners' Compendium, Gloria A. Decl., ¶ 3.) 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. (Id.) Gloria A. then describes how the nurses were going to call the police after she attempted to leave. (Id.) Gloria A. stated that her doctor found her incompetent, but her social worker said that she was not incompetent. (Id., ¶ 6.) Gloria A. further stated that she knew that she was not incompetent. (Id.)

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 without a choice, and losing control over her finances. (Id. ¶¶ 4, 12, 13, 18.) In other words, if she had been afforded her due process rights, the outcome in her situation may have been very different.

Accordingly, the petition on this ground is GRANTED. The court finds that section 1418.8(a) is facially unconstitutional in that it violates a patient's due process rights by failing to provide for adequate notice and opportunity to the patient to oppose the determination of incapacity, the determination of the absence of a legal substitute decision maker, the prescribed medical intervention and the right to seek review under section 1418.8(j).

B. Second Cause of Action: Health and Safety Code section 1418.8 – violation of California Constitution right to due process by failing to require adequate representation at the determination of incapacity;

Third Cause of Action: Health and Safety Code section 1418.8 – violation of California Constitution right to privacy by permitting physicians to make legal adjudications as to decisional incapacity;

Fourth Cause of Action: Health and Safety Code section 1418.8 – violation of California Constitution right to due process by failing to require neutral decision makers at the adjudications as to decisional incapacity

Fifth Cause of Action: Health and Safety Code section 1418.8 – violation of US and California Constitutions right to due process by failing to require a neutral decision maker at the review and approval or rejection of the treatment

Petitioners also assert that a patient's due process rights are violated because the statute does not require adequate representation at the determination of incapacity, permits a medical decision to be

made as to the legal decision of decisional incapacity, and it fails to require a neutral decisionmaker at the capacity determination and at the review of the prescribed medical treatment.

The court finds that Petitioners' arguments however, were already expressly or impliedly rejected by the Court of Appeal in *Rains, supra,* 32 Cal.App.4th 157, which challenged the constitutionality of section 1418.8. The trial court in *Rains* found that section 1418.8, as enacted in 1992, was unconstitutional because it violated the privacy and due process rights of nursing home patients who lacked capacity to give informed consent to recommended medical intervention. (*Id.* at165-166.) Prior to the matter reaching the Court of Appeal, the Legislature amended section 1418.8, and thus the Court of Appeal found its decision must be based on the amended version of the statute and had the parties brief its constitutionality postargument.[4] (*Id.* at 162.)

> The *Rains* court summarized the petitioners' due process arguments as follows:
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> First, that section 1418.8 permits an initial nonjudicial determination of the patient's incompetence by a physician or surgeon, preceding the subsequent medical intervention decision.
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> Second, that section 1418.8 unconstitutionally authorizes medical intervention in the case of such a patient without notice, hearing before an independent decision maker, testimony, cross-examination, a written statement by the fact finder, and a surrogate for the patient "whose only allegiances are to the desires or best interests of the patient, rather than to the provider."

(*Rains, supra* at 178.) In reviewing the amended version of section 1418.8, the Court of Appeal found that section 1418.8 did not violate due process provisions of the California or Federal Constitution. The Court of Appeal found that in adding subdivisions (b) and (c) to section 1418.8,[5] the amended statute set forth a clear test for the physician to determine a resident patient's capacity to make decisions

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[4] Although subsequent amendments to section 1418.8 were enacted in 1996 and 2006, those amendments are not significant for purposes of this petition.

[5] Health & Safety Code § 1418.8. Medical intervention requiring informed consent; resident lacking decision-making capacity; interdisciplinary team review

(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

concerning health care. (*Id.* at 179-180.) Petitioners' argument that patient capacity determination must be made after hearing before presumably an independent decision-maker was rejected, as the court found no merit to the petitioner's hypothetical possibility that a physician may misrepresent the mental capacity of a patient for financial gain. (*Id.* at 180-181.) Indeed, the Court of Appeal found no cases that suggest "that procedural due process requires postponement of medical intervention for a nursing home patient who is found by a physician to lack capacity to consent thereto, until in each case, the medical capacity issue is separately decided in some adversarial hearing." (*Id.* at 181.) Such a holding would not only be cumbersome to thousands of patients and to courts, but it would also presume the bias, if not dishonesty, of physicians as to patient capacity, which the court would not do. (*Id.* at 181-182.) Further, prompt and effective medical treatment of these patients would then be seriously jeopardized. (*Id.* at 182.) Instead, the court recognized that "our elected Legislature is, more than any other single institution, better able to reflect a proper balance of social values at stake in this significant and difficult problem, and that it has done so in enacting section 1418.8." (*Id.* at 182.) Thus, the *Rains*

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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.

....

(Health & Safety Code § 1418.8(a)-(c).)

court concluded that nursing home patients were not denied due process because their incapacity to provide consent to medical intervention was determined by a physician and surgeon rather than by a judicial or quasi-judicial hearing.

"Even though the statute allows the patient's physician to determine *initially* whether the patient lacks the capacity to make medical decisions, and the interdisciplinary team assessment the reasons for the treatment under section 1418.8 would also often include the physician who had initially prescribed the treatment under review, this initial decision is not final." (*Rains, supra* at 186.) The court found that due process was assured because there is the right to secure judicial review of a physician's determination of the patient's incapacity to give informed consent to that medical intervention, as provided in section 1418.8(j).[6] (*Id.*)

In light of *Rains,* the court finds that Petitioners' arguments challenging the constitutionality of section 1418.8 on the grounds that it violates due process by failing to require adequate representation at the determination of incapacity, that it permits a medical decision as to the legal decision of decisional incapacity and that it fails to require a neutral decisionmaker at the determination of decisional incapacity and at the review of the prescribed treatment, have already been rejected based on *Rains'* holding. Petitioners have provided no basis for this court to find otherwise. Thus, the petition as to these claims is DENIED.

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[6] Section 1418(j) states: "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."

IV. THE PETITION CHALLENGING SECTION 1418.8 AS UNCONSTITUTIONALLY AS APPLIED

As explained above, an as applied challenge 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. (*Tobe, supra* at 1084.) "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." (*Id.*)

A. Sixth Cause of Action: Health and Safety Code section 1418.8 – failure to comply with judicial precedent by failing to require a patient representative at the review to determine treatment, absent exigent circumstances

Petitioners contend that the Department is failing to protect the Constitutional right of patients to a patient representative as part of the IDT, claiming that *Rains* interpreted section 1418.8 as requiring a patient representative to be part of the IDT and to have the power of refusal as a legal surrogate would. The Department argues however, that *Rains* held that a patient representative is only required to be part of the IDT "where practicable," and that the patient representative does not have decision-making authority.

Section 1418.8(e) provides that the IDT "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." In *Rains*, the petitioner challenged section 1418.8 as facially

uneonstitutional on the ground that there may be some person in a nursing home who lacks any patient representative to serve on the IDT. (*Rains, supra*, 32 Cal.App.4th at 182-183.) The *Rains* court rejected this challenge, recognizing that there may be hypothetical rare instances in which the participation of a patient representative may not be "practicable because for example, a particular conservator of the patient or next of kin is out of country or unavailable, the court need not address such hypotheticals as they did not support a facial challenge to the statute and were best left to actual cases requiring such interpretation if presented. (*Id.*) The *Rains* court also stated:

> It is highly significant that section 1418.8, subdivision (e) requires a patient representative to be a member of the interdisciplinary team overseeing the patient's care, to consider the need for medical intervention from the patient's point of view. While there may be exigent circumstances in which the participation of such a representative is not practicable, due to temporary unavailability, illness, or similar causes, the Legislature clearly required the routine and ongoing participation of a patient representative in such medical care decisions to ensure that nothing is overlooked from the patient's perspective.

(Rains, supra, 32 Cal.App.4th at 166-67.)

Based on this language in *Rains*, Petitioners assert that a patient representative is therefore required in all cases except in rare cases of exigency, and that the Department has not enforced such a requirement. Such an as applied challenge was not addressed in *Rains* concerning the Department's claimed failure to include a patient representative as part of the IDT, and therefore the court finds this issue is ripe for adjudication.

Petitioners however, have not provided sufficient evidence to support their contention that a patient representative is not part of the IDT except in cases of emergency. Petitioners take issue with the Department's Antipsychotic Use Survey Tool because it repeats the language of section 1418.8 providing for the IDT to include "where practicable, a patient representative." (See Petitioners' Compendium of Exhibits filed November 5, 2013 ("Petitioners' Compendium"), Exh. 14.) Petitioners also point to two facilities' 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." (See Petitioners' Compendium, Exh. 12.) The Country Villa Health Services Operations Manual states that the suggested IDT members include facility representatives from the following departments: Activities; Rehabilitation; Nursing (licensed nurse, RNA and CNA); Nutritional Care; Social Services. In addition, the resident, resident family/responsible party and physician are invited to attend." (See Petitioners' Compendium, Exh. 13.) Further, Petitioners provide declarations from ombudsmen to support that patient representatives are rarely, if ever, part of the IDT.[7] Petitioners also provide documents from Mark H.'s medical records showing that no patient representative was part of his IDT team. (See Petitioners' Compendium, Exh. 3.) Petitioners also contend that there was no patient representative as part of Gloria A.'s IDT. (See Petitioners' Compendium, Exh. 4.)

A patient representative may include a family member or friend of the resident who is unable to take full responsibility for the health care decision of the resident, but who has agreed to serve on the IDT, or other person authorized by state or federal law. (Health and Safety Code § 1418.8(f).) *Rains* found that this definition is so broad that it is hard to see how a patient representative could not be found to serve as part of the IDT for the patient. (*Rains, supra*, 32 Cal.App.4th at 182 [Even if a patient lacks a spouse and has no surviving next of kin, and even if there is no conservator or person holding a power of attorney, and no public agency such as the ombudsman or public guardian willing to serve in this capacity, the statute still allows any "friend" of the patient to serve in this capacity and represent the patient's interests. This would include patient advocates, legal counsel, and all other persons having an

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[7] According to these ombudsmen declarations, they are not permitted to serve as a patient representative and therefore do not vote in the medical treatment decisions even though they may be present for the meetings. (See Petitioners' Compendium, Declarations of Ombudsman Geneva Carroll and Cheryl Simcox.)

interest in the welfare of the patient. It appears almost impossible to conceive of a patient who could not have a patient representative, under this standard.].)

While Petitioners' evidence is compelling and certainly seems to suggest that patient representatives are not being included in the IDT as contemplated by the statute and *Rains*, the court cannot conclude from the cases of Mark H. and Gloria A. that the statute is being applied unconstitutionally. Petitioners point to the apparent lack of patient representatives as part of Mark H.'s and Gloria A.'s IDT, but does not take this analysis one step further to demonstrate that a patient representative was practicable. *Rains* clearly contemplates that a patient representative would be practicable in all but the rare cases, and Petitioners' evidence seems to support that this is not the case. The reason why however, is not clear. *Rains* finds that an ombudsman can serve as a patient representative, yet the declarations of ombudsman submitted by Petitioners state that they cannot serve as patient representatives. Thus, is the issue that no one is willing to serve as a patient representative? Is the reason that the skilled nursing facilities and the intermediate care facilities are not adequately searching for a patient representative? The evidence is insufficient to support that the reason for the lack of patient representative as part of the IDT is because the statute is being applied unconstitutionally.

Further, the Department's inclusion of the express language of section 1418.8 for a patient representative, where practicable, and allowing facilities to also include such language, does not establish that the statute is being applied unconstitutionally, as *Rains* found that this language providing for a patient representative where practicable, was not facially unconstitutional. Moreover, the County Villa's Manual providing that the physician and resident's family are invited to attend the IDT meeting, docs not appear to comply with section 1418.8(e), but Petitioners once again have not established that the application of this manual has indeed resulted in exclusion of the resident's family, or patient

representative, from IDT such that the court may determine that the statute is being applied unconstitutionally. The petition on this ground is therefore DENIED.

B. Seventh Cause of Action: Health and Safety Code section 1418.8 – failure to comply with judicial precedent precluding use as to antipsychotic drugs, or in the alternative, providing adequate notice, counsel, evidence and a judicial hearing as to incapacity, necessity and the least intrusive alternative

Petitioners contend that the Department has interpreted section 1418.8 as authorizing administration of antipsychotic drugs, and therefore is unconstitutional as applied. *Rains* held that "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, supra*, 32 Cal.App.4th at 186.)

The Department counters that *Rains* does not preclude administration of antipsychotic drugs because this portion of *Rains* that is relied on by Petitioners, cannot properly be interpreted as establishing any limited use with respect to section 1418.8. The scope of treatments was not a contested issue in *Rains*, and thus this statement is neither a holding nor a determinative interpretation of the scope of section 1418.8. Moreover, even if this portion of *Rains* limited the scope of treatment permitted under section 1418.8, the Department claims that administration of antipsychotic rugs in appropriate cases is widely understood and accepted as a relatively routine and nonintrusive aspect of care provided at nursing facilities. (See Steinberg Decl.)

The eourt starts with the understanding 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.) The right of privacy in the California Constitution guarantees an individual the freedom to choose to reject, or refuse to consent to, intrusions of his bodily integrity. (Id. at 531-532.) This right extends to the right to refuse antipsychotic drugs. (*Keyhea v. Rushen* (1987) 178 Cal.App.3d 526, 540.) In addition to a state constitutional privacy right, adults also have a fundamental due process freedom to refuse to take antipsychotic medications. (*People v. Petty* (2013) 213 Cal.App.4th 1410, 1417.)

Although antipsychotic drugs have been recognized to have considerable benefit to mentally ill patients, they also have been the cause of considerable side effects. (*In re Qawi* (2004) 32 Cal.4th 1, 14-15.) Such side effects have been described as:

> Reversible side effects include akathesia (a distressing urge to move), akinesia (a reduced eapacity for spontaneity), pseudo-Parkinsonism (causing retarded muscle movements, masked facial expression, body rigidity, tremor, and a shuffling gait), and various other complications such as muscle spasms, blurred vision, dry mouth, sexual dysfunction, drug-induced mental disorders. (*Keyhea, supra*, 178 Cal.App.3d at p. 531, 223 Cal.Rptr. 746.) 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.*)

(*Id.* at 15.) A newer generation of antipsychotic drugs, called atypicals, have been considered more benign and effective but still controversial because atypical antipsychotics are difficult to administer without patient cooperation because they generally are not available in forms that can be injected. (*Id.*)

The court is unaware of any cases addressing the administration of antipsychotic drugs to patients found incompetent in skilled nursing facilities or intermediate care facilities under section 1418.8, but this issue concerning forced antipsychotic drug administration has been addressed by courts in the context of mentally ill patients as well as prisoners. Courts have held that the right to refuse antipsychotic medication is not absolute but may be limited by countervailing state interests. (*Id.*) In California, the state's interest in providing care to its citizens who are unable to care for themselves has been permitted to impose unwanted medical treatment on an adult when that adult has been adjudged

incompetent. (*Id.* at 15-16, citing to *Wendland, supra*, 26 Cal.4th at 535.) Another such countervailing state interest is when an individual is confined in a state institution, individual liberties must be balanced against the interest of the institution in preventing the individual from harming himself or others residing or working in the institution. (*In re Qawi, supra* at 15.)

A prison inmate's federal due process rights were found not to be violated even though he was forcibly medicated, where it was determined that he was a danger to himself and other and that the treatment was in his medical interest as determined by an independent medical board. (*Washington v. Harper* (1990) 494 U.S. 210, 229.) Harper, a prisoner, refused to continue taking prescribed antipsychotic medications while in prison. (*Id.* at 214.) The treating physician then sought to medicate Harper over his objection pursuant to the prison's policy. (*Id.*) The prison's policy had several steps, as follows:

> First, if a psychiatrist determines that an inmate should be treated with antipsychotic drugs but the inmate does not consent, the inmate may be subjected to involuntary treatment with the drugs only if he (1) suffers from a "mental disorder" and (2) is "gravely disabled" or poses a "likelihood of serious harm" to himself, others, or their property. Only a psychiatrist may order or approve the medication. Second, an inmate who refuses to take the medication voluntarily is entitled to a hearing before a special committee consisting of a psychiatrist, a psychologist, and the Associate Superintendent of the Center, none of whom may be, at the time of the hearing, involved in the inmate's treatment or diagnosis. If the committee determines by a majority vote that the inmate suffers from a mental disorder and is gravely disabled or dangerous, *216 the inmate may be medicated against his will, provided the psychiatrist is in the majority.
>
> Third, the inmate has certain procedural rights before, during, and after the hearing. He must be given at least 24 hours' notice of the Center's intent to convene an involuntary medication hearing, during which time he may not be medicated. In addition, he must receive notice of the tentative diagnosis, the factual basis for the diagnosis, and why the staff believes medication is necessary. At the hearing, the inmate has the right to attend; to present evidence, including witnesses; to cross-examine staff witnesses; and to the assistance of a lay adviser who has not been involved in his case and who understands the psychiatric issues involved. Minutes of the hearing must be kept, and a copy provided to the inmate. The inmate has the right to appeal the committee's decision to the Superintendent of the Center within 24 hours, and the Superintendent must decide the appeal within 24 hours after its receipt. See App. to Pet. for Cert. B-3. The inmate may seek judicial review of a committee decision in state court by means of a personal restraint petition or extraordinary writ. See Wash.Rules App.Proc. 16.3 to 16.17; App. to Pet. for Cert. B-8.

> Fourth, after the initial hearing, involuntary medication can continue only with periodic review. When respondent first refused medication, a committee, again composed of a nontreating psychiatrist, a psychologist, and the Center's Associate Superintendent, was required to review an inmate's case after the first seven days of treatment. If the committee reapproved the treatment, the treating psychiatrist was required to review the case and prepare a report for the Department of Corrections medical director every 14 days while treatment continued.

(*Washington, supra*, 494 U.S. at 215-16.) The U.S. Supreme Court found that this policy comported with federal Constitutional due process requirements. Substantively, the policy complied with the Due Process Clause as it permitted the state to treat a prison inmate who has a serious mental illness with antipsychotie drugs against his will, only if the inmate is a danger to himself or others and the treatment is in the inmate's medical interest. (*Id.* at 227.) Procedurally, the court found that Harper's interests were also adequately protected and met the requirements of due process. (*Id.* at 233.) Both the determination of whether the inmate suffered from a mental disorder and whether as a result of the disorder the inmate was a danger to himself, were determined by a medical professional, and then reviewed by a decisionmaker. (*Id.*) The hearing committee reviewed on a regular basis the type and dosage of drug to be administered and could make changes. (*Id.*) The court took no issue with the lack of judicial hearing as to these matters since these decisions may be best assessed by medical professionals. (*Id.*) Rather, the court focused on whether the independence of the decisionmaker was satisfactorily addressed in the policy, which it found because none of the hearing committee members could be involved in the inmate's current treatment or diagnosis. (*Id.*) The policy also provided for notice, the right to be present at an adversary hearing, and the right to present and cross-examine witnesses. (*Id.* citing to *Vitek, supra*, 445 U.S. at 494-496.)

In re Qawi (2004) 32 Cal.4th 1, 9-10, 27, addressed the issue of whether mentally disordered offenders ("MDOs") may be compelled to treat with antipsychotic medication. The Mentally Disordered Offender Act, enacted in 1985, requires that offenders who have been convicted of violent erimes related to their mental disorders and who continue to pose a danger to society, receive mental

health treatment during and after termination of their parole until their mental disorder can be kept in remission. (Penal Code § 2960, et seq.) The purpose of the Act is to provide MDO's with treatment while at the same time protecting the general public from the danger to society posed by an offender with a mental disorder. (*Id.*) The *Qawi* court addressed the issue of whether the petitioner, an MDO, could refuse antipsychotic medication for his mental disorder in the absence of a judicial determination of his incapacity to make such a decision. (*Id.* at 9.) The Qawi court found that instead of granting rights to former offenders committed under the MDO Act, the Legislature chose to reference the rights granted to involuntary mentally ill patients that have been civilly committed under the Lanterman-Petris-short Act ("LPS"), found in Welfare and Institutions Code section 5000, et seq. Thus, the Qawi court found that "in order to give MDO's the same rights as LPS patients, an MDO can be compelled to take antipsychotic medication in a nonemergency situation only if a court, at the time the MDO is committed or recommitted, or in a separate proceeding makes one of two findings: (1) that the MDO is incompetent or incapable of making decisions about his medical treatment, or (2) that the MDO is dangerous within the meaning of Welfare and Institutions Code section 5300."[8] (*Id.* at 9-10.) The court found that such interpretation also provided MDOs with the same right to refuse medication as mentally ill state prisoners, pursuant to Penal Code section 2600. (*Id.* at 10.)

In *Keyhea v. Rushen* (1986) 178 Cal.App.3d 526, a taxpayer action was brought challenging the practice at the California Medical Facility ("CMF") of involuntary treatment of prisoners with antipsychotic drugs. The decision to administer antipsychotic drugs involuntarily on a long term basis was made by the chairman of an institutional review board upon referral by a prison psychiatrist. (*Id.* at 531.) The chairman's decision would be made after an oral presentation by the referring psychiatrist, a review and discussion of the patient's file by the board members and an interview of the prisoner. (*Id.*) CMF's internal procedure provided for the board to review the decision to medicate every 90 days. (*Id.*)

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[8] Welfare and Institutions Code section 5300 requires two types of findings of dangerousness. There must first be a generalized finding of "demonstrated danger" to others, and there must also be a finding establishing recent acts or threats of violence. (Qawi, supra at 20.)

Prisoners were afforded no right to counsel at board hearings, and no right to judicial review. (*Id.*) Penal Code section 2600 provides that a prisoner may be deprived only of such rights as is necessary in order to provide for the reasonable security of the institution in which the prisoner is confined, and for the reasonable protection of the public. The *Keyhea* court found that by statute, state prisoners retained the same rights accorded to nonprisoners in this area, and further found that under the LPS statutory scheme, nonprisoners in California have a statutory right to refuse long-term treatment with antipsychotic drugs absent a judicial determination that they are incompetent to refuse treatment. (*Id.* at 534-537.) As such, the *Keyhea* court held that state prisoners, like nonprisoners under the the LPS, are entitled to a judicial determination of their competency to refuse treatment unless deprivation of this right is necessary to prison security. (*Id.* at 541-542.) The *Keyhea* court however, declined to rule on the related issue of whether adults without conservators have the right to a judicial determination of competency to refuse antipsychotic drugs under the provisions of Probate Code section 3200, et seq. (authorization of medical treatment for adults without conservators). (*Id.* at 537-539.)

In light of the above cases discussing administration of antipsychotic drugs in the context of mentally ill patients and prisoners, the court now turns to *Rains, supra*, 32 Cal.App.4th 157. *Rains* did not address this issue of whether or not administration of antipsychotic drugs is permitted under section1418.8, but *Rains* still provides this court with guidance. Specifically, *Rains* held that determination of incompetency by a physician did not violate due process, reasoning that requiring a judicial hearing as to capacity before allowing medical intervention would delay treatment of potentially thousands of elderly nursing home patients, and also the court found that the Legislature was better able to 'reflect a proper balance of social value at stake in this significant and difficult problem, and that it has done so in enacting section 1418.8." (*Rains, supra* at 181-182 [patients are not denied due process because their incapacity to give consent to medical intervention is initially determined by a physician and surgeon, rather than by a judicial or quasi-judicial hearing].) The court held that due process was assured because of the right to seek judicial review of a patient's incapacity to give informed consent to

that medical intervention, pursuant to section 1418.8(j). (*Id.* at 182.) Thus, *Rains* already finds that a judicial determination of competency is not required, and does not violate a patient's due process rights.

Thus, unlike mentally ill patients and state prisoners found in *Qawi* and *Keyhea* to have a right to a judicial determination as to competency before antipsychotic drugs may be administered without consent, these patients, as held by *Rains*, have no similar right to such a judicial determination as to competency. As such, the court may only conclude, based on the reasoning set forth in *Washington*, *Qawi* and *Keyhea*, that the Legislature must not have intended for section 1418.8 to apply to the administration of antipsychotic drugs. Accordingly, this court is guided by *Washington*, which found no due process violation in spite of the lack of judicial hearing, but focused instead on the fact that the independence of the decisionmaker was satisfactorily addressed in the policy, and that the policy provided for notice, the right to be present at an adversary hearing, and the right to present and cross-examine witnesses. (*Washington, supra* at 233.)

As found by this court and discussed above though, section 1418.8 currently provides for no notice to the patient himself or herself that he or she has been adjudicated incompetent, nor has the Department required such notification to patients. Further, the provision in section 1418.8(j) allowing a patient as well as others to seek judicial review of the determination of incompetency as well as the medical treatment, is of no assistance to the Department here. Even assuming a patient somehow receives notice that he or she has been determined incompetent by a physician or surgeon, section 1418.8(j) does not provide the same procedural safeguards found in *Washington* requiring an independent decisionmaker. Instead, section 1418.8(e) requires the same attending physician that has determined the patient to be incompetent to be a part of the IDT that reviews that physician's prescribed medical intervention prior to administration of the medical intervention. Thus, none of the procedural safeguards necessary for due process as found in *Washington*, *Qawi* and *Keyhea*, are found in section 1418.8.

Therefore, the court may only reach the conclusion that administration of antipsychotic drugs to patients in skilled nursing and intermediate care facilities was not intended as part of the medical intervention permitted under the statutory procedure set forth in section 1418.8. Such interpretation is consistent with *Rains*' holding rejecting the petitioner's due process challenge, in which the Court of Appeal also stated that "[i]n addition, 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, supra* at 186.) Although the Department asserts that the administration of antipsychotic drugs is routine in skilled nursing homes, the court simply does not find support for this position that antipsychotic drugs may be considered "nonintrusive and routine, ongoing medical intervention." Antipsychotic drugs have many serious side effects, which include reversible side effects, potentially permanent side effects, and on rare occasions, sudden death. (*Keyhea, supra* at 531.) In light of the serious nature of these antipsychotic drugs, courts have recognized that both mentally ill patients involuntarily committed to a facility as well as prisoners have rights before they may be administered these drugs against their will. Patients in skilled nursing facilities and intermediate care facilities are entitled to no less rights than mentally ill patients and prisoners, and therefore are either entitled to procedural safeguards consisting of either a judicial finding of incompetency as in *Qawi* and *Keyhea*, or some type of independent review process of the attending physician's recommendation to administer antipsychotic drugs along with notice and opportunity to be heard as in *Washington*. Since section 1418.8 does not provide such procedural safeguards, the court finds that the Department's application of section 1418.8 as permitting patients to be treated with antipsychotic drugs under this statutory procedure, violates these patients' due process rights. (See *Wendland, supra*, 26 Cal.4th at 548 ["If a statute is susceptible of two constructions one of which will render it constitutional and the other

unconstitutional in whole or in part, or raise serious and doubtful constitutional questions, the court will adopt the construction which, without doing violence to the reasonable meaning of the language used, will render it valid in its entirety, or free from doubt as to its constitutionality, even though the other construction is equally reasonable. The basis of this rule is the presumption that the Legislature intended, not to violate the Constitution, but to enact a valid statute within the scope of its constitutional powers. [Citations omitted.]"].)

Petitioner's claim that section 1418.8 is unconstitutional as-applied by the Department to permit administration of antipsychotic drugs, is GRANTED. Since section 1418.8 was not intended to permit administration of antipsychotic drugs, compliance with the procedures set forth in Probate Code section 3200 et seq. would still be required, except in emergency situations.[9] (See *Rains, supra* at 186.)

C. Eighth Cause of Action: Health and Safety Code section 1418.8 – failure to comply with judicial precedent precluding use of statute for treatments or discontinuation thereof which would result in death, such as, but not limited to, do not resuscitate, comfort care or discontinuation of treatment or for Physician Order for Life Sustaining Treatment (POLST) orders

Petitioners also challenge the Department's application of section 1418.8 as allowing physicians and IDTs to make end of life determinations, including creating and changing Physician Order of Life Support Treatment ("POLST") for patients in skilled nursing and intermediate care facilities. Petitioners claim that such application is unconstitutional because section 1418.8 only refers to medical interventions and not forbearance of treatment, particularly in end of life decisions.

In opposition, the Department claims that section 1418.8 is not unconstitutional if construed as permitting IDTs to make certain end of life care decisions for patients because they are an aspect of

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[9] It is important to note that Petitioners and the Department are not disputing the right to administer antipsychotic drugs to patients in emergency situations.

medical decisionmaking at skilled nursing facilities caring for the advanced elderly and ill. California statutes permit physicians and health care institutions to unilaterally decline to compel with directives relating to end of life care, including POLSTs, if the treatment would be medically ineffective or contrary to generally accepted health care standards that are applicable to the provider or institution. (See Prob. Code §§ 4735, 4781.2.) The Department makes the argument that it would seem to make little sense to construe section 1418.8 as barring an IDT from declining to continue medically ineffective treatment or life sustaining measures that would be contrary to generally accepted medical standards when the physician and the health care institution have such authority.

Further, the Department contends that it is not apparent that all end of life care decisions by nursing facilities would violate constitutional principles, referring to the example of an incapacitated resident for whom hospice care represents a determination that further treatment of a terminal condition would be futile and that the condition is likely to end the individual's life within six months. (See 42 C.F.R. § 418.22(b)(1).) Dr. Steinberg describes how hospice care provides palliative care and supportive services that ease a terminally ill patient's end of life. (See Steinberg Decl.)

The Department further cites to *Rains*' finding that the operation of section 1418.8 does not violate a patient's constitutional right of privacy as it does not constitute an "egregious breach of the social norms underlying the privacy right." (See *Rains, supra*, 32 Cal.App.4th at 177.) Thus, the Department concludes that end of life decisions made by IDTs, such as hospice care, are not an egregious breach of the social norms underlying the privacy right such that a patient's constitutional rights are violated.

The purpose of the POLST is for patients to identify their advance care wishes regarding life sustaining treatment. (See Probate Code §§ 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 § 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.[10] (Prob. Code § 4780(b).)

A competent adult has the right to refuse medical treatment, including treatment necessary to sustain life. (*Conservatorship of Wendland* (2001) 26 Cal.4th 519, 530.) This right is found in both common law and state constitutional law. (*Id.* at 531.) An incompetent person still retains the right, even though that person's lack of competency may make him or her incapable of participating in treatment decisions. (*Conservatorship of Drabick* (1988) 200 Cal.App.3d 185, 208.) Others may still make a decision that reflects that individual's interests, and taking the incompetent person's interests into aceount. (*Id.*)

Although the parties provided no case law addressing this issue of making end of life decisions for an incompetent person where there is no legal surrogate, there are cases addressing this issue in tbe context of conservatees that have been found incompetent and have a conservator appointed by the court pursuant to Probate Code section 2355. Where a conservatee is in a persistent vegetative state and has no hope of recovery, a conservator has authority under Probate Code section 2355 to authorize removal of a nasogastric tube if the decision is made in good faith and based on medical advice which includes the prognosis that there is no reasonable possibility of return to cognitive and sapient life. (*Conservatorship of Drabick* (1988) 200 Cal.App.3d 185, 216-217.) Section 2355 provides, "If the conservatee has been adjudicated to lack the capacity to give informed consent for medical treatment,

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[10] Probate Code § 4682. Authority of agent

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

the conservator has the exclusive authority to give consent for such medical treatment to be performed on the conservatee as the conservator in good faith based on medical advice determines to be necessary ...." (Prob. Code, § 2355, subd. (a).) The *Drabick* court found that "this statute, by necessary implication, gives the conservator power to withhold or withdraw consent to medical treatment under appropriate circumstances." (*Id.* at 200.) *Drabick* relied on the holding of *Barber v. Superior Court* (1983) 147 Cal.App.3d 1006, that physicians could not be prosecuted for homicide on account of their removal, at the family's request and without a court order, of a respirator and intravenous tubes from a patient in a persistent vegetative state, and that in the absence of legislative guidance, there was no legal requirement that prior judicial approval is necessary before any decision to withdraw treatment can be made. The *Drabick* court therefore concluded that since an incompetent person retains the right to have medical treatment decisions made in his bests interests, having the conservator exercise vicariously the conservatee's right to choose, guided by the conservatee's best interest, "produces a more just and compassionate result than leaving [her] with no way of exercising a constitutional right. (*Drabick, supra* at 209.) "To summarize, California law gives persons a right to determine the scope of their own medical treatment, this right survives incompetence in the sense that incompetent patients retain the right to have appropriate decisions made on their behalf, and Probate Code section 2355 delegates to conservators the right and duty to make such decisions." (*Id.* at p. 205.) "The state's interest in preserving life does not outweigh the patient's own rights." (*Id.*)

Subsequently, in *Wendland, supra*, the California Supreme Court concluded that a conservator may not withhold artificial nutrition and hydration from a conscious conservatee who is not terminally ill, comatose or in a persistent vegetative state, and who has not left formal instructions for health care or appointed an agent or surrogate for health care decisions, absent clear and convincing evidence the conservator's decision is in accordance with either the conservatee's own wishes or best interest.

Probate Code section 2355 provides that the conservator shall make health care decisions for the conservatee in accordance with the conservatee's individual health care instructions, if any, and other wishes to the extent known to the conservator; otherwise, the conservator shall make the decision in accordance with the conservator's determination of the conservatee's best interest.[11] (*Id.* at 540.) After analyzing cases in other states addressing the right to withhold artificial nutrition and hydration from incompetent but unconscious patients, the California Supreme Court found that in each case the court required a clear statement by the patient of the intent to refuse life-sustaining treatment when a conservator or guardian proposed to withdraw treatment from a conscious conservatee or ward in order to effectuate the latter's own right to refuse treatment. (*Id.* at 550.) In response to an amici curiae argument that this would result in many physicians refusing to follow a surrogate's instruction to withdraw life sustaining treatment absent judicial approval, the court found this not to be a valid concern. (*Id.* at 551.) The court reasoned that many patients have personally appointed agents or surrogates for health care decisions or provided formal instructions for health care, and thus this standard requiring clear and convincing evidence applied only when a conservator sought to withdraw

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[11] Probate Code § 2355. Medical treatment of conservatee adjudicated to lack capacity to make health care decisions

(a) If the conservatee has been adjudicated to lack the capacity to make health care decisions, the conservator has the exclusive authority to make health care decisions for the conservatee that the conservator in good faith based on medical advice determines to be necessary. The conservator shall make health care decisions for the conservatee in accordance with the conservatee's individual health care instructions, if any, and other wishes to the extent known to the conservator. Otherwise, the conservator shall make the decision in accordance with the conservator's determination of the conservatee's best interest. In determining the conservatee's best interest, the conservator shall consider the conservatee's personal values to the extent known to the conservator. The conservator may require the conservatee to receive the health care, whether or not the conservatee objects. In this case, the health care decision of the conservator alone is sufficient and no person is liable because the health care is administered to the conservatee without the conservatee's consent. For the purposes of this subdivision, "health care" and "health care decision" have the meanings provided in Sections 4615 and 4617, respectively.

(b) If prior to the establishment of the conservatorship the conservatee was an adherent of a religion whose tenets and practices call for reliance on prayer alone for healing, the treatment required by the conservator under the provisions of this section shall be by an accredited practitioner of that religion.

Cal. Prob. Code § 2355 (West)

life sustaining treatment from a conscious, incompetent patient who has not left legally cognizable instructions for health care or appointed an agent or surrogate for health care decisions. (*Id.*) *Wendland's* holding was limited only to the decision to withdraw life-sustaining treatment because of its effect on a conscious conservatee's fundamental rights, thereby justifying that high standard of proof. (*Id.* at 555.)

"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 ... 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." (*Id.* at 547.) This represents 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. Moreover, the decision to withdraw treatment is not reversible. (*Id.*) *Wendland* therefore applied a much higher standard in allowing life sustaining measures to be withheld for a conscious conservatee , i.e. clear and convincing evidence of the conservatee's wishes or in the conservatee's best interest, in contrast to a conservatee that is in a persistent, vegetative state with no hope of recovery, i.e. the decision belongs to the conservator.

Thus, this court is now tasked with deciding whether section 1418.8 permits such end of life decisions to be made by IDTs. The Legislature clearly intended in enacting section 1418.8 to provide a legislative solution that would allow timely medical treatment of incompetent nursing home patients on an ongoing basis, without the delay of securing a petition authorizing treatment under Probate Code section 3201.[12] (*Rains, supra*, 32 Cal.App.4th at 166.) Probate Code section 3201(b) provides for

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[12] Probate Code § 3201. Petition

(a) A petition may be filed to determine that a patient has the capacity to make a health care decision concerning an existing or continuing condition.

(b) A petition may be filed to determine that a patient lacks the capacity to make a health care decision concerning specified

petitioning a court to determine if a patient lacks capacity to make a health care decision, and to have a designated person appointed to make such a decision, if necessary. Section 1418.8 bypasses the petition required under Probate Code section 3201(b) and allows physicians and IDTs the ability to make such decisions for incompetent patients in nursing facilities. However, given that section 1418.8 has already been determined to permit a physician to determine incompetency and not to require a judicial determination of incompetency (see *Rains, supra*), as well as to allow a physician to determine that there is no surrogate decisionmaker available, it appears that the same reasoning that applies to the cases involving conservatees cannot be applied here. In both *Drabick* and *Wendland*, the conservators were appointed by the court after finding that the conservatees lacked capacity to give informed consent to the medical treatment. No such adjudication of incompetency is required here. Instead, the Court of Appeal in *Rains* already held that such judicial adjudication is not required, and instead judicial review may be sought as to the physician's determination regarding lack of capacity by the patient or some other interested person seeking appropriate judicial relief. Thus, the court cannot find that the same standard in permitting a conservator to withdraw life sustaining measures, applies here where there is no required adjudication of a patient's lack of competency before a patient's right to make such end of life decisions is taken away from him or her. To the extent that section 1418.8 provides for the IDT's review to include "[a] discussion of the desires of the patient, where known" (see section 1418.8(e)(3)), this cannot be the equivalent of what a conservator is tasked with under Probate Code section 2355. It bears repeating that Probate Code section 2355, provides that the conservator shall make health care decisions

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treatment for an existing or continuing condition, and further for an order authorizing a designated person to make a health care decision on behalf of the patient.

(c) One proceeding may be brought under this part under both subdivisions (a) and (b).

for the conservatee in accordance with the conservatee's individual health care instructions, if any, and other wishes to the extent known to the conservator; otherwise, the conservator shall make the decision in accordance with the conservator's determination of the conservatee's best interest. Nowhere in section 1418.8 does it require the IDT to make a health care decision based on the patient's individual health care instructions. Instead, the IDT reviewing the physician's prescribed medical intervention is to include a "discussion" of the patient's desires.

Further, even if the analysis in *Drabick* and *Wendland* could be applied to such incompetent patients here, the evidence supports that section 1418.8 "as applied" is allowing physicians and IDTs to make end of life decisions that are contrary to the holdings in *Drabick* and *Wendland* that an incompetent person still retains the right to determine the scope of his or her medical treatment and that the right is to be exercised by the conservator, if known. Petitioners' evidence supports that physicians and IDTs are making end of life decisions without consulting patients and without considering the patient's wishes as to end of life decisions.

The declaration of Jane Doe describes how her adult child who resides at a skilled nursing facility, was determined by a physician to lack capacity to make medical treatment decisions without any notice to Jane Doe or to her child. (See Petitioners' Supplement of Declarations, Jane Doe Decl.) A POLST form was placed in her child's chart, even though the form had never been signed by Jane Doe or her child or any other surrogate, and furthermore her child has had advanced directives since entering the facility. (Id.) The physician told Jane Doe that state law required a POLST, and Jane Doe discovered after speaking with other residents and families, that this practice occurs with many residents of the facilities where a POLST is placed in a patient's chart without any patient or surrogate signature. (Id.)

The declaration of Geneva Carroll, an ombudsman, describes the situation of Mark A., who was a resident at a skilled nursing facility and found to lack capacity, have no surrogate and no patient representative. A POLST was signed by a physician, but not by Mark A., that stated "full code" when Mark A. entered the nursing facility. (See Petitioners' Compendium, Carroll Decl., ¶ 36.) 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." (Carroll Decl., ¶ 40.) 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?" (Carroll Decl., ¶ 42.) 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. (Carroll Decl., ¶¶ 34, 37, 43-44.) Mark A. passed away at the facility while in the care of hospice in February 2013. (Carroll Decl., ¶ 44.)

Similarly, the declaration of ombudsman Cheryl Simcox describes being at IDT meetings that discuss decisions such as hospice care, DNR (Do Not Resuscitate), or the choice as to whether a resident be given liquids with the chance of aspiration and possible death. (See Petitioners' Compendium, Simcox Decl., ¶ 10.)

Social Worker Margaret Main also describes a patient whose wishes included that she did not want life sustaining treatment were conveyed to the RN and social service designee, but the primary physician determined that the patient lacked capacity and ehanged the POLST to CPR and full code. (Mann Decl., ¶ 9.) The social worker later found a cousin of the resident to sign the POLST reflecting the patient's wishes, but Main points out that the patient could have been subjected to various life sustaining treatments against the patient's wishes. (*Id.*)

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, and is not unconstitutional in allowing IDTs to make certain end of life decisions. (See Department's Opposition, pp.17-19.) Although the Department attempts to distinguish between certain end of life decisions that may be constitutionally permitted, such as hospice care when medical care would no longer be effective, the court need not address this issue at this juncture because even if correct, the Department currently provides no evidence to show that the statute is being applied in such a manner so as to make a distinction between such end of life care decisions. 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. 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.[13]

Section 1418.8 does not require a judicial determination of the patient's lack of capacity to make such decisions for himself or herself. 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. Also, the statute, as applied by the Department, is not being limited to IDTs 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

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[13] The Department also asserts in its brief that there are California statutes that expressly permit physicians and health care institutions to unilaterally decline to comply with directives relating to end of life care if the treatment would be medically ineffective or contrary to generally accepted health care standards, and that IDTs should be afforded the same permission here. (See Department's Opposition, 18:23-19:1, citing to Probate Code §§ 4735, 4781.2.) Section 1418.8 however, contains no express language permitting IDTs to do the same. (See *Cornette v. Dep't of Transp.* (2001) 26 Cal. 4th 63, 73-74 ["A court may not rewrite a statute, either by inserting or omitting language, to make it conform to a presumed intent that is not expressed."].)

instructions on such health care decisions without demonstrating that such treatment would be medically ineffective or contrary to generally accepted standards. Accordingly, this court finds that such application of section 1418.8 as permitting IDTs to make end of life decisions is unconstitutional. An incompetent patient in a skilled nursing facility or intermediate care facility still retains his or her right to refuse life sustaining treatment and for those wishes to be carried out to the extent possible, unless a physician or health care facility declines to carry out such wishes because it would result in medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution. (See Prob. Code § 4735.) Petitioners have demonstrated that the statute, as applied by the Department, is not being construed in such a manner. The petition to this claim is GRANTED.

CONCLUSION

The court is aware that this statute was the Legislature's attempt to deal with a very difficult and significant problem of how to provide timely and effective medical treatment to patients in skilled nursing facilities without delays that were often happening when a petition had to be filed in probate court. The court acknowledges that this order will likely create problems in how many skilled nursing facilities currently operate. (See Karl Steinberg, M.D. Decl.) The court has considered this burden and weighed it against due process concerns, and finds that the due process rights of these patients is more compelling. The stakes are simply too high to hold otherwise. Any error in these situations has the possibility of depriving a patient of his or her right to make medical decisions about his or her own life that may result in significant consequences, including death. A patient may not only lose the ability to make his or her health decisions, but also to manage his or her own finances, determine his or her visitors, and the ability to leave the facility. Accordingly, the court finds that Health and Safety Code

section 1418.8 is both facially unconstitutional and unconstitutional as-applied for the reasons stated above.

The petition for writ of mandate is GRANTED as herein stated above. Petitioners are to submit a proposed judgment and writ after submitting to the Department for approval as to form.

IT IS SO ORDERED.

DATED: JUN 24 2015

Evelio M. Grillo
JUDGE OF THE SUPERIOR COURT