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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT, DIVISION FOUR

CALIFORNIA ADVOCATES FOR NURSING HOME REFORM (CANHR), GLORIA A., and ANTHONY CHICOTEL,

Petitioners and Appellees/Cross-Appellants,

v.

KAREN SMITH, MD., MPH, as Director of the California Department of Public Health,

Defendant and Appellant/Cross-Appellee.

Case No. A147987

Alameda County Superior Court, Case No. RG13700100
The Honorable Evelio Martin Grillo, Judge

APPELLANT'S OPENING BRIEF

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

Case Name: *CALIFORNIA ADVOCATES FOR NURSING HOME REFORM (CANHR), GLORIA A., and ANTHONY CHICOTEL v. KAREN SMITH, MD., MPH, as Director of the California Department of Public Health*

Court of Appeal No.: A147987

CERTIFICATE OF INTERESTED PARTIES OR ENTITIES OR PERSONS
(Cal. Rules of Court, Rule 8.208)

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[ ] Interested entities or persons are listed below:

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	[ ]	[ ]	
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The undersigned certifies that the above listed persons or entities (corporations, partnerships, firms or any other association, but not including government entities or their agencies), have either (i) an ownership interest of 10 percent or more in the party if an entity; or (ii) a financial or other interest in the outcome of the proceeding that the justices should consider in determining whether to disqualify themselves, as defined in rule 8.208(e)(2).

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INTRODUCTION

Petitioners' challenge to Health & Safety Code section 1418.8 (section 1418.8) and its application to certain types of health care decisions fails as a matter of law: the additional procedures they claim are required, and the limitations they seek to impose on use of the statute, are not mandated by constitutional requirements. In light of the procedures and standards established by section 1418.8 and other relevant law, section 1418.8 does not violate the due process or privacy rights of nursing home residents, as this Court already determined in *Rains v. Belshé* (1995) 32 Cal.App.4th 157 (*Rains*). The trial court erred in invalidating the procedures crafted by the Legislature in section 1418.8 to ensure that vulnerable nursing home residents who lack capacity to provide informed consent for medical treatment or any authorized decisionmaker may access necessary medical care with appropriate safeguards.

The trial court's decision, if left standing, would threaten a crisis in the ability of those most in need of nursing home care to gain admission to these facilities. Many nursing homes are likely to refuse admission to individuals lacking decisionmaking capacity or surrogate decisionmakers on the ground that their medical needs cannot adequately be met under the limitations established in the decision, as some facilities already have done. The trial court's should be reversed.

The Legislature enacted section 1418.8 in 1992 to address a long standing conundrum faced by nursing homes: how to ensure that a nursing home resident may obtain needed medical care if the resident lacks the capacity to provide informed consent and also do not have a family member or other person with legal authority to make such decisions on the resident's behalf. Existing procedures under the Probate Code for judicial authorization of treatment, the Legislature determined, are too cumbersome

and inadequate to ensure that the medical needs of such residents can be met.

The Legislature's solution, which has been in place for 24 years, permits interdisciplinary teams, including a resident's attending physician and other skilled facility staff, along with a representative of the resident, where practicable, to make treatment decisions on behalf of a resident determined by his or her attending physician to lack capacity to consent to the treatment and who does not have a family member or legally authorized surrogate decisionmaker. The Legislature sought to safeguard residents' rights by, among other things: establishing standards and procedures to govern the physician's initial determinations that the resident lacks decisionmaking capacity and any surrogate decisionmaker; providing for a resident representative on the decisionmaking team, to the extent practicable; mandating consultation with and consideration of the resident's desires regarding the treatment regardless of the resident's incapacity; and preserving rights to judicial review.

This Court already rejected a challenge to the constitutionality of section 1418.8 brought shortly after its passage, concluding that the statute did not violate residents' rights to due process and privacy. (Rains, *supra*, 32 Cal.App.4th at p. 157.) Petitioners' arguments do not support overruling that prior, longstanding, precedent. As the Court determined in Rains, capacity determinations are medical decisions, and given the procedural safeguards established in section 1418.8, due process does not require notice to residents of the physician's determinations that trigger authority to utilize section 1418.8. But even if such notice were constitutionally required (and it is not), that provides no basis to invalidate the statute and prohibit its use, as the trial court erroneously concluded. Rather, principles of constitutional interpretation would require that such notice requirements

be read into the statute to preserve its constitutionality and permit its continued use consistent with the expressed will of the Legislature.

The trial court also erred in ruling that section 1418.8 cannot be used to obtain informed consent for administration of antipsychotic drugs. The Legislature intended that section 1418.8 be applied broadly to ensure that the medical needs of nursing home residents are met, and did not restrict in any way the types of medical interventions that could be authorized under the statute. Indeed, the statute expressly provides for review of any emergency use of chemical restraints, which often include antipsychotic drugs, and therefore contemplates decisionmaking regarding utilization of such drugs. In light of the procedural safeguards provided by section 1418.8, as well as those provided by other relevant state and federal law—including a requirement of monthly pharmacist review and review at least annually by an independent consultant of any prescription for antipsychotic drugs—authorization to administer such drugs to unrepresented and incapacitated residents does not violate due process or privacy rights.

Finally, petitioners fail to present a ripe or valid "as applied" challenge to the use of section 1418.8 for decisions relating to end-of-life care. Petitioners did not establish that the Director of the Department of Public Health, the sole respondent, applied or interpreted section 1418.8 in any unconstitutional manner or condoned any improper uses of the statute by nursing homes for such decisions. As the trial court's ruling and Judgment on this issue simply mirrors existing law and ethical requirements under which facilities must operate, a writ is unnecessary and inappropriate. The trial court erred in addressing petitioners' claim on this issue in the absence of any evidence that the Director applied or allowed the statute to be applied in an unlawful manner.

For these reasons, as set forth more fully below, this Court should vacate and reverse the trial court's Judgment.

BACKGROUND

Section 1418.8 was enacted almost 25 years ago, after extensive Legislative fact finding and debate. It was designed to be protective of patient autonomy and the rights of competent persons to consent to treatment, while also ensuring timely medical interventions for those who lack capacity and a surrogate decisionmaker. The Court previously addressed substantively the same arguments raised by petitioners here, and found that the statute passes constitutional muster.

A. The Legislature Adopts Section 1418.8 as a Solution to a "Legal Conundrum of Long Standing"

In enacting section 1418.8 in 1992, the Legislature sought to address a "very difficult and perplexing problem: how to provide nonemergency but necessary and appropriate medical treatment, frequently of an ongoing nature, to nursing home patients who lack capacity to consent thereto because of incompetence, and who have no surrogate or substitute decision maker with legal authority to consent for them." (*Rains, supra*, 32 Cal.App.4th at p. 166.) To address this "legal conundrum of long standing," (*Ibid.*), section 1418.8 allows an interdisciplinary team (IDT) of health professionals and other skilled staff from the care facility, along with an advocate for the resident, where practicable, to review and authorize medical treatment requiring informed consent, for such unrepresented residents who lack decisionmaking capacity. (Health & Saf. Code, § 1418.8 (§ 1418.8).)

In establishing this process, the Legislature recognized that the existing mechanisms for conservatorships or court authorization for medical treatments for such residents under provisions of the Probate Code were slow and inadequate, and therefore could interfere with residents' ability to receive timely medical interventions. As the Legislature found:

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

(c) Therefore, it is the intent of the Legislature to identify a procedure *to secure, to the greatest extent possible, health care decisionmakers for skilled nursing facility or intermediate care facility residents* who lack the capacity to make these decisions and who also lack a surrogate health care decisionmaker.

(Stats. 1992, ch. 1303, § 1, p. 6326, emphases added.)

The enactment of section 1418.8 was "the culmination of several years of intensive legislative debate over the right of non-conserved nursing home residents to make informed decisions about various issues involved with their care." (Assem. Com. on Health, Bill Analysis of Assem. Bill No. 1139 (1993-1994 Reg. Sess.) Apr. 13, 1993.) The statute, as initially adopted, was designed to sunset on January 1, 1995. (Stats. 1992, ch. 1303, second § 1, p. 6328.)[1] In 1994, the Legislature amended the statute and extended it for another two years, during which time it directed that a committee of various stakeholder groups meet to identify any needed changes to the legislation. (Stats. 1994, ch. 791, § 1, p. 3915.)

In 1996, the Legislature made one amendment requiring review of emergency uses of physical and chemical restraints, and repealed the sunset provision. (See Stats. 1996, ch. 126, § 1, p. 611.) The statute has remained unchanged since.

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[1] The enrolled bill contained two sections labeled "section 1."

B. Key Features of Section 1418.8

Section 1418.8 establishes an interdisciplinary team (IDT) review and decisionmaking process for medical interventions requiring informed consent (treatment) for residents or patients (residents)[2] of a skilled nursing facility or intermediate care facility (nursing home or facility)[3] who lack decisionmaking capacity or a surrogate decisionmaker.

Under section 1418.8, if a resident's "attending physician and surgeon" (attending physician) determines that a resident lacks capacity to provide informed consent to a proposed treatment, and that there is no person with authority to make the treatment decision on the resident's behalf (surrogate decisionmaker), the physician is then required to inform the facility of these determinations, and an IDT must be convened to review and authorize the proposed treatment. (§ 1418.8, subds. (a)-(e).)

It is important to note that IDTs are by no means the creation of section 1418.8—IDTs are a mandatory and key feature of all nursing home care, responsible for determining and overseeing the care of all nursing home residents. (See Health & Saf. Code, § 1418.81, subd. (c) [IDT "shall oversee the care of the resident using a team approach to assessment and care planning"].) Section 1418.8, however, authorizes an IDT also to act as a substitute decisionmaker for incapacitated and unrepresented residents. (See § 1418.8, subds. (d), (i).)

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[2] Section 1418.8 utilizes the terms "resident" and "patient" interchangeably.

[3] Skilled nursing facilities provide 24-hour skilled nursing and supportive care to resident individuals whose primary need is for the availability of skilled nursing care on an extended basis. (See Health & Saf. Code, § 1250, subd. (c)(1).) Intermediate care facilities provide 24-hour inpatient care to individuals who are developmentally disabled or who otherwise do not require continuous skilled nursing care, but have recurring need for skilled nursing supervision and require supportive care. (See *id.* § 1250, subds. (d), (g) and (h).)

Key features of the process and standards set out in section 1418.8 include:

Predicate Determinations by Physician: Section 1418.8 sets out standards and procedures by which the attending physician must determine a resident's decisionmaking capacity and the existence of any authorized surrogate decisionmaker. To make such determinations, the physician must interview the resident, review the resident's medical records, and consult with facility staff, and family members and friends of the resident, if identified. (§ 1418.8, subds. (b) & (c).)

A resident lacks health care decisionmaking capacity 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." (§ 1418.8, subd. (b).) The absence of any person with legal authority to make treatment decisions on a resident's behalf may be found if there is no "person designated under a valid Durable Power of Attorney for Health Care, a guardian, a conservator," or any "next of kin" available and willing to "take full responsibility" for such decisions. (*Id.*, subd. (c); see also subd. (f).)

The physician's determinations regarding incapacity and the lack of a surrogate decisionmaker, and the "basis for those determinations," must be documented in the resident's medical record. (§ 1418.8, subd. (*l*).) The physician must also notify the facility of these determinations. (*Id.*, subd. (a.).)

Convening of an IDT: An IDT at the facility must then "conduct a review of the prescribed medical intervention prior to the administration of the medical intervention." (§ 1418.8, subd. (e).) The IDT must include "the resident's attending physician, a registered nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the

resident's needs, and, where practicable, a patient representative." (*Id.*, subd. (e).)

Patient Representative: The resident's representative, who must be included on the IDT where practicable, may be a "family member or friend of the resident who is unable to take full responsibility for the health care decisions of the resident," or any "other person authorized by state or federal law[,]" such as a long-term care ombudsman. (*Id.*, subds. (e), (f).) The medical records documenting the attending physician's determinations that the resident lacks capacity to provide informed consent and any surrogate decisionmaker must be made available to the resident's representative. (*Id.*, subd. (*l*).)

IDT Review: The IDT, in reviewing a proposed treatment decision, must review of each of the following:

(1) The "physician's assessment of the resident's condition."

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

(3) The "desires of the resident," based on a patient interview, record review, and consultation with any identified family or friends.

(4) The "type of medical intervention to be used in the resident's care . . . ."

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

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

(§ 1418.8, subds. (e)(1)-(6).)

Any treatment initiated pursuant to section 1418.8 must be done "in accordance with acceptable standards of practice." (*Id.*, subd. (d).) The IDT must evaluate the utilization of the treatment "at least quarterly or upon a significant change in the resident's medical condition." (*Id.*, subd. (g).)

Determination of Resident's Views. As indicated above, section 1418.8 requires that, to determine the "desires of the resident," the IDT must (1) "interview the patient," (2) "review the patient's medical records," and (3) "consult with family members or friends, if any have been identified." (§ 1418.8, subd. (e)(3).)

Emergency Provisions: In the event of an emergency, the facility may administer treatment ordered by a physician to the resident, including applying "physical or chemical restraints." (§ 1418.8, subd. (h).) If physical or chemical restraints are applied, the IDT must meet "within one week of the emergency for an evaluation of the medical intervention." (*Ibid.*)

Judicial Review. Section 1418.8 preserves the rights of a resident or a representative to seek judicial review of the decision to provide a medical intervention. (§ 1418.8, subd. (j).) Such review "may encompass review of the initial medical determination that the patient lacks capacity to give informed consent." (*Rains*, *supra*, 32 Cal.App.4th at p. 185 & fn. 7.)

C. This Court Upholds the Constitutionality of Section 1418.8 in *Rains*

In *Rains*, this Court considered and rejected claims that section 1418.8 violated a nursing home resident's rights to privacy and due process.

In rejecting petitioner *Rains*' privacy claim, the Court examined the nature of petitioner's privacy interests in the context of nursing home care, and balanced those against the interests of the State in ensuring that residents receive timely medical interventions regardless of capacity to consent. (*Rains*, *supra*, 32 Cal.App.4th at pp. 172-177.) The Court found that in the context of nursing home care, a resident's reasonable expectations of privacy, and the seriousness of any infringement of privacy by IDT decisionmaking under the statute, are both "diminished." (*Id.* at pp. 174-175, 177.) Balanced against the interests in ensuring timely medical

care for residents, and in light of the safeguards afforded by the statute and deference to the solution devised by the Legislature, this Court concluded that "section 1418.8 does not violate the constitutional right of privacy." (*Id.* at pp. 175-177.)

In rejecting petitioner *Rains*' due process claims, the Court specifically considered and rejected her "interrelated contentions" that section 1418.8 unconstitutionally: 1) "permits an initial *nonjudicial* determination of the patient's incompetence by a physician or surgeon, preceding the subsequent medical intervention decision[;]" and 2) "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 . . . ." (*Rains*, *supra*, 32 Cal.App.4th at p. 178, emphasis in original.) The court examined these contentions and concluded that the statute "affords due process under both the state and federal Constitutions. (*Id.* at p. 187.)

D. Statement of the Case

Petitioners filed a petition for a writ of mandate on October 22, 2013, naming as respondent Ronald Chapman, M.D., in his official capacity as the Director of the Department of Public Health (Department). (JA 2.)[4] The petition asserted eight causes of action, asserting that section 1418.8 violates due process and privacy rights in several respects. Petitioners moved for issuance of a writ of mandate. (JA 22, 301.)

After the Director filed an opposition challenging petitioners' standing, among other things, petitioners moved to amend their complaint to add a "taxpayer" claim by petitioner CANHR's attorney. (JA 519.)

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[4] The Department's current Director Karen Smith, MD, MPH, was substituted upon the filing of this appeal.

Following a January 14, 2015 hearing, the trial court granted petitioners' motion to amend the petition. (JA 627.) Petitioners then filed their amended complaint, and the Director answered. (JA 629, 679.)

After the matter was fully briefed, hearings were held on February 19, 2015, and March 27, 2015. On June 24, 2015, the court issued an order granting, in part, the petition for a writ of mandate. (JA 705.) The court granted petitioners' claims on three issues: 1) that section 1418.8 violated due process by failing to require notice to residents of the physician's predicate determinations for use of the statute, and of the opportunity to seek judicial review; 2) that section 1418.8 is unconstitutional to the extent applied to authorize administration of antipsychotic drugs; and 3) that section 1418.8 is unconstitutional to the extent applied to authorize decisions relating to end-of-life care. (JA 711-721, 729-747.)

As directed by the court, petitioners submitted a proposed judgment and writ. The Director objected to petitioners' proposed judgment and writ, and submitted alternate proposed forms of both documents. (JA 799-820.)

The California Association of Health Facilities (CAHF) and California Hospital Association (CHA) both sought leave to file amicus curiae briefs regarding the form of the judgment and writ on October 5, 2015. (JA 749, 772.) The court granted CAHF and CHA status as interveners in connection with the terms of the judgment and writ. (JA 850.)

The trial court entered judgment on January 27, 2016 (Judgment). (JA 852.) The Judgment stayed issuance of the writ for 61 days from the entry of judgment. (JA 855.) Petitioners served notice of entry of the Judgment on February 3, 2016. (JA 857.)

The Director timely filed a notice of appeal on March 24, 2016. (JA 864.) Petitioners filed a notice of appeal the following day, March 25, 2016. (JA 867.)

STANDARD OF REVIEW

In reviewing a trial court's judgment on a petition for writ of mandate, this Court exercises its independent judgment on legal issues, reviewing such questions de novo. (*City of Oakland v. Oakland Police & Fire Ret. Sys.* (2014) 224 Cal.App.4th 210, 226). As such, the Court "must apply the same standard of review as the trial court, giving no deference to the trial court's decision." (*Ellison v. Sequoia Health Services* (2010) 183 Cal.App.4th 1486, 1495.)

In considering the constitutionality of a legislative act, the Court must "'presume its validity, resolving all doubts in favor of the Act.'" (*County of Sonoma v. State Energy Resources Conservation. Com.* (1985) 40 Cal.3d 361, 368, quoting *Cal. Housing Finance Agency v. Elliott* (1976) 17 Cal.3d 575, 594.) "'Unless conflict with a provision of the state or federal Constitution is clear and unquestionable," the Court "must uphold the Act. [Citations].'" (*Ibid.*)

ARGUMENT

I. AS THIS COURT CONCLUDED IN *RAINS*, FACILITIES ARE NOT REQUIRED BY DUE PROCESS TO PROVIDE FORMAL NOTICE TO RESIDENTS BEFORE UTILIZING SECTION 1418.8

Providing the type of notice to the resident of a physician's findings under section 1418.8 proposed by petitioners, whatever its value may be as matter of policy, is not constitutionally mandated. The trial court erred in holding that due process requires such notice. As this Court determined in *Rains*, section 1418.8 "affords due process under both the state and Federal Constitutions" through the procedural safeguards "granted not only by the statute itself," but also those provided by other state and federal regulatory standards. (*Rains, supra*, 32 Cal.App.4th at pp. 186-187.)

The trial court erroneously ruled that section 1418.8 is facially unconstitutional and enjoined its use on the grounds that the statute does not require that a resident be adequately notified in writing of (1) the physician's determination of incapacity; (2) the physician's determination that there is no surrogate decisionmaker; (3) the medical intervention prescribed by the physician and referral to the IDT for decisionmaking regarding the treatment; and (4) the availability of judicial review of the physician's determinations. (JA 853.) The due process clause of the state constitution does not require such notice.

A. *Rains* Correctly Concluded that Due Process Does Not Require Formal Notice to Residents

In *Rains*, this Court considered and correctly rejected the same argument advanced by petitioners here: that section 1418.8 "den[ies] procedural due process" to nursing home residents because it permits a medical intervention, following the physician's determination of incapacity, to be implemented "without notice" to the resident. (*Rains*, *supra*, 32 Cal.App.4th at p. 178.) The trial court was bound by *Rains*, and plainly erred in concluding that *Rains* "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." (JA 715-716, emphasis in original.)

Contrary to the trial court's statement, petitioner *Rains* specifically contended that section 1418.8 violated due process because it permits a medical intervention to be ordered after the physician's determination of incapacity "without notice" to the resident and a hearing by an independent fact finder. (*Rains*, *supra*, 32 Cal.App.4th at p. 178.) In concluding that determinations of a patient's capacity "are medical decisions" that do not require adversarial hearings, *Rains* rejected petitioner's claim that "notice" to the resident of a physician's determinations regarding lack of capacity

and the nonexistence of a surrogate decisionmaker are constitutionally required before the procedures of section 1418.8 may be utilized.

The trial court here erred both in concluding that this Court had not addressed this issue in *Rains*, and in deciding the issue contrary to this Court's holding that "the procedures provided by section 1418.8 do not violate the constitutional rights of nursing home patients to procedural due process or their right of privacy." (*Rains*, *supra*, 32 Cal.App.4th at p. 187.)

B. Section 1418.8 and Other Law Governing Resident Care Safeguard Residents' Rights to Due Process

There is no basis for this Court to revisit or depart from its conclusions in *Rains* that notice and hearing rights on the determination of incapacity are not required before a nursing home may utilize section 1418.8.[5] As this Court appropriately concluded in *Rains*, the determination of capacity to provide informed consent is a medical decision, and the procedural protections established under section 1418.8, particularly when considered in connection with safeguards provided by other state and federal law, adequately protect residents' rights to procedural due process.

1. A Physician's Determination of a Resident's Capacity to Provide Informed Consent Is a Medical Decision and Does Not Require an Evidentiary Hearing; Thus, Formal Notice to a Resident Is Not Required

Whether a nursing home resident has capacity to provide informed consent to treatment is a medical, rather than judicial, determination. And, as section 1418.8 and other relevant law safeguards resident's interests, formal notice of a physician's determination of incapacity and nonexistence of a surrogate decisionmaker is not required by due process.

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[5] This Court should depart from a prior decision only when there is "good reason" to overrule its precedent. (*Bourhis v. Lord* (2013) 56 Cal.4th 320, 327.)

Notice is generally considered an element of due process where necessary to give effect to the right to an adjudicatory hearing. (See *Goldberg v. Kelly* (1970) 397 U.S. 254, 267-268.) In *Marquez v. Department of Health Care Services* (2015) 240 Cal.App.4th 87 (*Marquez*), for example, this Court concluded that where there was no "undisputed entitlement to a hearing" regarding the State's entry of electronic data concerning a Medi Cal beneficiary, the contention that notice of entry of such data was required "puts the cart before horse." (*Id.* at pp. 114-115) This Court held in *Rains* that a physician's determination that a resident lacks decisional capacity is a medical decision that does not require an adjudicatory hearing. (*Rains*, *supra*, 32 Cal.App.4th at pp. 179-182.) Thus, petitioners' claim similarly puts the cart before the horse. Formal notice of the physician's determination is not be required by due process.

This Court recognized as much in *Rains* when it observed that petitioners' contentions that section 1418.8 improperly permits physicians to determine capacity, and authorizes medical intervention "without notice" and opportunity for hearing, were "interrelated." (*Rains*, *supra*, 32 Cal.App.4th at p. 178.) In concluding that the determination of incapacity by a physician did not violate due process, the Court rejected petitioner's claim that formal notice of the determination was required. (See *Id.* at pp. 176-187.)

This Court's conclusion in *Rains* that capacity determinations are "medical determinations" and do not require notice and adjudicatory hearings is consistent with other state statutes that restrict or remove rights to consent to or refuse medical treatment based on a physician's determination of incapacity. For example, Probate Code section 4658 authorizes physicians to determine, without providing formal notice to the patient, whether a patient lacks capacity for purposes of deciding whether to follow instructions in the patient's advance health care directive. And,

specifically as to nursing home residents, a resident's rights under the "Patient's Bill of Rights"—including the right to "consent to or refuse any treatment or procedure"—devolve to a "guardian, conservator, next of kin, sponsoring agency, or representative payer" if the patient is "found by his physician to be medically incapable of understanding the information." (Health & Saf. Code, § 1599.3; Cal. Code Regs., tit. 22, § 72527, subd. (a)(4).) These provisions do not require formal notice to the resident of the physician's determination of incapacity. (See Health & Saf. Code, §§ 1599-1599.4). Thus, state law already recognizes that physicians may properly make incapacity determinations that result in a resident's loss of the right to consent to medical treatment without formal notice being provided to the resident.

Indeed, in light of the safeguards afforded by section 1418.8, the statute appears to ensure greater protection to residents for whom treatment decisions are made under its provisions than residents who have a legally authorized surrogate decisionmaker, and thus fall outside the statute's purview.

Under section 1418.8, if a resident is determined to lack capacity or any surrogate decisionmaker, the decision whether to initiate a treatment proposed by the physician will be made by a team of licensed health care practitioners and other appropriate care givers, along with a representative of the resident where practicable. (§ 1418.8, subd. (e).) The IDT must follow the detailed procedures set out in the statute before authorizing the proposed treatment, including meeting with the resident and consulting family member or friends to determine the patient's desires, reviewing the physician's assessment of the resident's condition, considering the impact of and alternatives to the treatment, and documenting its determinations in the patient's record. (*Id.*, subds. (e)(1)-(6).)

The IDT's review of the proposed medical intervention necessarily may encompass review of the initial medical determination that the patient lacks capacity to give informed consent since these are "predicate and triggering condition[s] to the application of section 1418.8. (See *Rains*, *supra*, 32 Cal.App.4th at p. 185, fn. 7.) Moreover, the IDT must review the treatment decision at least quarterly, or upon a change in the resident's condition, thus requiring the IDT to periodically consider and take into account, among other things, whether a resident may have regained decisionmaking capacity. (*Id.*, subd. (g).)

In contrast, a resident whose rights devolve to a legally authorized decisionmaker pursuant to a physician's determination of incapacity will have all decisions regarding medical treatment made by a single individual, who may well be less familiar than IDT members with issues concerning medical care and rehabilitation, and who is not subject to any of the duties or procedural requirements applicable to an IDT. For example, the surrogate decisionmaker is not required to interview the resident or obtain other information regarding his or her desires, to consider alternatives, and to periodically review the treatment decision. (Cf. § 1418.8, subds. (e)(3), (e)(6), (g).) As this court noted in *Rains*, "it is very hard to see how the invasion of privacy is more serious when the issue is decided by a medical team, as opposed to a conservator, the holder (frequently a layman) of a patient's durable power of attorney, or a court relying on expert medical reports or testimony, since a decision by some outside person, even if only by default, will 'inevitably' be made under the circumstances." (*Rains*, *supra*, 32 Cal.App.4th at p. 175, quoting *Heller v. Norcal Mutual Ins. Co.* (1994) 8 Cal.4th 30, 44.)

2. Section 1418.8 Does Not Deprive Residents of Due Process When Considered in Light of the Applicable Regulatory Scheme

Moreover, while Section 1418.8 does not mandate notice to residents of the physician's determinations at issue, independent statutory and regulatory requirements mandate that facilities adequately inform their residents regarding their medical status, interventions, and right to consent. Thus, taken as a whole, the statutory scheme contains ample protections and comports with due process requirements.

Whether a statute violates procedural due process is not determined in isolation. Rather, courts examine the "entire statutory scheme" of which the statute is part. (*Bravo v. Ismaj* (2002) 99 Cal.App.4th 211, 223.) This Court recognized as much in *Rains* in rejecting petitioners' due process challenge to section 1418.8. As the Court noted, section 1418.8 "contemplates compliance with applicable federal and state requirements designed to protect nursing home patients, such as the standards set and regulations promulgated under 42 United States Code section 1395i–3 and 42 Code of Federal Regulations, section 483.1 et seq., which both limit and supplement the interdisciplinary team decisionmaking approach by granting certain rights and safeguards to affected residents." (*Rains*, *supra*, 32 Cal.App.4th at p. 186.) The Court also noted that: "The protections of state law which apply to any particular medical intervention or procedure would continue to apply. Consideration of these numerous statutory safeguards [citation] undermines the claim that section 1418.8 violates due process standards." (*Rains*, *supra*, 32 Cal.App.4th at pp. 186-187.)

In addition to the procedural requirements and protections provided by section 1418.8, other state and federal laws and regulations, including those referenced in *Rains*, ensure that residents for whom treatment decisions are made under section 1418.8 will be informed of the

physician's predicate determinations for utilization of the statute, treatment decisions, and of the opportunity to object to those determinations.

California's "Patient Bill of Rights" and related state and federal regulations identify critical rights of nursing home residents including the right to:

- be "fully informed" about his or "total health status";
- to "consent to or refuse any treatment or procedure";
- to receive "all information that is material" to the decision whether to accept or refuse any treatment or procedure; and
- to participate in their overall "plan of care, including the identification of medical, nursing and psychosocial needs and the planning of related services"; and
- to be "immediately informed" when there is a significant change in the resident's "physical, mental, or psychosocial status," or a "need to alter treatment significantly[.]"

(Cal. Code Regs., tit. 22, § 72527, subds. (a)(3)-(5); see also 42 U.S.C. § 1395i–3(c)(1)(A)(i); 42 C.F.R. § 483.10(b)(3), (b)(4), (b)(11)(B) and (C).)[6] Under these provisions, the attending physician should inform residents of the physician's determinations under section 1418.8, if not also the physician's intent to refer the treatment decision for IDT review, as those matters are relevant to the resident's health status, the opportunity to consent, and planning of care.

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[6] The federal regulations governing "resident rights" at 42 C.F.R. § 483.10 are applicable to all state nursing homes. (Prob. Code, § 1599.1(i)(1).) These rights, including those identified in the paragraph above, are clarified and strengthened in revised regulations set to take effect on November 28, 2016. (81 Fed. Reg. 68688, 68849-68854 (Oct. 4, 2016), to be codified at 42 C.F.R. §§ 483.10(c), (g).)

Additionally, residents must be advised that they "have the right to voice grievances to facility personnel free from reprisal and can submit complaints to the State Department of Health Services or its representative." (Health & Saf. Code, § 1599.2, subd. (c); see also 42 U.S.C. § 1395i-3(c)(1)(A)(vi); 42 C.F.R. § 483.10(f).)[7]

Patients must be "fully informed" of these rights "as evidenced by the patient's written acknowledgement prior to or at the time of admission." (Cal. Code Regs., tit. 22, § 72527, subd. (a)(1); see also 42 U.S.C. § 1395i–3(c)(1)(B)(i), (ii); 42 C.F.R. § 483.10(b)(1), (2).)[8] Thus, all nursing home residents should have been advised of these rights when admitted. Moreover, facilities are required to adopt and implement policies to "ensure that these rights are not violated." (Cal. Code Regs., tit. 22, § 72527, subd. (a).)

As noted above, section 1418.8 also requires that the IDT interview a resident to determine his or her desires regarding a proposed treatment before treatment is authorized under section 1418.8, notwithstanding that the resident has been determined by their attending physician to lack decisional capacity. (§ 1418.8, subd. (e)(3).)

In light of these protections, a resident capable of understanding his or her rights will be put on notice that a facility is not giving effect to his or her right to refuse treatment if it seeks to initiate treatment under section

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[7] Resident grievance rights are expanded under the revised regulations set to take effect November 28, 2016, including requiring written notification regarding how to file grievances, and of contact information for filing grievances or complaints with patient advocates, the state survey agency, the long-term care ombudsman, and others. (See 81 Fed. Reg. at pp. 68852, 68854-68855, to be codified at 42 C.F.R. §§ 483.10(g)(4)(i)(C), (j).)

[8] Resident rights to be informed are expanded under the revised regulations set to take effect November 28, 2016. (81 Fed. Reg. at pp. 68852-68853, to be codified at 42 C.F.R. §§ 483.10(g)(2), (g)(16).)

1418.8 contrary to the resident's desires or belief that he or she has capacity to give or refuse consent. This Court, in determining whether due process requires notice of an event or determination, has looked to whether the plaintiff will, in practice, have notice of the action at issue. (See *Marquez*, *supra*, 240 Cal.App.4th at p. 115 [noting that Medi Cal beneficiaries have "adequate notice" to challenge any incorrect computer coding of other health coverage (OHC) when they are told by providers that they are being referred to another provider "due to the apparent OHC: . . . there is nothing more that DHCS could tell them"].)

Accordingly, the procedures established by the Legislature under section 1418.8 do not violate due process. The regulatory scheme as a whole requires that residents be informed of their rights, including the right to refuse treatment, and have opportunity to exercise those rights.

C. The *Ramirez* Analysis is Inapposite

The trial court also erred in basing its conclusions regarding the requirements of due process, as applied to section 1418.8, on its analysis of the factors set out in *People v. Ramirez* (1979) 25 Cal.3d 260, 268 (*Ramirez*). (JA 717-720.)

First, *Ramirez* applies only to determine the process due when an individual is deprived by government action of a statutory or constitutional right. (*Ramirez*, *supra*, 25 Cal.3d at p. 269.) As this Court concluded in *Rains*, utilization of the procedures under section 1418.8 does not violate the due process or privacy rights of nursing home residents. This Court in *Rains* did not deem the *Ramirez* factors relevant to its analysis of petitioner's due process claim (see *Rains*, *supra*, 32 Cal.App.4th at pp. 178-187), and there is no reason for the Court to apply them here.

Second, *Ramirez* guides the determination of what process is due in the context of "adjudicative procedures." (*Ramirez*, *supra*, 25 Cal.3d at pp. 263–264; see *Marquez*, *supra*, 240 Cal. App. 4th 87, 112 [questioning

whether changing or entering other health coverage coding constitutes an "'adjudicative procedure[]' [citing *Ramirez*] targeted by our state's due process clause").] No adjudicative procedures are involved in the application of section 1418.8 to a health care decision.

Third, fundamental to the *Ramirez* analysis is the assumption that the individual's liberty or property interests will be affected by *state action*. (See, e.g., *Ramirez*, *supra*, 25 Cal.3d at p. 264 [factors call assessment of procedural protections required under "in light of the *governmental* and private interests at stake"], emphasis added.) As no government action is involved in a physician's or IDT's determinations and treatment decisions under section 1418.8, the *Ramirez* factors are inapt. *Ramirez's* first factor, for example, requires courts to consider "the private interest that will be affected by *the official action*." (*Id.* at p. 269, emphasis added.) The second factor, which examines "risk of an erroneous deprivation" of the private interest and "probable value of additional safeguards," thus rests on the predicate of "official action" that affects a protected interest. (*Ibid.*) The third factor addresses the "dignitary interest" in enabling the individual to present their story "before a *responsible government official*[.]" (*Ibid.*, emphasis added.) And the fourth factor exclusively addresses the "*governmental interest*." (*Ibid.*, emphasis added.)

The *Ramirez* analysis is inapplicable to review of petitioners' due process claim.

II. EVEN IF THIS COURT CONCLUDES THAT THE STATUTORY SCHEME PROVIDES INSUFFICIENT NOTICE, THE TRIAL COURT ERRED IN HOLDING SECTION 1418.8 FACIALLY INVALID

Even if this Court concludes that the statutory scheme provides inadequate notice, this Court may, and therefore must, deem any requirement to provide formal notice incorporated into section 1418.8 rather than declare the statute unconstitutional under well-established

principles of constitutional interpretation. The trial court disregarded this fundamental interpretive principle, as well as the requisite standard for declaring a statute facially invalid, in holding that section 1418.8 is "facially unconstitutional" and that its use is therefore "prohibited," based on its conclusion that additional procedural protections are required. (JA 721, 853.)

The trial court's Judgment, if given effect, would unnecessarily prohibit any use of the vital procedures established under the statute by the Legislature to ensure access to care for large numbers of nursing home residents, unless or until the Legislature approved, and the Governor signed, legislation adding the notice requirements identified by the court into the text of the statute. Even if the Court determines that written notice to residents of determinations relating to use of section 1418.8 is required, this element of the lower court's ruling must be vacated.

As courts must not interfere unnecessarily with the intent of the coordinate branches in enacting legislation, statutes must be interpreted to avoid doubt as to their constitutionality where reasonable to do so. (*Board of Ed. of San Francisco Unified School Dist. v. Mass* (1956) 47 Cal.2d 494, 499; *People ex rel. Reisig v. Broderick Boys* (2007) 149 Cal.App.4th 1506, 1522.) "The power of a court to declare a statute unconstitutional is an ultimate power; its use should be avoided if a reasonable statutory construction makes the use unnecessary." (*Syrek v. Cal. Unemployment Ins. Appeals Bd.* (1960) 54 Cal.2d 519, 526.) Thus, courts must "wherever possible, interpret a statute as consistent with applicable constitutional provisions, seeking to harmonize Constitution and statute." (*Cal. Housing Finance Agency v. Elliott* (1976) 17 Cal.3d 575, 594.)

Applying these principles, courts have regularly read notice, hearing, and other due process requirements into statutes rather than declaring them unconstitutional for failing to specify the protections required by due

process. (*Board of Ed. v. Mass*, *supra*, 47 Cal.2d at p. 499 [reading hearing and other requirements into statute where law could "be reasonably interpreted in a manner consistent with due process"]; *Horn v. County of Ventura* (1979) 24 Cal.3d 605, 616 [construing statute to require "reasonable notice and opportunity to be heard"]; *Braxton v. Municipal Court* (1973) 10 Cal.3d 138, 144-145 [noting that statute "must be construed so as not to violate the precepts of procedural due process; hence we interpret [statute] to require notice and a hearing"]; *Charles S. v. Board of Education* (1971) 20 Cal.App.3d 83, 96 [denying writ challenging constitutionality of statute on procedural due process grounds, and construing statute to include specific notice and hearing requirements].)

Nothing in section 1418.8 is inconsistent with requiring notice to residents of the physician's predicate determinations. Thus, if the Court determines that due process calls for such notice under section 1418.8, the Court must interpret the statute as incorporating those notice requirements rather than declaring it facially unconstitutional.

For the same reason, the trial court erred in holding that section 1418.8 is facially unconstitutional, and declaring that its use is "prohibited" to the extent it does expressly require notice to residents. (JA 721, 853.) A statute is unconstitutional on its face only when it presents "a total and fatal conflict with applicable constitutional prohibitions." (*Tobe v. City of Santa Ana* (1995) 9 Cal.4th 1069, 1084 (*Tobe*), internal quotations and citation omitted.) As section 1418.8 may reasonably be interpreted to include notice requirements, it does not present a "total and fatal conflict" with constitutional requirements, and therefore is not facially unconstitutional.

For the reasons above, even if the Court the statutory scheme fails to ensure adequate notice to resident, notice requirements must be "read into" section 1418.8 and the trial court's prohibition on any utilization of section 1418.8 must be reversed.

III. SECTION 1418.8 DOES NOT LIMIT THE SCOPE OF TREATMENTS THAT MAY BE AUTHORIZED, CONTEMPLATES IDT AUTHORIZATION FOR USE OF ANTIPSYCHOTIC DRUGS, AND TOGETHER WITH OTHER APPLICABLE REGULATORY REQUIREMENTS, PROVIDES SUFFICIENT CONSTITUTIONAL SAFEGUARDS FOR THEIR USE UNDER THE STATUTE

In enacting section 1418.8, the Legislature intended that the IDT decisionmaking process be made available to the greatest extent possible to ensure that residents' medical needs may be met, and did not limit the scope of treatments that could be authorized under its procedures. Indeed, the Legislature expressly recognized in the statute that "chemical restraints," of which antipsychotics are the most common, could be utilized under the statute, subject to prompt review by the IDT, and therefore contemplated authorization for use of antipsychotic medications under the statute. (§ 1418.8, subd. (h).) Section 1418.8, considered in conjunction with other regulatory requirements that ensure independent oversight of antipsychotic prescriptions for residents, adequately protects the constitutional interests of residents. The Legislature's determinations as to the appropriate balance of interests reflected in section 1418.8 are entitled to deference, and should be upheld. (*Rains*, *supra*, 32 Cal.App.4th at p. 177.)

The trial court erred in concluding that the Legislature "must not have intended" section 1418.8 to be utilized to authorize administration of antipsychotic drugs, and that the statute is unconstitutional as applied to use of such medications because it does not provide for a judicial determination of incapacity. (JA 735-737.) The trial court erroneously based its ruling on decisions addressing statutory rights to refuse antipsychotic drugs in the "very different statutory setting[s]" pertaining to prisoners and individuals

committed to state mental hospitals. (*Rains*, *supra*, 32 Cal.App.4th at p. 170.)

The Department shares petitioners' concerns about the potential for over-prescription of antipsychotic medications in nursing homes and has actively sought to address the issue through appropriate policy and other administrative interventions. The Department's "Antipsychotic Collaborative" and a partnership with numerous stakeholder groups have led to implementation of a variety of measures aimed at reducing unnecessary administration of antipsychotics. (JA 281-300, 558 [¶¶ 17]; 581-626.) Through these measures, antipsychotic use in the State has declined significantly. (JA 559, JA 762). Antipsychotic medications, remain, however, a critical element of medical treatment for some nursing home residents in appropriate circumstances, helping relieve the distress and harmful effects of certain conditions that have not successfully been mediated by other means. (See JA 557-558 [¶¶ 14-15, 19].)

The trial court's prohibition of antipsychotic medical interventions pursuant to section 1418.8, if left standing, would likely have far reaching and troubling impacts on individuals who lack decisional capacity or surrogate decisionmakers in need of nursing home care. Some nursing homes, having learned of the trial court's ruling, already have declined to accept such patients on the ground that the facilities do not believe they can adequately provide necessary care, and more may do so if the trial court's decision is affirmed. (JA 758-759, 777; see Cal. Code Regs., tit. 22, § 72515, subd. (b) [licensee shall "[a]ccept and retain only those patients for whom it can provide adequate care"].) This could lead to a crisis in access for individuals most in need of nursing home care.

Current residents receiving necessary antipsychotic medication also would be adversely affected by affirmance of the trial court's ruling. Many residents are likely to be immediately taken off these medications, leading

to "catastrophic" consequences not only in connection with their mental and physical condition, but also because many would be "highly likely" to require admission to the unfamiliar and less stable environments of acute care or psychiatric facilities. (JA 756-759, 762-763, 777-778.) In these facilities, these patients remain unrepresented, and are likely to be placed under the same treatment regimen without benefit of IDT decisionmaking by facility staff more familiar with the individual's condition and needs. (JA 778-780.)

The trial court's Judgment barring administration of antipsychotic drugs under section 1418.8 should be reversed.

A. The Legislature Intended that Section 1418.8 Be Utilized for Any Treatment Decisions Necessary to Meet Residents' Needs, and Contemplated Its Use to Authorize Antipsychotic Medication

The Legislature expressly intended that IDTs have authority to authorize treatments necessary to meet the medical needs of nursing home residents. As the Legislature stated in its findings and declarations in support of the statute, its intent was to "secure, *to the greatest extent possible*, health care decisionmakers" for unrepresented residents lacking decisionmaking capacity "to *ensure that the medical needs of nursing facility residents are met* even in the absence of a surrogate health care decisionmaker." (Stats. 1992, ch. 1303, § 1, emphases added.)

Consistent with the Legislature's stated purpose, section 1418.8 does not limit, in any way, the scope or nature of "medical interventions" that may be authorized by an IDT for unrepresented residents lacking decisionmaking capacity. The statute was intended to provide a substitute for informed consent for medical interventions that otherwise would require informed consent from the resident or a surrogate. (*Rains*, *supra*, 32 Cal.App.4th at p. 184.) Administration of antipsychotics is one such treatment that, absent emergency circumstances, requires informed consent.

(Health & Saf. Code § 1418.9; Cal. Code Regs., tit. 22, § 72528.) Informed consent is not required for medical procedures that are "common" or "simple and the danger remote and commonly appreciated to be remote." (*Cobbs v. Grant* (1972) 8 Cal.3d 229, 244-245.) Thus, the Legislature necessarily intended that section 1418.8 be available for use for medical interventions that are not routine or without risk.

Indeed, section 1418.8 *expressly* permits IDT authorization for "chemical restraints," which may include, under appropriate circumstances, use of antipsychotics. (See JA 574-575.) Subdivision (h) of section 1418.8 provides that such restraints may be utilized in emergency circumstances before an IDT review. The IDT must meet within one week of the emergency for "an evaluation of the intervention." (§ 1418.8, subd. (h).) In recognizing an IDT role in review of the use of chemical restraints, the Legislature necessarily contemplated the potential for IDT authorization for less severe therapeutic use of antipsychotics—following their temporary use as an emergency restraint—pursuant to appropriate recommendation by a physician and where consistent with applicable regulations and guidelines.

The trial court's conclusion that "the Legislature must not have intended for section 1418.8 to apply to the administration of antipsychotic drugs" cannot be squared with the Legislature's expressed intent and the language of the statute, as identified above. (JA 735.) In so holding, the trial court failed to "accord the Legislature the initial deference which is due to its judgment as to a solution." (*Rains*, *supra*, 32 Cal.App.4th at p. 177, citing *Hill v. National Collegiate Athletic Assn.* (1994) 7 Cal.4th 1, 7.) Courts "cannot insert or omit words to cause the meaning of a statute to conform to a presumed intent that is not expressed." (*Am. Civil Rights Foundation v. Berkeley Unified School Dist.* (2009) 172 Cal.App.4th 207, 217, internal quotations and citations omitted.)

Consistent with the Legislature's intent that section 1418.8 have the broadest application possible to ensure that the medical needs of unrepresented and incapacitated residents may be met, section 1418.8 provides authority for IDTs to give substituted consent on behalf of residents for administration of antipsychotic medications in accordance with applicable regulations and standards of practice.

B. In Light of the Regulatory Regime Governing Administration of Antipsychotics in Nursing Homes, the Protections Afforded by Section 1418.8, and the Context of Nursing Home Care, Authorization of Antipsychotic Medication under Section 1418.8 Does Not Violate Due Process

The state and federal governments have placed the use of antipsychotic medications in nursing homes under increased scrutiny in recent years, and their use is subject to a comprehensive and rigorous oversight scheme. That regulatory scheme includes regular independent review of all prescriptions for antipsychotic and other prescription medications, and enforcement of requirements for informed consent, or substituted consent by surrogates or by IDTs under section 1418.8, to administration of antipsychotics. Indeed, as described below, new regulations designed to strengthen these protections are set to take effect less than two weeks after this brief is filed. Consideration of these "numerous statutory safeguards[,]" regulations, and other measures "undermines the claim that section 1418.8 violates due process standards" in connection with administration of antipsychotics. (See *Rains*, *supra*, 32 Cal.App.4th at p. 187.)

The federal Nursing Home Reform Act, applicable to nearly all nursing homes in the state,[9] limits and provides for safeguards on the use of psychopharmacologic drugs. Significantly, administration of these medications as to any resident receiving such drugs is subject to review, at least annually, by an independent outside consultant. (42 U.S.C. §§ 1395i-3(c)(1)(D).) The law expressly provides that psychopharmacologic drugs may be administered only on the orders of a physician as part of a written plan of care "designed to eliminate or modify the symptoms for which the drugs are prescribed," and only if, at least annually, an "independent, external consultant reviews the appropriateness of the drug plan of each resident receiving such drugs." (42 U.S.C. §§1395i-3(c)(1)(D).)

The law also provides that residents have a right to be free from "chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms." (42 U.S.C. § 1395i-3(c)(1)(A)(ii).) Such restraints may only be imposed to "to ensure the physical safety of the resident or other residents," and "only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used," except in emergencies. (*Ibid.*)

Implementing regulations explicitly limit the use of antipsychotic drugs. In particular, facilities must ensure that antipsychotic drug therapy is "necessary to treat a specific condition as diagnosed and documented in

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[9] The Act applies to nursing homes that have provider agreements under the Medicaid or Medicare programs. (See *Cal. Advocates for Nursing Home Reform, Inc. v. Chapman* (N.D. Cal., June 3, 2013, No. 12-CV-06408-JST) 2013 WL 2422770, at *1; 42 U.S.C. §§ 1395i-3(g)(1)(A), 1396r(g)(1)(A) [requiring state certification of compliance by facilities].) Only a small fraction of the state's nursing homes are not certified for participation in these programs, in some cases because they are in process of obtaining such certification.

the clinical record;" and that residents receive "gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs." (42 C.F.R. §483.25(l)(1).)[10] Each resident's drug regimen must be reviewed on a monthly basis by a pharmacist, who must report "irregularities," and facilities must act on such reports. (42 C.F.R. §483.60(c).)[11]

The federal Centers for Medicare and Medicaid Services (CMS), which oversees state implementation of these programs, has issued comprehensive guidance based on these requirements for state "survey agencies," such as the Department, with oversight and enforcement authority over nursing homes. (See JA 563-579.) The guidelines are utilized in evaluating nursing home compliance with prohibitions on improper utilization of antipsychotics, as well as with informed consent requirements in connection with their use. (See *Ibid.*)

The Department, for its part, has undertaken a number of initiatives designed to reduce inappropriate administration of antipsychotics. Among other things, the Department helped form the "California Partnership to Improve Dementia Care and Reduce Unnecessary Antipsychotic

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[10] New regulations set to take effect November 28, 2016 also will require that "as needed" (PRN) orders for antipsychotic drugs be limited to 14 days, and not subject to renewal absent a renewed medical evaluation of "the appropriateness of the medication." (81 Fed. Reg. at p. 68863, to be codified at 42 C.F.R. § 483.45(e)(5).)

[11] New requirements designed to "strengthen the protections for residents" concerning pharmacy services are set to take effect November 28, 2016. (81 Fed. Reg. at pp. 68766.) These include requirements the pharmacists review a resident's medical record in connection with the monthly drug regimen review for new or returning residents, or for any resident prescribed or taking an psychotropic drug (including antipsychotics), and enhanced documentation requirements to ensure that the facility acts upon any irregularities identified by the pharmacist. (See 81 Fed. Reg. at pp. 68765-68774.)

Medication Drug Use in Nursing Homes," to work with a wide variety of stakeholder groups, including petitioners CANHR, representatives of nursing homes, and others, which developed strategies and goals to reduce the need to prescribe antipsychotic drugs, enhance enforcement of inappropriate uses, ensure informed consent, and to raise consumer awareness. (JA 581-626.)

In connection with these efforts, the Department developed an "Antipsychotic Use Survey Tool" and related guidance for Department investigators to utilize in reviewing compliance by nursing homes with regulatory requirements governing antipsychotic use, including requirements relating to informed consent. (See JA 288-300.) The Survey Tool expressly requires surveyors to evaluate whether the attending physician and facility complied with procedures required by section 1418.8 for the physician's determinations of incapacity and lack of a surrogate decisionmaker, and for IDT review of a prescription for or emergency use of antipsychotic drugs. (JA 291.)

The oversight, education, and enforcement measures undertaken by the Department, along with other government agencies and stakeholders, have helped to significantly reduce inappropriate administration of antipsychotics, and helped ensure that consent, or alternate authorization pursuant to section 1418.8, is obtained for their use. (See JA 558-559 [¶¶ 16-18], 581-626.)

In light of the considerations discussed above, utilization of section 1418.8 in connection with the administration of antipsychotic drugs comports with due process principles. These considerations include: the Legislature's intent to allow section 1418.8 to be broadly available for medical treatment necessary to meet residents' needs, and deference owed to the Legislature's solution; the extensive regulatory scheme governing antipsychotic drug use; the absence of any state role in the predicate

determinations for utilization of section 1418.8 and the prescription of antipsychotic drugs; and diminished reasonable expectations of decisionmaking autonomy applicable to residents in the nursing home context.

C. Judicial Precedent Does not Require an Independent Determination of Incapacity Before Antipsychotic Drugs May Be Administered to Residents

The trial court erroneously concluded, relying on judicial precedent applicable to individuals in state or federal custody, that section 1418.8 violates due process if utilized to authorize administration of antipsychotic drugs to residents without a determination of incompetency by a court or other independent decisionmaker. (JA 735-737.) This Court appropriately recognized in *Rains* that the administration of antipsychotic drugs to individuals in the custody of the state raises heightened due process considerations. The three principal decisions on which the trial court relied are limited to that context—indeed two construe statutory rather than constitutional rights to consent to treatment—and do not support the conclusion that section 1418.8 violates due process as applied to the administration of antipsychotic drugs.

The trial court relied principally on three decisions in concluding that administration of antipsychotic drugs cannot be permitted under section 1418.8: *Washington v. Harper* (1990) 494 U.S. 210 (*Washington*); *Keyhea v. Rushen* (1986) 178 Cal.App.3d 526 (*Keyhea*); and In re *Qawi* (2004) 23 Cal.4th 1 (*Qawi*). (JA 729-737.) In *Washington*, the Supreme Court determined that involuntary administration of antipsychotic drugs to a federal inmate did not violate the inmate's federal due process rights, where an independent medical board determined that the prisoner was a danger to himself and others, and that the treatment was in his medical interest. (*Washington*, *supra*, 494 U.S. at pp. 231-235.)

Keyhea involved a determination of the *statutory* rights of prisoners, committed to a state hospital, to refuse long-term treatment with antipsychotic drugs under a provision of the Penal Code. (*Keyhea*, *supra*, 178 Cal.App.3d at pp. 534-537.) The Court in *Keyhea* specifically "declined to rule that the constitutional right of privacy required a judicial finding of incompetency before the administration of psychotropic drugs on state prisoners who were thought to be incompetent and, therefore, could not provide informed consent." (*Rains*, *supra*, 32 Cal.4th at p. 169, citing *Keyhea*, *supra*, 178 Cal.App.3d at pp. 540-541.)

Qawi, similar to *Keyhea*, addressed whether a mentally disordered offender (MDO) involuntarily committed to a state hospital had a statutory right under a Penal Code provision relating to such offenders to refuse antipsychotic medication prescribed for his mental disorder in the absence of a judicial determination of his incapacity to make such a decision. (*Qawi*, *supra*, 32 Cal.4th at p. 9.)

Keyhea and *Qawi*, thus addressed only whether individuals in state custody had rights under relevant statutes to refuse antipsychotic drugs absent a judicial determination of incapacity. Neither addressed whether a judicial determination of incapacity was required by constitutional privacy or due process rights before such drugs could be administered involuntarily in a private facility.

In relying on these decisions, the trial court also failed to acknowledge this Court's explicit recognition in *Rains* that involuntary commitment to a state mental hospital has "attendant consequences" that "naturally trigger a need for rather extensive due process protections" that do not apply in the nursing home setting. (*Id.* at p. 185.) Such protections are not applicable, the Court suggested, to procedures by which the "equivalent of informed consent may be provided, by a patient representative, if practicable, so as to allow necessary medical treatment to

be afforded" to nursing home residents. (*Id.* at pp. 185-186.) Thus, this Court noted in *Rains* that the statutory scheme in *Keyhea* constitutes a "very different statutory setting" than section 1418.8. (*Rains*, *supra*, 32 Cal.App.4th at pp. 170.)

Indeed, as the Court recognized earlier in its decision, given the "particular nature" of the nursing home setting, a resident's reasonable expectation of decisionmaking autonomy in connection with medical care is "greatly lessened." (*Rains*, *supra*, 32 Cal.App.4th at pp. 173-174.) As the Court observed: "It is questionable if a person in need of medical care who is incompetent may ever have a *reasonable* expectation of privacy which would prevent timely medical intervention and treatment." (*Id.* at p. 173, emphasis in original.) Nursing home care is designed to provide "sustenance, shelter, and necessary medical care in a residential setting," and section 1418.8 accords with the reasonable expectation of residents that "if they became incompetent they will continue to receive their necessary medical care on a timely basis." (*Id.* at p. 174.)

The administration of antipsychotics to individuals in state custody differs also from uses of such medications in nursing homes, as nursing home care—including and especially in connection with the use of antipsychotics—is subject to a extensive regulatory requirements, as discussed above.

For these reasons, *Washington*, which likewise addressed the right of refusal of prisoners in federal custody, is similarly inapposite. (*Washington*, *supra*, 494 U.S. at 213.)

Finally, each of these cases concerned whether a judicial or other independent determination of incapacity was necessary to allow antipsychotic drugs to be administered *over the objections* of the individual in custody. None involved the issue presented here, whether a procedure to provide a substitute for informed consent for individuals in nursing homes

is consistent with constitutional principles. Under the trial court's ruling, section 1418.8 may not be utilized to authorize appropriate treatment with antipsychotic drugs even where the resident has no objection to taking them, or affirmatively desires the treatment.

The trial court's ruling is inconsistent with the Legislature's intent to permit section 1418.8 to be utilized to the "broadest extent possible" to facilitate needed medical treatment for unrepresented and incapacitated nursing home residents, and is unsupported by the precedent upon which the court relied. This Court appropriately determined in *Rains* that section 1418.8, considered also in connection with safeguards provided by other federal and state law, and in light of the balance of interests applicable in the nursing home setting, does not contravene residents' due process or privacy rights. Consideration of the statute's application to decisions regarding administration of antipsychotic drugs does not require any different result. The court's Judgment prohibiting use of section 1418.8 to authorize treatment with antipsychotic medications should be reversed.

IV. PETITIONERS FAIL TO PRESENT ANY BASIS FOR COURT INTERVENTION REGARDING USE OF SECTION 1418.8 FOR DECISIONS REGARDING LIFE SUSTAINING TREATMENT

The trial court's Judgment addressing utilization of section 1418.8 to decisions relating to end of life care should be reversed because petitioners have not demonstrated a need for judicial intervention, let alone an entitlement to judicial relief. Petitioners failed to present any evidence that the Director is applying section 1418.8 in an unconstitutional manner or allowing nursing homes to do so. Petitioners, therefore, have not presented a ripe or valid "as applied" challenge to the statute. The trial court's Judgment constitutes an improper advisory opinion that merely mirrors existing legal and ethical requirements in the context of decisions relating

to life-sustaining treatment. The trial court's Judgment on this issue, therefore, should be vacated.

A. Petitioners Fail to Establish a Ripe or Valid "As Applied" Claim

Petitioners fail to establish a ripe or valid as applied challenge to section 1418.8 because they did not establish that the Department was applying the statute in an impermissible manner, or condoning improper uses of the statute by nursing homes in connection with decisions regarding end-of-life care. Rather, petitioners submitted evidence only of alleged improper uses of the statute by *nursing homes* to make decisions regarding life-sustaining treatment for unrepresented and incapacitated residents. These allegations, if true, may give rise to tort or other claims against the nursing homes, but in the absence of any evidence of endorsement or authorization of such uses by the State, do not support a challenge to the constitutionality of section 1418.8 as applied to end-of-life care decisions.

An as-applied challenge looks to the manner or circumstances in which a statute or ordinance "has been applied" by the defendant. (*Tobe, supra,* 9 Cal.4th at p. 1084.) Such challenges contemplate "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." (*Ibid.*)

Moreover, given that only nursing homes utilize section 1418.8 and the necessity of "state action" to establish a constitutional violation, petitioners necessarily must demonstrate that the *Department* condoned or authorized an unconstitutional application of section 1418.8 to support their "as applied" claim. (See, e.g., *Deutsch v. Masonic Homes of California, Inc.* (2008) 164 Cal.App.4th 748, 761-762 [statute reviving childhood sexual abuse claims did not violate due process as applied as statute was

not facially unconstitutional, and delayed filing of claims by victims did not constitute state action].)

Petitioners, however, identified only alleged instances of improper applications of section 1418.8 by nursing homes, not by the Department, as discussed below.

1. Petitioners' Evidence Addresses Only Conduct by Physicians and Nursing Homes

Petitioners' claim, and the trial court's decision, rely solely on conclusory, incomplete, anecdotal, and hearsay evidence of allegedly improper decisionmaking by *physicians and nursing homes* in connection with end-of-life care decisions, such as to create or change do not resuscitate (DNR) orders, comfort care orders, and Physician Orders for Life Sustaining Treatment (POLST). (JA 334-337; 744-745.) However, most of the evidence relied upon by the trial court does not even relate to decisionmaking under section 1418.8, and none identifies improper applications of the statute condoned by the Department.

The trial court first relied on a declaration of "Jane Doe," the *parent* of an adult resident, alleging that a POLST was placed in her son's chart without her or her son's authorization. (JA 744; see JA 364-367.)[12] Because the son had a parent to act as a surrogate decisionmaker, the facility could not have been utilizing section 1418.8. Indeed, Ms. Doe's declaration does not identify that an IDT was involved in the creation of the POLST, at all. (See JA 364-367.) In any event, by her own advocacy, Ms. Doe obtained removal of the POLST. (JA 366 [¶ 14].)

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[12] A POLST may only be created or changed by an individual with decisionmaking capacity, or by a legally-authorized representative, in consultation with the resident's physician. (See Prob. Code, §§ 4870, 4871.2.)

The court similarly relied on the declaration of social worker Margaret Main, who describes an instance where a *primary physician* allegedly changed a resident's POLST to require that life-sustaining measures (CPR and "full code") be maintained, contrary to the resident's wishes. (JA 745; see JA 098 [¶ 9].) Ms. Main does not allege that an IDT was involved in the physician's action, much less one convened pursuant to section 1418.8. (See *ibid.*) The situation was resolved, in any event, after another social worker designated to assist the resident located a cousin of the resident willing to make health decisions for her, and the cousin signed a POLST reinstating the resident's apparent wishes to refuse life-sustaining treatment. (JA 745; see JA 098-099 [¶ 9].)

Portions of two declarations relied upon by the court relate to section 1418.8 decisionmaking, but neither address uses of the statute condoned by the State. One of these, the declaration of Cheryl Simcox, is wholly conclusory and fails to provide essential context, identifying only that Ms. Simcox attended IDT meetings as the resident representative at which there were "discussions" concerning decisions about "hospice care, DNR," or whether a resident could be given liquids given "the chance of aspiration and possible death." (JA 082 [¶ 10].)[13] There is no indication that decisions were made by the IDT. (*Ibid.*)

The other, by ombudsman Geneva Carroll, identifies that Ms. Carroll served as the patient representative on an IDT convened pursuant to section 1418.8 to address whether a terminal resident should be allowed to receive

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[13] As the resident representative, Ms. Simcox had authority to raise any objection to improper action by the IDT, and to call for investigation by the Department or seek judicial intervention. (See Health & Saf. Code, §§ 1419, subd. (d); 1420, subd. (a)(1) [complaint and investigation procedures]; *Rains, supra*, 32 Cal.App.4th at p. 185 [noting representative may seek judicial relief regarding treatment decision].)

hospice care, apparently contrary to instructions in a POLST. (JA 745; see JA 075-078.) Multiple attempts at treatment of injuries had failed and the hospital refused to readmit the resident for further treatment. (JA 077 [¶ 39].) While the declaration raises a question about the propriety of the facility's actions, in particular the IDT's changing of a POLST, it does not establish that the Department condoned the facility's or IDTs actions, or that the statute can never be constitutionally utilized in connection with end-of-life treatment decisions. The trial court's own Judgment, for example, expressly recognizes that IDTs may make such decisions under section 1418.8 to effectuate a resident's instructions or wishes, or to provide or initiate hospice and comfort care for residents under appropriate circumstances. (JA 855.)

The trial court erred in relying on petitioner's evidence of conduct by physicians and nursing homes as support for an as applied challenge to section 1418.8 against the Director.

The court also erroneously deemed the Department's arguments in this litigation as "evidence" of its application of section 1418.8. (JA 746.) The Department's positions expressed in this proceeding cannot be construed as applications of the statute supporting petitioners' claim. (See *Tobe*, *supra*, 9 Cal.4th at p. 1085 [as applied challenge to criminal statute ripe only after "the circumstances of its application have been established by conviction or otherwise"].)

The Department's argument below, moreover, was consistent with the trial court's Judgment. The Director argued only that not all health care decisions under section 1418.8 relating to end-of-life care would necessarily violate constitutional principles, and that petitioners' challenge to any such uses of the statute, therefore, was not supported. (JA 463-467.) The trial court's Judgment expressly recognizes that certain decisions

allowing the withholding or withdrawal of life-sustaining treatment under the statute are not unconstitutional. (JA 854-855.)

The only evidence before the trial court regarding an actual application or interpretation of section 1418.8 by the Department in relation to end-of-life care decisionmaking did not demonstrate any unconstitutional applications or interpretations of the statute. Petitioners submitted evidence that the Department had issued a Notice of Deficiency to a nursing home for improperly utilizing an IDT under section 1418.8 to create and change a resident's POLST. (JA 382-388.) Petitioners also submitted an informal "Question & Answer" document regarding informed consent issued by the Department's predecessor agency in 1995, which, although superseded, stated that section 1418.8 does not authorize the IDT to make decisions regarding "withdrawing or withholding life-sustaining treatment." (JA 507.)[14] The only evidence, thus, submitted regarding the Department's application of section 1418.8 in connection with decisionmaking regarding end-of-life care, did not demonstrate any unconstitutional applications or interpretations of the statute.

Petitioners' evidence relating to conduct by physicians and nursing homes fails to establish any allegedly unconstitutional application of section 1418.8 by the Director in connection with end-of-life care, necessary to support an "as applied" claim. As petitioners failed to "perfect a basis for ruling on such a challenge," the trial court should have declined to address it. (*Tobe*, *supra*, 9 Cal.4th at p. 1087; JA 466-467.) The trial court's Judgment on this issue, therefore, should be vacated.

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[14] A current version of the Department's "Question and Answer" guidance regarding informed consent, submitted by the Department, does not include the same question or answer from the 1995 document, and does not address any questions relating to section 1418.8. (JA 697-704; see Tr. 3/27/15 at 64:25-65:28.)

2. The Trial Court Erred By Issuing an Advisory Opinion on Application of Section 1418.8 to Decisions Relating to Life-Sustaining Treatment and Ordering Issuance of an Unnecessary Writ

Given that no nursing home was named in the lawsuit, and that no wrongdoing by the Department was established, the trial court's Judgment addressing applications of section 1418.8 to decisions relating to life-sustaining treatment constitutes an improper advisory opinion. The Judgment merely reflects existing legal principles applicable to such decisions, and therefore was unnecessary.

Without any evidence of a contrary interpretation by the Department, the trial court issued a broad ruling directing issuance of a writ declaring that use of section 1418.8 is generally prohibited for decisions regarding "the withholding or withdrawal of life-sustaining treatment for residents[.]" (JA 854.) The Judgment establishes several exceptions to this general prohibition:

(1) Decisions may be made under section 1418.8 to withdraw or withhold life-sustaining treatment if the decision is "consistent with the resident's individual health care instructions, if any, and other wishes, to the extent known;"

(2) Physicians and health care facilities may, "decline to comply with an individual health care instruction or decision that requires medically ineffective health care or care contrary to generally accepted standards applicable to the physician or facility pursuant to Probate Code sections 4735 and 4736;" and

(3) Section 1418.8 may be used to "provide or initiate hospice or comfort care," unless inconsistent with the resident's instructions or wishes, or if not in the resident's best interest.

(JA 854-855 [Part 1(III)(A)].)[15]

Because petitioners "did not establish that the [statute] has been applied in a constitutionally impermissible manner" by the Department, and failed to create a factual record on which a writ "limited to improper applications of the [statute] could have been fashioned," the trial court should have rejected or declined to address petitioners' "as applied" claim. (*Tobe*, *supra*, 9 Cal.4th at pp. 1083, 1087.) Rather, petitioners sought, in the abstract, to "enjoin any application of the [statute] to *any* person in *any* circumstance" in connection with end-of-life treatment. (*Id.*, 9 Cal.4th at p. 1087; see JA 052-053; 334-337.) In the absence of evidence of impermissible applications of section 1418.8 by the Department, and thus any ripe as applied challenge, the trial court's Judgment constitutes an improper advisory opinion. (See *Pacific Legal Foundation v. California Coastal Com.* (1982) 33 Cal.3d 158, 171 [proper role of judiciary does not extend to the resolution of abstract differences].) Courts generally must not "issue advisory opinions indicating 'what the law would be upon a hypothetical state of facts.'" (*Ibid.*)

The trial court also erred in issuing a judgment that simply mirrors existing legal and ethical requirements. "[A] writ of mandate will not issue where the petitioner's rights are otherwise protected." (*County of San Diego v. State* (2008) 164 Cal.App.4th 580, 596, citing *Grant v. Board of Medical Examiners* (1965) 232 Cal.App.2d 820, 827 and *Hutchison v. Reclamation Dist. No. 1619* (1927) 81 Cal.App. 427, 432–433.)

Decisions regarding the withholding or withdrawal of life-sustaining treatment for nursing home residents often are governed by a pre-existing

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[15] Facilities also are given 90 days to ensure that any decisions relating to life-sustaining treatment already made for residents under section 1418.8 conform to the terms of the judgment. (JA 855.)

or legally valid directive from the patient, such as an advanced health care directive, durable power of attorney for health care, DNR order, or POLST. (See Prob. Code, §§ 4600 through 4788.) However, in the absence of a valid directive, when a resident is unrepresented and lacks capacity to make a decision, the Probate Code provides procedures for obtaining court authorization to withdraw or withhold of life-sustaining measures pursuant to a judicial determination that the resident is unable to provide consent and that the decision is in accordance with the resident's best interest. (*Id.*, §§ 3201, 3208, subds. (c)(1)-(2).) The trial court's general prohibition on utilization of section 1418.8 to withhold or withdraw life-sustaining treatment reflects the existence of these procedures. (JA 844 (Part 1(III)(A).)

At the same time, the Judgment permits IDTs to make decisions to withhold or withdraw life-sustaining treatment in order to carry out a resident's individual health care instruction, if any, or to give effect to a resident's wishes, to the extent known. (JA 854-855 [Part III(A)].) This provision simply mirrors undisputed legal and ethical principles that generally obligate health care practitioners, conservators, and others to comply with decisions by competent individuals regarding treatment, or for those lacking and advance directive or decisionmaking capacity, to seek to carry out their wishes regarding treatment to the extent known. (See, e.g., Prob. Code, § 4650 [recognizing right of adult to control decision to have "life-sustaining procedures withheld or withdrawn"]; *Conservatorship of Drabick* (1988) 200 Cal.App.3d 185, 197 [in determination by conservator whether to discontinue life-sustaining treatment for incompetent person in persistent vegetative state, "'the patient's interests and desires are the key ingredients of the decision-making process'"], quoting *Barber v. Superior Court* (1983) 147 Cal.App.3d 1006, 1019.)

In addition, existing law permits a "health care provider or health care institution" to decline to comply with an individual health care instruction or health care decision, including a POLST, if it would require care that is "medically ineffective" or "contrary to generally accepted health care standards applicable to the physician or facility." (Prob. Code, §§ 4654, 4735-4736; 4781.2, subd. (b).) The court's Judgment simply reiterates this authority. (JA 855 [Part 1(III)(A)(1)].)

And finally, the Judgment preserves the rights of residents receiving benefits under Medicare or California's Medi Cal program to obtain and receive hospice and comfort care. (JA 855 [Part 1(III)(A)(1)].) This provision reflects rights guaranteed under these programs to receive hospice benefits where a physician determines that further treatment of a terminal condition would be futile and that the individual's prognosis is for a life expectancy of six months. (See 42 U.S.C. §§ 1395c; 1395d(a)(4), (d)(1); 42 C.F.R. § 418.22(b)(1); Welf. & Inst. Code §§ 14132, subd. (w); 14132.75.)

As the rights of residents already are protected by these existing provisions of law mirrored in the trial court's Judgment, the Judgment was unnecessary and should be vacated. (*County of San Diego v. State*, *supra*, 164 Cal.App.4th at p. 596.)

3. Courts Should Refrain from Unnecessary Intervention in Matters Involving End-of-Life Care Decisions

Both courts and the Legislature have emphasized that courts should avoid addressing issues of end-of-life care unless necessary, particularly in the absence of a concrete controversy. The unique circumstances and considerations in each individual case in which a decision relating to such care may need to be made or obtained on behalf of an incapacitated and

unrepresented resident call for judicial restraint where no unconstitutional application of the statute by the State has been identified.

This Court has cautioned that "[j]udicial intervention in 'right to die' cases should be minimal" in light of the complex ethical, moral, and legal considerations involved in cases involving end-of-life decisionmaking on behalf of incapacitated persons. (*Conservatorship of Morrison* (1988) 206 Cal.App.3d 304, 312, quoting *Matter of Jobes* (1987) 108 N.J. 394 [529 A.2d 434, 451].) "'Courts are not the proper place to resolve the agonizing personal problems that underlie these cases. Our legal system cannot replace the more intimate struggle that must be borne by the patient, those caring for the patient, and those who care about the patient.'" (*Ibid.*)

The Legislature similarly expressed, in establishing mechanisms and standards to govern health care instructions and decisionmaking for individuals without a legally authorized representative, that: "In the absence of controversy, a court is normally not the proper forum in which to make health care decisions, including decisions regarding life-sustaining treatment." (Prob. Code, § 4650.)

The same principle should guide the Court here, and call for vacating the trial court's Judgment addressing end-of-life care decisions.

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CONCLUSION

For the reasons above, the trial court's Judgment should be vacated and reversed.

Dated: November 17, 2016

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I certify that the attached **APPELLANT'S OPENING BRIEF** uses a 13 point Times New Roman font and contains **13,083** words.

Dated: November 17, 2016

KAMALA D. HARRIS
Attorney General of California

/s/Joshua Sondheimer
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Deputy Attorney General
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DECLARATION OF ELECTRONIC SERVICE AND SERVICE BY U.S. MAIL

Case Name: **CANHR et al v. Chapman, as Director of CDPH**
No.: **A147987**

I declare:

I am employed in the Office of the Attorney General, which is the office of a member of the California State Bar, at which member's direction this service is made. I am 18 years of age or older and not a party to this matter. I am familiar with the business practice at the Office of the Attorney General for collecting and processing electronic and physical correspondence. In accordance with that practice, correspondence placed in the internal mail collection system at the Office of the Attorney General is deposited with the United States Postal Service with postage thereon fully prepaid that same day in the ordinary course of business. Correspondence that is submitted electronically is transmitted using the TrueFiling electronic filing system. Participants who are registered with TrueFiling will be served electronically. Participants in this case who are not registered with TrueFiling will receive hard copies of said correspondence through the mail via the United States Postal Service or a commercial carrier.

On November 17, 2016, I electronically served the attached **APPELLANT'S OPENING BRIEF** by transmitting a true copy via this Court's TrueFiling system. Because one or more of the participants in this case have not registered with the Court's TrueFiling system or are unable to receive electronic correspondence, on November 17, 2016, I placed a true copy thereof enclosed in a sealed envelope in the internal mail collection system at the Office of the Attorney General at 455 Golden Gate Avenue, Suite 11000, San Francisco, CA 94102-7004, addressed as follows:

Office of the Clerk
Alameda County Superior Court - Main
1225 Fallon Street, Room G4
Oakland, CA 94612
RG13700100

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct and that this declaration was executed on November 17, 2016, at San Francisco, California.

Carmen Choy
Declarant

Signature

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