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

CASE NO. A147987

CALIFORNIA ADVOCATES FOR
NURSING HOME REFORM, et al.
Plaintiffs and Appellants,
vs.
KAREN SMITH, MD., MPH, as Director of the
California Department of Public Health,
Defendants and Appellants.

APPLICATION AND PROPOSED BRIEF OF *AMICI CURIAE* AMERICAN CIVIL LIBERTIES UNION FOUNDATION DISABILITY RIGHTS PROGRAM AND AMERICAN CIVIL LIBERTIES UNION OF NORTHERN CALIFORNIA IN SUPPORT OF PLAINTIFFS AND APPELLANTS

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TO BE FILED IN THE COURT OF APPEAL

APP-008

COURT OF APPEAL First APPELLATE DISTRICT, DIVISION Four	COURT OF APPEAL CASE NUMBER: A147987
ATTORNEY OR PARTY WITHOUT ATTORNEY: STATE BAR NUMBER: 163452 NAME: Susan Mizner FIRM NAME: ACLU Foundation STREET ADDRESS: 39 Drumm St CITY: San Francisco STATE: CA ZIP CODE: 94111 TELEPHONE NO.: 415-343-0781 FAX NO.: 415-395-0950 E-MAIL ADDRESS: smizner@aclu.org ATTORNEY FOR (*name*): Amici	SUPERIOR COURT CASE NUMBER:
APPELLANT/ PETITIONER: California Advocates for Nursing Home Reform RESPONDENT/ REAL PARTY IN INTEREST: Karen Smith	

CERTIFICATE OF INTERESTED ENTITIES OR PERSONS

(*Check one*): [X] INITIAL CERTIFICATE [ ] SUPPLEMENTAL CERTIFICATE

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2. a. [X] There are no interested entities or persons that must be listed in this certificate under rule 8.208.
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[ ] Continued on attachment 2.

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Date: 9/29/2017

Susan Mizner
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APPLICATION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF

Pursuant to California Rule of Court 8.200(c), the American Civil Liberties Union Foundation and the American Civil Liberties Union of Northern California respectfully apply for leave to file the concurrently lodged *amicus curiae* brief in support of petitioners and appellants California Advocates for Nursing Home Reform.

I. INTERESTS OF *AMICUS CURIAE*

The American Civil Liberties Union (ACLU) is a nationwide, nonprofit, nonpartisan organization of more the one million members dedicated to protecting the fundamental rights guaranteed by the Constitution and laws of the United States. The ACLU's Disability Rights Program envisions a society in which discrimination against people with disabilities no longer exists, where people with disabilities are valued, integrated members of the community, and where people with disabilities are not needlessly segregated into institutions such as nursing homes and psychiatric hospitals. The American Civil Liberties Union of Northern California (ALCU-NC), founded in 1934 and based in San Francisco, is the largest ACLU

affiliate, with more than 250,000 members. The ACLU Disability Rights Program and ACLU-NC are committed to the equality and liberty interests of all Californians with disabilities, and have an established history of fighting discrimination through legal advocacy. Both organizations have a strong interest in protecting the constitutional rights of nursing home residents perceived to lack capacity.

Under the statutory scheme at issue in this case, California nursing home residents perceived to be incapacitated are being subjected to major medical interventions without their consent. The statute authorizes such procedures without notice, independent determination of incapacity, or representation. Nursing homes use this statutory scheme to authorize major procedures including surgery, prescription of antipsychotic medications, and termination of life-sustaining treatment. The statute violates nursing home residents' state and federal constitutional and statutory rights to liberty, privacy, and due process.

This statute implicates the statutory and constitutional rights of people with disabilities in California. Permitting the statutory scheme to continue will dramatically restrict the equality and

liberty rights of California nursing home residents. For this reason, the ACLU and ACLU-NC have a substantial interest in the present matter.

II. NEED FOR FURTHER BRIEFING

The ACLU and ACLU-NC believe they can be of assistance to this Court by providing briefing on the broader context of surrogate decision-making and capacity. The processes for surrogate medical decision-making in analogous contexts, including prisons and locked psychiatric wards, illustrate the major constitutional shortcomings of section 1418.8, while evolving understandings of capacity explain the need to depart from earlier precedent on this statutory scheme.

Further, *amici* believe that they can assist the court by illustrating the statute's failures to comply with constitutional rights to privacy and liberty, as well as the statute's failure to comply with reasonable accommodation requirements mandated by the Americans with Disabilities Act and the Rehabilitation Act.

III. STATEMENT OF AUTHORSHIP

No party or counsel for a party authored the proposed *amicus* brief in whole or part. The cost for preparing and submitting the

proposed brief was borne entirely by *amicus curiae* and no person or entity made any monetary contribution intended to fund the preparation or submission of the proposed brief.

IV. CONCLUSION

For the foregoing reasons, the ACLU and ACLU-NC respectfully request that the Court accept and file this *amicus curiae* brief.

Dated: September 29, 2017

/s/Susan Mizner

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I. INTRODUCTION

Under California statutory law, certain adult residents of California nursing homes are being subjected to substituted medical decision-making by their treating medical professionals without notice, without any judicial or even independent determination of incapacity, and without representation. The existing scheme is being used to authorize extensive medical interventions including antipsychotic medications, electroconvulsive therapy (ECT), feeding tube surgery, and the cessation of care such as "do not resuscitate" orders or the withdrawal of nutrition and hydration, with no reasonable safeguards to protect the fundamental interests of these individuals to personal autonomy. The law thereby violates the state and federal constitutional liberty, privacy, and substantive and procedural due process rights of the residents. The trial court's order requiring notice and certain procedures should be upheld. But the trial court's ruling did not go far enough to adequately safeguard these fundamental rights. Additional protections should be ordered, including timely and effective notice before any capacity assessment (and at each stage thereafter), representation by counsel or a patients' rights advocate, and judicial review.

The arguments of Defendant and her *amici* that this case is governed by the 1995 opinion by a panel of this appellate district in *Rains v. Belshe* should be rejected. The court in *Rains* erred by minimizing the liberty interests at issue, and overstating the burdens of ordinary due process protections. And since *Rains*, the Supreme Court of California has clarified the requirements for involuntary medical treatment that are relevant here: "In California, *parens patri[a]e* may be used only to impose unwanted medical treatment on an adult when that adult has been adjudged incompetent." (*In re Qawi* (2004) 32 Cal.4th 1, 15–16 [7 Cal.Rptr.3d 780, 789, 81 P.3d 224, 231–32] [citing *Conservatorship of Wendland* (2001) 26 Cal.4th 519, 535 [110 Cal.Rptr.2d 412, 424, 28 P.3d 151, 161] [casting doubt on prior appellate court ruling for having "confused these two distinct concepts – the voluntary act of a competent person and the state's *parens patriae* power"]]; *cf. Rains v. Belshe* (1995) 32 Cal.App.4th 157, 175 [38 Cal.Rptr.2d 185, 194–95] [conflating concepts].) Also since *Rains*, we have gained important understandings about the nature of capacity – and how substituted decision-making by medical staff with respect to feeding tubes, psychiatric medications, ECT, end-of-life choices, and other major medical interventions poses great

dangers of harm to vulnerable individuals in nursing homes. Given these legal and non-legal developments, *Rains* is no longer persuasive authority.

The argument that the procedures and protections sought by Plaintiffs will wreak various forms of administrative havoc must also be rejected. California already requires much more stringent procedures for assessing capacity and making treatment decisions for similarly vulnerable populations, including inmates and mental health detainees. The facilities housing these populations have implemented the required procedures and they continue to function. The State may build upon this experience balancing the interest in prompt efficient determinations with the interest in protecting fundamental constitutional rights. The State may rely upon an array of existing resources, such as California's Long-Term Care Ombudsman Program, the Office of Administrative Hearings, the programs of the Superior Courts, each county's Public Guardian, and each county's Office of the Public Defender. And it may look to other states that have successfully implemented the necessary protections for nursing home residents. But the current scheme is unconstitutional. This Court should so rule.

II. STATEMENT OF THE CASE

A. Basic Principles

All competent Californians have a fundamental state and federal constitutional right to make decisions regarding medical care, including the right to refuse treatment and to choose among treatments. This fundamental right is based on the right to personal autonomy, and it extends to, and requires informed consent to, non-emergency[1] interventions in body and brain including antipsychotic medications, electroconvulsive therapy (ECT), surgeries such as surgeries to insert a feeding tube, and end-of-life care including cessation of treatment. And all Californians – from inmates with serious mental illness, to disabled conservatees, to mental health detainees, to defendants found "not guilty by reason of insanity," to nursing home residents without "next of kin" – are presumed competent to make these constitutionally protected medical decisions unless and until found otherwise. And if a person is competent, the person's expressed preference regarding medical treatment must be respected (unless contrary to accepted medical standards).

[1] Absent objection, consent may be presumed for emergency medical care. (See, e.g., *Cobbs v. Grant* (1972) 8 Cal.3d 229, 243 [104 Cal.Rptr. 505, 514, 502 P.2d 1, 10] ["the law provides that in an emergency consent is implied"].)

Procedural due process protections necessarily follow to protect this constitutional right to bodily autonomy. A determination that a Californian lacks capacity to make his or her own medical decisions and is subject to substituted medical decision-making based upon the state's *parens patriae*[2] power and the resulting treatment (or absence of treatment) requires a specific determination of incapacity that complies with due process. Due process in this context requires, at a minimum, effective notice, representation, and judicial review. Moreover, even when an individual has been adjudicated as lacking capacity, the liberty interests at issue require that medical decisions comply with and be supported by evidence of the individual's stated wishes where known.

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[2] Other forms of substituted medical decision-making implemented by advanced directive or delegation are based not on *parens patriae* but on the principle of giving effect to the choices of the individual. For example, a surrogate decision-maker who is selected by the individual through the Health Care Decisions Act (Prob. Code, § 4650 et seq.) is charged with standing in the shoes of the individual, and deciding as the individual would decide. (See *Conservatorship of Wendland* (2001) 26 Cal.4th 519, 535 [10 Cal.Rptr.2d 412, 28 P.3d 151] [discussing distinction between substituted decision-making based on the *parens patriae* power of the state to protect incompetent persons, and decision-making through the Health Care Decisions Act that "merely give[s] effect to the decision of a competent person, in the form either of instructions for health care or the designation of an agent or surrogate for health care decisions"].)

The constitutional touchstone is personal autonomy. Accordingly, if a person is competent, the person may refuse medical treatment altogether or choose between medical treatments (unless contrary to accepted medical standards). Where there is objective evidence raising a legitimate question about whether the person has the capacity to make a particular medical decision, then an assessment of capacity is done. Such an assessment must be done with great care before concluding that an individual lacks the capacity to make a medical decision, as a false positive imposes a severe constitutional injury. (See Declaration of Geneva Carroll, JA 71 [many nursing home residents are erroneously determined to be incompetent].) Important here, scientific research about capacity has expanded in the past two decades, and has disrupted prior assumptions by demonstrating that many individuals with significant medical conditions are capable of informed consent in particular situations.[3]

[3] See, e.g., Appelbaum and Grisso, The MacArthur Competence Assessment Tool for Clinical Research (MacCAT-CR) (2001) [finding that most patients hospitalized with serious mental illness have abilities similar to persons without mental illness for making treatment decisions, and that taken by itself, mental illness does not invariably impair decision-making capacities; that for many patients hospitalized with mental disorders, impairments in decision-making ability are temporary and improve with treatment; that mental illness alone, even when associated with the stress of hospitalization, appears

We also now know much more about enhancing capacity, and recognize that capacity is fluid, context-specific, and can be improved with simple modifications to a capacity assessment. Whenever possible, reasonable accommodations to enhance capacity and ameliorate deficits should be made before concluding that an individual lacks capacity.

Any one of us, imagining ourselves in a nursing home, perceived by staff as alone and without capacity, would want to feel secure that such a careful review be made before we were subjected to involuntary medical decision-making.

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rarely to impair treatment decisionmaking]; Kim et al., *Determining When Impairment Constitutes Incapacity for Informed Consent in Schizophrenia Research* (2007) 191 Brit. J. Psychiatry 38, 38–43 [noting that "diagnosis cannot be equated with decisional incapacity because there is too much heterogeneity in decisional abilities;" describing research employing capacity assessment instrument with individuals with schizophrenia, individuals with depression, and individuals with dementia; noting case-specific adaptation of instrument "to reflect the task-specific nature of decisional capacity;" and urging that capacity assessments be used flexibly depending upon the situation given the "risk-sensitive nature of capacity"]; Karlawish et al., *Interpreting the Clinical Significance of Capacity Scores for Informed Consent in Alzheimer Disease Clinical Trials* (2008) 16 Am. J. Geriatric Psychiatry, 568–74 [applying capacity assessment instrument to individuals with Alzheimer disease to determine capacity to consent to clinical trial, and noting that target score will vary depending upon the risks and benefits of the situation, and that instrument scores alone do not determine capacity].

B. Challenged Statutory Scheme

Essential constitutional protections are absent from the statutory scheme adopted by the California Legislature with respect to certain nursing home residents. For nursing home residents suspected by nursing home staff of lacking both capacity and a surrogate decision-maker (such as a health care power of attorney or "next of kin"), the current statutory scheme for implementing major nonemergency medical interventions without informed consent is replete with constitutional shortcomings. The system works like this:

First, there is a *two-pronged determination by the attending physician.* The resident's attending physician determines: (1) whether the resident lacks capacity; and (2) whether the resident lacks a substitute decision-maker like a family member. (Health & Saf. Code, § 1418.8(a)-(c).) The shortcomings of this assessment include:

- The competency assessment is not conducted by a neutral or independent party. An attending physician by definition is employed by, or in a business relationship with, the nursing home.

- There is no notice of the planned competency determination ahead of time or of its results after the fact to the resident, the county's Public Guardian, or California's Long-Term Care Ombudsman Program.

- The individual does not receive representation, a support person, or any independent advice.

- **<u>There is no judicial or any other review of the attending physician's two-pronged determination *at any time*</u>.** The attending physician's determination, without more, permits substituted decision-making by the institution.

Defendant asserts that a resident may independently initiate review by, for example, filing an action in superior court. (See Health & Saf. Code, § 1418.8(j).) Unsurprisingly, given the obstacles to such an action being brought by an "unbefriended" nursing home resident, there is no evidence of this occurring. And even were such a hypothetical action brought, the individual would remain subject to the physician's determination and the associated involuntary treatment until a court said otherwise.

Second, after the physician has unilaterally determined that the resident lacks both capacity and a surrogate decision-maker, *treatment (or lack of treatment) is recommended by the physician*. (Health & Saf. Code, § 1418.8(a), (e).) There is no limitation to the treatment or cessation of treatment that may be recommended. (See, e.g., Defendant's Combined Reply and Respondent's Brief at 15–16 ["The Legislature did not limit in any way the medical interventions that may be authorized under section 1418.8."].) Recommended treatments (or lack of treatment) currently being authorized under the statute

include:

- psychiatric medications such as antipsychotics like Risperdal (risperidone), Haldol (haloperidol), or Seroquel (quetiapine);
- electroconvulsive therapy (ECT);
- major medical procedures such as those requiring general anesthesia, an incision, or a bodily intrusion, like sterilization, amputation of a limb, or placement of a stomach tube for feeding; and
- the provision or withholding of life-sustaining or life-extending treatments such as cardiopulmonary resuscitation, mechanical ventilation, dialysis, and clinically assisted nutrition and hydration.

- There is no notice of the prescribed treatment to the resident, the county's Public Guardian, or California's Long-Term Care Ombudsman Program.
- The individual does not receive representation, a support person, or any independent advice.

Third, the *recommended treatment is reviewed by an "interdisciplinary team*." The "interdisciplinary team" is comprised of the attending physician, additional members of the nursing home staff, "and, where practicable, a patient representative." (Health & Saf. Code, § 1418.8(e).) The constitutionally-deficient elements of this step include:

- The "interdisciplinary team" is not neutral or independent. It is not judicial or quasi-judicial.

- While the "interdisciplinary team" is directed by the statute to discuss "the desires of the patient, where known," (Health & Saf. Code, § 1418.8(e)(3)) it is not required to implement such desires, or even to give any weight at all to the resident's desires.

- There is no notice of the treatment review to the resident, the county's Public Guardian, or California's Long-Term Care Ombudsman Program.

- The resident does not receive representation.

- There is no judicial or any other review of the prescribed treatment or cessation of treatment approved by the team. (The only exception is if the resident independently initiates review by, for example, filing an action in superior court. (Health & Saf. Code, § 1418.8(j).) There is no evidence of this occurring. And even if such a hypothetical action were brought, the individual would remain subject to the involuntary treatment until a court says otherwise.)

Finally, the *treatment is implemented.* The resident is subjected to the prescribed treatment or cessation of treatment, even over the vocal objection or even physical resistance of the resident if the attending physician has determined the individual lacks capacity.

C. Procedural History

Plaintiffs argued that the current scheme violates state and federal constitutional protections to autonomy and procedural due process. The trial court ruled in favor of the Plaintiffs in part, and ordered changes to the statutory process. The trial court ruled in favor

of Plaintiffs with respect to notice, ordering that residents must "be adequately notified in writing" if they have been deemed incompetent, if they have been found to lack next of kin or another substitute decision-maker, and if a medical intervention has been ordered by the attending physician. (Judgment (Jan. 27, 2016) at 2–3.) Residents must further "be adequately notified in writing" that they "may challenge, in a judicial proceeding, any of the above determinations or the decision to provide a medical intervention." (*Id.*)

The trial court also ordered that both the administration of nonemergency antipsychotic medications, and the removal or withdrawal of life-sustaining care could no longer be approved through the section 1418.8 statutory process. Instead, the institution must follow ordinary Probate Code procedures, which include judicial review and the right to representation. (*Id.* at 3.)

The trial court denied additional challenges to the statutory scheme, including claims that it violates the residents' constitutional rights by failing to provide representation, and by failing to require a neutral decision-maker at the determination of incapacity and at the review of the prescribed treatment. (Order Granting Petition for Writ of Mandate in Part and Denying in Part (June 24, 2015) at 20.)

The changes ordered by the trial court have been stayed pending appeal.

III. ARGUMENT

A. The Current Statutory Scheme is Unconstitutional.

All Californians, unless found incompetent, have a fundamental constitutional right to refuse medical treatment and to make other core decisions regarding medical care or bodily interventions. (Cal. Const., art. I, § 1; *In re Qawi* (2004) 32 Cal.4th 1, 14 [7 Cal.Rptr.3d 780, 787, 81 P.3d 224, 230] ["The starting point of the analysis is the 'relatively certain principle that a competent adult has the right to refuse medical treatment, even treatment necessary to sustain life.'"] [quoting *Conservatorship of Wendland* (2001) 26 Cal.4th 519, 530 [10 Cal.Rptr.2d 412, 28 P.3d 151]]; *Thor v. Superior Court* (1993) 5 Cal.4th 725, 732 [21 Cal.Rptr.2d 357, 360 855 P.2d 375, 378] ["[U]nder California law a competent, informed adult has a fundamental right of self-determination to refuse or demand the withdrawal of medical treatment of any form irrespective of the personal consequences."].)

This fundamental right to bodily autonomy has been recognized in cases regarding an array of important medical decisions including

decisions about antipsychotic medications, electroconvulsive therapy (ECT), surgeries, and end-of-life care (or withdrawal of treatment). (*In re Qawi*, *supra*, 32 Cal.4th at 14 [discussing constitutional right to refuse antipsychotic drugs]; *Maxon v. Superior Court* (1982) 135 Cal.App.3d 626, 633–34 [185 Cal.Rptr. 516, 520–21] [reviewing prerequisites to court order permitting therapeutic hysterectomy of conservatee]; *Scott S. v. Superior Court* (2012) 204 Cal.App.4th 326, 337–39 [138 Cal.Rptr.3d 730, 739–40] [reviewing prerequisites to court order permitting amputation of toe of conservatee]; *Conservatorship of Wendland*, *supra*, 26 Cal.4th at 546 [reviewing prerequisites to court order permitting withdrawal of artificial nutrition and hydration of conservatee]; *Conservatorship of Waltz* (1986) 180 Cal.App.3d 722, 733–34 [227 Cal.Rptr. 436, 442–43], *as modified (May 30, 1986)* [discussing requirements for order permitting conservator to consent to ECT treatment].)

Due process protections necessarily follow from the fundamental right to bodily autonomy. A determination that a Californian without a statutory surrogate decision-maker lacks capacity to make a major medical decision – and is therefore subject to substituted decision-making and the resulting treatment or absence

of treatment – requires a specific determination of incapacity by a court that complies with due process. As the Supreme Court of California has held, "*parens patri[a]e* may be used only to impose unwanted medical treatment on an adult when that adult has been adjudged incompetent." (*In re Qawi*, *supra*, 32 Cal.4th at 15–16.) At a minimum, due process protections for such major bodily intrusions unsupported by informed consent by the individual (or his or her delegate) require notice, representation, and judicial review. The statutory scheme provides none of these protections.

In determining competency, the court must carefully and specifically assess the elements of such a status:

> [S]uch a court order divesting the conservatee of the right to make his or her own medical decisions cannot be made *absent a specific determination by the court that the conservatee cannot make those decisions.* In view of the fundamental nature of the right affected, the court should not make such a determination unless it finds that the conservatee lacks the mental capacity to rationally understand the nature of the medical problem, the proposed treatment and the attendant risks.

(*In re Qawi*, *supra*, 32 Cal.4th at 18 [emphasis in original] [internal quotations omitted].)

Following the Supreme Court of California's directive in *Qawi*, an appellate court in this District has reiterated that the trial court must make particularized findings before subjecting a conservatee to

involuntary medical treatment, including determining "whether the patient is able to understand the benefits and the risks of, as well as the alternatives to, the proposed intervention," and "whether the patient is able to understand and to knowingly and intelligently evaluate the information required to be given patients whose informed consent is sought and otherwise participate in the treatment decision by means of rational thought processes." (*K.G. v. Meredith* (2012) 204 Cal.App.4th 164, 180 [138 Cal.Rptr.3d 645, 659] [quoting *In re Qawi*, *supra*, 32 Cal.4th at 18].)

The evaluations underlying these findings must be made with great care, given the constitutional rights at stake. Reasonable accommodations that can enhance capacity and ameliorate deficits should be provided before concluding that an individual lacks capacity. These accommodations, which are required by the Americans with Disabilities Act and the Rehabilitation Act, include:

- Selecting times and environmental conditions that enhance capacity for the individual (in the morning, for example, for an individual with a cognitive impairment who experiences late-day confusion);

- Ameliorating the effects of medication, stress, pain, infection, or other physiological or psychological conditions before evaluation (treating anemia, low blood oxygen, or low blood pressure before an assessment, for example, or delaying an assessment until after a round of antibiotics for a person with a

urinary tract infection);

- Using time, sensitivity, patience, and compassionate persistence;

- Identifying and providing a support person or advocate;

- Supporting communication and ameliorating hearing, vision, or speech deficits (using plain language, communication devices, or memory aids, for example, or incorporating a support person who can comprehend and repeat impaired speech);

- Discussing directly with the individual the purpose and basis of the evaluation; and

- Repeating or extending the evaluation over time.

"In view of the fundamental nature of the right affected," (*In re Qawi*, *supra*, 32 Cal.4th at 18) the court's assessment must necessarily include a review of the type of capacity assessment undertaken, and the reasonable accommodations employed (or not) by the examiner to enhance capacity.

Moreover, even when an individual is properly found to lack capacity, even with supports, additional considerations are required to minimize the scope of the constitutional intrusion. These include following the individual's stated interests, where demonstrated,[4] and

[4] Where the stakes are greatest, as with decisions that end the individual's life, the evidence of the individual's stated interests must be clear and convincing. (*Conservatorship of Wendland*, *supra*, 26 Cal.4th at 547 [discussing "deference to the patient's own wishes" as

employing the least intrusive medical alternative. (See, e.g., *Maxon v. Superior Court*, *supra*, 135 Cal.App.3d at 633–34 ["Because we view a hysterectomy as a serious and intrusive invasion of [the conservatee's] right of privacy, we believe that any such order must be supported by clear and convincing evidence of the medical necessity for the operation as well as by a finding that the hysterectomy is the least intrusive means possible to achieve the objective."].)

California courts have applied this basic constitutional framework in protecting vulnerable people in analogous contexts, including:

- Individuals with serious mental illness placed under a Lanterman-Petris-Short Act conservatorship (Welf. & Inst. Code, § 5000 et seq.). (*Riese v. St. Mary's Hospital & Medical Center* (1987) 209 Cal.App.3d 1303, 1312–13 [271 Cal.Rptr. 199, 204–05]; *Scott S. v. Superior Court*, *supra*, 204 Cal.App.4th at 338–39.)

- Individuals with a disabling condition placed under a Probate Code conservatorship (Prob. Code, § 1800 et seq.). (*Conservatorship of Wendland*, *supra*, 26 Cal.4th at 546.)

- Inmates in state prison with serious mental illness. (*Keyhea*

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the "primary standard for decisionmaking" for Probate Code conservators, but finding that conservator must present clear and convincing evidence of the conservatee's wishes in order to withdraw artificial nutrition and hydration on that basis given importance of the decision and the risk of error].)

v. Rushen (1986) 178 Cal.App.3d 526, 534–36, 540–42 [223 Cal.Rptr. 746, 750–52, 754–56].)

- Individuals committed for treatment because they are "not guilty by reason of insanity." (*In re Greenshields* (2014) 227 Cal.App.4th 1284, 1290 [174 Cal.Rptr.3d 482, 485], *as modified (Aug. 12, 2014)*.)

- Individuals with mental illness found to meet the standards of the Mentally Disordered Offenders Act (Pen. Code, § 2960 et seq.). (*In re Qawi*, *supra*, 32 Cal.4th at 27–28.)

- Individuals found to meet the standards of the Sexually Violent Predators Act (Welf. & Inst. Code, § 6600 et seq.). (*In re Calhoun* (2004) 121 Cal.App.4th 1315, 1341 [18 Cal.Rptr.3d 315, 333].)

- Criminal defendants found incompetent to stand trial (Pen. Code, § 1367 et seq.). (*People v. O'Dell* (2005) 126 Cal.App.4th 562, 568–69 [23 Cal.Rptr.3d 902, 905].)

Nursing home residents must be protected by equally robust constitutional safeguards.[5] The nursing home residents perceived as without guardians or "next of kin" and perceived as lacking capacity

[5] Thus, it is not only the constitutional rights of privacy, liberty, and due process that demand relief here; it is also equal protection. (*In re Greenshields*, *supra*, 174 Cal.Rptr.3d at 485 ["The inquiry is not whether persons are similarly situated for all purposes, but whether they are similarly situated for purposes of the law challenged. [Defendants who are not guilty by reason of insanity] are similarly situated to persons civilly committed who may be subject to treatment with antipsychotic medication against their will."] [internal citation omitted]; *In re Calhoun*, *supra*, 121 Cal.App.4th at 1351] ["Equal protection principles require that a sexually violent predator] be provided with the same right as [a mentally disordered offender] to refuse antipsychotic medication."].)

are similarly vulnerable to bodily intrusions that by their nature raise constitutional concerns. They live in institutional, segregated settings, and are often denied the day-to-day freedoms enjoyed by other individuals such as coming and going.[6] They have significant mental and/or physical disabilities; they are apparently without family or friends; and they are perceived by staff to lack the ability to exercise their right to personal autonomy.

Bluntly stated, nursing homes are using the statutory scheme to implement major medical decisions that an individual might choose to

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[6] Under law, many nursing home residents have these rights and freedoms. However, as the Plaintiffs demonstrated, these rights and freedoms are often denied in actual nursing homes. (See Declaration of Gloria A., JA 65 [detailing steps taken by nursing home staff to prevent Gloria A. from leaving the facility]; Declaration of Geneva Carroll, JA 72 [describing chemical and physical restraints being used to keep people from "wandering or falling"]; Declaration of Margaret J. Main, JA 346 [absent permission, a resident cannot go shopping, take a walk or go to church]; Declaration of Clayton McDaniel, JA 474 [detailing facility's call to police who forcibly returned Gloria A. to the facility]; *accord* CANHR, *Your Right to Leave: A Guide to the Rights of Long-Term Care Consumers to Be Free From Forced Placement* (2015), at 2 http://www.canhr.org/reports/YourRightToLeaveGuide.pdf ["There are a number of ways facilities use to lock their residents inside: Actually locking the doors and refusing to let residents out; [p]lacing alarms on doors and "re-directing" residents inside when they attempt to leave; [t]elling residents they cannot leave, that a doctor has not signed off on a "pass", or that some friend or family member has to approve the resident walking out the door; [p]roviding no physical assistance to residents who tell staff members they want to leave but are physically unable to get out of the door."].)

reject, and that can function to serve the interests of the institution by simplifying or ending care, including:

***Antipsychotic medications*.** California courts have frequently reviewed the right to refuse antipsychotic medications. In 2004, the Supreme Court of California stated:

> [The state constitutional right to privacy] clearly extends to the right to refuse antipsychotic drugs. No doubt such commonly used drugs, the phenothiazines, have been of considerable benefit to many mentally ill patients. … But they also have been the cause of considerable side effects. Reversible side effects include akathesia (a distressing urge to move), akinesia (a reduced capacity for spontaneity), pseudo-Parkinsonism (causing retarded muscle movements, masked facial expression, body rigidity, tremor, and a shuffling gait), and various other complications such as muscle spasms, blurred vision, dry mouth, sexual dysfunction, drug-induced mental disorders. A potentially permanent side effect of long-term exposure to phenothiazines is tardive dyskinesia, a neurological disorder manifested by involuntary, rhythmic, and grotesque movements of the face, mouth, tongue, jaw, and extremities, for which there is no cure. On rare occasions, use of these drugs has caused sudden death.
>
> Although a new generation of antipsychotic drugs, the so-called atypicals, have been regarded as being more benign and effective, considerable controversy remains over both their efficacy and the extent and nature of their side effects. … The basic constitutional and common law right to privacy and bodily integrity is therefore especially implicated by the forced administration of medications with such potential adverse consequences.

(*In re Qawi*, *supra*, 32 Cal.4th at 14–15 [citations omitted].)

The potential adverse consequences are particularly salient for

the nursing home residents at issue here. In May 2011, the Office of Inspector General for the U.S. Department of Health and Human Services released a report reviewing the issue of atypical antipsychotic drugs being prescribed for elderly nursing home residents for off-label conditions, including residents with dementia. Dementia is the condition specified in the FDA "boxed" warning because the effects associated with these drugs include increased risk of death in elderly persons with dementia. The report found that in a single six-month period, 14 percent of elderly nursing home residents had Medicare claims for atypical antipsychotic drugs, with the large majority of claims for off-label conditions, primarily dementia. Moreover, 22 percent of the atypical antipsychotic drugs claimed were not administered in accordance with Centers for Medicare and Medicaid Services' standards regarding unnecessary drug use in nursing homes. (U.S. Department of Health and Human Services, Office of Inspector General, *Medicare Atypical Antipsychotic Drug Claims For Elderly Nursing Home Residents* (2011), at https://oig.hhs.gov/oei/reports/oei-07-08-00150.pdf.)

Despite the potentially serious consequences for residents, the "interdisciplinary team" may nevertheless prescribe and administer

these sedating medications under the statutory scheme. (See Declaration of Geneva Carroll, JA 72 [physical restraints are used to keep people from "wandering or falling;" chemical restraints are used to keep people from "yelling [or] crying"].)

***ECT treatment*.** The California Court of Appeal for the Fourth District has discussed the rational fears of ECT treatment supporting an individual's right to refuse:

> [E]ven in his nonpsychotic moments, including during his testimony, he understands ECT could cause memory loss and could kill him and fears these demonstrated side effects. … [E]ven though he has a mental illness which causes him to be paranoid about ECT and many other things, this fact alone cannot be used to negate the presence of a rational fear of ECT which causes him to refuse the treatment even during his nonpsychotic moments. It is not per se irrational to fear possibly irreversible memory loss, which is one of the required consent items … nor is it per se irrational to fear death, even if its occurrence during ECT is rare.

(*Conservatorship of Waltz*, *supra*, 180 Cal.App.3d at 732.) While an individual resident might reject this treatment, the nursing home might select it despite such objection. First, health care professionals view this treatment much more favorably than members of the public. Second, the intervention can reduce agitation, making it easier to care for the resident.

***Feeding tube surgery*.** Feeding tube surgery is commonly

ordered for nursing home residents, and raises significant liberty interests. A 2009 article from the Journal of American Medical Directors Association reviews the problem:

> The use of PEG [percutaneous endoscopic gastrostomy] tubes in patients with advanced dementia is controversial. The perceived benefits of tube-feeding by physicians and surrogate decision-makers include improved survival, better nutritional status and reduced risk of complications such as aspiration pneumonia. However, there is a significant body of literature to the contrary. The majority of studies fail to demonstrate that tube feeding in persons with advanced cognitive impairment accomplishes these outcomes. Despite the mounting evidence against any benefit to insertion of feeding tubes, the intervention continues to be extensively practiced.

(Kuo et al., *Natural History of Feeding Tube Use in Nursing Home Residents With Advanced Dementia* (2009) 10:4 JAMDA 264–20 [citations omitted].) And in 2014, the American Geriatrics Society issued a statement urging that "feeding tubes are not recommended for older adults with advanced dementia," as "hand feeding has been shown to be as good as tube feeding for the outcomes of death, aspiration pneumonia, functional status, and comfort" and "tube feeding is associated with agitation, greater use of physical and chemical restraints, healthcare use due to tube-related complications, and development of new pressure ulcers." Nevertheless:

> As many as 34% of U.S. nursing home residents with advanced dementia have feeding tubes, two-thirds of which are inserted

> during an acute hospital stay. Caregivers report little conversation surrounding feeding tube decisions (more than half of caregivers report no conversation or one that lasts less than 15 minutes), and at times, families feel pressure for their use. Nursing homes with low rates of feeding tube use have environments that promote the enjoyment of food and administrative support and empowerment of staff to promote hand feeding, along with practices that foster shared decision-making among surrogate caregivers.

(American Geriatrics Society, *American Geriatrics Society Feeding Tubes in Advanced Dementia Position Statement* (2014) 62:8 J. Am. Geriatr. Soc. 1590, 1590–91, at http://onlinelibrary.wiley.com/doi/10.1111/jgs.12924/pdf.) In other words, hand feeding is recommended over a feeding tube, but this less intrusive option requires staff time.

Withdrawal of life-sustaining care. In 2001, the Supreme Court of California reviewed the grave liberty interest raised by the withdrawal of life-sustaining care from an individual by a surrogate decision-maker:

> The ultimate decision is whether a conservatee lives or dies, and the risk is that a conservator, … by withdrawing artificial nutrition and hydration, will make a decision with which the conservatee subjectively disagrees and which subjects the conservatee to starvation, dehydration and death. This would represent the gravest possible affront to a conservatee's state constitutional right to privacy, in the sense of freedom from unwanted bodily intrusions, and to life. … [T]he decision to treat is reversible. The decision to withdraw treatment is not.

(*Conservatorship of Wendland*, *supra*, 26 Cal.4th at 547.) Given the ultimate stakes, the Supreme Court of California ruled that clear and convincing evidence of the individual's wishes is required to support the withdrawal of life-sustaining treatment under the *parens patriae* power. (*Id.* at 524.) Yet as the trial court recognized, in nursing homes, physicians routinely make these life-and-death decisions for residents perceived as incapacitated without input from the residents or their surrogates. (See Order Granting Petition for Writ of Mandate in Part and Denying in Part (June 24, 2015) at 40–41 [nursing home interdisciplinary team transferred resident perceived to lack capacity to "comfort care only" resulting in his death; no evidence that resident was asked about or agreed to the transfer to hospice care and death].)

The individuals covered by the statutory scheme are afforded none of the basic protections recognized and understood as required by the state and federal constitutions in analogous contexts.

1. The Scheme is Unconstitutional Because It Fails to Ensure Effective Notice.

In *Vitek v. Jones*, the United States Supreme Court held that the Due Process Clause of the Fourteenth Amendment entitled a state prisoner to certain procedural protections, including notice, an

adversary hearing, and provision of counsel, before he could be transferred involuntarily to a state mental hospital under a state statute. (*Vitek v. Jones* (1980) 445 U.S. 480, 489–90 [100 S.Ct. 1254, 1262, 63 L.Ed.2d 552].) The Court held that the physician's assessment was insufficient to deprive the prisoner of his due process rights. (*Id*. at 491 ["Nebraska's reliance on the opinion of a designated physician or psychologist for determining whether the conditions warranting a transfer exist neither removes the prisoner's interest from due process protection nor answers the question of what process is due under the Constitution."].)

Accordingly, the *Vitek* Court affirmed that the prisoner was entitled to, inter alia, "[w]ritten notice to the prisoner that a transfer to a mental hospital is being considered." (*Id*. at 494; *cf. Mullane v. Central Hanover Bank & Trust Co*. (1950) 339 U.S. 306, 313 [70 S.Ct. 652, 656–57, 94 L.Ed. 865].) Similarly, in the context of a pending reestablishment of a conservatorship, the California Court of Appeal has reiterated that "[a]n elementary and fundamental requirement of due process in any proceeding which is to be accorded finality is notice reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford

them an opportunity to present their objections." (*Conservatorship of Moore* (1986) 185 Cal.App.3d 718, 725 [229 Cal.Rptr. 875, 879] [quoting *Mullane v. Central Hanover Bank & Trust Co., supra,* 339 U.S. at 314–15].)

In this matter, the statute does not require that the resident receive effective, particularized notice at *any* stage of the process. And even under the trial court's order, the resident deemed incompetent does not receive notice until ***after*** the physician has found him or her to be incompetent. (*Cf. Vitek, supra,* 445 U.S. at 494 [requiring notice of decision "being considered"].)

The Defendant's claim that relief is not required because other state and federal laws require notice is unavailing, as the cited provisions are inadequate. For example, the Probate Code section cited by the Defendant: has no substantive or constitutional standards; occurs ***after*** the determination of no capacity; is waived when the treating physician deems the notice to not be "possible;" and does not extend to the steps that occur after the finding of no capacity. (See Prob. Code, § 4732 ["A primary physician who makes or is informed of a determination that a patient lacks … capacity, … shall promptly record the determination in the patient's health care record and

communicate the determination to the patient, if possible …"].) Similarly, the state and federal law provisions cited review patients' rights, but do not apply to or discuss the notice requirements associated with a determination of capacity or with the steps that follow a finding of no capacity. (*Cf.* Defendant's Combined Reply and Respondent's Brief at 29 [citing Cal. Code Regs., tit. 22, § 72527(a)(3)-(5), (c)(1); 42 U.S.C. § 1395i-3(c)(1)(A)(i)].) And certainly the general notice of patients' rights provided at the time of admission, while properly required, does not substitute for the specific notice required by the constitutional matters at issue here. (*Cf. id*. at 30.) In any event, to the extent these state and federal law requirements are generally consistent with the constitutional rights of "unbefriended" nursing home residents, they do not detract from the Plaintiffs' claim here that specific notice is constitutionally required and must meet constitutional standards.

Effective notice – provided with any communication supports needed – is constitutionally required ***before*** any competency assessment or determination is made – and at ***each*** subsequent stage of the process.

2. The Scheme is Unconstitutional Because It Fails to Ensure Representation.

As a matter of due process, the United States Supreme Court has required the assignment of an advocate in situations comparable to the ones at issue here. In *Vitek*, the Court reasoned:

> A prisoner thought to be suffering from a mental disease or defect requiring involuntary treatment probably has an even greater need for legal assistance [than prisoners who are illiterate and uneducated], for such a prisoner is more likely to be unable to understand or exercise his rights.

(*Vitek v. Jones*, *supra*, 445 U.S. at 496–97 [plur. opn.].) Thus, the Court held that "qualified and independent assistance must be provided" to such a prisoner. (*Id*. at 497 [binding conc. opn. of Powell, J.].)

State courts have recognized a right to counsel under the due process clause of their respective state constitutions. For instance, New York's highest court recognized a right to appointed counsel in the situation presented here. (*Rivers v. Katz* (N.Y. 1986) 504 N.Y.S.2d 74, 81 [81 N.Y.2d 485, 497, 495 N.E.2d 337, 343–44] ["We hold, therefore, that in situations where the State's police power is not implicated, and the patient refuses to consent to the administration of antipsychotic drugs, there must be a judicial determination of whether the patient has the capacity to make a reasoned decision with respect

to proposed treatment before the drugs may be administered pursuant to the State's *parens patriae* power. … [T]he patient should be afforded representation by counsel."] [citations omitted].)

Furthermore, in *Wetherhorn v. Alaska Psychiatric Institute* (Alaska 2007) 156 P.3d 371, 383, the Supreme Court of Alaska observed that "[b]ecause ... a respondent's fundamental rights to liberty and to privacy are infringed upon by involuntary commitment and involuntary administration of psychotropic medication proceedings, the right to counsel ... is guaranteed by the due process clause of the Alaska Constitution."

California appellate courts have also found that individuals have a due process right to representation when facing involuntary medical treatment:

> ["U]nder California law a competent, informed adult has a fundamental right of self-determination to refuse or demand the withdrawal of medical treatment of any form irrespective of the personal consequences." [*Thor v. Superior Court*, *supra*, 21 Cal.Rptr.2d at 361.] This right is rendered meaningless if a person cannot adequately and through competent assistance of counsel and necessary experts challenge a psychiatric determination that he or she is incompetent to refuse antipsychotic medication.

(*Department of Corrections v. Office of Admin. Hearings* (1997) 53 Cal.App.4th 780, 790 [61 Cal.Rptr.2d 903, 909]; see also *Keyhea v.*

Rushen, *supra*, 178 Cal.App.3d at 542 n.14 ["[T]hese protections [notice, judicial hearing, judicial determination, personal appearance, and assistance of counsel] are to be implied from the right to a judicial determination of competency and are a necessary and integral part of that right. To divorce these protections from the right to a court determination of competency would deprive that right of any meaningful significance."]; *In re Roger S*. (1977) 19 Cal.3d 921, 938 [141 Cal.Rptr. 298, 308, 569 P.2d 1286, 1296] [minors being confined to mental hospital]; *In re Hop* (1981) 29 Cal.3d 82, 94 [171 Cal.Rptr. 721, 728–29, 623 P.2d 282, 289] [developmentally disabled adults being confined to state hospital].)

California state law guarantees the right to representation in analogous contexts. Individuals in mental health facilities under the Lanterman-Petris-Short Act are guaranteed representation under state law at a capacity hearing regarding involuntary treatment with medications or with ECT. (California Department of Health Care Services, *Rights for Individuals In Mental Health Facilities Admitted Under the Lanterman-Petris-Short Act* (2014), at 16, 19, at http://www.dhcs.ca.gov/services/Documents/DHCS_Handbook_Engli

sh.pdf;[7] *accord* Welf. & Inst. Code, § 5333(a), (d). See also Pen. Code, §§ 2602(c)(6) (state prisoner "certified" as subject to involuntary medication is provided with "expedited access to counsel"); 1370(a)(2)(D)(i) (representation provided at hearing

[7] The State's handbook for individuals in mental health facilities sets out the relevant standards:

A capacity hearing, which is also called a Riese hearing, may be held to determine whether you can refuse treatment with medications. The capacity hearing is conducted by a hearing officer at the facility where you are receiving treatment or by a judge in court. The hearing officer will determine whether you have the capacity to consent to or refuse medication as a form of treatment.

You have the right to be represented at the capacity hearing by an advocate or by an attorney. Your representative will help you prepare for the hearing and will answer questions or discuss concerns that you may have about the hearing process.

If you disagree with the capacity hearing decision, you may appeal the decision to a superior court or to a court of appeal. Your patients' rights advocate or attorney can assist you with filing an appeal. …

You also have the right to refuse electroconvulsive treatment (ECT) or any form of convulsive therapy. However, if a court has determined that you lack the capacity to make this decision, then ECT may be given without your consent. An advocate or a public defender can assist you with the hearing process.

(California Department of Health Care Services, *Rights for Individuals In Mental Health Facilities Admitted Under the Lanterman-Petris-Short Act* (2014), 16, 19, at http://www.dhcs.ca.gov/services/Documents/DHCS_Handbook_English.pdf.)

determining involuntary medical intervention for defendants found incompetent to stand trial); Welf. & Inst. Code, §§ 5350.5(a) (counsel appointed to conservatees who cannot afford one for hearings to determine capability to accept voluntary counsel); 5365 (court will appoint counsel to conservatee or proposed conservatee within five days after petition for conservatorship); Prob. Code, § 3205 (court will appoint attorney where petition filed regarding capacity of adult without conservator to consent to medical treatment); *Keyhea v. Rushen* (Super. Ct. Solano County, 1986, No. 67432), Order Granting Plaintiff's Motion for Clarification and Modification of Injunction and Permanent Injunction, at 10.)

Here, given the intrusive nature of the bodily intrusions being employed, and the inherent vulnerability of the individuals, this Court should rule that the existing scheme is unconstitutional because it does not ensure that the resident has representation throughout each step leading up to involuntary major medical interventions.

3. The Scheme is Unconstitutional Because It Fails to Ensure Judicial Review or Any Neutral Hearing.

In numerous analogous contexts, state and federal courts have found that judicial review of a determination of incapacity and of the

proposed treatment is required before intrusive involuntary medical treatments may be imposed. (See, e.g, *Vitek v. Jones*, *supra*, 445 U.S. at 495–97; *Keyhea v. Rushen*, *supra*, 178 Cal.App.3d at 535; *In re Qawi*, *supra*, 32 Cal.4th at 27 ["mentally disordered offender" can be compelled to be treated with antipsychotic medication in nonemergency situations only if: "(1) he is determined by a court to be incompetent to refuse medical treatment; (2) the [mentally disordered offender] is determined by a court to be a danger to others"]; *Conservatorship of Wendland*, *supra*, 26 Cal.4th at 554 [court must find "by clear and convincing evidence, either that the conservatee wished to refuse life-sustaining treatment or that to withhold such treatment would have been in his best interest"]; *Conservatorship of Waltz*, *supra*, 180 Cal.App.3d at 733 [trial court was required to find "clear and convincing evidence that [conservatee] lacked the capacity to consent to or refuse ECT"].)[8]

But in this statutory scheme, there is no requirement of any independent, judicial, or quasi-judicial review of the determination of

[8] *Accord* Welf. & Inst. Code, § 5332(b) [Antipsychotic medication "shall be administered [involuntarily] only when treatment staff have considered and determined that treatment alternatives to involuntary medication are unlikely to meet the needs of the patient, and upon a determination of that person's incapacity to refuse the treatment, in a hearing held for that purpose."]

incapacity or the proposed medical treatment. Even under the trial court's order (which the Defendant is challenging), the resident is merely notified that they "may challenge" these determinations "in a judicial proceeding." (Judgment, (Jan. 27, 2016) at 3.) There is no evidence that this is an option reasonably available to or exercised by the individuals at issue. There is no case law that has arisen from this population. This is unsurprising, given their segregation from the community, purportedly diminished capacity, and apparent lack of next of kin. Accordingly, this entirely illusory form of "self-help" is inadequate to protect the constitutional interests of the inherently vulnerable population at issue. The existing scheme is unconstitutional.

The Defendant's citations to advanced health care directives, health care powers of attorney, and Physician Orders for Life-Sustaining Treatment (POLST) as analogous forms of substituted medical decision-making in which judicial review is not required are unavailing. (See Appellant's Reply Brief at 89.) These forms of medical decision-making are chosen freely by an individual when competent, and are designed to protect liberty interests by enshrining the individual's stated choices and selected decision-maker. Unlike in

the scheme challenged here, the stated choices cannot be overridden, even if the treating physician disagrees. (See *Conservatorship of Wendland*, *supra*, 26 Cal.4th at 534.) It is true that the doctor decides when a person is incompetent under the Health Care Decisions Act, as in the challenged statutory scheme. But under the Health Care Decisions Act, the individual affirmatively grants the doctor this limited authority in advance, as part of an informed choice. It is not comparable to the unchecked authority delegated here.[9]

4. The Scheme is Unconstitutional Because It Fails to Protect Self-Determination.

As the Supreme Court of California has reiterated, "deference to the patient's own wishes" is the "primary standard for decisionmaking" in circumstances where the individual is believed to lack capacity. (*Conservatorship of Wendland*, *supra*, 26 Cal.4th at 545.) The challenged scheme here is unconstitutional because it fails to protect self-determination. First, the scheme includes no review of the capacity determination to ensure that it is carefully done in a manner to enhance capacity and to avoid false positives. Second,

[9] Of note, advanced health care directives and health care powers of attorney are only permitted where the treating health care professionals are excluded from the process. (See Prob. Code, §§ 4659, 4674(c).)

although the "interdisciplinary team" is directed by the statute to discuss "the desires of the patient, where known," the scheme does not ensure that the institution implements such desires (where not contrary to medical standards). (Health & Saf. Code, § 1418.8(e)(3).)

5. The Defendant's Position that There is No State Action Triggering Constitutional Standards Must Be Rejected.

But for the state's legislative action, the major medical interventions being implemented under the challenged scheme, unsupported by informed consent, would be unlawful. (*Cruzan v. Director, Missouri Dep't of Health* (1990) 497 U.S. 261, 269 [110 S.Ct. 2841, 2846, 111 L.Ed.2d 224] ["At common law, even the touching of one person by another without consent and without legal justification was a battery."].) It is only because the state has enacted Health and Safety Code section 1418.8, authorizing an attending physician to unilaterally determine capacity and the lack of a surrogate decision-maker, that this issue is before the Court. The Defendant's position that there is no state action here must be rejected.

B. This Court's Decision in *Rains* Does Not Govern the Petition Here Given Subsequent Case Law and Understandings.

This Court's decision in *Rains* does not govern this case. As an initial matter, this Court is free to disagree with a panel decision from another division (as is the *Rains* decision), and even with a panel decision from the same division. (See *Tourgeman v. Nelson & Kennard* (2014) 222 Cal.App.4th 1447, 1456 n.7 [166 Cal.Rptr.3d 729, 737–38]; *Cedars-Sinai Medical Center v. Superior Court* (1998) 18 Cal.4th 1, 21 [conc. opn. of Baxter, J.] [74 Cal.Rptr.2d 248, 261, 954 P.2d 511, 524].) Here, given subsequent case law, together with developments in our understandings about capacity and the interventions at issue, *Rains* is no longer persuasive.[10] The Court should exercise its discretion to depart from it.

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[10] And as the trial court properly ruled, the panel in *Rains* did not address all of the claims brought in this matter, including Plaintiffs' notice claims. (Order Granting Petition for Writ of Mandate in Part and Denying in Part (June 24, 2015) at 11–12 ["After reviewing *Rains* … the court is not persuaded that *Rains* addressed the specific issues presented by [Plaintiffs] here. … [T]his court sees nothing in *Rains* that addresses the issue presented by [Plaintiffs] as to whether a patient's due process rights under the California Constitution [are] violated by failing to provide notice and opportunity to the patient to oppose the determination of lack of capacity, absence of a legal substitute decision maker and the prescribed medical intervention."].)

1. Case Law Subsequent to *Rains* Has Altered and Clarified the State of the Law.

Subsequent to *Rains*, the Supreme Court of California has clarified the state of the law. First, the Supreme Court of California drew a clear constitutional distinction between substituted decision-making chosen in advance by the individual, and substituted decision-making authorized by the state:

> All of the laws just mentioned [the Health Care Decisions Act and its predecessors] merely give effect to the decision of a competent person, in the form either of instructions for health care or the designation of an agent or surrogate for health care decisions. Such laws may accurately be described, as the Legislature has described them, as a means to respect personal autonomy by giving effect to competent decisions: "In recognition of the dignity and privacy a person has a right to expect, the law recognizes that an adult has the fundamental right to control the decisions relating to his or her own health care, including the decision to have life-sustaining treatment withheld or withdrawn." [Health Care Decisions Act, § 4650(a)]. This court made essentially the same point in *Thor v. Superior Court*, *supra*, 5 Cal.4th 725, 740, where we described "the [former] Natural Death Act and other statutory provisions permitting an individual or designated surrogate to exercise conclusive control over the administration of life-sustaining treatment [as] evidenc[ing] legislative recognition that fostering self-determination in such matters enhances rather than deprecates the value of life."
>
> In contrast, decisions made by conservators typically derive their authority from a different basis – the *parens patriae* power of the state to protect incompetent persons. Unlike an agent or a surrogate for health care, who is voluntarily appointed by a competent person, a conservator is appointed by the court because the conservatee has been adjudicated to lack the

capacity to make health care decisions.

(*Conservatorship of Wendland*, *supra*, 26 Cal.4th at 534–35 [internal quotation omitted].) Thus, as a constitutional matter, even a court-appointed conservator to an individual adjudicated to be incompetent may not make the decision to end life-sustaining care absent proof, "by clear and convincing evidence, either that the conservatee wished to refuse life-sustaining treatment or that to withhold such treatment would have been in his best interest." (*Id.* at 554.) The Court found that the decision to withdraw nutrition and hydration was so important that it required, as a matter of constitutional law, judicial review. (*Id.* at 547.)

Next, our highest court has ruled since *Rains* that, as a constitutional matter, "*parens patri[a]e* may be used only to impose unwanted medical treatment on an adult when that adult has been adjudged incompetent." (*In re Qawi*, *supra*, 32 Cal.4th at 15–16.) As to such adjudication, the court must specifically determine that the conservatee cannot make his or her own medical decisions, with findings as to each element of the status. (*Id.* at 18.) And given the side effects of antipsychotic medications, the Court noted that "basic constitutional and common law right to privacy and bodily integrity is

therefore especially implicated by the forced administration of medications with such potential adverse consequences." (*Id.* at 15.)

Following *Qawi* and applying principles of equal protection, two appellate courts have found that additional categories of individuals subject to involuntary treatment must be afforded equivalent procedural protections with respect to involuntary antipsychotic medications. (*In re Calhoun*, *supra*, 121 Cal.App.4th at 1322 ["In light of our Supreme Court's recent opinion in *In re Qawi*, … we must conclude that [sexually violent predators] have the same right to refuse antipsychotic drugs as mentally disordered offenders … under the Mentally Disordered Offender Act."]; *In re Greenshields*, *supra*, 227 Cal.App.4th at 1292 [Defendant found not guilty by reason of insanity, but who had not been adjudicated incompetent to refuse antipsychotic medication "is similarly situated to the defendants in *Qawi* and *Calhoun* [and] is entitled to similar treatment absent a compelling state interest to the contrary. … [T]he inquiry is not whether persons are similarly situated for all purposes, it is whether they are similarly situated for purposes of the law challenged. [Persons not guilty by reason of insanity, mentally disordered offenders, and sexually violent predators] are similarly situated for

purposes of determining whether they may be treated with antipsychotic medication against their will. Administration of unwanted antipsychotic medication involves a constitutionally protected liberty interest."] [citations omitted].)

In light of *Wendland* and *Qawi*, and their progeny, it is clear that the medical decisions at issue in this matter – involuntarily imposed upon vulnerable individuals pursuant to *parens patriae* – are subject to constitutional limitations. For interventions such as antipsychotic medications, ECT, feeding tubes, and withdrawal of life-sustaining treatments to be lawful under the state and federal constitutions, the State must ensure that the residents have notice, representation, and a hearing. Further, even when a resident is properly adjudicated to lack capacity, his or her stated wishes must be followed, and the least intrusive option implemented, given the fundamental interests at issue. As the Plaintiffs have easily demonstrated, none of these constitutional requirements is met by the current scheme.

2. Current Knowledge About Capacity and the Interventions at Issue Should Inform the Constitutional Analysis.

In the decades since *Rains* was decided, we have gained

knowledge and experience that inform our constitutional analysis. In particular, our understanding of capacity has radically evolved since the Court reviewed the challenged statutory scheme in *Rains*. We now know that capacity can be enhanced with reasonable accommodations, such that a person initially perceived as incompetent may in fact be competent. We now appreciate that capacity may vary depending upon the context or decision at issue. We also know that an individual's capacity may be temporarily impaired by circumstances such as a fever or infection, or even the time of day, and that capacity may be restored when those circumstances are absent. And we know more about how substituted decision-making with respect to the major medical interventions at issue here can harm vulnerable individuals in nursing homes. These contemporary understandings make clear that procedural due process protections are necessary to prevent the risks and harms of the attending physician getting the capacity determination wrong.

Appropriate and effective capacity assessments that protect self-determination "[a]ssum[e] decisional capacity in adults while recognizing a spectrum of developing, partial, complete, fluctuating, and diminishing decisional capacities," and recognize and employ

"ways to enhance decisional capacities." (Center for Practical Bioethics, *Guidelines for the Determination of Decisional Incapacity* (2015) at 3, at https://www.practicalbioethics.org/files/ethics-consortium-guidelines/Determination-of-Decisional-Incapacity.pdf.) Important guidelines include:

> Decisional capacity is task-specific, that is, a person has or lacks capacity for a particular decision at a particular time and under a particular set of circumstances. …
>
> Decisional capacity may fluctuate; therefore:
>
> 1. Attention must be given to enhancing capacity before reaching a determination of incapacity.
>
> 2. The factors that diminish decisional capacity may include physiological dysfunction, psychological disorders, and medication effects.
>
> 3. Evaluations for decisional capacity must be repeated over time and in varying circumstances to reach a confident conclusion.

(*Id.* at 3–4.) Measures to support capacity include identifying times and environmental conditions that enhance capacity, ameliorating the effects of medication or psychological or physiological stressors, and overcoming communication barriers. (*Id.* at 5.)

Providing supports to enhance capacity has been incorporated into a concept known as supported decision-making. "Supported decision making … is a process of working with an individual to

identify where help is needed and devising an approach for providing that help … enabl[ing] the person to make decisions based on his or her wants and preferences." (U.S. Department of Health & Human Services, Administration for Community Living, *Supported Decision Making Program* (2017) at https://www.acl.gov/programs/consumer-control/supported-decision-making-program.) Supported decision-making emphasizes an individual's "autonomy, presumption of capacity, and right to make decisions on an equal basis with others," and "acknowledge[s] that individuals with disabilities will often need assistance in decision-making through such means as interpreter assistance, facilitated communication, assistive technologies and plain language." (Dinerstein, *Implementing Legal Capacity Under Article 12 of the UN Convention on the Rights of Persons with Disabilities: The Difficult Road from Guardianship to Supported Decision-Making* (2012) 19 Hum. Rts. Brief, 3–4.)

Reasonable accommodations to enhance capacity and to support decision-making are protective of the constitutional interests at stake in this matter, and are also required by the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. Yet many health care providers are not properly trained or informed about how

to assess decisional capacity:

> At all levels, healthcare providers have received inadequate training and monitoring in the practice of determining decisional incapacity. Those techniques that have been used traditionally to determine decisional incapacity, such as the mini-mental status exam or consulting a psychiatrist, are not always adequate to address the subtle complexity of this clinical determination in a critical and open process. There is evidence that the determination of decisional incapacity tends to be made by clinicians without a full appreciation for the possible errors in judgment that may be made in reaching conclusions about incapacity.

(*Guidelines for the Determination of Decisional Incapacity*, *supra*, at 2.)

Thus, under the existing statutory scheme, with its deference to the treating physician's determination, there is no way to be sure whether the individual subject to involuntary major medical treatment truly lacks capacity, or was simply assessed in a manner that did not take his or her disabilities into account. A constitutional scheme requires more.

C. There Are Alternative, Feasible, and Constitutional Means to Manage Competency Determinations and Medical Decision-Making for Nursing Home Residents Who May Lack Capacity and Surrogate Decision-Makers.

The court should reject the Defendant's argument that the constitutional procedures and protections sought by Plaintiffs will

wreak various forms of havoc. Given its long experience with other vulnerable populations, California has numerous tools and models at hand to provide alternative, feasible, and constitutional means to manage competency determinations and medical decision-making for nursing home residents who may lack capacity and surrogate decision-makers. Specifically:

- Facility staff may file petitions regarding capacity and major medical interventions under internal guidelines where needed.[11]

- Advocacy and representation to the resident may be provided in a variety of ways, including by a panel attorney, the county Public Defender, or by a trained patients' rights advocate.[12]

- Hearings may be held promptly and in a convenient location.[13]

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[11] See, e.g., Welf. & Inst. Code, § 5332(c) ["Each hospital in conjunction with the hospital medical staff or any other treatment facility in conjunction with its clinical staff shall develop internal procedures for facilitating the filing of petitions for capacity hearings and other activities required pursuant to this chapter."].)

[12] See, e.g. Welf. & Inst. Code, § 5333(a) ["Persons subject to capacity hearings pursuant to [Welfare and Institutions Code] Section 5332 shall have a right to representation by an advocate or legal counsel. 'Advocate,' as used in this section, means a person who is providing mandated patients' rights advocacy services …."].)

[13] See, e.g., Welf. & Inst. Code, § 5334(a), (b) ["Capacity hearings required by [Welfare and Institutions Code] Section 5332 shall be heard within 24 hours of the filing of the petition whenever possible. … Capacity hearings shall be held in an appropriate location at the facility where the person is receiving treatment, and shall be held in a manner compatible with, and the least disruptive of, the treatment being provided to the person."].)

- The hearing officer may be a superior court judge, an administrative law judge, a court-appointed commissioner or referee, or a court-appointed hearing officer.[14]

These are basic, feasible, and constitutionally required protections that the State can and should be providing to the nursing home residents at issue here. The institutions at issue are comparably resourced to the jails, prisons, and hospitals that already implement these types of measures. Moreover, nursing homes can and should take lawful, affirmative steps to reduce the numbers of residents who are subject to involuntary treatment based on *parens patriae*.[15]

IV. CONCLUSION

For all of the reasons stated, this Court should find the statutory scheme to be unconstitutional.

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[14] See, e.g., Welf. & Inst. Code, § 5334(c) ["Capacity hearings shall be conducted by a superior court judge, a court-appointed commissioner or referee, or a court-appointed hearing officer."].)

[15] For example, nursing homes can implement reasonable accommodations and supports that enhance capacity. They can adopt effective administrative methods that encourage and memorialize advanced directives, health care powers of attorney, and all available next of kin, periodically and particularly at the time that individuals with capacity are admitted. Where an individual cannot provide information about next of kin, a facility can perform reasonable internet searches. Facilities can review orders for antipsychotic drugs and feeding tubes to determine which ones are truly necessary, and which ones can be avoided.

Respectfully submitted this 29th day of September 2017.

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CERTIFICATE OF COMPLIANCE

I, Susan Mizner, hereby certify that the attached brief uses 14 point Times New Roman font. According to the word processing program I used to prepare this brief, the text of the brief (excluding signatures and this certificate) contains 10,416 words in length.

Dated: September 29, 2017

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I am employed in the County of San Francisco. I am over the age of eighteen years and not a party to the within action. My business address is: 39 Drumm Street, San Francisco, California, 94111. My electronic service address is: smizner@aclu.org

On September 29, 2017, I served true copies of the following document described as:
APPLICATION AND PROPOSED BRIEF OF AMICI CURIAE AMERICAN CIVIL LIBERTIES UNION FOUNDATION DISABILITY RIGHTS PROGRAM AND AMERICAN CIVIL LIBERTIES UNION OF NORTHERN CALIFORNIA IN SUPPORT OF PLAINTIFFS AND APPELLANTS
On the interested parties in this action as follows:

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

Executed on September 29, 2017, at San Francisco, California.

Maria Gabriela Sanchez

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For: Hon. Evelio M. Grillo

Superior Court Case No.:
RG13700100

STATE OF CALIFORNIA
Court of Appeal, First Appellate District

PROOF OF SERVICE

(Court of Appeal)

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

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

09-29-2017

Date

/s/Susan Mizner

Signature

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