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-Appellees,

v.

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

Defendant and Appellant.

Case No. A147987

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

COMBINED REPLY AND RESPONDENT'S BRIEF

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INTRODUCTION

Petitioners seek to re-litigate issues already decided by this Court when it upheld the constitutionality of Health and Safety Code section 1418.8 in *Rains v. Belshé* (1995) 32 Cal.App.4th 157 (*Rains*), and to transform doctors' examinations of their patients and caregiver meetings into adversarial hearings. Petitioners fail to justify revisiting *Rains*, or to establish that constitutional considerations bar utilizing section 1418.8 to authorize appropriate treatment of nursing home residents, including with antipsychotic medication. For these reasons, the trial court's Judgment requiring written notice to residents before initiating treatment under the statute, and barring the statute's use to administer antipsychotic drugs, should be reversed, and petitioners' cross-appeal should be denied.

The restrictions and procedures urged by petitioners are not constitutionally required, and if adopted would effectively deny necessary medical care to nursing home residents who are determined to lack capacity to make their own health care decisions, and do not have an authorized representative to make such decisions on their behalf (unbefriended). Such a result would contradict the Legislature's express purpose in establishing a non-judicial mechanism for substituted surrogate decisionmaking regarding proposed medical treatment for nursing home residents in these circumstances so that these residents can receive timely and necessary medical treatment.

Petitioners' principal claim, that section 1418.8 violates due process and privacy rights because it does not provide for an adjudication of a resident's lack of decisionmaking capacity and a panoply of rights associated with adversarial hearings, was already rejected by this Court in its decision in *Rains*. Petitioners fail to provide any basis to revisit the Court's ruling. Indeed, section 1418.8 is just one of a number of state statutes that allow surrogates to exercise a patient's right to consent to or

refuse medical treatment based upon a physician's determination that the patient lacks capacity, and thus, without requiring an adjudication of incapacity.

Moreover, residents' rights to privacy and due process are adequately safeguarded by the protections afforded by both section 1418.8 and other applicable law. Most importantly, while petitioners contend that residents must be provided written notice of any determination that the resident lacks decisionmaking capacity regarding their health care, state law already requires that physicians advise their patients of any such determination. And, residents are entitled to both a judicial hearing to determine their incapacity if they dispute the physician's determination, and also, as this Court recognized in *Rains*, to seek judicial review of the physician's determinations or the treatment decisions authorized under section 1418.8.

Petitioners mistake alleged failures by nursing homes to comply with regulatory requirements as evidence of section 1418.8's unconstitutionality. But any regulatory violations by nursing homes provide no basis to find section 1418.8 unconstitutional. Petitioners fail to establish that section 1418.8, when implemented as intended by the Legislature or as authorized by the Department, violates residents' rights, as would be necessary to demonstrate the statute's unconstitutionality. To the extent any nursing home violates patient care requirements in utilizing section 1418.8, residents have numerous avenues for recourse, including actions for injunctive and monetary relief and seeking administrative sanction.

Petitioners fail to justify the trial court's prohibition on administration of antipsychotic medications pursuant to section 1418.8. Petitioners and the trial court rely on case authority involving forced administration of such treatment to persons detained and involuntarily committed to state institutions, which this Court in *Rains* recognized involved very different statutory settings that call for heightened due process protections. The

Legislature did not limit in any way the medical interventions that may be authorized under section 1418.8, and the legislative history makes clear that the Legislature intended that the statute provide a mechanism for substituted surrogate decisionmaking in connection with proposed treatment with psychotherapeutic drugs.

Petitioners also fail to support the trial court's issuance of a ruling, in the absence of an actual controversy involving concrete circumstances, regarding section 1418.8's application to decisionmaking regarding the withholding or withdrawal of life-sustaining treatment. Petitioners do not identify any evidence that the Department of Public Health (Department) or its Director, defendant-appellant Karen Smith (Director) condoned or authorized any constitutionally impermissible uses of the statute in connection with end-of-life care decisions. The trial court issued its ruling limiting section 1418.8's application to such decisions in the absence of any actual dispute or specific set of circumstances involving an approved but constitutionally impermissible use of the statute to withhold or withdraw life-sustaining treatment. The trial court's decision on this issue, therefore, is an improper advisory opinion and should be vacated.

However, were the Court to affirm this part of the Judgment, it should preserve the exceptions included in the trial court's ruling that allow section 1418.8 to be used to authorize hospice care and the withholding or withdrawal of life-sustaining treatment when consistent with a resident's instructions or known wishes. Removing these exceptions, as petitioners urge, would improperly deny residents legally protected rights to receive hospice care and to provide instructions, while competent, for their future care after they have lost decisionmaking capacity.

For the reasons above, the trial court's Judgment should be reversed, and petitioners' cross-appeal denied.

ARGUMENT

REPLY BRIEF

I. THIS COURT IN *RAINS* ALREADY REJECTED PETITIONERS' CLAIM THAT FORMAL NOTICE IS REQUIRED UNDER SECTION 1418.8, AND PETITIONERS PROVIDE NO BASIS TO REVISIT THE COURT'S RULING

As the Director established in her Opening Brief, this Court expressly considered and rejected the argument that "notice" and an opportunity for hearing regarding a nursing home resident's capacity to make decisions regarding their health care was required by due process before treatment could be initiated under section 1418.8. (Appellant's Opening Brief (AOB) 22-24.) Petitioners read *Rains* far too narrowly in asserting that the Court did not address whether due process requires notice to residents. *Rains* precludes petitioners' "notice" claim.

Moreover, petitioners fail to demonstrate that nursing homes' use of section 1418.8 deprives residents of rights provided by statute or involves "state action," as necessary for procedural due process rights under the state Constitution to apply. If procedural due process rights apply, section 1418.8 must be construed as it operates together with safeguards established under other laws and regulations governing nursing home care. Together with these other protections, state and federal law ensures that residents are provided notice of a physician's determination of incapacity and protects residents' due process and privacy rights.

The trial court's ruling that section 1418.8 violates due process because it does not require written notice to the resident regarding the physician's determinations of the resident's lack of capacity to make

decisions regarding their health care (decisional incapacity)[1], lack of an authorized representative, prescribed treatment, and regarding rights to seek judicial review provided by other law—should be reversed.

A. *Rains* Decided that Notice and Hearings Are Not Required Before Treatment May Be Authorized Under Section 1418.8

Petitioners read *Rains* far too narrowly in asserting that this Court did not address in that decision whether notice to a resident was required by due process. Petitioners rely on the premise that a decision is not authority for points not considered or resolved. However, as the Court expressly stated in its summary of petitioner Rains' argument, petitioner Rains—represented by the same counsel representing petitioners here—in fact *did* specifically argue that "notice" and hearing rights were required by due process. (*Rains*, *supra*, 32 Cal.App.4th at pp. 161-162, 178.) However, this Court in *Rains* rejected petitioner Rains' due process claim. (*Id.* at pp. 178-182.)

The Director agrees, as petitioners argue, that a judicial decision "is not authority for a point that was not actually raised and resolved." (*Fairbanks v. Superior Court* (2009) 46 Cal.4th 56, 64.) But petitioners are wrong in contending that this Court did not resolve whether due process requires formal notice and hearing rights in *Rains*.

Petitioners concede that this Court recognized that "the issue of notice was raised" by petitioner in *Rains*. (Combined Respondents' and Cross-Appellants' Opening Brief (RB/AOB) 33.) But petitioners illogically contend that "there is no holding" in the decision addressed to the argument that due process required notice. (RB/AOB 33.) To the contrary, this

[1] Further references in this brief to "decisional" or "decisionmaking" capacity, or to "incapacity" are intended to relate to capacity to make decisions regarding health care unless identified otherwise.

Courts' rejection of petitioners' due process claims necessarily included and rejected petitioner Rains' claim that "notice" and hearings regarding decisional incapacity are required before section 1418.8 may be used.

Notice is generally required as a matter of due process only where an opportunity for an adversarial hearing also is required. (See *Marquez v. State Dept. Health Care Services* (2015) 240 Cal.App.4th 87, 114-115 (*Marquez*) [where entitlement to hearing was not clear, argument that notice of Department action was required "puts the cart before the horse"].) Thus, the Court's holdings in *Rains* that physicians, rather than judges or other independent decisionmakers, may determine that a patient lacks decisionmaking capacity, and that an adversarial hearing on the matter is not required, specifically responded to and rejected the argument that section 1418.8 violates due process because it does not require "notice" and other due process protections associated with an adjudicative hearing. (See *Rains*, *supra*, 32 Cal.App.4th at pp. 178-182.) The absence of a holding expressly rejecting the aspect of petitioner's due process claim asserting that "notice" is required by due process does not mean *Rains* left the issue of "notice" open for future decision.

The trial court here, therefore, erred in concluding that the question of notice to residents was not resolved in *Rains*. As the trial court's ruling conflicts with and is precluded by *Rains*, its judgment should be reversed.

B. Procedural Due Process Rights Do Not Apply Here Because Section 1418.8 Does Not Threaten Statutory Rights or Involve State Action

Petitioners fail to establish that application of section 1418.8 deprives residents of statutorily conferred rights or involves state action, as required to support application of procedural due process rights under the state Constitution. As procedural due process rights do not attach, the trial court erred in holding that section 1418.8 violates residents' due process rights.

1. Section 1418.8 Does Not Threaten to Deprive Residents of Statutory Rights

Petitioners fail to establish that section 1418.8 threatens statutorily conferred rights necessary to give rise to procedural due process protections under the state constitution.

Petitioners' "notice" claim asserts a violation of the due process clause of the state Constitution. (JA657.)

However, a litigant asserting a procedural due process claim under the state Constitution must identify "a statutorily conferred benefit or interest of which he or she has been deprived to trigger procedural due process under the California Constitution and the *Ramirez* analysis of what procedure is due." (*Ryan v. California Interscholastic Federation-San Diego Section* (2001) 94 Cal.App.4th 1048, 1071 (*Ryan*), citing *People v. Ramirez* (1979) 25 Cal.3d 260, 271; see also *Las Lomas Land Co., LLC v. City of Los Angeles* (2009) 177 Cal.App.4th 837, 855 ["The California due process clause does not protect all conceivable property interests, but only those property interests or benefits that are conferred by statute."]; *Schultz v. Regents of Univ. of California* (1984) 160 Cal.App.3d 768, 787 (*Schultz*) ["*Ramirez* does not apply to govern the due process rights of a public employee who has no statutory benefit subject to deprivation . . . ."].

This is a significant limitation on the scope of procedural due process protection under the state Constitution. As the court noted in *Schultz*: "*Ramirez*' requirement of a statutorily conferred benefit limits the universe of potential due process claims: presumably not every citizen adversely affected by governmental action can assert due process rights; identification of a statutory benefit subject to deprivation is a prerequisite." (160 Cal.App.3d at p. 786.)

Petitioners, however, fail to identify any statutory rights subject to deprivation supporting their due process claims. Petitioners assert that

section 1418.8 threatens *constitutional* guarantees of privacy, liberty, property, and life. But even if a procedural due process claim under the state Constitution could be premised upon the alleged threat of deprivation of more generalized constitutional rights, petitioners fail to establish that section 1418.8 threatens such guarantees.

This Court in *Rains* previously considered and rejected petitioners' contention that due process requires notice and hearing rights because section 1418.8 violates the constitutional right of "autonomy privacy" underlying the right to refuse medical treatment. (*Rains*, *supra*, 32 Cal.App.4th at pp. 171-172.) The Court acknowledged that nursing home patients "have a legally protected privacy interest in their own personal bodily autonomy and medical treatment," and that competent persons may have rights to provide or withhold consent. (*Ibid*.) However, the Court appropriately recognized that the right of privacy, "much as any other constitutional right, is not absolute," and that no source of law imposes an "absolute and inflexible right to refuse treatment for persons determined *not* to be competent." (*Id.* at pp. 171, 172, original italics.) Any such rule, the Court noted, in the context of persons determined by their physicians to lack capacity to make medical decisions and who need treatment, but who have no surrogate authorized to consent on their behalf, "would lead to unacceptable neglect of the medical needs of incompetent persons." (*Id.* at p. 172.) After carefully balancing the private and governmental interests at issue, the Court accordingly held that "section 1418.8 does not violate the constitutional right of privacy." (*Id.* at pp. 175-177.)

Petitioners provide no basis to revisit or overrule this Court's prior ruling on this point in *Rains*, as discussed in Part V, below. There is no basis, therefore, for petitioners' claim to notice and hearing rights based on an alleged threat to residents' privacy interests. (See *Rains*, *supra*, at pp. 171, 175.).

Petitioners' claims that section 1418.8 also threatens liberty, property, or life lack any basis. (RB/AOB 28.) Section 1418.8 authorizes an interdisciplinary team (IDT) of caregivers at a facility to act as a substitute surrogate decisionmaker regarding consent to *medical treatment* if a physician has determined a nursing home resident lacks decisional capacity and any authorized surrogate. However, the physician's determinations, even though predicates to using section 1418.8, are made *independently* of that statute. The designation of the IDT as a surrogate decisionmaker under the statute, however, does not deprive an individual of constitutionally-protected interests in liberty, property, or life.

The trial court's suggestion that liberty interests are implicated by section 1418.8 because deceased petitioner Gloria A. was required to have permission by her physician to leave the facility, and was denied on one occasion, lacks any basis. (JA720.) Section 1418.8 says nothing about facility policies regarding residents leaving the facility premises. Physicians must assess the decision making capacity of all residents irrespective of section 1418.8. Thus, the physician's determination that a resident lacks decisional capacity, if a basis for placing a resident under restrictions regarding leave, is not made *pursuant to* section 1418.8.[2] Similarly flawed logic underlies the Court's suggestion that "a physician's determination of lack of capacity" may also deprive a patient from being able to control their finances or limit their access to communications.

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[2] The determination by Gloria A.'s physician that she should not be permitted to attend a picnic with a particular person on one instance had nothing to do with section 1418.8. Rather, Gloria A.'s physician stated that he had determined, independent of section 1418.8, that based on his assessment of her decisionmaking capacity she should not leave the facility without a responsible party, and that on the occasion in question "the person she wished to go with was not believed to be a responsible party who would ensure her safety and compliance with medication." (JA474.)

(JA718.) Section 1418.8 does not concern a resident's right to make decisions regarding their personal affairs. And any determination that a resident lacks the ability to manage or make decisions regarding their *personal affairs* is necessarily distinct from a determination of their incapacity to make health care decisions. (See Health & Saf. Code, § 1418.8, subd. (b) (§ 1418.8).)

Finally, section 1418.8 cannot properly be considered to threaten residents' right to life. Decisions regarding life-sustaining treatment under section 1418.8 concern giving effect to the resident's rights to self determine care and whether further curative treatment would be effective or otherwise appropriate, not about whether to "end life" as petitioners contend. (See RB/AOB 30, 77-78.) As one court has noted:

> It is precisely the aim and purpose of the many decisions upholding the withdrawal of life-support systems to accord and provide as large a measure of dignity, respect and comfort as possible to every patient for the remainder of his days, whatever be their number. This goal is not to hasten death, though its earlier arrival may be an expected and understood likelihood.

(*Bouvia v. Superior Court* (1986) 179 Cal.App.3d 1127, 1144.)

Because section 1418.8 does not, on its face, threaten to deprive residents of statutory or constitutional rights, rights of procedural due process under the state constitution do not attach.

2. Section 1418.8 Does Not Involve State Action

Petitioners also fail to support their claim that there is "[s]ufficient" state action to support a due process claim. (RB/AOB 56). There is not.

Petitioners suggest that state action (or inaction) exists to support their due process claim because the State has a duty to "oversee and assure compliance with state law." (RB/AOB 38.) But Petitioners never established, nor did the trial court find, that the Director has any judicially enforceable duty with respect to enforcing section 1418.8, much less that

she was failing to comply with that duty. Any such failure, in any event, would not support petitioners' claim that section 1418.8 itself violates residents' due process rights.

State action is not involved in applying section 1418.8. Private sector physicians determine whether the requisite conditions for utilizing the statute are met, and IDTs at private nursing homes review proposed treatment decisions pursuant to the statute's provisions. Petitioners identify no basis to find that the State is so "significantly involved" in decisions under section 1418.8 that the action of private sector physicians and nursing facilities under the statute "may be fairly treated as that of the State itself." (*Garfinkle v. Superior Court* (*Wells Fargo Bank*) (1978) 21 Cal.3d 268, 276-277 (*Garfinkle*), citations and internal quotations omitted.)

That section 1418.8 is a legislative enactment does not establish a sufficiently close nexus with the State such that any actions taken pursuant to the statute may be deemed state action. (See *Kruger v. Wells Fargo Bank* (1974) 11 Cal.3d 352, 360-364 (*Kruger*) [rejecting contention that because bank's right of setoff is provided by statute, it constitutes state action].) Rather, other indicia of significant state involvement in actions taken by private parties pursuant to a statute must be present before the private conduct may be considered "state action." (See *id.* at p. 361; *Garfinkle*, *supra*, 21 Cal.3d at pp. 276-282.) No such indicia of state involvement exist here.

In *Blum v. Yaretsky* (1982) 457 U.S. 991, 1002-1012 (*Blum*), for example, the United States Supreme Court held that the decisions of physician review committees to transfer or discharge nursing home residents did not involve state action, even though the decisions were made to comply with statutory requirements and authorized by regulation. As the Court noted, those decisions are not encouraged or compelled by the

government, but rather "turn on medical judgments made by private parties . . . ." (*Id.* at p. 1008.)

This Court similarly determined recently that the state's identification of the existence of third-party health insurance information of a Medi-Cal beneficiary, which could cause treatment under Medi-Cal to be delayed or denied, does not constitute state action, since an "out-of-network" health care provider's decision to treat or refer the beneficiary for in-network treatment "lies with the private provider, not [the State]." (*Marquez*, *supra*, 240 Cal.App.4th at p. 107.) Since the determinations regarding a resident's decisional capacity, lack of surrogate, and proposed treatment similarly lie with private physicians and reviewing IDTs at private nursing facilities, the state is not significantly involved in decision under section 1418.8.

The State, in enacting section 1418.8, also has not delegated to private parties any powers that are "traditionally the exclusive prerogative of the State" sufficient to support state action. (*Blum*, *supra*, at pp. 1004–1005, citations and internal quotations omitted; see also *Garfinkle*, *supra*, 21 Cal.3d at pp. 280-282 [rejecting argument that statute regulating nonjudicial foreclosure delegated a "traditional judicial function" and therefore involved state action].) Determining a patient's decisional capacity has never been the exclusive prerogative of the State. Private physicians necessarily make capacity determinations on a routine basis in determining whether a patient, or a patient's family member or other authorized agent, may provide consent to treatment. (See *Cobbs v. Grant* (1972) 8 Cal.3d 229, 243–244.)

The designation of a surrogate decisionmaker for a person deemed to lack decisional capacity, likewise, is not a power that has been reserved exclusively to the State prior to enactment of section 1418.8. Family, kin, and others responsible for the care of an individual are recognized under common law as having authority to make decisions on behalf of persons

deemed to lack decisional capacity, even in the absence of having been designated by the incapacitated person. (See *Cobbs v. Grant*, *supra*, 8 Cal.3d at pp. 243-244.)

The Legislature's resolution of a dilemma faced by private nursing homes to help ensure that incapacitated and unbefriended residents can have medical decisions made on their behalf, does not turn medical decisionmaking under section 1418.8 into acts of the State. As our Supreme Court noted in *Garfinkle*, where statutory provisions are enacted "primarily for the benefit" of the affected parties and "limit" otherwise unregulated exercise of powers by a private actor, "it cannot realistically be claimed" that action by the private party under the statute may be deemed the action of the State. (*Garfinkle*, *supra*, 21 Cal.3d at p. 279.) Section 1418.8 is one such statute.

Section 1418.8 was expressly adopted "primarily for the benefit" of incapacitated and unbefriended nursing home residents to ensure timely access to treatment under appropriate procedural protections. (See *Rains*, *supra*, 32 Cal.4th at pp. 178-179.) And, section 1418.8 subjects decisionmaking by IDTs to limitations and controls that do not apply to individuals with the same surrogacy powers. Those limitations include the requirement that a patient representative participate in the IDT's review where practicable, team decisionmaking, and quarterly reassessments of the medical intervention. (See AOB 26-27.) The actions of private physicians and nursing homes under section 1418.8, therefore, cannot be said to involve "state action."

Because use of section 1418.8 does not deprive residents of statutory rights or involve state action, procedural due process rights under the state Constitution do not apply.

C. Even Assuming Due Process Rights Apply, Section 1418.8 and Other Law Adequately Safeguard Residents' Rights

Petitioners misconstrue the physician's assessment of a resident's decisional capacity, and the IDT's review of proposed treatment under section 1418.8, as "hearings" subject to the traditional requirements of due process. (See RB/AOB 29 [asserting residents must be provided notice "*prior* to the physician's determinations" (italics added)]; JA657 [referring to IDT review as "the hearing (statutorily termed review) as to medical treatment"].) But neither a doctor's exam, nor the IDT's review, are carried out by the state, and neither are "adjudicative procedures" to which traditional "notice" requirements under the state Constitution's due process clause apply. (See AOB 31-32; *Marquez*, *supra*, 240 Cal.App.4th at p. 112 [questioning whether state agency's entry of codes relating to other health coverage maintained by Medi-Cal beneficiaries "constitutes an 'adjudicative procedure[ ]' [citing *Ramirez*] targeted by our state's due process clause"].) For this reason, as well, the requirements of procedural due process, and the *Ramirez* analysis of "what process is due," are inapplicable to section 1418.8.

Nevertheless, even assuming for the sake of argument that the procedures under section 1418.8 are potentially subject to the requirements of due process, petitioners' claims would fail anyway. Petitioners fail to rebut the Director's demonstration that, as the Court also held in *Rains*, the "numerous statutory safeguards" provided by section 1418.8 along with other "applicable federal and state requirements designed to protect nursing home patients," ensure that resident's rights to procedural due process, including rights to meaningful notice, are not infringed. (AOB 28-31; *Rains*, *supra*, 32 Cal.App.4th at pp. 186-187.)

1. Other Applicable Law Requires that a Physician Advise a Patient of a Determination that the Patient Lacks Decisional Capacity

First, in addition to the procedural protections provided by section 1418.8 itself, applicable federal and state law provides that a physician *must provide notice to a patient* of any determination that the patient lacks capacity to make decisions regarding their health care. (See AOB 16-19, 24-31.) Most relevant, Probate Code section 4732 specifically requires that: "A primary physician who makes or is informed of a determination that a patient lacks or has recovered capacity [to make health care decisions], . . . shall promptly record the determination in the patient's health record *and communicate the determination to the patient*, if possible . . . ." (Prob. Code, § 4732, italics added; see also *id.*, § 4609 [defining "capacity"].) Other statutory and regulatory provisions similarly require that residents be "fully informed" of their "total health status, including *but not limited to*, his or her medical condition," their rights to "consent to or refuse any treatment or procedure," and of any significant change in their "mental, or psychosocial status." (Cal. Code Regs., tit. 22, § 72527, subds. (a)(3)-(5), (c)(1); 42 U.S.C. § 1395i-3(c)(1)(A)(i); 42 C.F.R. § 483.10(c), (g); see AOB 29.)

Oral notice of the physician's determination of incapacity under section 1418.8 satisfies the requirements for notice. "[D]ue process does not require any particular notice form or procedural method." (*Rutherford v. California* (1987) 188 Cal.App.3d 1267, 1279.) Courts have frequently held that oral notice satisfies due process requirements where timeliness is a factor or the circumstances or the interests involved warrant less formal procedures. (See *Cleveland Bd. of Educ. v. Loudermill* (1985) 470 U.S. 532, 546 [oral notice of charges supporting proposed termination of tenured public employee]; *Goss v. Lopez* (1975) 419 U.S. 565, 581 [oral notice of

charges supporting brief student suspension]; *In re Phillip F.* (2000) 78 Cal.App.4th 250, 259 [oral notice on record of continued hearing date regarding termination of parental rights]; *Marmion v. Mercy Hospital & Medical Center* (1983) 145 Cal.App.3d 72, 90 [oral notice of decision to terminate medical resident]; *Bird v. McGuire* (1963) 216 Cal.App.2d 702, 714 [oral notice of trial].)

2. The Patients' Bill of Rights and Mandatory Admission Contract Advise Patients of Rights to a Judicial Determination of Capacity in the Event of a Dispute and Rights to Oppose Care Decisions

The state Patients' Bill of Rights and mandatory state nursing home admission contract also require that residents be provided notice of their rights to raise any grievances regarding their care and, more specifically, that they have the right to a court determination of their decisional incapacity if they dispute their physician's assessment. (See Cal. Code Regs., tit. 22, § 72527, subd. (c); California Standard Admission Agreement for Skilled Nursing Facilities and Intermediate Care Facilities (Admission Agreement), at Motion for Judicial Notice (MJN) Exh. A.)

As part of the admission process to a facility, all prospective residents must be provided with a standard admission contract that advises residents of important rights as a patient, and that must include a copy of the "Patients' Bill of Rights," also identified as the "Resident Bill of Rights." (Health & Saf. Code, §§ 1599.61; 1599.75, subd. (b); see MJN, Exh. A [Attachment F].) Each resident, or an authorized representative, must provide written acknowledgment that they have been informed of the Patients' Bill of Rights. (Health & Saf. Code, § 1599.74, subd. (c); Admission Agreement at p. 4, at MJN, Exh. A.)

The Patients' Bill of Rights specifically advises residents that they have the right to have their decisional capacity determined in court if they dispute their physician's assessment. In particular, residents are advised

that capacity determinations may be made by a court, "or by the patient's physician unless the physician's determination is disputed by the patient or patient's representative." (Cal. Code Regs., tit. 22, § 72527, subd. (c).)

Pursuant to the Patients' Bill of Rights and related federal regulations, nursing homes must provide residents with information not only about their rights as residents, but also must "encourage[] and assist[]" residents "to exercise their rights as a patient . . . ." (Cal. Code Regs., tit. 22, § 72527, subd. (a)(7).). Among other things, nursing homes must notify residents, in writing, that they may:

- Raise "any grievances" to facility staff and outside representatives free from interference or reprisal. (Cal. Code Regs., tit. 22, § 72527, subd. (a)(7).); and
- File a complaint "with the State or Federal Survey Agency concerning any suspected violation of state or federal nursing facility regulations . . . . (42 C.F.R. § 483.10(g)(4)(i)(D).)

To help ensure that residents can obtain assistance, if necessary, in exercising and enforcing these rights, nursing homes must provide residents with the names, descriptions, and contact information for relevant state agencies and advocates. In particular, nursing homes must provide written notice, and post "in a form and manner accessible and understandable to residents," complete contact and background information about:

- "All pertinent State regulatory and informational agencies[;]" and
- "All pertinent . . . resident advocacy groups, such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services and private advocacy services[;]

(42 C.F.R. § 483.10(g)(4)(i)(C), (g)(5)(i)-(ii).)

Section 1418.8 itself also requires that even residents determined by their attending physician to lack decisional capacity are, nevertheless, advised of the treatment recommended by the physician. Under the statute, the IDT must interview the resident to determine the resident's desires with respect to the proposed medical intervention, and therefore must inform the resident of the proposed treatment. (§ 1418.8, subd. (e)(3).)

For all the reasons stated above and in the Director's Opening Brief, and as this Court previously determined in *Rains*, residents' rights to due process are adequately protected by the safeguards afforded by section 1418.8 and "the protections of state law which apply to any particular medical intervention or procedure." (*Rains*, *supra*, 32 Cal.App.4th at p. 186; see AOB 28-31.) Thus, even if the Court does not conclude that its rejection of petitioner's "notice" claim in *Rains* is preclusive of petitioners' "notice" claim here, and even if the Court determines that procedural due process protections apply to the non-adjudicative procedures involved in section 1418.8, trial court's ruling that section 1418.8 violates due process because it does not require written notice to residents should be reversed.

II. SECTION 1418.8 IS NOT FACIALLY INVALID, EVEN IF THE COURT DETERMINES THAT DUE PROCESS REQUIRES ADDITIONAL PROCEDURES

Petitioners fail to offer any support for the trial court's conclusion that section 1418.8 is facially invalid, and that its use must be "prohibited" because it does not require written notice to affected nursing home residents of the predicate determinations for its application. (See JA853.) As the Director identified in her Opening Brief, the trial court's ruling ignores core principles of statutory construction which require that courts deem procedural safeguards incorporated into a statute where necessary to comport with due process, so long as doing so is not inconsistent with the statutory scheme. (AOB 33-34.)

Indeed, the trial court appears not to have intended to invalidate and prohibit use of the statute. The court's detailed rulings in petitioners' favor on the statute's use in connection with antipsychotic drug treatment and decisions regarding end-of-life care—including provisions for a transitional period to implement its rulings—otherwise would be unnecessary and superfluous.

Thus, even if this Court determines that due process requires that residents be afforded written notice of the matters addressed in the trial court's decision, the trial court's conclusion that section 1418.8 is facially unconstitutional and that its use must be prohibited, must be vacated and reversed.

As the Director previously demonstrated, statutes must be construed, to the extent possible, as consistent with constitutional requirements. (AOB 33.) Applying this principle, courts must, and routinely do, read challenged statutes as requiring notice, hearing, or other procedural protections mandated by due process, where doing so does not conflict with the statute, rather than declare the law facially invalid. (AOB 33-34.)

Petitioners' response that reading notice requirements into the statute would conflict with section 1418.8, because there is "nothing in the statute requiring notice," misses the point. (RB/AOB 38.) The principle that procedural protections deemed constitutionally required must, where possible, be "read into" a statute necessarily presumes that the law in question *does not already require such procedures*. Our Supreme Court has specifically "reaffirmed a long line of cases holding that we will infer the due process right to a hearing—*even in the face of statutory silence* . . . ." (*Kopp v. Fair Pol. Practices Com.* (1995) 11 Cal.4th 607, 645, fn. 47, original italics.) In all cases in which courts have determined that constitutionally required procedural protections may be deemed included in

a statute, the statutory text necessarily was silent as to those procedures. (See *ibid*. [citing cases]; AOB 33-34.)

Petitioners' only other argument in support of the trial court's finding of facial invalidity—that "redrafting" of the statute is necessary because a specific set of "legislative mandates is required at different times in the statutory process"—is unclear and appears inapposite. (RB/AOB 38.) If this Court determines that due process requires written notice to residents along the lines outlined in the trial court's Judgment, it is of no matter that such notice may be required at different times "in the statutory process" or during a patient's residence at a nursing home. The notice requirement may be deemed applicable at whatever stage necessary or appropriate.

If construed to include a written notice requirement, section 1418.8 would be consistent with the constitutional requirements alleged by petitioners to apply here, and would not present a "total and fatal conflict" with constitutional prohibitions necessary for a finding of facial invalidity. (*Tobe v. City of Santa Ana* (1995) 9 Cal.4th 1069, 1084 (*Tobe*), internal quotations and citation omitted.) Thus, section 1418.8 cannot properly be declared facially unconstitutional even if written notice is deemed necessary.

The trial court's conclusion that the statute is "facially invalid" and that its use therefore must be "prohibited" must be reversed. Nothing in the procedures outlined in the statute would conflict with a requirement to provide notice as outlined in the Judgment. If this Court concludes that such notice is required by due process, it must, therefore, deem those requirements incorporated into section 1418.8 and give effect to the Legislature's purposes in providing an appropriate mechanism to ensure that incapacitated and unbefriended nursing home residents may obtain timely and necessary medical care. (See *Braxton v. Municipal Court* (1973) 10 Cal.3d 138, 144 145 [construing statute to require notice and

hearing prior to campus exclusion order because "statute must be construed so as not to violate the precepts of procedural due process"].)

III. PETITIONERS FAIL TO ESTABLISH ANY BASIS TO BAR TREATMENT WITH ANTIPSYCHOTIC MEDICATIONS UNDER SECTION 1418.8

Petitioners fail to support the trial court's determination, based on a misapplication of distinguishable case authority, that the Legislature must not have intended section 1418.8 to be utilized to authorize administration of antipsychotic medication. Judicial precedent regarding rights to refuse treatment with antipsychotic drugs in the "very different statutory setting" of involuntary commitment and incarceration does not, as this Court previously determined in *Rains*, require that there be an adjudication of a nursing home residents' incapacity before treatment may be authorized under section 1418.8. (*Rains*, *supra*, 32 Cal.App.4th at p. 170.) Section 1418.8, by its plain text, does not limit in any way the type of treatments that may be authorized pursuant to the statute. And the Legislature made clear that it intended the statute to be given broad application to any decision regarding a prescribed medical intervention requiring consent. Indeed, the legislative history demonstrates that the Legislature specifically intended that section 1418.8 provide a mechanism for substituted decisionmaking for treatment with antipsychotic drugs.

Antipsychotic drugs, when used as medically appropriate, are a critical element of medical treatment for some nursing home residents. (See JA557-558.) The trial court's ruling, however, improperly bars application of section 1418.8 for such treatment, directly contrary to the text of the statute and the Legislature's intent. If left standing, the trial court's ruling will have predictable, far-reaching, and serious negative consequences for nursing home residents and the health care system. (See JA559-560; 761-764.)

A. Section 1418.8 Was Intended by the Legislature to Allow Administration of Antipsychotic Drugs, as CANHR Itself Recognized

As the Director established in her Opening Brief, section 1418.8 does not limit the types of treatments that may be authorized under its procedures, and the Legislature expressly declared its intent that section 1418.8 be applied "to the greatest extent possible" 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, p. 6326-6327; AOB 37.) The Legislature contemplated that section 1418.8 could be utilized to administer antipsychotic medications. (AOB 35-39.)

Petitioners, adopting the trial court's rationale, nevertheless contend that the Legislature "must not have intended" that section 1418.8 apply to administration of antipsychotic drugs. (RB/AOB 43, citing JA735.) Contrary to CANHR's new position, the legislative history makes clear that section 1418.8 was specifically designed to provide a mechanism for substituted decisionmaking in connection with proposed antipsychotic drug treatment for incapacitated and unbefriended residents. As described below, new regulations expanding the Patients' Bill of Rights promulgated shortly before section 1418.8's enactment included specific requirements to verify consent for use of psychotherapeutic drugs. Nursing facilities specifically urged the Legislature to adopt the legislation that resulted in section 1418.8 in light of concerns about compliance with these new regulations.

In May 1992, the Department of Health Services finalized regulations expanding the "Patients' Bill of Rights." (See Cal. Code Regs., tit. 22, §§ 72527-72528; see Register 1992, No. 22 (May 27, 1992).) These provisions required that nursing homes establish policies and procedures for verifying consent or refusal "to the administration of psychotherapeutic

drugs" and for identifying "who may serve as a patient's representative when an incapacitated patient has no conservator or attorney in fact under a valid Durable Power of Attorney for Health Care." (Cal. Code Regs., tit. 22, § 72527, subds. (e)(1), (2).)

Additionally, federal regulations adopted pursuant to the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) (Pub. L. 100-203) (also known as the Nursing Home Reform Act), published in September 1991, effective April 1, 1992, provide that all nursing home residents have the right to refuse treatment, and to be fully informed about and participate in planning their care and treatment "[u]nless adjudged incompetent or otherwise found to be incapacitated under the laws of the State . . . ." (Medicare and Medicaid; Requirements for Long Term Care Facilities (56 Fed.Reg. 48826, 48867-48868 (Sept. 26, 1991)) [former 42 U.S.C. § 483.10(b)(4), (d)(2), (3)]), italics added, at MJN, Exh. C.)

These regulations also specifically addressed the administration of antipsychotic drugs in nursing homes. The regulations provided that such medications may be utilized for treatment only where "antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record," and that residents receiving antipsychotic drugs "receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated . . . ." (See former 42 U.S.C. § 483.25(l)(2)(i), (ii), at MJN, Exh. C.)

The Legislature was aware of this background, and that nursing homes were urging legislators to adopt a mechanism for substituted consent to medical treatment in nursing homes, including administration of antipsychotic drugs. For example, an Assembly committee analysis noted that proposed federal regulations pursuant to federal legislation under the Nursing Home Reform Law, as well as proposed state regulations, "will require nursing facilities to obtain informed consent for a wide variety of

procedures and interventions," and that associations representing these facilities were concerned about its implications for treatment of residents "who are unable to grant informed consent have no one to act in their behalf." (Assembly Committee on Human Services, Analysis of AB 3209 as amended in committee, for May 6, 1992 Hearing (1991-1992 Reg. Sess.), at MJN, Exh. G.)

An August 1992 Senate Floor Analysis similarly noted that one such association argued that this bill "is needed due to the recent publication of informed consent regulations governing the administration of *psychotropic drugs*, physical restraints and the prolonged use of devices such as feeding tubes." (Senate Rules Committee, Office of Senate Floor Analyses, 3d Reading Analysis of AB 3209 (1991-1992 Reg. Sess.) August 30, 1992, at MJN, Exh. H, italics added.) The Department of Aging recognized the 1992 state informed consent regulations as a critical factor behind the legislation in a report to the Governor regarding Assembly Bill 3209 (AB 3209), the legislation passed by Legislature to enact section 1418.8. (MJN, Exh. M; see also Exh. N [identifying same background in Department of Health Services report to Governor regarding 1994 amendments].)

Passage of the AB 3209 followed against this backdrop. AB 3209 was passed by the Assembly on May 28, 1992, and by the state Senate on August 30, 1992. (2 Assem. Final Hist. (1992-1993 Regular Session) p. 2138, at MJN, Exh. D.) The Governor signed the bill into law on September 30, 1992. (*Ibid*.)

In light of the above, it is beyond dispute that the Legislature, in adopting section 1418.8 with no limitations on the types of treatments that could be authorized, intended that section 1418.8 resolve the dilemma faced by nursing homes regarding compliance with state and federal regulations identifying new consent requirements for use of antipsychotic drugs.

Indeed, at the time section 1418.8 was being debated in the Legislature, petitioner California Advocates for Nursing Home Reform (CANHR) itself asserted—contrary to its current litigation position—that section 1418.8 provided authority to administer antipsychotic drugs. Commenting to a state senator on a provision of the original legislation that would have allowed the attending physician and nursing facility to "initiate a treatment that requires informed consent," CANHR contended that the provision was unacceptable because it would allow a facility to continue previously authorized "treatment" that could include "chemical and/or physical restraints," but also to initiate "such treatment." (MJN, Exh. K.)

CANHR's use of the term "treatment" in connection with its concern regarding use of "chemical restraints," demonstrates that CANHR was referring to uses of a psychotropic drug for purposes of treatment under section 1418.8, rather than as an emergency restraint. Indeed, section 1418.8's provision addressing emergency use of chemical restraints, subdivision (h), was not added to the statute until 1996, well after CANHR's letter. (See Leg. Counsel's Dig., Sen. Bill 1848 (1995-1996 Reg. Sess.), 1 Stats. 1996, ch. 126, p. 50, at MJN, Exh. F.) The term "chemical restraint" refers to use of a drug to "control behavior and used in a manner *not required* to treat the patient's medical symptoms." (Cal. Code Regs., tit. 22, § 72018, italics added.)

After section 1418.8 was enacted in 1992, CANHR also objected, in a letter to the chairperson of the Assembly Health Committee, to a proposal to remove the statute's sunset date, asserting that the statute allows residents "to be drugged up" with only the consent of the IDT. (MJN, Exh. L.) CANHR opposed removal of the sunset provision on the ground

that no statistics had been presented as to how many residents "have been given drugs" pursuant to the statute. (*Ibid.*)[3]

The trial court's assertion, echoed by CANHR, that the Legislature must not have intended for section 1418.8 to apply to the administration of antipsychotic drugs, is squarely contradicted by the legislative history, and must be rejected.

B. Rules of Statutory Construction Compel the Conclusion that the Legislature Intended that Section 1418.8 Apply to Antipsychotic Drug Treatment

The trial court's conclusion, and petitioners' contention, that the Legislature "must not have intended" section 1418.8 to apply to administration of antipsychotic drugs also contravenes several fundamental principles of statutory construction. (RB/AOB 43; JA734.) Application of these rules compels the opposite conclusion as a matter of law.

First, the starting point in interpreting a statute is, of course, "its text, as statutory language typically is the best and most reliable indicator of the Legislature's intended purpose." (*Larkin v. Workers' Comp. Appeals Bd.* (2015) 62 Cal.4th 152, 157.) Section 1418.8 contains no limitation on the types of medical interventions that may be authorized under the statute. Neither the trial court nor petitioners identify anything in the statutory language that constitutes a limitation. There is, therefore, no basis for petitioners' contention, and the trial court's conclusion, that the Legislature "must not have intended" section 1418.8 to be used to authorize antipsychotic drug treatment. (See § 1418.8, subd. (e).) Courts cannot

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[3] The Legislature also was made aware that petitioner in the first challenge to section 1418.8—an original writ to this Court (*Doherty v. Lungren*, No. A060010)—contended that section 1418.8 allows the physician and IDT to "authorize and apply *any and all forms of medical treatment,*" including "chemical and/or physical restraints." (MJN, Exh. P [see Verified Petition, at p. 3, italics added].)

interpret a statute "to conform to a presumed intent that is not expressed." (*American Civil Rights Foundation v. Berkeley Unified School Dist.* (2009) 172 Cal.App.4th 207, 217, internal quotations and citations omitted). The text of section 1418.8 unambiguously applies to any "medical intervention" or "health care decision," and therefore to decisions to authorize treatment with antipsychotic drugs. The Court's inquiry as to the statute's application to treatment with antipsychotic drugs need go not further.

Petitioners seek to establish a limitation on the use of section 1418.8 based on presumed legislative intent that was not only "not expressed," but also *contrary* to the Legislature's declared intent that the statute be applied broadly to ensure that the treatment needs of incapacitated and unbefriended nursing home residents may be met. In its enacted findings and declarations supporting the statute, the Legislature declared that its intent was to ensure that "the medical needs of nursing facility residents are met," and to secure, "to the greatest extent possible," decisionmakers for unbefriended residents who lack capacity to make "medical treatment decisions." (Stats. 1992, ch. 1303, §§ 1(b), (c), p. 6327, at MJN, Exh. D.) Any limitation upon the scope of medical treatments that may be authorized under section 1418.8 would thwart, rather than implement, the Legislature's express intent.

The trial court based its conclusion regarding the Legislature's intent on the reasoning in three decisions, "*Washington, Qawi, and Keyhea*." (JA735.) However, those decisions do not support the trial court's discovery of an unexpressed Legislative intent.

In re Qawi (2004) 32 Cal.4th 1 (*Qawi*), cannot serve to support any presumed legislative intent, as it was decided in 2004, long *after* section 1418.8 was adopted and amended.

As to the remaining two decisions, *Washington v. Harper* (1990) 494 U.S. 210 (*Washington*) and *Keyhea v Rushen* (1986) 178 Cal.App.3d 526

(*Keyhea*), the only supportable conclusion, directly contrary to that drawn by the trial court, is that the Legislature was *aware* of these decisions and did not believe they limited the type of treatments that may be authorized under section 1418.8.

The Legislature must be presumed to have been "aware of judicial decisions already in existence, and to have enacted or amended a statute in light thereof." (*People v. Giordano* (2007) 42 Cal.4th 644, 659, internal quotations and citations omitted.) Thus, when the Legislature enacted section 1418.8 with *no requirement* for an adjudication of decisional incapacity and with *no limitations* on the treatments for which substituted consent could be given by the IDT, the Legislature must be presumed to have concluded that *Washington* and *Keyhea* did not bar antipsychotic drug treatment from being authorized under the statute, as it could or would otherwise have so provided.

Indeed, in *Rains*, this Court *relied* on both *Washington* and *Keyhea* in concluding that section 1418.8 did not violate privacy or due process rights. (*Rains*, *supra*, 32 Cal.App.4th at pp. 170, 177, 180, 184, 185, fn. 7, 186-187.) As the Court noted in *Rains*, section 1418.8 involves a "very different statutory setting" than those involved in *Washington, Keyhea*, and other decisions that relate to the rights of prisoners or individuals who are detained or involuntarily committed to mental hospitals by the State. (*Rains*, *supra*, 32 Cal.App.4th at pp. 170.) Those circumstances, the Court appropriately noted, trigger a need for "rather extensive due protections" not applicable in the context of care provided in private nursing homes. (*Id.* at p. 185.)

Finally, the trial court's presumption that the Legislature intended to place limits, albeit unexpressed *either in the statute or the legislative history*, on "medical interventions" and "health care decisions" under section 1418.8 cannot be squared with the Legislature's broad definition of

the term "health care decision" in other related statutes. The Legislature must be presumed to have intended that identical terms or phrases used in statutes relating to the same subject have the same meaning, absent any indication to the contrary. (*Dieckmann v. Superior Court* (1985) 175 Cal.App.3d 345, 356.)

Section 1418.8 establishes procedures for substituted decisionmaking for unbefriended residents unable to make "health care decisions" or a "decision" regarding their own "health care." (§ 1418.8, subds. (a) (d), (e) (f); see also subd. (c) ["medical treatment decision"].) In the Health Care Decisions Law, which addresses advance instructions and directives authorizing surrogate health care decisionmaking for individuals after they lose decisional capacity, the Legislature defined the term "health care decision" to include "[a]pproval or disapproval of diagnostic tests, surgical procedures, and *programs of medication*." (Prob. Code, § 4617, subd. (b), italics added.) The term "health care" is defined as "*any* care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a patient's physical *or mental* condition." (*Id.* § 4615, italics added.) In light of these definitions, there is no basis to conclude that the Legislature intended to prohibit antipsychotic medications from being authorized under section 1418.8.

Petitioners mischaracterize the Director's position with respect to the significance of section 1418.8, subdivision (h), which authorizes emergency use of physical and chemical restraints prior to IDT review. (RB/AOB 39-40.) Under this provision, the IDT must review a facility's decision to utilize a "chemical restraint" in an emergency "within one week of the emergency." (§ 1418.8, subd. (h).) The Director does not assert that this provision "expressly permits" treatment with antipsychotic drugs. (*Id.* at 39.) Rather, the Director contends only that this provision contemplates continued use of the drug following resolution of the emergency if

authorized by the IDT upon its review. Subdivision (h)'s provision regarding *emergency* use of chemical restraints also suggests that drugs which can be used as chemical restraints, such as antipsychotics, may be prescribed for appropriate treatment just as any other "medical intervention" when authorized in advance pursuant to the statute.

Finally, petitioners' assertion that this Court in *Rains* created a limitation on the scope or type of treatments that may be authorized under section 1418.8, and that this limitation bars treatment with antipsychotic drugs pursuant to the statute, fails under scrutiny. (RB/AOB 41.) Petitioners point to the Court's statement that "section 1418.8 by its own terms applies only to the relatively nonintrusive and routine, ongoing medical intervention, which may be afforded by physicians in nursing homes; it does not purport to grant blanket authority for more severe medical interventions such as medically necessary, one-time procedures which would be carried out at a hospital or other acute care facility." (*Rains*, *supra*, 32 Cal.App.4th at p. 186.)

Since section 1418.8 includes no limitations on the type of treatments or health care decisions to which it may apply, the Court's statement in *Rains* appears to have been intended only to reflect that section 1418.8 addresses medical interventions prescribed by a resident's "attending physician and surgeon" (§ 1418.8, subds. (a), (e).) The statute, therefore, appears to apply to decisions regarding treatment ordered by the resident's physician that would be carried out "in the nursing home," rather than treatments that would be ordered by an acute care physician and carried "out at a hospital or acute care facility." (*Rains*, *supra*, 32 Cal.App.4th at p. 186.) Particularly as the Court in *Rains* indicated its statement was based on the statute's "own terms," the Court clearly did not intend to create, nor could it properly have created, a limitation on the type of treatments that

may be authorized under the statute that is not found anywhere in the statute's text.

Even if the Court in *Rains* purported to create a limitation on section 1418.8's use, antipsychotic drug treatment would fall well within its scope as understood by the Court. Appropriate treatment with antipsychotic medications is recognized as an important and routine aspect of care provided at nursing homes for some residents. (See JA282-300, 557-560, 563-579.) Such treatment, therefore, is a "routine, ongoing medical intervention, which may be afforded by physicians in nursing homes," and not akin to the more "severe" interventions such as "one-time procedures which would be carried out at a hospital or other acute care facility," described by the Court. (*Rains*, *supra*, 32 Cal.App.4th at p. 186.)

Petitioners' argument, and the trial court's conclusion, that the Legislature must not have intended that section 1418.8 be utilized to authorize treatment with antipsychotic drugs is contradicted by the statute's text and legislative history, conflicts with fundamental rules of statutory construction, and is not mandated by decisional law or this Court's interpretation of the statute in *Rains*. The trial court's decision on this issue, therefore, should be reversed.

C. Administration of Antipsychotics Pursuant to Section 1418.8 Does Not Violate Residents' Privacy or Due Process Rights

1. For the Same Reasons Identified by this Court in *Rains*, the Authorities on Which Petitioners Rely Are Inapposite Because They Address Rights to Refuse Antipsychotic Drugs in "Very Different" Settings Involving State Custody

Petitioners' and the trial court's reliance on cases involving the right of individuals in *state custody*—including prisoners and those subject to involuntary civil commitment—to support barring antipsychotic drug

treatment under section 1418.8 in private nursing homes is misplaced. This Court in *Rains* specifically declined to find cases arising in those custodial contexts as controlling, since the context of state-imposed treatment of individuals involuntarily held in state custody naturally gives rise to enhanced due process concerns and protections.

As this Court expressly recognized in *Rains*, that question of the right of persons involuntarily committed by the state to refuse treatment, including antipsychotic drugs, has "attendant consequences" that "naturally trigger a need for rather extensive due process protections." (*Rains*, *supra*, 32 Cal.App.4th at p. 185.) As the Court noted, however, section 1418.8 involves a "very different statutory setting." (*Id.* at p. 170.) For this reason, the Court concluded that decisions such as *Washington*, *supra*, 494 U.S. 210, and *Riese v. St. Mary's Hospital & Medical Center* (1987) 209 Cal.App.3d 1303 (*Riese*), do not require a judicial or quasi-judicial adjudication of incapacity before medical treatment requiring consent may be authorized for unbefriended individuals in private *nursing homes* under section 1418.8. (See *Rains*, *supra*, 32 Cal.App.4th at pp. 170, 177, 180, 184, 185, fn. 7, 186-187.) Since *Washington* and *Riese* involved rights to refuse treatment with antipsychotic drugs, this Court *already necessarily considered and rejected* the proposition that section 1418.8 violates due process if used to authorize such treatment. Petitioners identify nothing that requires any different result today.

Petitioners' repeated references to the noncontroversial principle that a "competent" adult has a right to refuse medical treatment does not support their claim that section 1418.8 is unconstitutional as applied to antipsychotic treatment. (RB/AOB 43-46.) The principle does not resolve the issue presented by petitioners' claim: whether section 1418.8 violates a resident's constitutional rights as applied to treatment with antipsychotic drugs because it does not require a judicial or quasi judicial determination

of decisional incapacity. Because this Court, in upholding section 1418.8, looked to the same cases cited by petitioners involving consent to antipsychotic drug treatment, the Court necessarily determined in *Rains* that constitutionally permissible treatments under section 1418.8 include treatment with antipsychotic drugs.

Petitioners' exaggerated assertion that *Rains* results in the "elimination of personal autonomy as to medical care" should be rejected. (RB/AOB 45.) This Court in *Rains* specifically considered the implications of section 1418.8 upon the "legally protected privacy interest in their own personal bodily autonomy and medical treatment, under the rubric of 'autonomy privacy.'" (*Rains*, 32 Cal.App.4th at p. 171, internal quotations and citation omitted.) Balancing the private and public interests involved, the reasonable expectation of privacy, and the seriousness of the invasion of privacy at issue, the Court determined that section 1418.8 does not violate residents' rights to autonomy privacy. (*Id.* at p. 177.) As discussed below, at Part V(B)(1), section 1418.8 is just one of a number of statutes relating to private, non-custodial settings that permit substituted decisionmaking on behalf of individuals based on a physician's determination of incapacity.

Indeed, in light of the fact that this Court in *Rains* relied upon *Washington* and *Keyhea*, and addressed rights of refusal to antipsychotic drugs, the Court necessarily contemplated the potential use of *section 1418.8* to administer such drugs. (*Rains*, *supra*, 32 Cal.App.4th at pp. 170, 177, 180, 184, 185, fn. 7, 186-187.) In determining that section 1418.8 passes constitutional muster, the Court necessarily determined that section 1418.8 comports with constitutional requirements, *including* when used to authorize treatment with antipsychotic drugs.

2. Petitioners' Other Points and Authorities Do Not Support Prohibiting Antipsychotic Treatment Under Section 1418.8

a. *Qawi* Does Not Require Barring Antipsychotic Drug Treatment Under Section 1418.8

In *Qawi*, the Court addressed the extent to which a "mentally disordered offender" (MDO) committed to state custody may, under the "MDO Act," refuse antispsychotic medication absent a judicial determination of incapacity. (32 Cal.4th at p. 9.) As background to its interpretation of the statutory rights at issue, the Court examined rights under the state Constitution, common law, and other state law relating to the right to refuse antipsychotic medication. (*Id.* at pp. 14-27.) Petitioners rely on one sentence, made in the context of this overview, in which the Court stated that in California, *parens patriae*—the state's interest "'in providing care to its citizens who are unable . . . to care for themselves'"—may be used "only to impose unwanted medical treatment on an adult when that adult has been adjudged incompetent." (RB/AOB 54, citing *Qawi*, *supra*, 32 Cal.4th at pp. 15-16.) This statement does not, however, support petitioners' claim to bar administration of antipsychotic drugs under section 1418.8.

Among other things, the statement in *Qawi* speaks only to the right to impose "unwanted" treatment, and therefore, to the extent applicable outside the context of civil commitment, only supports a requirement that incapacity be adjudicated in the event that the patient *disputes* the physician's determination or treatment decision. This is consistent with existing protections for residents under the Patients' Bill of Rights in the event section 1418.8 is used to authorize treatment with antipsychotic drugs. As noted above, the Patients' Bill of Rights requires that a resident's incapacity to consent to treatment be determined in court in the event the

resident disputes the physician's incapacity determination. (See Cal. Code Regs., tit. 22, § 72527, subd. (c).) Section 1418.8, therefore, cannot properly be utilized to "impose" antipsychotic treatment upon a resident absent a court determination of the resident's decisional capacity in the event of a dispute. Accordingly, section 1418.8—even assuming it is appropriately identified as a *parens patriae* statute—does not contravene the principle identified in *Qawi* when applied to administration of antipsychotics or any other type of medical intervention.

b. This Court in *Rains* Was Aware of the Risks Posed by Antipsychotic Drugs When It Upheld the Constitutionality of Section 1418.8

Petitioners' references to the risks of antipsychotic drugs do not in any way compel a conclusion that an adjudication of decisional incapacity is constitutionally required before antipsychotic drugs may be administered to a resident under section 1418.8. (RB/AOB 41-42.) Both *Washington* and *Keyhea* discussed the risks and potential side effects of antipsychotic drugs, and since this Court in *Rains* discussed and relied upon those cases, this Court already was aware when it decided *Rains* that use of such drugs can involve significant risks. (See *Keyhea*, *supra*, 178 Cal.App.3d at pp. 531-532; *Washington*, *supra*, 494 U.S. at pp. 229-230.) However, this Court determined in *Rains* that despite those risks, treatment under section 1418.8 need not be preceded by an adjudication of the resident's decisional incapacity or the proposed treatment. As the Court stated, quoting from *Washington*: "'Notwithstanding the risks that are involved, we conclude that an inmate's interests are adequately protected, and perhaps better served, by allowing the decision to medicate to be made by a medical professional rather than a judge.'" (*Rains*, *supra*, 32 Cal.App.4th at p. 177, quoting *Washington*, *supra*, 494 U.S. at pp. 231-232.)

Indeed, as the state Supreme Court recognized in *Qawi*, most antipsychotics used now are from "a new generation of antipsychotic drugs, the so-called atypicals," which are "regarded as being more benign and effective" than the class of antipsychotics discussed in *Washington* and *Keyhea*. (*Qawi*, *supra*, 32 Cal.4th at p. 15.) The atypicals also, unlike the previous generation of antipsychotics, can be administered orally rather than by injection. (*Ibid*.) Other commonly used medications, are "much more risky" than antipsychotics, and associated with "many more serious adverse events and deaths." (JA557.)

c. The Cases of Gloria A. and Mark H. Do Not Support Petitioners' Claim

Petitioners' contentions regarding the administration of antipsychotic medication to two individuals, deceased petitioner Gloria A., and to a deceased nursing home resident Mark H., likewise, do not, and cannot, establish that section 1418.8 is unconstitutional as applied to the administration of antipsychotics. (See RB/AOB 42-43.) Indeed, petitioners' evidence fails to establish that these individuals were even administered antipsychotics pursuant to section 1418.8.

Gloria A. was a 62-year old nursing home resident who was administered Seroquel, an "aytipical" antipsychotic. (See JA293). However, the record does not establish that Seroquel was authorized for her pursuant to section 1418.8. (See JA141-142; see also JA394 [noting consent for reduction in Seroquel "obtained by MD"].) As her physician identified, Gloria A.'s cousin apparently acted as her surrogate during her initial stay at the facility. (JA472.) Gloria A. also was given Seroquel "early in her stay." (JA473.) Use of Seroquel was reviewed, as required by regulation, by a consultant pharmacist in March 2013, who noted: "Benefits outweigh risks," and "actively reducing dose" at that time. (JA141.) Petitioners concern regarding a standard warning about use of Seroquel by

"elderly" patients, Gloria A. was just 63 in 2013. (See JA031). By May 2013, her use of Seroquel was discontinued. (JA473; JA137.)

Similarly, the record does not establish that Mark H. was administered Seroquel pursuant to section 1418.8. Mark H., a 62-year old man, was identified as having capacity to consent to treatment upon his admission to a nursing home in April 2012. (JA119.) He signed consent forms for "psychotherapeutic drug use" shortly after his admission, on or about April 26, 2012. (JA127-128.) According to the documentary record, Mark H. was interviewed by a psychiatrist shortly thereafter, on May 1, 2012, who, after determining that Mark H. was communicating adequately, identified that Mark H. had consented ("voted") to discontinue routine administration of Seroquel. (JA131.) However, Mark H. also apparently agreed to continue a prescription for the drug as needed. (*Ibid*.) Almost three months later, on July 20, 2012, an apparently independent "psyche [*sic*] medication review" was conducted, in which it was noted that Mark H. had been on Seroquel, and that dose reductions would be attempted and continue if he remained stable. (JA129.)

On July 24, 2012, a form signed by an IDT, convened under section 1418.8 at his nursing home, reflected that Mark H. had been determined to lack decisional capacity or any person with authority to make health care decisions on his behalf, and "could not be conserved by Placer County Public Guardian." (JA124-125.) Accordingly, an IDT was appointed under section 1418.8. (JA125.) No physician's orders are included in the record, and the record does not identify the IDT as having prescribed an antipsychotic at any time thereafter, or when the Seroquel was discontinued. However, a note in his chart identifies that by December 2012, after he had been placed under hospice care at the facility, he was "not taking any psychotropic medications." (JA121.)

These incomplete documentary "cases," therefore, fail even to demonstrate applications of section 1418.8 to antipsychotic drugs, much less that use of section 1418.8 to authorize antipsychotic drug treatment is constitutionally impermissible.

Petitioners do not dispute that the Department has undertaken focused efforts to curb inappropriate administration of antipsychotic drugs to nursing home residents, including instituting new protocols and heightened scrutiny of antipsychotic use. (See AOB 39-42.) Nor do petitioners dispute that these efforts have substantially reduced unnecessary uses of antipsychotic medications in these facilities. (*Ibid*.) Particularly in light of these new protocols instituted by the Department and its heightened scrutiny of nursing homes' use of antipsychotic medications, petitioners fail to establish that prohibiting their use under section 1418.8 is constitutionally required.

In light of the above, petitioners fail to establish that application of section 1418.8 to authorize treatment of nursing home residents with antipsychotic drugs presents a "clear and unquestionable conflict" with constitutional norms, as required to establish a constitutional violation. (*County of Sonomy v. State Energy Resources Conservation and Development Com.* (1985) 40 Cal.3d 361, 368.) As the Supreme Court stated in *County of Sonoma*: "In considering the constitutionality of a legislative act we presume its validity, resolving all doubts in favor of the Act. Unless conflict with a provision of the state or federal Constitution is clear and unquestionable, we must uphold the Act." (*Ibid*.) For the reasons above, the administration of antipsychotic drugs under section 1418.8 cannot properly be held unconstitutional, and the trial court's determination to the contrary should be reversed.

IV. PETITIONERS FAIL TO IDENTIFY ANY ACTUAL CONTROVERSY INVOLVING AN UNCONSTITUTIONAL APPLICATION OF SECTION 1418.8 BY THE DEPARTMENT; THUS, THE TRIAL COURT'S BROAD RULING REGARDING END-OF-LIFE CARE UNDER THE STATUTE CONSTITUTES AN IMPERMISSIBLE ADVISORY OPINION

As the Director demonstrated in her Opening Brief, petitioners fail to present an actual controversy concerning the constitutionality of section 1418.8 as applied to decisions to withdraw or withhold life-sustaining treatment. Petitioners fail to present competent evidence of unconstitutional uses *of the statute* to make decisions regarding such care on behalf of residents, or to establish that the *Department* has applied or interpreted the statute in a constitutionally impermissible manner. (AOB 46-56.) As petitioners fail to establish essential elements of an "as-applied" constitutional claim, there is no basis for a writ on this issue.

The trial court's ruling does not resolve ay dispute with the Department regarding *its* application of the statute in any actual case or set of circumstances. Rather, the trial court effectively sought to craft rules governing the withdrawal and withholding of life-sustaining treatment under section 1418.8 in *any* circumstance. That part of the trial court's Judgment addressing decisions regarding life-sustaining treatment, therefore, is an improper advisory opinion and should be vacated.

A. Because Petitioners Fail to Establish that the Department Is Improperly Applying Section 1418.8 in Connection with End-of-Life Care, Petitioners Fail to Establish an "As Applied" Challenge

Petitioners fail to support a valid "as applied" challenge regarding the application of section 1418.8 to decisions concerning the withholding or withdrawal of life-sustaining treatment.

As the Director demonstrated in her Opening Brief, petitioners fail to identify any evidence that the Department is applying section 1418.8 in an unconstitutional manner. (AOB 47-51.) Petitioners' contention in response, that an as applied claim "does not require conduct by a defendant" is misguided. (RB/AOB 49.) Even petitioners' own quotation from the leading case on such claims, *Tobe*, *supra*, 9 Cal.4th 1069, makes clear that a petitioner, to support an as applied challenge, must demonstrate the manner or circumstances in which a statute "has been applied." (*Tobe*, *supra*, 9 Cal.4th at p. 1084). Indeed, a petitioner seeking to enjoin future applications of a statute in particular circumstances must show not just isolated instances of such allegedly impermissible applications, but rather "a pattern of impermissible enforcement." (*Id.* at p. 1085.) Necessarily, the applications of the statute must be by the entity *charged with interpreting or enforcing it*. (See *id.* at p. 1089 ["[A]n as applied challenge assumes that the statute … violated is valid and asserts that the manner of enforcement against a particular individual or individuals or the circumstances in which the statute … is applied is unconstitutional."].)

Petitioners, however, fail to identify evidence that the *Department* has engaged in any pattern of interpreting or enforcing the statute in an unconstitutional manner. As the Director demonstrated in her Opening Brief, the anecdotal, conclusory, incomplete, hearsay declarations submitted by petitioners, even if considered by the Court, relate only to alleged conduct by some individual nursing homes. (AOB 48-51.) The only evidence before the Court regarding the Department's application of section 1418.8 in connection with end-of-life care decisions demonstrates that the Department took a position *consistent* with petitioners' views on the limits of the statute when it cited a nursing facility for utilizing section

1418.8 to create and change a resident's Physician Orders for Life-Sustaining Treatment form (POLST). (JA382-388.)[4]

Evidence of allegedly improper uses of section 1418.8 by individual private nursing homes in connection with end-of-life care does not demonstrate that the *statute* is unconstitutional as applied to such decisions. (See *Deutsch v. Masonic Homes of California, Inc.* (2008) 164 Cal.App.4th 748, 761 [delayed filing of sexual abuse claims under statute reviving such claims did not demonstrate statute's unconstitutionality as applied].)

Petitioners, apparently recognizing that they cannot support an "as applied" mandamus claim regarding end-of-life decisions under section 1418.8 in the absence of any evidence of the Department's improper applications of the statute, forward a new argument on appeal—that the Department had a *duty* to take some form of enforcement action (not identified by petitioners) to curb improper uses of the statute by facilities in connection with end-of-life care. (RB/AOB 48-50, 56-58.) Petitioners did not assert this theory below. (See JA052-053, 334-337.) As this argument rests upon disputed facts regarding the Department's awareness of problems requiring any action, it must be deemed waived. (*Richmond v. Dart Industries, Inc.* (1987) 196 Cal.App.3d 869, 879.) In any event, petitioners' new-found theory does not support their "as-applied" claim.

First, even assuming that petitioners demonstrated that the Department was aware of a sufficiently widespread problem with respect to nursing homes' utilization of section 1418.8 in constitutionally impermissible ways in connection with end-of-life care (which it was not),

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[4] A POLST is a type of advance directive to health care providers, signed by the resident while competent or by any legally authorized surrogate decisionmaker, providing instructions regarding whether or not to use or withhold life-sustaining treatment. (*Ibid.*; see Prob. Code, §§ 4780-4786.)

that the Department had a duty to take enforcement action, and that it failed to do so, it would demonstrate only that the Department failed to act. Any such scenario would not demonstrate that section 1418.8 is unconstitutional as applied to decisions regarding withholding or withdrawing life-sustaining treatment.

Such an unpled claim would fail, in any event, even were it before this Court (and it is not). Petitioners do not establish that unconstitutional uses of section 1418.8 by nursing homes to withhold or withdraw life-sustaining treatment are widespread, or that the Department was aware of a need to take any particular measures to curb any such widespread abuses. To the contrary, the only evidence in the record relating to the Department's awareness of an abuse of the statute demonstrates that a district office of the Department *did* take enforcement action against a facility upon determining that the facility had utilized an IDT under section 1418.8 to authorize a change to a resident's POLST. (JA382-388.)

Additionally, petitioners fail to identify any ministerial duty upon the Department, enforceable in mandamus, with respect to enforcement of section 1418.8. Mandamus is available only "to compel the performance of a clear, present, and ministerial duty." (*Schwartz v. Poizner* (2010) 187 Cal.App.4th 592, 596.) However, petitioners cite only Health & Safety Code section 1279, which requires the Department to conduct regular inspections of nursing homes. (RB/AOB 50, 54, 56, 57.) There is no evidence that the Department failed to comply with this duty. The Department has broad discretion in exercising its authority to enforce the laws and regulations governing nursing home care, and to issue regulations as appropriate. (See, e.g., Health & Saf. Code, §§ 1275 [regulations], 1280 [citations], 1294 [suspensions and revocations], 1423-1425 [citations and penalties], 131200 [regulations].)

Nor does it follow that, in light of the inspections carried out by the Department, that it was aware of constitutionally improper uses of section 1418.8 by nursing facilities in connection with end-of-life care. Petitioners imply that the Department would or should have been aware that nursing homes were utilizing the statute to elect hospice care for residents.[5] (RB/AOB 52-53.) But even if true, the trial court's Judgment recognizes that utilizing the statute to provide or initiate hospice care is *not constitutionally* impermissible. (JA855.) Thus, the Department's awareness that nursing homes were utilizing the statute for such referrals would not have triggered any duty to take enforcement action.

B. Because Petitioners Fail to Establish Any Actual Controversy Relating to the Department's Application of Section 1418.8 in Connection with End-of-Life Care, the Trial Court's Judgment Is an Improper Advisory Opinion

Because petitioners fail to "establish that the [statute] has been applied in a constitutionally impermissible manner either to themselves or to others" by the Department, the trial court's Judgment, which seeks to delineate constitutionally permissible and impermissible uses of section 1418.8 in connection with end-of-life care, is an improper advisory opinion. (*Tobe*, *supra*, 9 Cal.4th at p. 1083.) For this reason, as well, the trial court's judgment should be reversed. (See AOB 42-53.)[6]

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[5] As described in further detail, *infra* at Part VIB, hospice care provides individuals certified as having a terminal illness that will cause death within six months with specialized pain management and other care, and social service and spiritual support.

[6] Petitioners' suggestion that the Director waived any argument on this issue by not raising it in its answer to the petition lacks any merit. (RB/AOB 47.) The Director raised the same contention in her opposition to petitioners' motion for a writ, arguing that petitioners' claim relating to end-of-life care decisions "cannot appropriately be determined in the abstract without an actual controversy and distinct set of facts and

(continued…)

A justiciable claim must address a "definite and concrete" controversy. (*Pacific Legal Foundation v. Cal. Coastal Com.* (1982) 33 Cal.3d 158, 171.) Petitioners' claim relating to end-of-life care, however, seeks "only to obtain general guidance, rather than to resolve specific legal disputes." (*Id.* at p. 170.) Petitioners' claims require consideration of a broad range of hypothetical circumstances under which section 1418.8 could be used in connection with decisions to withdraw or withhold life-sustaining treatment—some of which may be constitutionally impermissible, and some of which may not. However, an as-applied challenge "contemplates analysis of the facts of a *particular case or cases* to determine the circumstances in which the statute or ordinance *has been applied* and to consider whether *in those particular circumstances* the application deprived the individual to whom it was applied of a protected right." (*Tobe*, *supra*, 9 Cal.4th at p. 1084, italics added.)

Yet, petitioners' action does not seek to resolve a controversy concerning use of the statute under a particular set of circumstances relating to decisions to withhold or withdraw life-sustaining treatment, but rather to "enjoin any application of the [statute] to any person in any circumstance" in connection with end-of-life care. (*Tobe*, *supra*, 9 Cal.4th at p. 1087.) Petitioners' action seeks an advisory opinion on these issues and should, therefore, be rejected.

Contrary to petitioners' suggestion, the fact that one of the petitioners is a "taxpayer" provides no basis to avoid the rule against advisory opinions. (RB/AOB 49.) Even in actions where petitioners assert standing under the liberal standing rules of a taxpayer action, courts should decline

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(…continued)
circumstances involving a party . . . ." (JA464) In any event, a legal argument is waived on appeal only if not raised in a party's opening brief. (*Lambert v. Carneghi* (2008) 158 Cal.App.4th 1120, 1133.)

to consider actions that are "merely a general challenge to a statute; posed in a vacuum[,]" where "no specific application of the statute is involved." (*Fiske v. Gillespie*, 200 Cal.App.3d 1243, 1245.)

The trial court's ruling regarding the application of section 1418.8 to decisions regarding end-of-life care appears to have been motivated by its concern that "[n]owhere in section 1418.8 does it require the IDT to make a health care decision based on the patient's individual health care instructions." (JA744.) However, the trial court's concern was misplaced because the Health Care Decisions Law explicitly requires that health care providers and institutions comply with a resident's individual health care instructions. (Prob. Code, § 4733, subds. (a), (b).)

Contrary to the trial court's understanding, section 1418.8 itself does require physicians and nursing homes to make decisions in accordance with a resident's instructions or wishes. Physicians and nursing homes are authorized to initiate treatment under the statute only "in accordance with acceptable standards of practice." (§ 1418.8, subd. (d).) Medical standards require that health care providers and facilities act in accordance with a resident's directives or desires. (See *Bouvia v. Superior Court, supra*, 179 Cal.App.3d at pp. 1140-1141.) Moreover, physicians and nursing homes may be subject to administrative sanction if they take action under the statute that is inconsistent with "the desires of the resident[.]" (§ 1418.8, subd. (k).)

If that were not enough, constitutional and other statutory law also require that caregivers carry out a patient's instructions and known wishes regarding their care—including whether to forgo life-sustaining treatment. (See *Bartling v. Superior Court* (1984) 163 Cal.App.3d 186, 195 ["The right of a competent adult patient to refuse medical treatment is a constitutionally guaranteed right which must not be abridged."].)

The trial court also appears to have been motivated by its unsupported conclusion that "petitioners' evidence supports that physicians and IDTs are making end of life decisions without consulting patients and without considering the patient's wishes as to end of life decisions." (JA744.) However, as the Director demonstrated in her Opening Brief, most of the evidence upon which petitioners and the trial court rely does not even relate to decisionmaking under section 1418.8. (AOB 48-51.) None of the evidence identifies improper applications of the statute to withhold or withdraw life-sustaining treatment that have been condoned or authorized by the Department.

The trial court's Judgment recognizes that some applications of section 1418.8 to decisions regarding life-sustaining treatment do not violate constitutional norms. These include decisions that are consistent with a resident's individual health care instructions or known wishes and to provide or initiate hospice care. (JA854-855.) However, petitioners fail to present any actual case or circumstance involving use of the statute in a manner authorized or condoned by the Department that is alleged to violate a residents' constitutional rights. The trial court's effort to fashion a set of rules for use of the statute in the absence of any such dispute constitutes an improper advisory opinion, and the trial court's Judgment addressing these issues should, therefore, be reversed.

RESPONDENT'S BRIEF

If this Court construes the trial court's Judgment as prohibiting any use of section 1418.8, the issues raised by petitioners in their cross-appeal would be superfluous and petitioners would lack standing for their cross-appeal. (See *Nevada County Office of Education v. Riles* (1983) 149 Cal.App.3d 767, 779 [party may not appeal judgment in their favor].) The Director's brief in response to petitioners' Opening Brief, therefore, presumes this Court's agreement that the trial court's ruling does not invalidate or prohibit use of the statute.

Petitioners' cross-appeal first asserts various grounds why section 1418.8 should be held to violate due process. Each of these arguments was directly or implicitly rejected by this Court in *Rains*, as the trial court properly concluded, and petitioners fail to identify any valid basis for revisiting those rulings. Petitioners also urge that this Court reject the exceptions identified in the trial court's Judgment to the general prohibition it establishes on use of section 1418.8 for decisionmaking regarding withholding or withdrawing life-sustaining treatment. Although the Director maintains that the trial court's ruling on these end-of-life care issues should be reversed for the reasons just addressed in Part IV above, if this Court is inclined to affirm that part of the Judgment, the exceptions drawn by the trial court should be preserved. Removing these exceptions would deny terminally ill residents legally protected rights to receive humane treatment at the end of life through hospice care, and to have their instructions and wishes regarding the use or forbearance of life-sustaining treatment carried out by their caregivers. For these reasons, as set forth below, petitioners' cross-appeal should be denied in its entirety.

V. THIS COURT IN *RAINS* PROPERLY HELD THAT THE ADDITIONAL PROCEDURES URGED BY PETITIONERS ARE NOT CONSTITUTIONALLY REQUIRED, AND PETITIONERS FAIL TO ESTABLISH ANY BASIS TO REVISIT *RAINS* WITH RESPECT TO THOSE CLAIMS

This Court in *Rains* expressly rejected petitioners' claims, reasserted here, that section 1418.8 denies due process or privacy rights because it allows treating physicians to determine a resident's decisional incapacity, without necessity of a judicial or quasi-judicial hearing and an appointed representative, and allows physicians to participate on the IDT. Petitioners fail to justify their attempt to re-litigate these issues already twice decided against them by this Court.[7] The trial court properly determined that these claims are precluded by this Court's holding in *Rains*, and its conclusion should be affirmed. (JA721-724.)

A. *Rains* Established that Section 1418.8 Does Not Violate Due Process or Privacy Rights Even Though It Does Not Require a Hearing to Determine Incapacity

This Court could not have been clearer in *Rains* in rejecting the argument that section 1418.8 violates due process or privacy rights because it allows physicians to determine decisional incapacity, without opportunity for a judicial or quasi judicial hearing. As this Court held: "Nursing home patients are not denied due process because their incapacity to give consent to medical intervention is initially determined by a physician and surgeon, rather than by a judicial or quasi-judicial hearing. (*Rains*, *supra*, 32 Cal.App.4th at p. 182.)

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[7] Prior to *Rains*, this Court rejected an original writ petition seeking to "invalidate section 1418.8 on constitutional grounds." (*Rains*, 32 Cal.App.4th at p. 165 [noting denial of petition in Case No. A060010]; see also MJN, Exh. P [containing petition in action].)

The Court similarly rejected petitioner Rains' claim that the procedures under section 1418.8 violate residents' rights of autonomy protected by the right to privacy. The Court noted that "it is far from clear" that a judicial hearing regarding a resident's incapacity "would result in better and more timely medical care to nursing home patients," or that "this alternative would be any more sensitive to privacy rights[.]" (*Rains*, *supra*, 32 Cal.App.4th at pp. 176-177.) As the Court concluded, the balance of interests—including residents' reasonable expectations of privacy, the seriousness of the invasion of their privacy interests, and the necessity of ensuring timely treatment of incapacitated and unbefriended nursing home residents—"does not support invalidation of section 1418.8" on privacy grounds. (*Id.* at p. 177.)

Petitioners provide no justification for this Court to re-examine its prior decision.

B. Petitioners Fail to Provide Any Special Justification to Revisit or Overrule this Court's Holdings in *Rains*

1. Post-*Rains* Decisions Do Not Provide Any Basis to Revisit *Rains*

Petitioners do not provide any basis for this Court to reopen and overrule its determination in *Rains* that adversarial hearings, preceded by written notice, on the physicians' determination of incapacity are not constitutionally required. Petitioners must establish some "special justification" for this Court to overrule its own precedent. (*Fashion Valley Mall, LLC v. N.L.R.B.* (2007) 42 Cal.4th 850, 877; see also *Bourhis v. Lord* (2013) 56 Cal.4th 320, 327 [requiring "good reason" to overturn precedent].) "Special justification" requires more than "the belief 'that the precedent was wrongly decided.'" (*Kimble v. Marvel Entertainment, LLC* (2015) 135 S.Ct. 2401, 2409, citation omitted.) However, petitioners

largely contend only that *Rains* is flawed, and fail to identify any other justification to warrant this Court revisiting its decision.

Apart from criticizing this Court's decision in *Rains*, petitioners principally rely on unsupported statements—mischaracterized as "holdings"—in two cases decided since *Rains* to support their argument that 1418.8 violates due process and privacy rights by not requiring a judicial determination of incapacity. (See RB/AOB 63-67.) However, the statements in these decisions provide no basis to revisit, much less overrule, this Court's holding in *Rains*.

Petitioners first suggest, erroneously, that *Conservatorship of Wendland* (2001) 26 Cal.4th 519 (*Wendland*) holds that a judicial determination of incapacity is required "to effectuate the state's *parens patriae* interest in treating persons without their consent." (RB/AOB 64.) But *Wendland* did not so hold.

In *Wendland*, the Court considered whether a conservator, granted authority pursuant to Probate Code section 2355 to make health care decisions for a conservatee, could withhold artificial nutrition and hydration from a conscious conservatee who is not terminally ill, comatose, or in a persistent vegetative state, in the absence of formal instructions for health care or an appointed agent or surrogate, and if so, under what circumstances. (*Wendland*, *supra*, 26 Cal.4th at pp. 523-526.) In the course of the Court's analysis of background principles, the Court contrasted laws that give effect to health care decisions made by competent persons, with decisions by *conservators*, which the Court asserted "typically derive their authority . . . from the *parens patriae* power of the state to protect incompetent persons." (*Id.* at pp. 535.) Then, in the language upon which petitioners rely, the Court stated that a conservator "is appointed by the court because the conservatee 'has been adjudicated to

lack the capacity to make health care decisions.'" (*Ibid*., quoting Prob. Code, § 2355, subd. (a).)

This statement is not a holding regarding all the circumstances under which *parens patriae* powers may be exercised, nor a holding of any kind. (Nor, with due respect to the Supreme Court, does it appear to be entirely accurate.)[8] Rather, the *Wendland* Court's statement merely reflects the capacity determination necessary to support a conservator's authority to make health care decisions for a conservatee pursuant to Probate Code section 2355, subdivision (a).

But even the conservatorship statutes themselves do not limit a conservator's health care decisionmaking authority to those circumstances where the conservatee has been adjudicated as lacking decisional capacity. Under Probate Code section 2354, even where there has been no such determination, a conservator may give consent to the conservatee's medical treatment, unless the conservatee objects, and may give consent for emergency treatment even *if the conservatee does not consent*. (Prob. Code, § 2354, subds. (a), (c).)

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[8] A conservator of the person is appointed not based on their capacity to make health care decisions, but rather based on an individual's *inability to care for themselves*—specifically, a determination that the person is "unable to provide properly for his or her personal needs for physical health, food, clothing, or shelter." (Prob. Code, § 1801, subd. (a).) Under the Probate Code, whether a person has, or lacks, capacity to give informed consent to *medical treatment* is a distinct issue: thus, a conservatee may or may not be determined also to lack capacity to consent to medical treatment. (*Id*., §§ 2354 [treatment of conservatee not adjudicated to lack capacity to give informed consent], 2355 [treatment of conservatee adjudicated to lack decisional capacity].) Thus, contrary to the *Wendland* Court's statement, a conservator of the person may be appointed without the individual having been judicially determined to lack capacity to consent to medical treatment.

Indeed, in circumstances closely analogous to those addressed by section 1418.8, state law gives even broader authority to private caregivers to consent to treatment for persons with developmental disabilities who lack any authorized representative, without those individuals having been adjudicated to lack decisional capacity. Many developmentally disabled individuals receive care through private nonprofit facilities known as "regional centers," which contract with the State to coordinate services and supports for such persons. (See Welf. & Inst. Code, § 4620.) The director of a regional center, or his or her designee, may consent to medical treatment of persons under their care if the person "has no parent, guardian, or conservator legally authorized to consent to medical, dental, or surgical treatment on behalf of the person," and as to any developmentally disabled adult, if the person is "mentally incapable of giving his own consent." (Welf. & Inst. Code, § 4655, subds. (a), (b).) No adjudication or court order regarding such incapacity is required. (See *ibid*.)

Moreover, as the Director demonstrated in her Opening Brief, other statutes similarly recognize that an individual's right to make decisions about their own health care may be transferred to surrogates upon a physician's determination that the individual lacks capacity to give or refuse consent. (See AOB 25-26, citing Prob. Code, § 4658 & Health & Saf. Code, § 1599.3.) These statutes evidence this Court's recognition in *Rains* that the right of an individual deemed by a physician to lack capacity for informed consent is not "absolute and inflexible," as such a rule "would lead to unacceptable neglect of the medical needs of incompetent persons." (*Rains*, *supra*, 32 Cal.App.4th at p. 172.)

Section 1418.8, therefore, is just one of a number of statutes that, in balancing the individual rights of autonomy with the public interest in ensuring that incapacitated persons may have critical medical treatment decisions made on their behalf, allow such decisions to be made for persons

deemed by a physician to lack decisional capacity, without requiring an adjudication absent any dispute. To the extent these statutes are premised upon the state's *parens patriae* interests, reading *Wendland* as petitioners urge, would require invalidation of these procedures, and flood the courts with petitions for determinations of incapacity in a broad range of circumstances. Any such result would be directly contrary to the Legislature's admonition 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, subd. (c).)

Finally, *Wendland* cannot be read as petitioners claim because *Wendland* specifically cited *Rains* in recognizing the right of privacy as a source of the right of a competent adult to refuse medical treatment. (*Wendland*, *supra*, 26 Cal. 4th at p. 532.) Had the high Court believed *Rains* contradicted anything in its decision, it presumably would have said so.

As the above demonstrates, *Wendland* did not, as petitioners claim, hold that an adjudication of health care decisionmaking capacity is required before the state's *parens patriae* powers may be invoked.

Petitioners' reliance on dicta in *Qawi*, *supra*, 32 Cal.4th at pp. 15-16, is similarly misplaced. In *Qawi*, the court addressed the extent to which the Mentally Disordered Offender Act may be construed to allow an MDO committed to state custody to refuse antispsychotic medication absent a judicial determination of incapacity. (32 Cal.4th at p. 9.) As background to its interpretation of the statutory rights at issue, the Supreme Court examined rights under the state Constitution, common law, and other state law relating to the right to refuse antipsychotic medication. (*Id.* at pp. 14-27.) Petitioners rely on one sentence, made in the context of this overview, in which the Court—citing the passages in *Wendland* discussed above as

the sole, indirect, support—stated as petitioners assert here that in California, *parens patriae* may be used "only to impose unwanted medical treatment on an adult when that adult has been adjudged incompetent." (RB/AOB 54, citing *Qawi*, *supra*, 32 Cal.4th at pp. 15-16.) This statement, however, cannot be interpreted to implicitly overrule of *Rains*, for several reasons.

As an initial matter, the Court's statement in *Qawi* was unnecessary to the decision as the decision rested not on its discussion of the constitutional underpinning of the *statutory* rights addressed there, but rather on its interpretation of the statutory rights of MDOs to refuse antipsychotic medication, particularly in relation to rights granted under other civil commitment statutes. As the court's statement was not necessary to its decision, it was therefore dicta. (See *Qawi*, *supra*, 32 Cal.4th at pp. 9-10, 21-28; see also *id.* at 30 [dis. Opn. of Brown, J. [noting majority's "free-ranging and circuitous foray well outside the designated confines" of statutory rights referenced in the MDO statute].)

As in *Wendland*, whether an adjudication of incapacity is constitutionally necessary for assertion of *parens patriae* authority over an individual's health care decisions was neither raised nor decided in *Qawi*. As petitioners themselves argue, a judicial decision stands only for propositions "actually passed upon by the Court." (*Hart v. Burnett* (1860) 15 Cal. 530, 598; see *Cobb v. University of So. California* (1995) 32 Cal.App.4th 798, 803 ["Decisions of our Supreme Court are not controlling authority for propositions not considered therein."].)

Further, the statement in *Qawi* does not reflect "compelling logic" and need not be accorded any persuasive authority. (*Gogri v. Jack In The Box, Inc.* (2008) 166 Cal.App.4th 255, 272, internal quotations omitted.) The Court's statement is preceded by no reasoning, cites as support only the inaccurate statement in *Wendland* relating to the basis for a *conservator's*

authority for health care decisionmaking under Probate Code section 2355, and arises in what this Court identified as the "very different statutory context" of persons involuntarily committed to a state institution. (*Rains*, *supra*, 32 Cal.App.4th at p. 170; see *Qawi*, *supra*, 32 Cal.4th at p. 15-16.) Where, as here, a statement by the Supreme Court is only a "passing reference" that was "not intended to be an authoritative statement of the rule in California[,]" this Court need not follow it. (*Simons v. Young* (1979) 93 Cal.App.3d 170, 188.)

Petitioners' reliance on *Qawi's* quotation from *Riese*, in which the court agreed with a psychiatrist that the determination of "competence" is not "'a clinical, medical, or psychiatric concept,'" but rather "'relates to the world of law,'" likewise does not provide any basis to revisit *Rains*. (*Qawi*, *supra*, 32 Cal.4th 1, quoting *Riese*, *supra*, 209 Cal.App.3d at p. 1321; see RB/AOB 34-35.) First, the quotation from *Riese* is inapposite as it relates to the broad concept of competence not only as to medical decisionmaking, but also as to an individual's "'rights (and obligations) relating to person, property and relationships.'" (*Riese*, *supra*, 209 Cal.App.3d at p. 1321.) A physician's capacity determination under section 1418.8 is much narrower, and relates solely to the capacity to make decisions regarding health care. (§ 1418.8, subd. (b).)

Moreover, *Riese* was decided prior to *Rains*, and this Court in *Rains* was aware of and specifically distinguished *Riese* as involving a "very different statutory setting." (*Rains*, *supra*, 32 Cal.App.4th at p. 170.) Both *Riese* and *Qawi* addressed *statutory* rights to a judicial determination of incapacity, and therefore neither addressed nor resolved whether a judicial determination of decisional incapacity is constitutionally required, particularly outside of the context of involuntarily commitment involved in those decisions. On the issue of determining a nursing home resident's decisional capacity under section 1418.8, this Court concluded in *Rains* that

the determination is a "medical decision," and does not require a judicial or quasi-judicial hearing, notwithstanding the Court's awareness of *Riese*. (*Rains*, *supra*, 32 Cal.App.4th at pp. 179-182.) *Qawi's* "passing reference" to the quotation from *Riese*, therefore, also cannot be taken as "an authoritative statement of the rule in California[.]" (*Simons v. Young*, *supra*, 93 Cal.App.3d at p. 188.) The statement in *Qawi*, therefore, also does not provide any basis to revisit this Court's holding in *Rains*.

Petitioners fail to establish that *Rains* has been called into question or overruled by any subsequent authority, and therefore fail to establish any basis for revisiting *Rains*' conclusion that a judicial adjudication of incapacity is not required to utilize section 1418.8.

2. This Court in *Rains* Considered and Rejected the Claim that the Possibility of Medical Error Requires Adjudications of Incapacity

Petitioners' conclusory, hearsay declarations by non-physicians, and speculation that physicians may disagree or even err in assessing decisional capacity, likewise fail to support any re-examination of this Court's holdings in *Rains*. (See RB/AOB 20-21; JA721-724.)

This Court in *Rains* expressly rejected the notion that "'the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing.'" (*Rains*, *supra*, 32 Cal.App.4th at p. 185, quoting *Parham v. J.R.* (1979) 442 U.S. 584, 609.) As the Court continued, "'[c]ommon human experience and scholarly opinions suggest that the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions . . . may well be more illusory than real.'" (*Ibid*.)

Additionally, courts have repeatedly affirmed that the requirements of due process cannot be determined by the risk of error in borderline or

unusual cases. As the United States Supreme Court noted in the seminal case, *Mathews v. Eldridge* (1976) 424 U.S. 319, 344 (*Mathews*), "procedural due process rules are shaped by the risk of error inherent in the truthfinding process as applied to *the generality of cases*, not the rare exceptions." (Italics added.)

Moreover, as the Court determined in *Mathews*, the necessity of adjudicatory hearings is substantially diminished where the issue turns upon medical judgment. In *Mathews*, the Supreme Court concluded that evidentiary hearings prior to termination of disability benefits were not required, noting that such determinations typically turned upon "'routine, standard, and unbiased medical reports by physician specialists,' [citation] concerning a subject whom they have personally examined." (*Mathews, supra*, 424 U.S. at p. 344.) In that context, the Court noted, "the potential value of an evidentiary hearing, or even oral presentation to the decisionmaker" is "substantially less" than in contexts where disputed factual issues beyond medical judgment are involved. (*Id.* at pp. 344-345.)

And finally, irrespective of the above, petitioners fail to provide any competent evidence demonstrating that errors regularly occur with respect to capacity determinations. Petitioners did not present any expert testimony by a physician or other witness qualified to testify regarding the instances of error in incapacity determinations under section 1418.8. The conclusory, incomplete, hearsay testimony of long-term care ombudsmen cited by petitioners does not support any claim that any physician improperly assessed a resident's capacity to give informed consent before utilizing section 1418.8. (See RB/AOB 20-22.)

For the reasons above, petitioners fail to provide any sufficient basis to revisit this Court's conclusion in *Rains* that residents "are not denied due process because their incapacity to give consent to medical intervention is initially determined by a physician and surgeon, rather than by a judicial or

quasi-judicial hearing." (*Rains*, *supra*, 32 Cal.App.4th at p. 182.) Petitioners' claims that such adjudications of incapacity are required by due process, therefore, should be rejected. (See RB/AOB 60-68).

Because no hearing is required, as this Court concluded in *Rains*, petitioners' additional contention, dependent upon the existence of an adjudication of incapacity, that a patient advocate is required by due process at any such hearing, also must be rejected. (See RB/AOB 69-71.)

C. *Rains* Correctly Rejected the Argument that the Attending Physician's Participation in the IDT Review Violates Due Process

As the trial court properly recognized, petitioners' argument that section 1418.8 violates due process because it allows a physician to "decide treatment" as part of the IDT's review also was rejected by this Court in *Rains*. (RB/AOB 71-72; JA724.) Petitioners offer no basis to revisit this issue.

This Court in *Rains* rejected petitioner Rain's suggestion that physicians "will abuse their powers and subject patients to unnecessary procedures under section 1418.8." (*Rains*, *supra*, 32 Cal.App.4th at p. 183, fn. 6.) The Court noted that any such conduct could be contrary to the "prevailing ethics of the medical profession and ignores the need for participation by a patient representative under the statute." (*Ibid.*) Indeed, other members of the IDT, also subject to professional standards to act in the patients' best interests, serve on the IDT, and decisions to authorize treatment prescribed by the physician must be made based on a "team approach." (§ 1418.8, subd. (e).) Thus, a physician lacks authority to authorize treatment on his or her own under the IDT review.

The physician's participation, rather simply ensures that the physician may engage in a dialogue with the other members of the IDT regarding the

resident's condition, the reasons for the proposed treatment, and the potential risks and alternatives.

Moreover, as the Court noted in *Rains*, the IDT's actions also are subject to judicial review. As the Court concluded, even though the IDT *"would also often include the physician who had initially prescribed the treatment* under review," the IDT's decision is subject to review by a neutral decisionmaker if the patient, his or her representative, or any other party authorized to act on the resident's behalf seeks judicial review of the team's decision. (*Rains*, *supra*, 32 Cal.App.4th at p. 186, italics added.) As noted above, residents are entitled to a judicial determination of their decisional incapacity in the event of any dispute over the physician's determination. (Cal. Code Regs., tit. 22, § 72527, subd. (c).)

Petitioners' reference to several pre-*Rains* decisions provides no basis to revisit this Court's holding in *Rains* on this point. (See RB/AOB at p. 72.) The cases cited by petitioners each involve decisionmaker neutrality in the context of judicial or quasi-judicial hearings. The IDT review of the physician's assessment of the resident's condition and proposed treatment under section 1418.8 are not hearings or adjudications. Indeed, this Court *relied* in *Rains* on two of the decisions cited by petitioners in reaching its conclusions that the procedures under section 1418.8 do not violate due process rights. (*Rains*, *supra*, 32 Cal.App.4th at pp. 180, 184, 186, 187 [citing *Washington v. Harper*, *supra*, 494 U.S. at pp. 222, fn. 8, 231-232, 235], and 185 [citing *Goldberg v. Kelly* (1970) 397 U.S. 254, 258-261].)

Petitioners' contention that section 1418.8 violates due process because a neutral decisionmaker is not required for the IDT's review of the prescribed treatment, therefore, should also be rejected.

D. Section 1418.8 Comports with Due Process, if Applicable, Because Residents' Rights Are Adequately Safeguarded

Petitioners' arguments that section 1418.8 denies due process on the grounds previously rejected by the trial court also fail because due process rights do not attach under section 1418.8, and even if applicable, are not violated by the absence of the various procedural elements identified by petitioners.

For reasons addressed in Part I(B) *supra*, section 1418.8 does not threaten to deprive residents of any statutory rights, does not involve state action, and does not involve an adjudication regarding statutorily-protected interests, as required to invoke the protections of procedural due process under the state Constitution. Even if procedural due process rights properly attach, for reasons addressed in Part I(C), *supra*, and in the Director's Opening Brief, pp. 28-31, section 1418.8 comports with due process. Probate Code section 4732 and provisions of the Patients' Bill of Rights require that residents receive notice of the physician's determinations of decisional incapacity, of their rights to raise complaints and objections to decisions regarding their care, and regarding how to obtain assistance in asserting their rights.

Requiring formal written notice, and an adjudication of incapacity even where the resident does not dispute the physician's determinations or proposed treatment, would provide no additional benefit to residents, and would, as this Court already noted in *Rains*, conflict with the Legislature's intent in providing an alternative to judicial procedures for obtaining authorization for treatment of incapacitated and unbefriended nursing home residents. Requiring adjudications of incapacity contrary to the Legislature's express intent would result in "gridlock" that would "serve no one's interests—least of all, those of the patients whose medical care would

be necessarily delayed." (*Rains*, *supra*, 32 Cal.App.4th at p. 184.) Thus, section 1418.8 comports with due process. (*Id.* at p. 187.)[9]

VI. IF THIS COURT AFFIRMS THAT PART OF THE JUDGMENT ADDRESSING END-OF-LIFE CARE, THE EXCEPTIONS PERMITTING HOSPICE REFERRALS AND DECISIONS CONSISTENT WITH THE RESIDENT'S INSTRUCTIONS AND WISHES SHOULD BE PRESERVED

For the reasons set out at Part IV, *supra*, the Court should vacate and reverse the advisory opinion contained in the court's Judgment addressing end-of-life care decisionmaking under section 1418.8. However, were the Court to affirm that part of the Judgment, the form of Judgment as adopted by the trial court should be preserved. The form of the Judgment was the product of significant input and debate by the parties and interveners below, and ensure that residents' rights to hospice care and to direct their future care after losing decisional capacity are not infringed. (See JA749-851.)

Although the trial court's Judgment broadly declares that use of section 1418.8 is prohibited to make decisions "regarding the withholding or withdrawal of life-sustaining treatment," the court excepted from this prohibition:

1) Decisions that are "consistent with the resident's individual health care instructions, if any, and other wishes, to the extent known;" and

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[9] Petitioners' argument at pages 72-75 of their Opening Brief asserts, incorrectly, that a statement in the trial court's order granting the petition improperly expands the scope of IDT review under section 1418.8. This argument does not address any adverse ruling, and indeed attacks language in a part of the order favorable to petitioners. Therefore, it is not a proper argument for review. (See *Marich v. MGM/UA Telecommunications, Inc.* (2003) 113 Cal.App.4th 415, 431 [comments by trial court are not rulings reviewable on appeal; ruling in appellant's favor may not be challenged].)

2) Decisions to "provide or initiate hospice or comfort care to a resident, unless inconsistent with the resident's individual health care instructions, if any, and other wishes, to the extent known, or if such care would not be in the resident's best interest."

(JA854-855, § III(A), (A)(3).)

Petitioners' challenges to these exceptions are misguided and unsupported by law. Contrary to petitioners' contentions, nothing in section 1418.8 or any other authority precludes applying the statute to decisions regarding the withholding or withdrawal of life-sustaining treatment. Further, removing the exceptions, as petitioners urge, would violate residents' legally protected rights to obtain hospice care and to have their own instructions and wishes regarding treatment carried out. Barring any use of section 1418.8 for decisions regarding life-sustaining treatment would cause unnecessary pain, distress, and hospitalization for many terminally ill, unbefriended residents.

1. Section 1418.8 Does Not Preclude Appropriate End-of-Life Care Decisionmaking

Section 1418.8 does not, contrary to petitioners' argument, preclude decisionmaking regarding end-of-life care under any or all circumstances.

As the trial court recognized, a statute authorizing a surrogate to consent to medical treatment "by necessary implication" also authorizes the surrogate to "withhold or withdraw consent to medical treatment under appropriate circumstances." (*Conservatorship of Drabick* (1988) 200 Cal.App.3d 185, 200 (*Drabick*); see JA740, 854-855.) Section 1418.8, in providing authority to initiate any medical intervention, therefore, necessarily implies decisionmaking authority regarding the withholding or withdrawal of a medical intervention under appropriate circumstances. If construed otherwise, nursing homes could be required to impose unwanted life-sustaining measures on incapacitated and unrepresented residents,

contrary to a resident's express instructions, unless or until a court order is obtained.

The Legislature intended that section 1418.8 be applied broadly to ensure that unbefriended nursing home residents lacking decisional capacity have substituted surrogate decisionmakers "to the greatest extent possible" for any "health care decision," and did not exclude any particular types of decisions or medical interventions from its purview. (See Stats. 1992, ch. 1303, §§ 1-3, pp. 6326-6327, at MJN, Exh. D.) A "health care decision" under the state Health Care Decisions Law is defined to include: "Directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation." (Prob. Code, § 4617, subd. (c).)

Petitioners' assertion that a reference to "day to day medical treatment decisions" in the Legislature's findings *limits* section 1418.8 to "routine" health care decisions mischaracterizes the Legislature's statement. In that part of its findings, the Legislature identified the need for section 1418.8 in light of the fact that Probate Code procedures were cumbersome and sometimes unavailable for use "*in situations in which* day-to-day medical treatment decisions must be made on an on-going basis." (Stats. 1992, ch. 1303, § 1(b), p. 6327, at MJN, Exh. D, italics added.) Thus, the Legislature was merely reflecting circumstances for which Probate Code procedures are inadequate. Particularly in light of its intent that section 1418.8 be available "to the greatest extent possible," petitioners' interpretation of this language lacks any basis.

There is similarly no merit to petitioners' contention that the statement in *Rains* that section 1418.8 applies only to treatments "which may be afforded by physicians in nursing homes" precludes decisionmaking under section 1418.8 regarding end-of-life care. For the reasons discussed in Part II(B), *supra*, the Court appears to have intended to

reflect only that section 1418.8 addresses medical interventions prescribed by a resident's "attending physician and surgeon," and therefore may not apply to interventions ordered, for example, by other specialists at a hospital or acute care facility. (§ 1418.8, subds. (a), (e).) Attending physicians for nursing home residents are routinely faced with issues regarding whether a terminally ill, incapacitated, and unbefriended patient should receive the benefits of hospice care in their remaining days, or whether the circumstances addressed in a resident's instructions or known wishes regarding life-sustaining treatment are met and should be carried out.

2. If Affirmed, the Judgment Must Permit Referral to Hospice Under Section 1418.8

The trial court's Judgment appropriately recognizes that nursing home residents should not be deprived of their rights to receive hospice benefits solely because they lack decisional capacity and have no authorized surrogate decisionmaker. Disallowing a hospice election under section 1418.8, as petitioners urge, would deprive terminally-ill residents of rights to receive the specialized care and social service support provided through hospice. Such a result would subject residents to invasive procedures, unnecessary pain, and transfers to acute care facilities, including residents who before losing decisional capacity provided instructions that life-sustaining measures not be utilized. No law requires such a result.

a. Hospice Care and Entitlement to Hospice

Hospice care is designed to support the physical and emotional comfort of terminally ill patients after treatment for their terminal condition is no longer believed to be effective or appropriate. (Medicare Program; Hospice Care (48 Fed.Reg. 56008, 56008 (Dec. 16, 1983)); Cal. Code Regs., tit. 28, § 1300.68.2.) Hospice is described as "an approach to treatment that recognizes that the impending death of an individual

warrants a change in focus from curative care to palliative care." (48 Fed.Reg., *supra*, at p. 56008.) "Palliative care" is defined as "patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering," and that addresses a patient's "physical, intellectual, emotional, social, and spiritual needs." (42 C.F.R. § 418.3.)

Eligibility for hospice generally requires that a physician determine that an individual has a "terminal illness," meaning a life expectancy of six months or less if the illness runs its course. (42 C.F.R. § 418.22; Cal. Code Regs., tit. 22, § 51349, subd. (c).)

Hospice uses an interdisciplinary team approach to deliver "medical, social, psychological, emotional, and spiritual services through use of a broad spectrum of professional and other care-givers with the goal of making the individual as physically and emotionally comfortable as possible." (48 Fed.Reg., *supra*, at p. 56008; see also Cal. Code Regs., tit. 28, § 1300.68.2.) And, contrary to petitioners' suggestion that hospice requires transfer to a separate hospice facility, the goal of hospice is to enable terminally ill individuals to "continue life with minimal disruption in normal activities while remaining primarily in the home environment." (48 Fed.Reg., *supra*, at p. 56008; see also Cal. Code Regs., tit. 28, § 1300.68.2, subd. (a)(2)(G) [requiring services in enrollee's "home or primary place of residence" to the extent appropriate].) Individuals unable to remain at home may, and regularly do, receive such care in nursing homes. (See JA766.)

Terminally ill residents are eligible to receive hospice care as a benefit under the federal Medicare program, and if eligible for Medi-Cal, under that program as well. (42 U.S.C. § 1395d(a)(4); 42 C.F.R. § 418.20; Welf. & Inst. Code, §§ 14132, subd. (w) & 14132.75; Cal. Code Regs., tit. 22, § 51349, subds. (a), (c).) Hospice care under Medicare and Medi Cal may be initiated by an eligible resident, or by a representative of the resident, by

signing a hospice "election statement" that acknowledges, among other things, the individual or representative's understanding of the nature of hospice care and that services to address the terminal condition are waived. (42 C.F.R. § 418.24; Cal. Code Regs., tit. 22, § 51349, subd. (d).)

Additionally, private health plans in the state are required to cover hospice services. (Cal. Code Regs., tit. 28, § 1300.67.)

b. The Trial Court Appropriately Preserved Hospice Elections Under Section 1418.8

After the trial court issued its order granting the petition, in part, the Director, and intervener California Association of Health Facilities (CAHF), urged that hospice be excepted from the court's general ruling prohibiting section 1418.8's application to decisions regarding life-sustaining treatment. (JA764-768, 802, 818-819.) As the Director and CAHF argued, preventing unrepresented residents determined to lack decisional capacity from having the opportunity to receive hospice care would be inhumane and deprive them of benefits to which such residents are entitled by law. (JA764-768, 818.)

The trial court included an exception in the Judgment, similar to that proposed by the Director, permitting section 1418.8 to be utilized to authorize hospice or comfort care unless it would be "inconsistent with the resident's individual health care instructions, if any, and other wishes, to the extent known, or if such care would not be in the resident's best interest." (JA855; see also JA802.)

c. Hospice Elections Under Section 1418.8 Are Consistent with Applicable Law and Constitutional Rights

Petitioners would deprive residents of the opportunity to receive hospice care, contending that section 1418.8 and federal Medicare regulations do not permit an IDT to consent to hospice on behalf of an

unbefriended resident determined to lack decisionmaking capacity. However, neither section 1418.8 nor Medicare regulations bar consent to a hospice election by an IDT acting in accordance with section 1418.8.

Petitioners' contention that section 1418.8 does not permit a hospice election because the statute is limited to only "day-to-day curative treatment" lacks any merit. (RB/AOB 86.) Nothing in section 1418.8 bars its application to decisions to utilize palliative care, and an election to utilize hospice care—which includes "nursing care," "physician's services," "medical appliances and supplies, including drugs and biological," and other health services—is as much a medical intervention as "curative" care. (42 C.F.R. § 418.202.) Additionally, hospice care is, in fact, provided on a "day-to-day" basis in nursing homes. A nursing home association estimates that just among those residents covered by section 1418.8, approximately 15% "currently receive hospice or palliative care through the section 1418.8 process." (JA766.)

Petitioners' suggestion that unbefriended and incapacitated residents are not entitled to hospice as a Medicare benefit is misguided. (RB/AOB 88.) The Medicare regulations are designed to *allow* a surrogate to elect hospice on behalf of a patient so long as the representative has authority to do so "under State law (whether by statute or pursuant to an appointment by the court of the State)." (42 C.F.R. §§ 418.3, 418.24(a)(1).) Nothing suggests that the regulations were designed to establish that *only* individuals may elect hospice on behalf of an incapacitated person. Rather, the agency's intent appears to have been to *enable* a representative to make a hospice election so long as the surrogacy relationship is authorized under state law. (See 48 Fed.Reg., *supra*, at p. 56010 [providing for election through representative to "assure access to hospice services by all individuals who need them"].) Section 1418.8 provides such authority under California law for the IDT to provide substituted consent for any

medical intervention, including a hospice election, on behalf of an incapacitated and unbefriended nursing home resident.

Use of section 1418.8 to authorize hospice does not constitute an "egregious breach of the social norms underlying the privacy right," the standard necessary to establish a violation of the right to privacy. (*Rains*, *supra*, 32 Cal.App.4th at p. 177.) Hospice referrals require a physician's independent medical determination that curative care will no longer be effective against a terminal illness. (42 C.F.R. § 418.22; 22 Cal. Code Regs. § 51349, subd. (c).) A hospice election, therefore, represents a determination that a change in the focus of treatment to palliative care is warranted to ensure a resident's comfort and support in the final stage of life. (See 48 Fed.Reg., *supra*, at p. 56008.) Allowing such decisions to be made on behalf of incapacitated residents who lack any person to make such decisions on their behalf, and consistent with the resident's instructions or known wishes, is humane rather than a breach of social norms underlying the right of privacy.

Petitioners' contentions that a resident will have no opportunity for a hearing and be deprived of other procedural rights in connection with a hospice election under section 1418.8 is incorrect, for the reasons discussed *supra*, at Part I(C). As identified there, residents are entitled to a hearing if they dispute the determination that they lack capacity to elect hospice, and as this Court noted in *Rains*, may also seek judicial review of the physician's or IDT's determinations. (Cal. Code Regs., tit. 22, § 72527, subd. (c); *Rains*, *supra*, 32 Cal.App.4th at pp. 185-186 & fn. 7, citing § 1418.8, subd. (j).)

Petitioners claim of instances of "error" with respect to diagnoses of terminal illness are premised upon multiple layers of hearsay and lack any foundation. (See RB/AOB 51-52, 90.) These alleged instances, in any

event, provide no basis to call into question the constitutionality of hospice elections under section 1418.8.

Likewise, the record as to Mark H. does not call into question the constitutionality of hospice referrals under section 1418.8. As the incomplete documents in the record indicate, Mark H. was 62 years old when admitted to a nursing home after having suffered traumatic brain injury and a severe wound in an auto accident, which among other things required amputations of both his legs above the knee. (See JA076, 119, 129.) He also was reported as having been homeless, and to be suffering from multiple additional health conditions including "peripheral vascular disease, encephalopathy, convulsions, hypertension, and dysphagia requiring G-tube." (JA076, 115.)

Upon his admission to the nursing home in April 2012, Mark H. was identified as having capacity to execute the admission agreement. (JA119.) However, several months after his admission, he was determined to lack capacity to consent to treatment and any surrogate decisionmaker, and an IDT was constituted under section 1418.8. (See JA124-125.) Prior to doing so, the nursing home apparently had attempted to have a conservator appointed on his behalf, but the IDT identified that he "could not be conserved by Placer Co. Public Guardian." (JA124, 129.) After multiple hospitalizations during which physicians attempted to treat his severe wound, the hospital refused to admit him for further treatment. (JA077, 116.) Antibiotics also failed to control infection of his wound. (JA116.) Reportedly at the recommendation of hospital staff, the IDT was then convened in December 2012, including a patient representative from the long-term care ombudsman's office, to review whether a hospice referral was appropriate. (*Id.*) There is no indication that Mark H. left advance instructions regarding end-of-life care, or that his wishes regarding such care were known.

The IDT reviewed Mark H.'s condition and interviewed him, along with the Ombudsman, to determine his desires regarding the hospice election and his health care instructions. The IDT determined that he was non-responsive. (JA116.) The IDT determined that in light of his "continued decline without possibility of recovery, a hospice referral is appropriate." (*Id.*) Although the IDT also appears to have changed a POLST from one requiring full treatment to "Do Not Resuscitate/DNR," and "Comfort Care," the POLST created upon his admission apparently had been completed by his physician without Mark H.'s signature. (JA076.) Therefore, there is no evidence that the IDT acted contrary to Mark H.'s wishes or instructions.[10]

Additionally, the Ombudsman, whose participation was requested by the facility, does not report having disputed either the determinations that Mark H. lacked capacity to make a decision regarding end-of-life care, or the IDT's decision to authorize a hospice referral on his behalf. (See JA076-078, 116.) Therefore, there is no evidence of any dispute regarding the IDT's determinations.

While receiving hospice care, Mark H. remained at the nursing home, continued to receive food, and received pain medication and other supportive services. (See JA116, 121-123.) He passed away several months after beginning hospice care on February 14, 2013. (See JA118.)

Allowing IDTs to elect hospice for a terminally ill resident under section 1418.8, consistent with the resident's instructions or wishes and best interests, preserves statutory rights to elect hospice and constitutional rights to self-determine care. To the extent the Judgment is affirmed, the

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[10] And, even if the IDT had acted contrary to Mark H.'s instructions or wishes, it would establish only that the nursing home acted improperly, but not that section 1418.8 is unconstitutional to the extent applied to hospice elections.

exception permitting initiation and provision of hospice care under section 1418.8 should be preserved.

3. If Affirmed, the Judgment Must Permit Decisionmaking Under Section 1418.8 to Carry Out a Resident's Instructions and Known Wishes Regarding Life-Sustaining Treatment

a. Removing the Exception for Resident Instructions Would Deprive Residents of Constitutional and Statutory Rights to Control Their Care

Petitioners' argument that section 1418.8 cannot be used to carry out a resident's valid health care instruction would impermissibly deprive residents of this constitutionally protected right to provide direction for health care decisions to be made on their behalf after they have lost decisional capacity.

As the court recognized in *Drabick*, a competent adult has the right to refuse medical treatment, and this right "survives incompetence in the sense that incompetent patients retain the right to have appropriate decisions made on their behalf[.]" (*Drabick*, *supra*, 200 Cal.App.3d at p. 205). As the court stated: "The state's interest in preserving life does not outweigh the patient's own rights." (*Ibid*.)

California statutory law specifically protects this right, as well. The Health Care Decisions Law expressly recognizes that an individual "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." (Prob. Code, § 4650, subd. (a).) Thus, an adult "may give an individual health care instruction," which may be "written or oral direction concerning a health care decision for the patient." (*Id.*, §§ 4609, 4623, 4670.) As noted above, a "health care decision" specifically may include: "Directions to provide, withhold, or withdraw artificial nutrition and

hydration and all other forms of health care, including cardiopulmonary resuscitation." (*Id.* § 4617.)

Petitioners assert, incorrectly, that section 1418.8 cannot be used to implement a resident's individual health care instruction because "a supervising health care provider" or an "employee of the health care institution" may not be designated as the agent of a resident. (RB/AOB 80-81, citing Prob. Code § 4701.) However, an individual may provide an oral or written instruction to forgo life-sustaining treatment without designating an agent. (See Prob. Code § 4670.) Moreover, the policy considerations supporting the bar on individuals involved in a resident's care from being *designated* as an agent for health care decisionmaking are not the same as those involved in section 1418.8. Section 1418.8 is intended to ensure that a process for substituted decisionmaking is available for individuals after they have lost decisional capacity and an authorized representative is not, or is no longer, available. Thus, concerns regarding potential undue influence or coercion by existing caregivers in a resident's *designation* of an agent are not present.

There is no validity to petitioners' contention an adjudication of incapacity is required before a resident's individual health care instruction regarding life-sustaining treatment may be given effect. The Legislature made clear that the determination that an individual lacks capacity to make a health care decision, and thus that their individual health care instruction should be given effect, "*shall* be made by the primary physician." (Prob. Code, § 4658, italics added.) Indeed, the Legislature specified that "[i]n 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." (*Id.* § 4650.) Moreover, as identified above, residents are entitled to a judicial determination of capacity in the event of any dispute about a physician's capacity determination, and any capacity or treatment

determination by the physician or IDT may be subject to judicial review. (Cal. Code Regs., tit. 22, § 72527, subd. (c); *Rains*, *supra*, 32 Cal.App.4th at pp. 185-186 & fn. 7).

For the reasons above, barring use of section 1418.8 to carry out a patient's instructions to forgo life-sustaining treatment would improperly deprive residents of their rights under state law to have their instructions regarding their future care carried out after they have lost decisional capacity.

b. Removing the Exception for Carrying Out Known Resident "Wishes" Also Would Deprive Residents of the Right to Control Their Care

Petitioners' argument that the Judgment impermissibly permits section 1418.8 to be used also to implement a resident's known wish to forgo life-sustaining treatment is similarly misplaced. Caregivers generally must act consistently with a resident's wishes as a matter of professional responsibility, if not also to ensure respect for patient dignity and autonomy protected by the constitutional right of privacy. Removing this exception from the Judgment would conflict with this obligation and deprive residents of these protected interests.

Physicians and nursing homes are required to give effect to a resident's wishes under section 1418.8, since they may initiate treatment only "in accordance with acceptable standards of practice." (§ 1418.8, subd. (d).) Such standards necessarily include acting in accordance with a patient's wishes. (*Bouvia v. Superior Court*, *supra*, 179 Cal.App.3d at pp. 1140-1141.) Moreover, physicians and nursing homes may be subject to administrative sanction, if not other liability, for *failing* to act under the statute consistent with "the desires of the resident[.]" (§ 1418.8, subd. (k).) Barring application of section 1418.8 to effectuate a resident's known

wishes would conflict with these requirements and protections under section 1418.8.

Other relevant statutes similarly require surrogates and agents of an incapacitated resident to make health care decisions, in the absence of individual health care instructions, consistent with the patient's "wishes to the extent known." (Prob. Code, §§ 4658 [agents designated by power of attorney], 4714 [surrogates, and persons acting as surrogates].)

At the same time, if this part of the trial court's Judgment is affirmed, the Director would not oppose the addition of a requirement that "clear and convincing" evidence of a conscious resident's wishes to forgo or withdraw life-sustaining treatment be required. (See *Wendland*, *supra*, 26 Cal.4th at pp. 545-546.)

Particularly with this clarification, utilization of section 1418.8 to implement a resident's known wishes that life-sustaining measures be used, or not used, would not appear to constitute an "egregious breach of the social norms underlying the privacy right," and would therefore appear consistent with residents' privacy rights. (*Rains*, *supra*, 32 Cal.App.4th at p. 177.) "[I]incompetent patients retain the right to have appropriate decisions made on their behalf," and allowing the IDT to carry out a resident's clearly established wishes would "produce a more just and compassionate result than leaving [the resident] with no way of exercising a constitutional right." (*Drabick*, *supra*, 200 Cal.App.3d at pp. 205, 209.)

Petitioners' contention that section 1418.8 cannot be applied to treatment decisions relating to end-of-life care because they do not require the same procedures applicable to *conservatorship* proceedings was properly rejected by the trial court, and should be rejected here for the same reasons. As the trial court noted, "given that section 1418.8 has already been determined to permit a physician to determine incompetency and not to require a judicial determination of incompetency (see *Rains*, *supra*) . . . ,

it appears that the same reasoning that applies to the cases involving conservatees *cannot be applied here*." (JA743, italics added.)

The Legislature has emphasized that in absence of a dispute, surrogate decisionmaking for residents lacking decisional capacity, including regarding life-sustaining treatment, does not require judicial intervention. The Health Care Decisions Law specifies that advance health care directives are "effective and exercisable free of judicial intervention," and that health care decisions by surrogates and agents similarly are effective "without judicial approval." (Prob. Code, § 4750, subds. (a)-(c).) Similarly, health care providers must implement and follow a resident's POLST without need for a judicial determination that the resident has lost decisional capacity. (See Prob. Code, § 4781.2.)

Removing the Judgment's exceptions for decisions regarding life-sustaining treatment based on resident's instructions or known wishes would cause residents to be subjected to unwanted "painful, invasive, confining, and to them incomprehensible" measures to sustain life, such as transfers to hospital intensive care units, cardio-pulmonary resuscitation (CPR), chest compression, ventilators, nasogastric tubes, and surgically-inserted feeding tubes, some of which may be ineffective and cause undesirable complications. (JA765; see also JA560.) To ensure that a resident's dignity is respected with respect to end of life care, the Judgment should preserve a resident's constitutional and statutory rights to provide direction as to the use of life-sustaining treatment. As our Supreme Court has observed, "'[n]o state interest is compromised by allowing [an individual] to experience a dignified death rather than an excruciatingly painful life.'" (*Thor v. Superior Court* (*Andrews*) (1993) 5 Cal.4th 725, 741, quoting *Donaldson v. Lungren* (1992) 2 Cal.App.4th 1614, 1622.)

4. Petitioners' Objection Regarding the Rights of Physicians and Facilities to Decline Patient Instructions Misapprehends the Judgment

Petitioners' remaining objection mistakenly contends that Part III(A)(1) of the Judgment permits section 1418.8 to be used to decline instructions or decisions that would require treatment that is ineffective or contrary to generally accepted medical standards. (RB/AOB 83-86.) This provision of the Judgment, however, merely paraphrases rights provided under Probate Code sections 4735 to any *health care provider or institution* to decline to comply with such instructions. The provision in the Judgment simply makes clear that the prohibition on decisionmaking *under section 1418.8* regarding life-sustaining treatment set out in the Judgment does not affect the rights provided directly and only to health care providers and institutions under Probate Code section 4735 to decline to follow a patient's instructions. (JA855.) Physicians and institutions have this authority separate and apart from section 1418.8. The Judgment does not grant any authority to physicians or facilities to do so *pursuant to section 1418.8*. Petitioners' objection to this portion of the Judgment, therefore, is misplaced.

CONCLUSION

For the reasons above, the trial court's Judgment should be vacated and reversed. If Part III of the Judgment is affirmed, the exceptions set out in the Judgment should be preserved, subject to clarification as set out above.

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Dated: June 13, 2017

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I certify that the attached **COMBINED REPLY AND RESPONDENT'S BRIEF** uses a 13 point Times New Roman font and contains 21,815 words.

Dated: June 13, 2017

XAVIER BECERRA
Attorney General of California

/S/JOSHUA N. SONDHEIMER
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Deputy Attorney General
Attorneys for Defendant and Appellant Karen Smith, MD, MPH, Director of the California Department of Public Health

DECLARATION OF SERVICE BY U.S. MAIL

Case Name: **CANHR et al v. Chapman, as Director of CDPH**

Case No.: **A147987**

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COMBINED REPLY AND RESPONDENT'S BRIEF

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Clerk of the Court
Alameda County Superior Court
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 June 13, 2017, at San Francisco, California.

R. Manalastas
Declarant

Signature

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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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EXHIBIT - EXHIBITS	Exhibit D
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EXHIBIT - EXHIBITS	Exhibit F
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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.

06-13-2017

Date

/s/Joshua Sondheimer

Signature

Sondheimer, Joshua (152000)

Last Name, First Name (PNum)

California Dept of Justice, Office of the Attorney General

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