Court of Appeal, Second District, Division 6, California.
Patrick FURLONG, Individually and as Successor-in-Interest, etc., Plaintiff and Appellant,
v.
CATHOLIC HEALTHCARE WEST et al., Defendants and Respondents.

2d Civil No. B172067.
(Ventura County Super. Ct. No. CIV 217837).
Dec. 22, 2004.

Steven Hintz, Judge, Superior Court County of Ventura.
Law Offices of Jody C. Moore, Mona A. Sampson; Perkins Coie, LLP, Kathryn L. Tucker for Plaintiff and Appellant Patrick Furlong.

Baker, Manock & Jensen, Andrew R. Weiss, Dirk B. Paloutzian for Defendant and Respondent Arturo Sidransky.

Engle & Bride, Benjamin J. Engle, Andrew H. Covner for Defendant and Respondent Bennet Lipper.

Reback, McAndrews & Kjar, Thomas F. McAndrews, Heidi L. Kjar for Defendant and Respondent Richard Handin.

Bauer, Harris, Clinkenbeard & Ramsey, LLP, Hugh S. Spackman, Maureen E. Clark for Defendant and Respondent Catholic Healthcare West dba St. John's Regional Medical Center.

COFFEE, J.

*1 Patrick Furlong, individually and as successor-in-interest to his deceased mother, Margaret K. Furlong, brought an action against respondents Catholic Healthcare West, dba St. John's Regional Medical Center (hospital), and Drs. Richard Handin, Bennet Lipper, and Arturo Sidransky. His action sought injunctive relief, damages, and attorney's fees based in part on alleged violations of the Elder Abuse Act, the federal Patient Self-Determination Act (PSDA), the Health Care Decisions Law, and the Business and Professions Code. (Welf. & Inst.Code, §§ 15600 et seq.; 42 U.S.C. §§ 1395cc(f), 1396a(w); Prob.Code, §§ 4600 et seq.; Bus. & Prof.Code, § 17200.) The trial court sustained demurrers brought by respondents and dismissed the action. Furlong appeals, contending the court erred in concluding that the allegations of his amended complaint did not state a cause of action for elder abuse or an unfair business practice. We affirm.

Factual and Procedural Background
Because this appeal challenges the trial court's order sustaining demurrers without leave to amend, we summarize and accept as true all material allegations of the amended complaint.

Margaret, age 82, was a resident of Glenwood Care Center (Glenwood), a skilled nursing facility. She suffered from atherosclerotic cardiovascular disease, hypertension, severe

rheumatoid arthritis, chronic leukopenia with anemia, and osteoporosis. Despite these medical conditions, she was capable of making her own health care decisions.

In February of 2001, Margaret expressed her health care wishes to her primary care physician, Dr. Falcon. Dr. Falcon completed and signed a document entitled, “Physician Documentation of Preferred Intensity of Treatment,” stating that Margaret had the capacity to make decisions regarding her health care and did not want CPR (defined as cardiac compressions, defibrillation, intubation mechanical ventilation, advanced cardiac life support medications or vasopressors). A few months later, in July of 2001, Margaret signed a document entitled “Consent-Withhold CPR,” stating that she understood what a “no CPR order” entailed and consented to an order not to use CPR. She also completed an “Emergency Medical Services-Prehospital Do Not Resuscitate (DNR) Form, An Advance Request to Limit the Scope of Emergency Medical Care.” The latter form indicated that she agreed to the DNR directive and gave permission to hospital emergency care personnel to implement it. Finally, the Glenwood physician order sheets also contained an order for “No CPR,” commencing on July 24, 2001. This order was renewed monthly, was effective through March 30, 2002, and was signed by one of Margaret's physicians.

While at Glenwood, Margaret developed a severe stage 4 decubitus ulcer over the left shoulder, exposing her glenohumeral bone, and a left shin decubitus ulcer, exposing her anterior tibial bone. These conditions caused Margaret to suffer from chronic and debilitating pain requiring routine pain medications as follows: Vicodin, one tablet every four hours for moderate pain; Vicodin, two tablets every four hours for severe pain; and Vioxx, 12.5 mg daily for arthritis. Margaret routinely complained of pain and requested pain medication to ease her suffering.

*2 On March 2, 2002, Margaret was taken from Glenwood to hospital's emergency room by her daughter-in-law, Linda Furlong, for treatment of vomiting and abdominal pain. Linda Furlong was given transfer papers to take with Margaret to the hospital. Linda Furlong provided the following documents to the hospital's emergency department personnel: (1) “Physician Documentation of Preferred Intensity of Treatment,” signed by Dr. Falcon; (2) “Consent-Withhold CPR,” signed by Margaret and the Social Services Director of Glenwood; (3) “Emergency Medical Services-Prehospital Do Not Resuscitate (DNR) Form, An Advance Request to Limit the Scope of Emergency Medical Care,” signed by Margaret and Dr. Falcon; (4) Glenwood physician order sheets for March 1, 2002, through March 30, 2002, including a current order for “No CPR”; and (5) several orders for pain medication, along with recent laboratory data, personal history data, and physical examination results.

Margaret was assessed at approximately 4:00 p.m. in the emergency room by hospital nursing personnel, the emergency department physician, Dr. Handin, and later by admitting physician, Dr. Lipper. Appellant alleges that the hospital and Drs. Handin and Lipper knew that Margaret was elderly and frail, and that life-saving measures might be necessary and imminent. Despite knowing this, appellant alleges, respondents “willfully and recklessly failed to ensure that Margaret's health care wishes were ascertained, documented, and followed.” Margaret was lucid upon admission to the emergency room and capable of expressing her health care wishes. Despite this, appellant alleges, no one asked about her end-of-life wishes or ascertained that she, in fact, wanted no heroic or life-saving measures.

Margaret was admitted to the hospital at approximately 10:15 p.m. and the admission paperwork erroneously stated that she did not have an advance directive. At 1:15 a.m. on March 3, 2002, she suffered a respiratory and cardiac arrest. Dr. Sidransky provided emergency medical services during a “code blue” and failed to inquire of the hospital staff about Margaret's health care wishes when he arrived at her bedside. Consequently, Margaret was intubated and given advance cardiac life support medications. She survived the arrest and regained consciousness.

Appellant alleges that as a direct result of the wrongful resuscitation, Margaret endured extreme pain and suffering over the ensuing 10 days. During this period, in addition to her other medical conditions, her decubitus ulcers were infected and she endured pain associated with a small bowel obstruction and bowel impaction. Finally, appellant alleges, there was significant pain associated with intubation and the numerous other invasive procedures performed after her resuscitation and until her death. Due to intubation, she was unable to communicate that she was in pain and request pain medications. She was described as restless, complaining of pain, and unable to respond to questions or follow commands.

*3 On March 12, 2002, Margaret died after withdrawal of life support. According to appellant, her death certificate states that the immediate cause of death was “respiratory failure” due to “aspiration pneumonia” for one week. Appellant alleges that his mother was forced to experience a protracted dying process, against her wishes and right to refuse unwanted medical treatment. Appellant alleges that during the 10 days following her resuscitation, the hospital had a duty to regularly monitor Margaret's physical pain and mental condition. Appellant alleges the hospital was aware of her severe rheumatoid arthritis, which required routine doses of Vicodin prior to her hospitalization, of her severe infected shoulder and shin wounds that were so deep her bones were exposed, and of the pain associated with intubation and dying. Despite awareness of these conditions, appellant alleges the hospital did not implement a pain management program to relieve her pain.

The hospital utilized a form entitled “Critical Care Flow Sheet” that required its staff to assess the quality and frequency of Margaret's pain at least once per 12-hour shift. The pain assessment category on the form was broken down to include a determination of whether the pain was “absent,” “sharp,” “pressure-like,” or “other.” Appellant alleges the category for pain assessment on the Critical Care Flow Sheet was not filled out by the nursing staff for 17 of the last 19 shifts of Margaret's life. On three shifts, nursing staff documented that Margaret's pain was “difficult to assess,” “unable to assess verbally,” or “unable to assess completely.” Appellant alleges the hospital's failure to assess Margaret's pain was the result of inadequately training its staff in current pain management concepts. He alleges the hospital failed to train its staff for budgetary reasons, i.e., to ensure that revenues exceeded expenses.

Appellant also alleges that Dr. Lipper failed to manage Margaret's pain in that he should have ordered pain medication to be administered on a routine basis, rather than on a “prn” or “as needed” basis. The “prn” order given by Dr. Lipper relied on Margaret to communicate that she was in pain before pain medication would be given. Because she could not speak, she could not request pain medication or inform her care providers that she was in fact suffering. Appellant

alleges that such an order was in conscious disregard of Margaret's health, rights and well-being.

Finally, appellant alleges that the Department of Health Services, the state agency responsible for ensuring regulatory compliance with state laws and regulations governing acute care hospitals, conducted an investigation into the wrongful resuscitation of Margaret and concluded that the hospital "failed to ensure a patient's right to refuse life-sustaining treatment," in violation of California Code of Regulations, title 22, section 70707, subdivision (b)(6).

Appellant's second amended complaint asserts six causes of action. The first cause of action was brought on behalf of Margaret for negligence against all respondents based on their breach of the duty to provide appropriate care and disregard of her health care wishes. Appellant alleges the hospital's violation of California Code of Regulations, title 22, section 70707, subdivision (b)(6), in failing to ensure her right to refuse life-sustaining treatment, constituted negligence per se.

*4 The second cause of action was brought on behalf of appellant for damages against all respondents for negligent infliction of emotional distress, based in part on the emotional distress he suffered in watching his mother lie in pain in the hospital and in having to make the decision to withdraw her life support measures.

Appellant's third cause of action was brought against the hospital under the Elder Abuse and Dependent Adult Civil Protection Act (Elder Abuse Act) based on the hospital's failure to manage Margaret's pain as described above, failure to determine her health care wishes, and wrongful resuscitation. (Welf. & Inst.Code, §§ 15600 et seq.) As for the wrongful resuscitation, appellant alleges the hospital willfully and consciously ignored or violated state and federal regulations requiring it to document whether a patient has executed an advance CPR directive, protect a patient's rights in this regard, and to honor the patient's health care wishes.

Appellant further alleges the hospital violated its own policies and procedures in failing to determine Margaret's health care wishes. He alleges the hospital was aware of its obligations under the federal PSDA to ascertain whether she had an advance directive and to offer written materials regarding her right to direct her own medical care if she did not. The hospital developed procedures obligating its staff to determine upon admission whether or not a patient had executed an advance directive and to offer materials and guidance to a patient in the event he or she did not have one. Appellant alleges the hospital used a form on admission entitled "Conditions of Admission and Treatment (Part I)," delineating for each patient on admission its policies and procedures regarding advance directives. The form indicates that the hospital has a duty under the PSDA to provide information concerning a patient's right to formulate advance directives. The form requires that an appropriate box be checked to indicate that such written information was provided to a patient and to indicate whether the patient had an advance directive. Appellant alleges that no box was checked on the form to indicate that any written materials were provided to Margaret or her family. He alleges that the hospital's policy is to refer a patient to "chaplain services" if he or she does not have an advance directive and document the referral. Appellant alleges that there is no reference in Margaret's chart that any

referral was made to chaplain services. Instead, appellant alleges, the hospital failed to identify her health care wishes and erroneously stated that she did not have an advance directive.

Appellant alleges that Margaret's cardiac arrest did not occur until nine hours after her admission to the hospital. He alleges a delay of nine hours to determine her health care wishes and document them in the chart “is willful and reckless and constitutes a conscious disregard of her rights” for purposes of the Elder Abuse Act.

*5 Appellant's fourth cause of action was brought against Drs. Lipper, Handin, and Sidransky for elder abuse. Appellant alleges that Dr. Handin, the emergency department physician, and Dr. Lipper, the admitting physician, failed to review the documentation brought from Glenwood to the emergency room, failed to record the existence of her health care wishes, and failed to inquire of Margaret directly about her wishes. Appellant alleges that Drs. Handin and Lipper were aware of their obligations under the PSDA, Margaret's condition was stable while under their care, and there was sufficient time (nine hours) for them to make an inquiry and document Margaret's health care wishes. Appellant alleges that Dr. Sidransky provided emergency medical services during the code blue when Margaret suffered her cardiac arrest, Dr. Sidransky failed to inquire of the hospital staff about her health care wishes when he arrived at her bedside, failed to review the documentation readily available in her medical chart to ascertain her “no code” status, resuscitated her against her wishes, and acted in conscious disregard of her express wishes in doing so. Appellant alleges that Drs. Handin, Lipper, and Sidransky subjected Margaret to “neglect” as that term is defined in the Elder Abuse Act.

Appellant adds, as against Dr. Lipper only, that Dr. Lipper committed elder abuse by failing to monitor, assess, and manage Margaret's level of pain on a daily basis. He alleges that Dr. Lipper's failure to provide her with a pain management regimen violated specific directives of the California Medical Board and the Pain Patient's Bill of Rights enacted by the California Legislature. (Health & Saf.Code, § 124961.) He alleges that by making a “prn” order, Dr. Lipper forced Margaret to experience severe pain as a prerequisite to obtaining pain medication at a time when she could not communicate verbally, and that Dr. Lipper's actions were in conscious disregard of her health and safety in that she suffered from multiple painful medical conditions.

As a fifth cause of action against the hospital and the doctors, appellant alleges that the failure to identify Margaret's health care wishes and wrongful resuscitation violated the Health Care Decisions Law. (Prob.Code, §§ 4600 et seq.)

Finally, as a sixth cause of action against the hospital and doctors, appellant seeks damages and injunctive relief for unfair business practices. (Bus. & Prof.Code, §§ 17200 et seq.) Appellant alleges the hospital offered services for a fee as part of a general business practice. The alleged unlawful, unfair and fraudulent practices include the failure to honor Margaret's health care wishes; failure to meet her physical and mental health needs (elder abuse); failure to make and implement an appropriate plan of care as required by the Pain Patient's Bill of Rights; failure to maintain accurate medical records; and failure to maintain adequate personnel.

Respondents demurred to all causes of action of the amended complaint except the two negligence claims. With respect to the third and fourth causes of action under the Elder Abuse Act, respondents contended appellant had not pleaded facts showing that they were guilty of (1) neglect as defined in the act; or (2) “recklessness, oppression, fraud, or malice in the commission of this abuse.” (Welf. & Inst.Code, § 15657.) Respondents argued the amended complaint pleaded facts showing only professional negligence, not culpable, reckless conduct as required by the act. (Ibid.)

*6 With respect to the sixth cause of action for unfair business practices, respondents contended that a statutory cause of action under Business and Professions Code sections 17200 et seq. was not intended to apply to a garden variety medical negligence claim, and that appellant had not alleged any unlawful acts. Respondents argued that appellant's conclusory allegations concerning their failure to honor Margaret's health care wishes and meet her physical and mental health needs did not show an unlawful act under either the Elder Abuse Act or the Health Care Decisions Law, and, hence, his claim of an unfair or unlawful business practice failed.

Appellant opposed the demurrers, arguing the facts alleged show conduct that rose to the level of recklessness and exhibited a conscious disregard for Margaret's rights and health care wishes. Appellant added that any federal, state, or local law or regulation can serve as the predicate for an action under Business and Professions Code sections 17200 et seq., and that factual allegations of elder abuse were sufficient to state such a claim.

The trial court sustained the demurrers to appellant's statutory causes of action for elder abuse, violation of the Health Care Decisions Law, and unfair business practices without leave to amend. The court stated that the allegations of misconduct “do not amount to the kind of egregious, reckless, oppressive, or malicious misconduct required for the elder abuse cause of action,” and “do not show an unlawful or deceptive business practice.” The court added that “[m]edical negligence does not support a separate cause of action under Business and Professions Code [section] 17200.”

Following the hearing on the demurrers, appellant voluntarily dismissed his negligence causes of action to allow this appeal to proceed immediately. The court then dismissed the entire action against respondents.

Standard of Review

On appeal from a judgment of dismissal following the sustaining of a demurrer without leave to amend, we review the trial court's ruling de novo, exercising our independent judgment to determine whether the complaint states a cause of action under any legal theory. (Ochs v. Pacificare of California (2004) 115 Cal.App.4th 782, 788.) We accept as true the properly pleaded allegations of facts in the complaint, but not the contentions, deductions or conclusions of fact or law. (Blank v. Kirwan (1985) 39 Cal.3d 311, 318.) If no liability exists as a matter of law, we must affirm the sustaining of the demurrer. (Traders Sports, Inc. v. City of San Leandro (2001) 93 Cal.App.4th 37, 43-44.)

Appellant does not challenge the trial court's order sustaining the demurrers to the fifth cause of action for violation of the Health Care Decisions Law. (Prob.Code, §§ 4600 et seq.) He seeks only to reinstate the third and fourth causes of action for elder abuse and the sixth cause of action for unfair business practices. He does not contend he should have been granted leave to amend these causes of action. Rather, he contends the amended complaint sufficiently alleged the elements of elder abuse and unlawful business practices.

The Third and Fourth Causes of Action for Elder Abuse

*7 The Elder Abuse Act is codified in Welfare and Institutions Code sections 15600 et seq.FN1 The purpose of the act is "to protect a particularly vulnerable portion of the population from gross mistreatment in the form of abuse and custodial neglect." (Delaney v. Baker (1999) 20 Cal.4th 23, 33.) The act affords heightened remedies to encourage private enforcement of the law, including damages for the decedent's pain and suffering, attorney's fees and costs, and possible punitive damages. In order to state a cause of action under the act, the plaintiff must plead facts showing two elements: (1) the defendant has subjected an elder to physical abuse as defined by section 15610.63, neglect as defined by section 15610.57, or financial abuse as defined by section 15610.30; and (2) the defendant acted with recklessness, malice, oppression, or fraud in the commission of the abuse. (§ 15657.)

FN1. All further statutory references are to the Welfare and Institutions Code unless otherwise stated.

In pleading the first element above, appellant's amended complaint alleges elder abuse by "neglect." Section 15610.57 defines neglect as follows:

"(a) 'Neglect' means either of the following:

"(1) The negligent failure of any person having the care or custody of an elder ... to exercise that degree of care that a reasonable person in a like position would exercise. [¶] ...

"(b) Neglect includes, but is not limited to, all of the following:

"(1) Failure to assist in personal hygiene, or in the provision of food, clothing, or shelter.

"(2) Failure to provide medical care for physical and mental health needs.

"(3) Failure to protect from health and safety hazards.

"(4) Failure to prevent malnutrition or dehydration."

Our Supreme Court has held that the acts proscribed by section 15657 do not include acts of simple professional negligence, but refer to forms of abuse or neglect performed with some state of culpability greater than mere negligence. (Delaney v. Baker, supra, 20 Cal.4th at p. 32.) As Delaney explained, "In order to obtain the remedies available in section 15657, a plaintiff must demonstrate by clear and convincing evidence that defendant is guilty of

something more than negligence; he or she must show reckless, oppressive, fraudulent, or malicious conduct. The latter three categories involve ‘intentional,’ ‘willful,’ or ‘conscious' wrongdoing of a ‘despicable’ or ‘injurious' nature .... ‘Recklessness' refers to a subjective state of culpability greater than simple negligence, which has been described as a ‘deliberate disregard’ of the ‘high degree of probability’ that an injury will occur.... Recklessness, unlike negligence, involves more than ‘inadvertence, incompetence, unskillfulness, or a failure to take precautions' but rather rises to the level of a ‘conscious choice of a course of action ... with knowledge of the serious danger to others involved in it.’ “ (Id. at p. 31, citations omitted.)

The Supreme Court reasoned in Delaney that section 15657.2 limits the application of section 15657 against health care providers. Section 15657.2 mandates that professional negligence claims against a health care provider shall be governed by those laws that specifically apply to professional negligence causes of action. The court concluded the interplay between sections 15657 and 15657.2 makes it clear that the goal of the Elder Abuse Act was to provide heightened remedies for “ ‘acts of egregious abuse’ against elder and dependent adults ... while allowing acts of negligence in the rendition of medical services to elder and dependent adults to be governed by laws specifically applicable to such negligence.” (Delaney v. Baker, supra, 20 Cal.4th at p. 35.) The high standard imposed by section 15657 protects health care providers from liability under the statute “for acts of simple or even gross negligence.” (Covenant Care, Inc. v. Superior Court (2004) 32 Cal.4th 771, 785, italics added.)

*8 The court in Delaney found it instructive that the statutory definition of “neglect” provided in section 15610.57 “gives as an example of ‘neglect’ not negligence in the undertaking of medical services but the more fundamental ‘[f]ailure to provide medical care for physical and mental health needs.’ “ (Delaney v. Baker, supra, 20 Cal.4th at p. 34.) The Supreme Court recently revisited this notion in Covenant Care, where it held: “As used in the [Elder Abuse] Act, neglect refers not to the substandard performance of medical services but, rather, to the ‘failure of those responsible for attending to the basic needs and comforts of elderly or dependent adults, regardless of their professional standing, to carry out their custodial obligations.’ [Citation.] Thus, the statutory definition of neglect speaks not of the undertaking of medical services, but of the failure to provide medical care.” (Covenant Care, Inc. v. Superior Court, supra, 32 Cal.4th at p. 783.)

In Delaney, the decedent had stages 3 and 4 (down to the bone) bedsores on her ankles, feet, and buttocks at the time of her death. While a patient at the defendant skilled nursing facility, the decedent was frequently left lying in her own urine and feces for extended periods of time. This neglect occurred despite persistent complaints to nursing staff, administration, and a nursing home ombudsman. (Delaney v. Baker, supra, 20 Cal.4th at p. 27.) Based on these facts, the jury found the defendant facility and two of its owners liable for reckless neglect, and awarded monetary damages for the decedent's pain and suffering and medical expenses. The Supreme Court upheld the award of heightened remedies, holding that a health care provider acting as a care custodian who engages in the reckless neglect of an elder will be liable under section 15657. (Delaney, at pp. 27-28, 34.)

Similarly, in Covenant Care, the plaintiff alleged that the decedent, who was known to the defendant skilled nursing facility to be suffering from Parkinson's disease and was unable to

care for his personal needs, was left in his bed, unattended and unassisted for excessively long periods of time. As a result, he could not feed or hydrate himself and became malnourished. He was also left in his own excrement for long periods, which resulted in him developing ulcers on his body that exposed muscle and bone, causing him to become septic and severely dehydrated. The court held that the alleged conduct was egregious enough to subject defendant to punitive damages. (Covenant Care, Inc. v. Superior Court, supra, 32 Cal.4th at p. 778.)

In Mack v. Soung (2000) 80 Cal.App.4th 966, the court reversed an order sustaining a demurrer to an elder abuse claim based upon allegations that during the decedent's final days, the defendant physician concealed an untreatable stage 3 bedsore suffered by the decedent after being left in a bedpan for 13 hours, consistently opposed the decedent's hospitalization as her health declined, withdrew as her physician after her condition became critical, refused to respond to requests to hospitalize her, and abruptly abandoned her care.

*9 In Intrieri v. Superior Court (2004) 117 Cal.App.4th 72, the appellate court reversed a summary judgment in favor of a nursing home, concluding that triable issues of fact remained in dispute as to the reckless conduct element of the elder abuse cause of action. There, the decedent was injured and ultimately died following an unprovoked altercation with a non-Alzheimer's patient who had entered the Alzheimer's unit. The court found a reasonable inference of conscious disregard of the safety of the Alzheimer's patients where the evidence showed that the defendant provided unfettered access to the vulnerable residents of the Alzheimer's unit to anyone who could read the code posted over the keypad, and the decedent developed untreated bedsores on her right foot that eventually led to amputation of her right leg below the knee. (Id. at pp. 84-85.)

The facts of the present case are vastly different from those summarized above. Here, we are confronted not with the failure to give medical care, but the giving of medical care, albeit unwanted. We conclude the allegations of the amended complaint are insufficient to state a cause of action for elder abuse against any of the respondents. The allegations do not show “neglect” as defined in section 15610.57, and they do not show the requisite culpable or reckless conduct as against any respondent.

In particular, as for Dr. Handin, the emergency room physician, appellant alleges that he committed elder abuse by failing to ascertain Margaret's end-of-life wishes and document same in her chart. No other factual allegations are alleged as to him. Dr. Handin is not alleged to have failed to provide medical care to her, he is not alleged to have been present during the wrongful resuscitation, and he is not alleged to have withheld pain medication. There are, thus, no allegations showing “neglect” as defined by section 15610.57.

Similarly, as for Dr. Sidransky, he is charged with “neglect” based on his conduct in responding to a code blue emergency and resuscitating a dying patient. Like Dr. Handin, he did not fail to provide her with medical care. Additionally, the amended complaint is devoid of any allegations that would lead to a reasonable inference of reckless conduct by Dr. Sidransky. There are no allegations that her health care wishes were attached to her chart. Instead, appellant alleges the admission paperwork erroneously stated Margaret did not have an advance directive. The allegations, thus, do not show that Dr. Sidransky, in responding to a code blue,

acted in “conscious” or “deliberate disregard” of a “ ‘high degree of probability’ that an injury will occur.” (Delaney v. Baker, supra, 20 Cal.4th at p. 31.) The allegations of wrongdoing as to him amount, if anything, to mere negligence.

As for Dr. Lipper, the admitting and treating physician, appellant alleges two theories of liability. The first theory involves Dr. Lipper's alleged failure to ascertain and document Margaret's health care wishes, discuss with her these matters, and offer her written materials regarding her right to direct her medical care. As with the other doctors, these allegations describe negligent conduct only, not recklessness. The second theory relies on factual allegations concerning his failure to assess and manage her pain prior to her death. The allegations state that Dr. Lipper ordered pain medication to be administered on an as-needed basis, rather than around the clock. He is not alleged to have withheld pain medication and, consequently, the allegations describe, at most, medical malpractice, but not the culpable or reckless conduct required for application of section 15657.

*10 Finally, as to the hospital, the gist of appellant's allegations is that it failed to determine and document Margaret's health care wishes, participated in her wrongful resuscitation, and failed to manage her pain. As above, the allegations do not rise to the level of recklessness required for application of section 15657 or amount to a “ ‘conscious choice of a course of action ... with knowledge of the serious danger to others involved in it.’ “ (Delaney v. Baker, supra, 20 Cal.4th at pp. 31-32.) The allegations show that hospital staff was unaware of the existence of her advance care directive due to the negligence of the emergency room personnel in ascertaining this information upon her admission. Although appellant alleges the hospital was aware of and violated federal and state law in failing to ascertain Margaret's health care wishes, he does not allege facts showing that the hospital knowingly, intentionally, or willfully violated such regulations. Contrary to appellant's contention, the hospital's alleged failure to take any steps to ascertain her wishes does not show a conscious or deliberate course of action, undertaken with knowledge of the dire consequences. Likewise, the resuscitation of a dying patient does not amount to the failure to provide medical care as discussed in Delaney, but rather describes negligence in the undertaking of medical care.

As for the hospital staff's failure to assess and manage Margaret's pain, appellant alleges that hospital nursing staff did not fill out the Critical Care Flow Sheets for 17 of the last 19 shifts of her life, itemizing the intensity, location, frequency and duration of her pain. Appellant does not allege, however, that the hospital staff disregarded Dr. Lipper's directive to administer pain medication to Margaret as needed or that she never received any pain medication. Instead, appellant alleges that “[r]ather than receiving regular doses of pain medication, Margaret was required to suffer in silence until a nurse or staff member noticed her grimacing in pain.... Even when she did obtain pain medication based on a nurse noticing she was grimacing in pain, she was required to remain in pain [until the medication] took effect.” Taken as a whole, the allegations against the hospital staff in failing to complete the Critical Care Flow Sheets and manage Margaret's pain describe negligence or perhaps gross negligence in the level of care provided, but they do not describe the requisite culpable or reckless conduct required for application of section 15657.

Finally, we reject appellant's contention that the court's ruling on the demurrers erroneously denied him the opportunity to present expert declarations attesting that the conduct of the hospital and the doctors constituted recklessness or egregious conduct for purposes of the Elder Abuse Act. Appellant has not demonstrated that such a conclusion of law is a proper subject for expert testimony. (See Summers v. A.L. Gilbert Co. (1999) 69 Cal.App.4th 1155, 1178-1184.) He is not, in any event, entitled to present opinion evidence unless and until he pleads sufficient factual allegations to support the cause of action.

The Sixth Cause of Action for Unfair Business Practices

*11 Appellant next challenges the trial court's ruling that his sixth cause of action did not state an unlawful or unfair business practice. He contends his claim for an unfair business practice is supported by the alleged violations of the Elder Abuse Act and the PSDA, i.e., "unlawful" acts. The alleged unlawful acts are the same acts alleged to be the basis for the Elder Abuse Act and PSDA, i.e., that the hospital and the doctors failed to honor Margaret's health care wishes.

The purpose of the Unfair Practices Act is to "safeguard the public against the creation or perpetuation of monopolies and to foster and encourage competition, by prohibiting unfair, dishonest, deceptive, destructive, fraudulent and discriminatory practices by which fair and honest competition is destroyed or prevented." (Bus. & Prof.Code, § 17001.) Although the chapter is to be liberally construed (Bus. & Prof.Code, § 17002), the allegations of the second amended complaint do not fall within the ambit of any of the acts specified by the Legislature to be offenses against the chapter. (See Bus. & Prof.Code, §§ 17040-17051.) The alleged failure of the hospital and the doctors to ascertain and document Margaret's health care wishes does not amount to an unfair, dishonest, deceptive, destructive, fraudulent or discriminatory practice that destroys or prevents fair and honest competition.

Appellant cites no authority allowing him to transform a medical negligence claim into a claim under Business and Professions Code section 17200. (Compare Brownfield v. Freeman Marina Hospital (1989) 208 Cal.App.3d 405 [hospital's failure to offer information to rape victim about the "morning-after pill" did not amount to an unfair business practice under Bus. & Prof.Code, §§ 17001 et seq.].)

We reject appellant's contention that he can show an unfair business practice by alleging violations of the Elder Abuse Act and the PSDA. As noted above, he has not stated a cause of action for elder abuse, and the single alleged violation of the PSDA by the hospital will not support an unfair business practice claim. Generally, there must be repeated, ongoing violations to establish an unfair business practice. (See, e.g., People v. Casa Blanca Convalescent Homes, Inc. (1984) 159 Cal.App.3d 509, 527, disapproved on other grounds in Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Co. (1999) 20 Cal.4th 163, 185 [defendant operated nine nursing home facilities in which multiple patients were repeatedly subjected to abuse and neglect; continuing violations of statutory requirements regarding staffing and medical documentation constituted a pattern of behavior pursued as a "business practice"].) To the extent a single instance of unfair or unlawful conduct may suffice to support a claim under Business and Professions Code section 17200 (see Podolsky v. First Healthcare Corp. (1996) 50 Cal.App.4th 632, 653-654), we observe that appellant's amended complaint seeks injunctive relief as the remedy for the alleged unfair or unlawful business practice.

Because appellant's amended complaint describes medical care provided to an individual patient, there is nothing for a court to enjoin. Under these circumstances, we conclude the single instance of conduct alleged by appellant is insufficient to state a claim under section 17200. To the extent the allegations of his amended complaint conclude that the medical care provided by the hospital is part of a general unfair business practice to defraud the elderly, there are no facts alleged to support such a conclusion. On demurrer, we do not assume as true conclusions of fact or law.

*12 The trial court properly concluded that the sixth cause of action failed to allege facts sufficient to state a claim under Business and Professions Code section 17200.

Attorney's Fees
Appellant requests that we award him attorney's fees under section 15657 and Code of Civil Procedure section 1021.5. Our affirmance of the trial court's judgment renders this request moot.

The judgment is affirmed. Costs on appeal are awarded to respondents.

We concur: GILBERT, P.J., and YEGAN, J.
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