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IN THE
Court of Appeal
OF THE STATE OF CALIFORNIA
FIRST APPELLATE DISTRICT
DIVISION FOUR

CALIFORNIA ADVOCATES FOR NURSING HOME REFORM, GLORIA A., and ANTHONY CHICOTEL,
Petitioners, Respondents, and Cross-Appellants,

v.

KAREN SMITH, M.D., as DIRECTOR OF THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH,
Defendant, Appellant, and Cross-Respondent.

Appeal from the Superior Court of the State of California
for the County of Alameda, Case No. RG13700100
Hon. Evelio Martin Grillo

AMICI CURIAE BRIEF OF CALIFORNIA MEDICAL ASSOCIATION, CALIFORNIA DENTAL ASSOCIATION, AND CALIFORNIA HOSPITAL ASSOCIATION IN SUPPORT OF APPELLANT AND CROSS-RESPONDENT

COLE PEDROZA LLP
Curtis A. Cole, SBN 52288
(curtiscole@colepedroza.com)
*Cassidy C. Davenport, SBN 259340
(cassidydavenport@colepedroza.com)
2670 Mission St., Suite 200
San Marino, California 91108
Tel: (626) 431-2787
Fax: (626) 431-2788

Attorneys for Amici Curiae

CALIFORNIA MEDICAL ASSOCIATION, CALIFORNIA DENTAL ASSOCIATION, and CALIFORNIA HOSPITAL ASSOCIATION

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Other Authorities

INTRODUCTION

Twenty-five years ago, the Legislature created a procedure to assure that patients in skilled nursing and intermediate care facilities who are incapacitated *and* unfriended nevertheless receive the treatment they need. That procedure no longer is available, however, because the Alameda Superior Court has commanded that "the use of Health and Safety Code section 1418.8 is prohibited." (JA852-853.) Based on the example of one patient, Petitioner Gloria A., the court declared the statute unconstitutional *on its face*. (JA712-721, 853-854.) Then, based on nothing more than anecdotes about a few other patients, the court declared the statute unconstitutional *as applied* by the California Department of Public Health. (JA725-747, 854-855.) Not only did the court prohibit use of the statutory procedure, generally, but the court prohibited all physician–ordered antipsychotic medication (JA729-737, 854) and Physician Orders for Life Sustaining Treatment ("POLST"), specifically, unless authorized pursuant to the Probate Code. (JA737-747, 854-855.)

There will be significant negative consequences, only one of which was acknowledged by the court. (JA747 ["this order will likely create problems in how many skilled nursing facilities currently operate"].) Far more importantly, there will be adverse impacts on the patients because they will not receive the treatments they need. There will be adverse impacts on physicians, as well, because they no longer will be able to satisfy the requirement for informed consent to provide the treatments they know their incapacitated and unfriended patients need. There will be adverse consequences for governmental and insurer payors of health care because *treatable chronic conditions* will deteriorate to the point of becoming so *acute* that the patients will have to be treated at *acute care* hospitals, under the "emergency" exception to the requirement for informed consent. There will be adverse consequences for those hospitals, as well, since patients will have to remain in hospitals rather than being transferred to skilled nursing and intermediate care facilities for the nursing and other assistance they need.

These and other consequences of the court's Order and Judgment are unjustified. The statutory procedure was a good solution to the problem the Legislature addressed. There was a prior constitutional challenge, and the statute was found constitutional. Now, in response to this renewal of that earlier challenge, the Department provided competent evidence demonstrating the statute still achieves the legislative goals of (a) treatment that is in the best interests of the patients while (b) protecting their individual autonomy.

Finally, the written notice requirement of the Order and Judgment is unnecessary. The statute contains patient protections that make it constitutional. The record in this case demonstrates that physicians take into consideration patient "wishes" and "best interests," just as the statute requires. The record also demonstrates how the "patient representative" feature of the statutory procedure can operate as the Legislature intended. It could be that the only real issue is why, as the lower court put it, "no one is willing to serve as a patient representative?" (JA728.)

INTERESTS OF *AMICI CURIAE*

California Physicians, Dentists, And Hospitals Are Concerned That Their Patients Receive The Medical Care They Need

The California Medical Association ("CMA") is a non-profit, incorporated, professional association of more than 43,700 member physicians practicing in the State of California, in all specialties. The California Dental Association ("CDA") represents over 27,000 California dentists, more than 70% percent of the dentists practicing in the State. CMA's and CDA's membership includes most of the physicians and dentists engaged in the private practices of medicine and dentistry in California. The California Hospital Association ("CHA") represents the interests of more than 400 hospitals and health systems in California, having approximately 94 percent of the patient hospital beds in California, including acute care hospitals, county hospitals, non-profit hospitals, investor-owned hospitals, and multi-hospital systems. CMA, CDA, and CHA are active in California's courts in cases involving issues of concern to the health care industry.

Thus, *Amici* represent a wide variety of health care providers and hospitals.

Amici's Affiliated Organizations Reflect Other Interests In Medical Care, As Well

Some funding for this brief was provided by organizations and entities that share *Amici*'s interests, including physician-owned and other medical and dental professional liability organizations and non-profit entities engaging physicians, dentists, and other health care providers for the provision of medical services, specifically The Cooperative of American Physicians, Inc., The Dentists Insurance Company, The Doctors Company, Kaiser Foundation Health Plan, Inc., Medical Insurance Exchange of California, NORCAL Mutual Insurance Company, and The Regents of the University of California.

Amici **And Their Affiliated Organizations Regularly Provide Input To The California Legislature And To California Appellate Courts**

CMA, CHA, and CDA have provided substantial input to the Legislature on health care issues. *Amici* also have been active before the California Supreme Court and Courts of Appeal in cases affecting California health care providers, including *Fein v. Permanente Medical Group* (1985) 38 Cal.3d 137, *Western Steamship Lines, Inc. v. San Pedro Peninsula Hospital* (1994) 8 Cal.4th 100, *Bird v. Saenz* (2002) 28 Cal.4th 910, and *Ruiz v. Podolsky* (2010) 50 Cal.4th 838. They recently filed a brief in and orally argued *Flores v. Presbyterian Intercommunity Hospital* (2016) 63 Cal.4th 75.

On issues relating to health care for elder and dependent adults, *Amici* filed briefs in *Delaney v. Baker* (1999) 20 Cal.4th 23, *Covenant Care, Inc. v. Superior Court* (2004) 32 Cal.4th 771, and *Winn v. Pioneer Medical Group* (2016) 63 Cal.4th 148.

Amici also are active in the Courts of Appeal. For example, *Amici* filed a letter brief in *Corenbaum v. Lampkin* (2013) 215 Cal.App.4th 1308, and a full brief in a case that Division One of this

District of the Court of Appeal recently decided, *Chan v. Curran* (2015) 237 Cal.App.4th 601.

CMA separately filed briefs in *Thor v. Superior Court* (1993) 5 Cal.4th 725, *Arato v. Avedon* (1993) 5 Cal.4th 1172, and *Conservatorship of Wendland v. Wendland* (2001) 26 Cal.4th 519, all three decisions of which are cited by the parties in this case.

Amici **Have Developed Policies And Offered Their Input To Others On The Issues In This Case**

As to the broad issue in this case – health care decisions for incapacitated and unfriended patients – *Amici* have developed policies. CMA, CHA, and the Alliance of Catholic Healthcare, for example, produced a model policy entitled "Health Care Decisions For Unrepresented Patients." The stated "purpose" of that policy document was "to provide a process for making ethically and medically appropriate treatment decisions on behalf of persons who lack health care decision-making capacity and for whom there is not a surrogate decision-maker." That policy only was directed at general acute care hospitals, however, not skilled nursing and intermediate care facilities, because the latter were covered by the procedure in Health and Safety Code section 1418.8.

Amici **Support All Of The Public Policies That The Court Should Consider In This Case**

As to the specific issues in this case – use of antipsychotic medications and decisions about end-of-life treatment – *Amici* support the principle that a competent individual has the fundamental right to accept or refuse a proffered medical treatment, even if the treatment or intervention is necessary to sustain or preserve life. CMA, for example, through its various educational and informational activities, has long urged its members to respect and implement the decision of a patient with decision-making capacity, or of a surrogate decision-maker for patients who lack decision-making capacity. CMA has thus defended patients' autonomy interests for many years.

As to the even broader issue – assuring health care for all Californians – *Amici* and their members share the objective of promoting high quality, cost-effective health care. *Amici* have long-championed the rights of all patients to receive necessary and appropriate medical care. As a part of these efforts, *Amici* have vigorously objected to legislative, regulatory, and judicial actions that would inappropriately interfere with the rights of mentally incapacitated patients to have proper medical decisions made on their behalf.

Amici **Disclaim Authorship Of This Brief By Any Party Or Counsel To This Litigation**

This brief was not authored, either in whole or in part, by any party to this litigation or by any counsel for a party to this litigation. No party to this litigation or counsel for a party to this litigation made a monetary contribution intended to fund the preparation or submission of this brief.

AMICI HAVE MANY REASONS FOR CONCERN ABOUT THIS CASE

The Judgment Is So Broad As To Obstruct Treating The Chronic And Acute Medical Conditions Of These Incapacitated And Unfriended Patients

California physicians want to provide the best possible treatment for *all* their patients, including their incapacitated and unfriended patients who reside in skilled nursing and intermediate care facilities. That is precisely what the Legislature intended when it enacted Health and Safety Code section 1418.8. As a result of the enactment of that statute, despite such patients lacking health care decision-making capacity and having no familial or other surrogate decision-makers, those patients would receive treatment.

Now, however, the Superior Court Judgment (JA852-855) broadly prohibits "the use" of that statute (JA853), [1] with the result that these patients will suffer. Proof of the basis for *Amici's* concern can be found in the evidence that was provided by the Department of Public Health, in particular the expert witness opinion testimony in support of the Department's position. (JA552-561.)

The Judgment Will Subvert Other Goals For These Incapacitated And Unfriended Patients

Until its use was prohibited by the Superior Court, Section 1418.8 provided a good way for California health care providers to

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[1] The Judgment in this case (JA852-855) applies to *all* physician determinations made pursuant to Section 1418.8 because of the broad "command" by the Superior Court in Part I of the Judgment. (JA853-854.) Part I was not limited to specific types of treatment, as were Parts II and III.

simultaneously achieve their goals to (1) maximize the likelihood that the most appropriate person will make medical decisions on behalf of mentally incapacitated patients, (2) ensure that those decisions are voluntary and well-informed, and (3) facilitate the prompt delivery of individualized and proper medical care to all patients. *Amici* are concerned that the Judgment will subvert these goals.[2] There is no need to disrupt well-established decision-making practices between patients, surrogate decision-makers, patients' attending physicians, and facility staff members – practices that have historically benefited, rather than harmed, incapacitated unfriended patients.

Instead Of The Statutory Process For Surrogate Decision-Making, It Once Again Will Be Necessary For Courts To Decide For These Patients

Until Section 1418.8 was enacted, only judges were able to authorize treatment for these patients. The problem was that judicial approval was costly to pursue and the proceedings often were delayed in Superior Court probate departments. The delays were unacceptable to everyone involved – the patients, their physicians, the staffs at the facilities where the patients resided, and even the judges expected to act as the patients' decision-makers – because the time for medical

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[2] For the same reasons, CMA filed an *Amicus Curiae* Brief in the Court of Appeal in *Conservatorship of Wendland*, *supra,* arguing that the same three goals would be subverted by the trial court's decision in that case. (*Amicus Curiae* Brief of the California Medical Association in Support of Appellants, filed June 16, 1999, in *Conservatorship of the Person of Robert Wendland,* case no. C029439, pp. 1-2.)

intervention often was limited. Section 1418.8 was the solution to that problem.

The Superior Court's Requirement Of Formal, Written Notification Will Be Counterproductive

Physicians know that many (if not most) of these patients, upon receiving the formalistic written notice the Superior Court claims to be constitutionally necessary, will immediately disagree (if not completely reject) their physicians' assessments of health care decision-making incapacity. The physician-patient relationship (and therefore the efficacy of treatment) will be impaired (if not destroyed). Until now, the statutory procedure has operated in a way that *maintains* the physician-patient relationship (and therefore the efficacy of treatment), by allowing physicians to do so orally. So too does another statutory obligation of physicians to communicate to patients. (Prob. Code, § 4732 ["shall promptly communicate the determination to the patient"]; see also Prob. Code, §§ 4658, 4730.) That statutory process allows the physician to be sensitive to the patient's level of comprehension, fear, agitation, etc.

Petitioners Argue That Physicians Should Not Determine Patient "Health Care Decision-Making Incapacity" And, Instead, Should Wait For Judicial Assessment Of "Legal Competence" Before Treating Those Patients

Amici are concerned that this Court of Appeal might agree with Petitioners who argue for patient health care decision-making incapacity to be judicially, not medically, assessed. Specifically, Petitioners argue in their cross-appeal that the Superior Court erred because "it did not require adequate notice prior to the physician's determination of competence and surrogacy, nor did it require a hearing." (Combined Respondents' Brief and Cross-Appellants' Opening Brief, hereafter referred to as "RB/XAOB," p. 59.) The idea was stated most simply in the summary of Petitioners' cross-appeal as "notice and opportunity to oppose," meaning "notice as to the factual interview of the patient or findings by the physician" and opportunity to oppose at "a judicial adjudication." (*Id.* at 29.) Petitioners refer to this process as "judicially determined incapacity" (*id.* at 30), a significantly different process than that of Health and Safety Code section 1418.8.[3]

Petitioners' Arguments Are Based On False Assumptions

Petitioners' arguments ignore medical reality, as revealed in the record (*e.g.*, the medical record of patient Mark H., JA115-131, and declaration of the attending physician of patient Gloria A., JA470-475) and, instead, rely on false assumptions. For example, in order for Petitioners to make their point that physicians lack "neutrality," Petitioners falsely assume that physicians first decide on a medical intervention against patient wishes and only then decide the patient is decisionally incapacitated. Petitioners ignore even their own evidence (*e.g*., declaration of ombudsman for patient Gloria A., JA089-091, and declaration of Petitioners' expert witness social worker, JA097-098)

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[3] It is this aspect of the case that reveals that Petitioners disagree with the fundamental approach of the statute – to rely upon health care providers rather than the courts – to assess incapacity and to make surrogate decisions.

that proves it is the other way around – that physician determinations of decision-making capacity are made soon at the outset of residency at the skilled nursing or intermediate care facility and, thereafter, are regularly reevaluated.

For another example, as even Petitioners' own evidence proves, decision-making capacity is a *continuum* rather than a *point* in time. Physicians assess a fluctuating situation. (See, *e.g.*, JA097 ["This is generally done with a form known as History and Physical with boxes at the bottom where the physician may check 'has capacity', 'has no capacity' or has 'fluctuating capacity'. In place of 'fluctuating capacity' some forms state 'resident can make needs known but not make medical decisions'"].) Petitioners ignore this fact and, instead, assume that physicians determine patients have a *fixed* inability to reason so that Petitioners can conflate physicians' concept of decision-making incapacity with judges' concept of legal incompetence.

The Judgment In This Case Not Only Will Adversely Impact Patients In Skilled Nursing And Intermediate Care Facilities But Also Will Adversely Impact Patients In Acute Care Hospitals

Amici are concerned that, because these incapacitated and unfriended patients no longer will be able to receive the treatment they otherwise would receive at skilled nursing or intermediate care facilities pursuant to the consent process provided by Section 1418.8, these patients will have to wait until their conditions deteriorate to the point that their problems become acute, requiring care in California's acute care hospitals.[4] Even then, after the patients are transferred from the skilled nursing and intermediate care facilities where they reside, there will be a problem. Acute care hospitals always have had fewer legal options than do skilled nursing or intermediate care facilities in regard to informed consent for such patients.[5] Staff at acute care hospitals will find themselves in the same or worse legal bind which the Judgment in this case has placed California skilled nursing and intermediate care facilities.

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[4] This concern was expressed by Respondent Department of Public Health's expert witness in gerontology, Dr. Karl Steinberg (JA552-561), in particular as it relates to patients suffering from psychotic episodes or self-injurious behavior. (JA559-560.)

[5] For example, the interdisciplinary team consent process established by Section 1418.8 only applies to skilled nursing or intermediate care facilities.

STATEMENT OF THE CASE AS IT RELATES TO THE ISSUES OF INTEREST TO *AMICI CURIAE*

Only two individuals were specifically identified by the Superior Court in its Order, Petitioner Gloria A. (JA720-721) and patient Mark H., who was misidentified in the court's Order as "Mark A." (JA745.) As previously cited (*supra*, p. 19) there was competent evidence both as to Gloria A. (JA470-475) and as to Mark H. (JA115-131) that demonstrated the correctness of the assessments and treatment decisions made by their physicians, nurses, and other health care providers.[6]

Factual Background

Patient (and Petitioner) Gloria A.

Gloria A. was assessed by her attending physician, Clayton McDaniel, M.D. (JA067, 470-477.) His diagnosis was "hepatic encephalopathy and possible dementia." (JA471.) He assessed that "she did not have decision-making capacity" (JA471) in part because "maintaining the ability to make decisions on her own was dependent upon her compliance with her medications as 'she may develop delirium easily,' which occurred multiple times after she was cleared to make decisions on her own[.]" (JA472.) Gloria A. was under

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[6] The other two individuals who were mentioned in the court's Order (JA744-745) were never identified, neither by Petitioners in the Petition nor by the court in the Order. Notably, those other two patients are not even mentioned in Petitioners' summary of the evidence for this appeal and cross-appeal. (RB/XAOB, pp. 18-28.)

Dr. McDaniel's care from December 2012 to February 2014, when she died. (JA471.)

With respect to her mentation, not surprisingly, Gloria A. saw the situation differently from her physician. (JA065 ["They just want to control me by saying I'm incompetent and they know I get angry when they treat me poorly so they say I'm incompetent"] and JA067 ["They just give me what they want, and tell me what it's for"].) So too did Patsy Spence, who spoke with Gloria A., in Ms. Spence's capacity as "ombudsman" at the facility where Gloria A. resided. (JA090 ["when she first came to the nursing facility, I believe what occurred was that she was deemed to lack capacity by her physician"] and JA095 ["many of the residents of skilled nursing facilities in Santa Cruz County seem to have the intermittent capacity to make medical treatment decisions"].)

Petitioners imply that the medication Seroquel was wrongly prescribed by Dr. McDaniel to Gloria A.[7] (See, *e.g.*, RB/XAOB, p. 20.) Dr. McDaniel explained,

> Gloria A. was treated with Seroquel early in her stay to help alleviate significant agitation and aggression associated with her encephalopathy. The use of Seroquel, was tapered and discontinued as her condition improved. I believe it was medically appropriate,

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[7] Petitioners did not present competent, expert witness opinion evidence to the court to demonstrate Dr. McDaniel's assessment was inaccurate and his treatment was improper. Instead, Petitioners relied upon the declarations of Gloria A. and her ombudsman. Petitioners relied on other ombudsmen declarations to provide anecdotal information about other patients. (JA062-102.)

> humane, and in furtherance of efforts to improve Gloria A.'s well-being, to utilize this medication.

(JA473.)

The Department's expert witness, Dr. Steinberg, further explained why the "administration of antipsychotic medications is a widely accepted and common element of nursing home care, and subject to increased attention and oversight." (JA557. Emphasis in heading deleted.) Specifically, he testified to his opinion that,

> it is clear that if section 1418.8 protection for unbefriended, incapacitated nursing home residents were taken away for residents suffering from psychotic episodes or self-injurious behavior, this would result in a great deal of unnecessary distress for patients, and often lead to more traumatic and expensive care. Residents suffering from severe distress, if unable to receive the benefit of antipsychotic medications, will almost certainly be sent to a hospital on an emergency basis for treatment.

(JA559-560.)

As Gloria A. and Dr. McDaniel both said in their declarations, Dr. McDaniel discontinued the Seroquel. That is not to say that her decision-making capacity was stable, however, as Dr. McDaniel explained: "Although her capacity fluctuated and whether she had decision-making capacity was, at times, unclear, as the responsible caregiver for Gloria A., continuing the determination that she lacked capacity seemed most prudent to ensure that she received necessary care." (JA473.) He described the fluctuation in her course (JA473-474), including an episode just three weeks prior to her death, when "after refusing lactulose, she was confused and forgetful. She left the facility and was later found at a local grocery store eating a banana, soaking wet (nursing note 2/8/14). The police had to be called to locate her, and she had to be brought back to the facility in a wheelchair." (JA474.)

Patient Mark H.

Mark H. was 62 years old when he was involved in a motor vehicle accident, as a result of which he had multiple health issues. (JA115 ["bilateral above-the-knee amputation, peripheral vascular disease, encephalopathy, convulsions, hypertension, and dysphagia requiring G-tube"] JA119 ["traumatic brain injury"].) After receiving acute care at a hospital, he was transferred from the acute care hospital to a skilled nursing facility and then transferred back to the hospital. This happened several times. (JA116.) On the last such occasion, the staff at the hospital raised the question of POLST. (*Id.* ["Hospital staff called the facility and suggested his POLST be reviewed and the EPPLE Act Committee meet to determine the possibility of a hospice referral for the resident"].)

The interdisciplinary team discussion at the skilled nursing facility following that recommendation from the hospital was documented.

> Ombudsman attempted to ask resident's wishes with respect to changing POLST to DNR; resident did not respond. RNNP and ADON approached resident with Ombudsman asking simply: "Do you want to live or die?" Resident did not respond to direct question, even with a change in facial expression. Question was asked in several different ways, with no response. EPPLE Act Committee finds that change of POLST to DNR is warranted, and with a continued decline in condition without the possibility of recovery, a hospice referral is

> appropriate and will be arranged; should hospice accept resident for admission, the Committee agrees with admission to hospice for end-of-life care.

(JA116.)

Geneva Carroll was the Ombudsman to whom the Note referred. As she explained in her declaration,

> Recently I was asked by the social worker for Lincoln Meadows Skilled Nursing Facility in Placer County, California, to be the Patient Representative at a meeting being convened to consider treatment as to a resident of Lincoln Meadows. The meeting was convened under what I understood to be the Eppel Act, where decisions are made as to treatment for incompetent residents or residents who have no family or friends.
>
> I responded that I would attend the meeting as the ombudsman but that I could not be his representative as I was not so permitted as an ombudsman.

(JA075. Paragraph numbers deleted.)

> The [IDT] policy also says that there's to be a personal representative "when applicable" but doesn't say what that means and there never is a personal representative at the meetings whether it's IDT or care planning. I might go, but I can't be the personal representative.

(JA079.) She explained that she attended the meeting, but she made it clear she did so as ombudsman and not as the patient's "legal representative." (JA075-076.) That explains why the signature block for "Ombudsman Signature" (JA116) was signed by the Quality Services Nurse. That the form had a block for "Ombudsman

Signature" obviously meant that facility regarded the ombudsman as a patient representative for purposes of the Section 1418.8 procedure.[8]

The POLST order for Mark H. provided under the heading "Cardiopulmonary Resuscitation (CPR)" for two options: "Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B)" and "Do Not Attempt Resuscitation/ DNR (Allow Natural Death)." (JA117. Emphasis in original.)

Nowhere in her declaration did the ombudsman, Ms. Carroll, claim that she objected to the change of POLST to DNR.

Mark H. died on February 14, 2013, while under hospice care. (JA118.)

Procedural History

For purposes of this appeal, the operative pleading is the First Amended Complaint. Petitioners are California Advocates for Nursing Home Reform, which characterizes itself as an "advocacy organization" (JA637-638), as well as one of its attorney-employees, Anthony Chicotel (JA638), and a nursing home patient, Gloria A. (JA638.) Gloria A. was the only Petitioner directly affected by Health and Safety Code section 1418.8.

The Department of Public Health filed a Return By Answer. (JA540-550.)

There were three hearings in the matter, but no trial. Petitioners never proved that Dr. McDaniel (or any of the other physicians to which Petitioners referred in the anecdotal, hearsay evidence provided

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[8] Why the ombudsman refused to be the patient representative never was explained by her or Petitioners.

by Petitioners) incorrectly assessed Gloria A.'s decision-making capacity (or that of any of the other patients). Petitioners simply assumed the assessment was incorrect.[9]

The court ruled on June 4, 2015. The court's order (JA705-748) was in four parts, the last two of which were the actual rulings. (JA711-724 ["Facially Unconstitutional"], JA725-747 ["Unconstitutional As Applied"].) The court entered judgment on January 27, 2016. (JA852-855.) The judgment was in three parts. Part I. of the judgment (JA853-854) addressed the general issue in this case, relating to surrogate informed consent decisions for patients like Petitioner Gloria A. Parts II. and III. of the judgment (JA854-855) addressed the two specific issues in this case, physician orders of antipsychotic medications and Physician Orders For Life Sustaining Treatment ("POLST"), respectively.

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[9] Worse, Petitioners assumed that physicians like Dr. McDaniel are non-neutral or even biased, due to conflicts of interest. Worse still, Petitioners implied that physicians are unethical, if not dishonest, in ignoring patient wishes and in making decisions contrary to patients' best interests. (See discussion, *infra*, under point heading III.)

SUMMARY OF ARGUMENT BY *AMICI CURIAE*

Health and Safety Code section 1418.8 is constitutional, most certainly *on its face,* and there are many reasons why. Respondent Department of Public Health capably describes the most important reasons in its Appellant's Opening Brief, and *Amici* will not burden this Court by repeating those reasons. Rather, *Amici* offer the following, additional reasons.

Amici submit that Section 1418.8 is a good solution to the problem the Legislature addressed, as the Department explained and proved with competent evidence. The record in this case (particularly the physician declaration explaining the care of Gloria A. and the medical records explaining the care of Mark H.) reveal that the statutory procedure is operating just as the Legislature assumed it would, where physicians and the other health practitioners who agree to participate in the statutory procedure consider their patients' "wishes" and "best interests." The Superior Court's new requirement of written notice does nothing to improve that legislative solution and, to the contrary, diminishes it.

But even assuming for the sake of argument that physicians should provide the formalistic, four step written notice (JA853-854) the lower court insists is required by the California Constitution – and, to be sure, *Amici* contend physicians should *not* be required to do so – the court was wrong not to consider the adverse impact of its ruling on this population of patients, who no longer will be able to receive the "timely and effective medical treatment" that the Legislature intended. As explained by Respondent's expert witness (JA552-561), those patients' medical conditions will deteriorate for lack of "medical interventions" to the point that the legal formality of "informed consent" becomes irrelevant. Treatment will be delayed until there is an emergency, at which point the "emergency" exception to the requirement of an "informed consent" will allow the patients to receive the care they need.

Even that, however, is not enough for Petitioners. In their cross-appeal, Petitioners ask this Court of Appeal to rule still further, that only judges can assess patient decision-making capacity, in an adversarial proceeding with advocates for patients. (See, *e.g.*, RB/XAOB, p. 91 ["the treating physician may not be the decisionmaker as to incapacity" and "the resident is entitled to an advocate as to issues of decisional capacity"] and p. 71 ["some sort of representative, a counsel substitute"].) That totally defies the Legislature's directive, in Probate Code section 4658, that the primary physician determines health care decision-making capacity.

Finally, even if this Court is not persuaded by the Department's more competent evidence, the judgment at least should be reversed so that the matter can be remanded for further proceedings. Petitioners should be required to present *competent* evidence to support their allegations – that California physicians routinely misstate patient decision-making capacity in order to improperly overcome patient resistance, then restrain patients, and finally deny those patients end-of-life treatment – although *Amici* know that Petitioners will be unable to prove any of it. Petitioners also should be required to answer the very important question raised by the lower court, "is the issue that no one is willing to serve as patient representative?" (JA728.)

LEGAL ANALYSIS

I. EVEN THOUGH SECTION 1418.8 DOES NOT REQUIRE THAT THE PATIENTS RECEIVE FORMAL, WRITTEN NOTICE, THE STATUTORY PROCEDURE NEVERTHELESS IS CONSTITUTIONAL

That is the reason why Part I. of the Judgment should be reversed.

A. Section 1418.8 Was A Good Solution To The Problem Of How To Satisfy The Doctrine Of Informed Consent When The Patient Is Incapacitated And Unfriended

Section 1418.8 was an effective solution to the problem that arose when a physician realized his or her patient lacked capacity to meaningfully evaluate the nature of the treatment recommended by the physician (which treatment is described in the statute as “medical intervention”) and, in particular, to evaluate the consequences of the treatment. (That is why the patient is described as “incapacitated.”) Fortunately, in that circumstance, the physician usually was able to turn to family or friends with legal authority to evaluate the proposed treatment and to decide *for* the patient. In doing so, the family member or friend would act as a “surrogate” decision-maker for the patient. The physician had a definite problem, however, if the patient’s family and friends all refused to be the patient’s surrogate decision-maker, or when there were no family or friends with legal authority, or when there simply were no family or friends. (That is why the patient is described as “unfriended.”)

More to the point of the treatment, however, *it was the patient who really had a problem* because, without treatment, the patient's medical condition would deteriorate, for example, when the patient's chronic condition deteriorated and became an acute episode. The patient's reasonable expectation, of course, was that the physician would treat the patient's medical condition – precisely so that the patient's medical condition would not deteriorate. That was the patient's expectation even during those periods of time when the patient's *mental* condition deteriorated.

Mental deterioration sometimes occurs as patients get older, which is one reason why they reside at skilled nursing and intermediate care facilities – for assistance in living. The whole point of skilled nursing and intermediate care is to assure that the patients continue to receive food, shelter, and nursing care on an ongoing and timely basis. It is far less expensive than receiving such care in a hospital.

The Legislature enacted Section 1418.8 precisely to assure that such patients would continue to receive necessary care. To that end, the Legislature provided for surrogate decision-makers who would be the next best thing to family and friends who agreed to assume responsibility for the patients: the patient's attending physician, responsible nurse, and others on the health care team at the skilled nursing or intermediate care facility where the patient had chosen to reside. And, to be sure, the Legislature provided for a "patient representative," whether family, friends or a similarly interested person, to participate.[10] The Legislature's solution to the problem not only was rational; it was consistent with patient expectations. It also was consistent with social norms. (*Rains v. Belshe* (1995) 32 Cal.App.4th 157, 174.)

Most importantly for purposes of this appeal, Section 1418.8 was and still is consistent with the California Constitution. Contrary to the arguments of Petitioners and the holding of the Superior Court in this case, "the statute does not violate the constitutional privacy rights or due process rights of those nursing home patients who are determined by a physician to lack capacity to give informed consent to recommended medical intervention, and who do not have another person with legal authority to give that consent." (*Rains v. Belshe, supra,* 32 Cal.App.4th at 166.)

B. The Superior Court Held That Section 1418.8 Was Unconstitutional Simply Because The Statute Failed To Require Formal Written Notice To The Patients

The Superior Court declared Section 1418.8 unconstitutional and, in doing so, deprived patients of the benefits of the statutory procedure. The court's rationale was that the statute "does not require that the resident be adequately notified *in writing*." (JA853. Emphasis added.) The court felt that there was something to be

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[10] As the lower court noted, "An ombudsman can serve as a patient representative[.]" (JA728.) As Petitioners' expert witness put it, an ombudsman is "an independent person to represent the patient." (JA099.) As the Department of Public Health argues, the patient representative is "an advocate for the patient" (AOB, p. 14), "such as a long-term care ombudsman." (AOB, p. 18.)

gained by requiring written notification to those patients, even though by definition their attending physicians had determined the patients lacked the capacity to make decisions regarding health care and even though the physicians were obligated to "communicate the determination to the patient." (Prob. Code § 4732.)

But there is the obvious question, what is to be gained by also requiring *written* notice to such patients?[11] Perhaps the court assumed that *all* patients – with the only exception being those patients formally declared legally incompetent – who receive the written notices will be able *to understand* what the notices say, *to appreciate* the treatment to which the notices relate, *to weigh* the risks and benefits of the treatments, *to decide* that they do not want the treatments, and *to challenge* the determinations of their attending physicians. That is, perhaps the court assumed that *all* patients – including those determined by their physicians to be decisionally incapacitated but not yet determined by a judge to be legally incompetent – have the requisite ability to appreciate the written notice. (See, *e.g.*, JA718-719 ["To the extent that any of those patients are competent enough to want to challenge these determinations"].)

More likely, the court agreed with the unproven assumption of Petitioners' argument: that physicians incorrectly assess patients' health care decision-making capacity. That is, the court incorrectly assumed patients are being incorrectly assessed by physicians, and,

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[11] As the lower court itself noted, "If in fact, the patient lacks capacity, then the patient will likely be unable to understand the nature of these determinations[.]" (JA719, fn. 3.)

therefore, it follows that those patients do have the mental capacity necessary to understand and evaluate the written notices the court requires.

Most simply stated, the Superior Court – unlike the Legislature *but very much like Petitioners* – questioned the intent of attending physicians who assess the mental capacities of their patients. That was wrong.

C. While The Legislature Trusted Attending Physicians To Correctly Assess Patient Decision-Making Capacity, The Superior Court Did Not

For purposes of Section 1418.8, the Legislature obviously trusted that California physicians would endeavor to correctly assess their patients' health care decision-making capacity. For example, in subsection (a), the Legislature made clear that it is "the physician and surgeon [who] determines that the resident lacks capacity to make decisions concerning his or her health care" and then, in subsection (e), repeated the point, "the physician has determined that the resident lacks capacity to make health care decisions[.]"[12] In subsection (b), the Legislature explained to physicians (as well as all others reading Section 1418.8) that "a resident lacks capacity to make a decision regarding his or her health care if the resident is unable to understand the nature and consequences of the proposed medical intervention,

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[12] The patients are identified in the statute as "residents" or "patients" because the statute is in that chapter of the Health and Safety Code relating to "Quality of Long-Term Health Facilities."

including its risks and benefits, or is unable to express a preference regarding the intervention." That the Legislature trusted physicians to make those assessments also is apparent in the next sentence of subsection (b), "[t]o make the determination regarding capacity, the physician shall interview the patient, review the patient's medical records, and consult with skilled nursing or intermediate care facility staff, as appropriate, and family members and friends of the resident, if any have been identified." Finally, the Legislature did not require a formal court determination that the resident is legally incompetent.

Unlike the Superior Court, the Legislature assumed that any attending physician "believes in good faith that the action is consistent with this section and *the desires of the resident*, or if unknown, *the best interests of the resident*" (§1418.8(k), emphasis added), invoking the "dual standard" the Legislature previously announced in Probate Code section 2355.[13] In other words, the Legislature trusted that California physicians only would take action in the good faith belief that those actions were consistent with *the wishes of their patients* or, if unknown, *the best interests of their patients*.

The Superior Court apparently does not share the Legislature's confidence in California physicians. As explained above, the court's requirement for written notice only makes sense if it is assumed that physicians incorrectly assess patient health care decision-making incapacity. Another indication of the court's negative assumption

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[13] That same dual standard was described by the California Supreme Court in *Conservatorship of Wendland, supra*, 26 Cal.4th 519, 542-552 ["The primary standard: a decision in accordance with the conservatee's wishes"] and 552-554 ["The best interest standard"]).

about physicians is that the court said absolutely nothing in its Order or in the Judgment about *oral discussions* in which physicians communicate their assessments and their recommendations to their patients, as required by Probate Code section 4732. (See also, Prob. Code, § 4730; Health & Saf. Code, § 4732.) That too was wrong.

D. While The Legislature Built "Significant Safeguard" Features Into Section 1418.8, The Court Did Not Regard Those Safeguards As Sufficient

The Legislature built many patient protection features into Section 1418.8. In *Rains v. Belshe*, *supra,* those features were characterized as "significant safeguards." (32 Cal.App.4th at 184.)

Subsection (e) provides for the "interdisciplinary team" that includes "where practicable, a patient representative." It requires "an interdisciplinary team review of the prescribed medical intervention prior to the administration of the medical intervention." It specifies that "[t]he review shall include," among other things, "a discussion of the desires of the patient, where known. To determine the desires of the resident, the interdisciplinary team shall interview the patient, review the patient's medical records and consult with family members or friends, if any have been identified."

Subsection (f) provides, "[a] patient representative may include a family member or friend of the resident . . . or any other person authorized by state or federal law."[14]

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[14] An ombudsman can be a patient representative, as was assumed by the skilled nursing facility where patient Mark H. resided, although some ombudsmen apparently refuse to accept that responsibility. (JA

Subsection (g) requires that "[t]he interdisciplinary team shall periodically evaluate the use of the prescribed medical intervention[.]"

Subsection (h) provides, with respect to emergencies, "[i]f the emergency results in the application of physical or chemical restraints, the interdisciplinary team shall meet within one week of the emergency for an evaluation of the medical intervention."

Subsection (j) provides, "[n]othing in this section shall in any way affect the right of a resident of a skilled nursing facility or intermediate care facility for whom medical intervention has been prescribed, ordered, or administered pursuant to this section to seek appropriate judicial relief to review the decision to provide the medical intervention."

And, as noted above, subsection (k) provides immunity from administrative sanctions against physicians and other health care providers, *but only if* the action "is in accordance with reasonable medical standards" and "if the physician or health care provider believes in good faith that the action is consistent with this section and the desires of the resident, or if unknown, the best interests of the resident."

Finally, subsection (l) provides that "[t]he determinations required to be made [by the attending physician] pursuant to subdivisions (a), (e), and (g), and the basis for those determinations shall be documented in the patient's medical record and shall be made available to the patient's representative for review."

JA 728 ["the declarations of ombudsman submitted by Petitioners state that they cannot serve as patient representatives"].)

The Superior Court acknowledged these protections (JA721-724), as well as the authority of *Rains v. Belshe* (JA724) that held these protections were adequate to satisfy "constitutional muster." (32 Cal.App.4th at 184 ["Section 1418.8, thus, affords significant safeguards which, when we consider the statutory scheme in its totality, including the right to the participation and consent of a patient representative, and the right to object and secure a decision by a neutral and independent decision maker, meet the requirements of due process"].) Nevertheless, the Superior Court went on to find the statutory protections to be constitutionally insufficient because the statute failed to also require written notice. (JA712-721, 853 ["prohibited to the extent that said section does not require that the resident be adequately notified in writing"].)

Simply stated, in addition to distrusting physicians, the court apparently distrusts all of the patients' other health care providers who are on the interdisciplinary teams the Legislature trusted to serve as surrogate decision-makers. That was wrong, as well.

E. Even Though The Legislature Created A Non-Governmental Procedure For Patients And Their Health Care Providers To Make Decisions, The Court Assumed The Procedure Was An Exercise In Governmental Power

The Superior Court also agreed with Petitioners that a decision by way of the interdisciplinary team process created by Section 1418.8 is an exercise of "official action" or "*parens patriae*" power of the State to protect incompetent persons. (See JA718 ["the official action"]; RB/XAOB, pp. 67-68 ["the State's *parens patriae* interest"].) The court's reasoning in that regard, like Petitioners' argument, was wrong. The authority of the interdisciplinary team does not derive from the State's power – *parens patriae* – meaning that the State is exercising its power through the interdisciplinary team. The members of the team are the patient's own health care providers, and they are a team because they work together at the facility with which the patient contracts for his or her assisted living. The team can include the patient's own family, if they are available and willing to participate. The authority of the team derives from the patient's decision to reside at the facility, rather than at home or in an acute care hospital.

While it is true that a conservator appointed by the court, such as the conservator in *Conservatorship of Wendland*, *supra,* 26 Cal.4th 519, derives his or her authority from the *parens patriae* power of the State, that is because the conservator is appointed by the court. (26 Cal.4th at 535.) But "an agent or surrogate for health care, who is voluntarily appointed by a competent person" does not derive his or her authority from the *parens patriae* power of the State, nor does the interdisciplinary team at a skilled nursing or extended care facility. That is a different type of surrogate decision-maker – one not addressed by the California Supreme Court when it decided *Conservatorship of Wendland.* The interdisciplinary team is far more like a voluntarily appointed surrogate than like a conservator. That is because the team consists of those health care providers and others who have agreed to accept responsibility for the patient's care,[15] and, more importantly, whom the patient either has selected or at least accepted to be his or her caregivers.

The goal of the Legislature in enacting Section 1418.8 was to provide for precisely the opposite of what the court assumed, based on Petitioners' misleading arguments. The Legislature pointedly provided for a nongovernmental (that is, non-judicial) solution to the problem, to assure that population of patients would get the treatment they needed and get it quickly. That solution was a surrogate decision-making team consisting of the patient's attending physician, the patient's nurse, as well as "other appropriate staff in disciplines as determined by the resident's needs, and, where practicable, a patient representative," collectively referred to as an "interdisciplinary team." And, to assure consideration of "the desires of the patient," the Legislature further provided that "the interdisciplinary team shall interview the patient." (Health & Saf. Code, § 1418.8(e)(3).)

Only failing that did the Legislature provide for a governmental solution to the problem where "[t]he patient is unable to consent to the recommended care[.]" (Prob. Code, § 3208(a)(3).) That is, a court order.

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[15] The interdisciplinary team "shall include the resident's attending physician, a registered professional nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident's needs, and, where practicable, a patient representative[.]" (Health & Saf. Code § 1418.8(e).)

II. THE STATUTORY PROCEDURE WAS THE BEST WAY TO RECONCILE THE CONFLICTING POLICY CONSIDERATIONS OF SURROGATE DECISION-MAKING FOR THESE INCAPACITATED AND UNFRIENDED PATIENTS

That is the reason why Parts II. and III. of the Judgment should be reversed, as well.

A. The Department Of Public Health Correctly Applied Section 1418.8 To Physician Orders For Antipsychotic Medications And For POLST

The two "medical interventions" the Superior Court identified in the second part of its ruling, holding the statute unconstitutional *as applied* by the Department of Public Health, related to (1) physician orders of antipsychotic medications and (2) Physician Orders For Life Sustaining Treatment, known as "POLST." (JA854-855.) Admittedly, those second and third parts of the ruling present narrower questions than the first part. Both questions, however, are highly technical and implicate health care public policy:

1) What is the best procedure for physician orders of antipsychotic medications for patients who are incapacitated and unfriended?

2) What is the best procedure for POLST for patients who are incapacitated and unfriended?

Those are questions that are best answered by the Department, acting in its quasi-legislative capacity, because the Department is the most qualified branch of California government to answer the very technical questions Petitioners raise in their *as applied* constitutional challenge.

For that same reason, the Department should be presumed to have correctly answered those questions in this case, if only because the Department's analysis was based upon information from competent and qualified sources. And, the Director of the Department, who is a physician, was unlikely to conflate a physician's assessment of a patient's decision-making capacity with a judge's assessment of a petitioner's legal competence, as the lower court did.

Regardless of which branch of California government tries to answer the two specific questions Petitioners raise, however, the analysis should be based upon information from competent and qualified sources. It certainly should not be based on unproven assumptions, as occurred here. Nor should it be based on hearsay, unqualified opinion, and conclusory statements – such as those presented in the Petitioners' declarations.

B. Proxy Decision-Makers – That Is, Surrogates – Are Necessary For Patients Who Do Not Have The Capacity To Make Health Care Decisions For Themselves

The focus of the Superior Court's analysis is on informed consent by patients assessed by their physicians to be incapacitated. As one group of commentators put it, "[i]nformed consent *presupposes* decisional capacity" (William M. Altman, Patricia A Parmelee, Michael A Smyer, *Autonomy, Competence, and Informed Consent In Long Term Care: Legal And Psychological Perspectives,* 37 Villanova Law Rev. (1992) 1671, 1701, emphasis added), meaning the right has limitations.

> Inherently intertwined with the notions of autonomy and informed consent is the concept of "competency," for informed consent law primarily protects those capable of making decisions on their own behalf. Yet beyond this firm grounding in legal theory, the law continues to search for a workable application of the informed consent doctrine to avoid inappropriate denial of decisional autonomy while at the same time intervening on behalf of those unable or unwilling to make decisions for themselves.

(*Id.* at 1672. Footnote omitted.) The analysis of informed consent includes several elements; (a) "Decision-making capacity," which capacity is (b) "Informed," and which decision is (c) "Voluntary." (*Id.* at 1678-1685. Emphasis in sub-headings deleted.)

The decisional capacity that is presupposed for the informed consent of a patient can be by a person other than the patient. "In some instances, the law permits surrogates to make decisions on behalf of the incompetent person." (*Id.* at 1672, fn. 5, citing Paul B. Solnick, *Proxy Consent for Incompetent Non-Terminally Ill Adult Patients* (1987) 6 Journal of Legal Medicine 1, 16-29, emphasis added.)

The best solution to the problem is to allow the decisions to be made for the patients by surrogates, typically family members, who presumably know the patient's wishes. But that leaves the situation which Health and Safety Code section 1418.8 addressed, where there is no such person to serve as surrogate. That situation was addressed by the author of an article that considered the issue from the opposite perspective, when an incapacitated patient *agrees* to treatment. (Frederick A. Vars, *Illusory Consent*: *When An Incapacitated Patient Agrees To Treatment* (2009) 87 Or.L.Rev. 353, 395-399.) Where a patient has no willing and available surrogate, the treating physician still should not make the decision alone.

> It is not meaningful for a doctor to "consent" to her own treatment decisions. Where else can we turn for consent? The existing statutory fall-back option is guardianship. But guardianship is a time-consuming process, and it may be infeasible to appoint a guardian before treating every incapacitated patient, especially when the patient is assenting to treatment. This problem is exacerbated in the outpatient setting, where much treatment of dementia takes place. It may make sense to create a more expedited process to obtain interim consent while the guardianship process is pursued. An ethics review board or, probably better, an independent patient-advocate could be made available for consultation and provisional decision-making.

(*Id.* at 396.) In the situation where the patient refuses treatment, just as with consenting to treatment, "surrogates would have the power, subject to court overrule, to veto treatment." (*Id.* at 398.)

That is what Section 1418.8 provides.

C. With Respect To Antipsychotic Medications, Petitioners Raise An Issue In Which There Are Conflicting Policy Considerations

Part II. of the Judgment (JA854) relates to antipsychotic drugs. Petitioners assume that there is no medical benefit to such drugs. That is, Petitioners say nothing whatsoever about the other dimensions to the issue. For example, Petitioners say nothing about the problem of patients who need to be treated for self-destructive behavior. For another example, Petitioners say nothing about the problem of patients who are combative.[16]

The use of informed consent as a way of requiring judicial review for such drug treatment was proposed at least as early as 1988. (Comment, *A Bright Thread For California's Legal Crazy Quilt: A Proposed Right To Refuse Antipsychotic Drugs* (1988) 22 U.S.F.L.Rev. 341.) The author compared such drugs to psychosurgery and electroconvulsive therapy (*id.* at pp. 352-359) and argued that the Lanterman Petris Short Act should be amended to protect the right to refuse unwanted antipsychotic medication. (*Id.* at pp. 359-370.) The author rejected the then recent California decisions in *Keyhea v. Rushen* (1986) 178 Cal.App.3d 526 (*id.* at 379 ["idiosyncratic law and without an explicit statutory right to refuse antipsychotic medication"]) and *Riese v. St. Mary's Hosp. and Med. Center* (1987) 196 Cal.App.3d 1388. (*Id.* at 379 ["gap in its reasoning is troubling"].)

Suffice to say, in the late 1980's, the courts in *Keyhea* and *Riese* were addressing a controversial issue, and the comment in the U.S.F. Law Review implied that the controversy was still being debated by some.

But then, in 1992, the Legislature enacted Section 1418.8. Even though the statute addressed Petitioners' concern about

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[16] That was the problem with which the California Supreme Court had to grapple in *Gregory v. Cott* (2014) 59 Cal.4th 996.

"physical and chemical restraints" in subsection (h), Petitioners continued to disagree. Petitioners challenged the statute in court, the Legislature amended the statute, and the statute was upheld. Since then, the statute has functioned as the Legislature intended. Now, over twenty years later, Petitioners revive that old controversy, arguing that physicians prescribe psychotherapeutic medications to this population of patients as "chemical restraints," rather than as "medical treatment," citing the examples of Petitioner Gloria A. and Mark H. (RB/XAOB, pp. 40-43, 46.)

Amici absolutely reject Petitioners' overgeneralization that physicians only prescribe psychotherapeutic medications to achieve "chemical restraint" and never to achieve "medical treatment." *Amici* cite the evidence in the record in this case as a demonstration of how Seroquel was prescribed for treatment, not restraint. (JA127-131, 473.) More to the point, the evidence in the record explains how these drugs are used for "treatment," not just "restraint" of those patients "suffering from psychotic episodes or self-injurious behavior[.]" (JA557-560.) There is no competent evidence to the contrary, let alone to support Petitioners' argument.

There is another dimension to the issue that Petitioners ignore: what happens when such drugs no longer can be prescribed by physicians for these patients? They wind up in mental hospitals. The situation will return to that which existed before psychotherapeutic medications and skilled nursing facilities were available – when there instead were many more mental hospitals.

> A movement away from mental hospitals had begun in the mid-1950s. The national census of mental hospitals declined from a peak of 643,000 in 1954 to 579,000 by 1963. The predominant, though contested, explanation for the drop is that the discovery and introduction of major tranquilizers (e.g., Thorazine) was the decisive event. Patients who were previously hospitalized could now be safely treated, or at least more safely ignored, on an outpatient basis. Another interpretation points to the adoption by Congress in 1956 of amendments to Social Security that provided greater aid to states to support the aged in nursing homes. Mental hospitals had been filled with unwanted older people suffering only from a harmless senility. By transferring such patients from mental hospitals to nursing homes, the states could transfer the cost of upkeep to the federal government. Probably both drugs and nursing homes had some effect on the decline of mental hospitalization.

(Paul Starr, *The Social Transformation of American Medicine* (1982) p. 365. Footnotes omitted.) Petitioners say nothing to allay concerns that, without the availability of "both drugs and nursing homes" for physicians to treat this patient population, the social and economic "effect" will be increased mental hospitalization.

Finally, even assuming the controversy about antipsychotic drugs that was debated in the 1980s and then addressed by the Legislature in the early 1990s should be debated yet again, as Petitioners are determined to do, it is the Department of Public Health that should be trusted to weigh the conflicting policy decisions. Failing that, it is the Legislature that should reexamine the controversy.

D. With Respect To End-Of-Life Health Care Decisions, Petitioners Raise An Issue With Some Of The Most Profound Questions Of Public Policy

Part III. of the Judgment (JA854-855) relates to using IDT for POLST/end-of-life care. Petitioners have "sensationalized" the issue, by suggesting that physicians are using IDT's to hasten death. (RB/XAOB, p. 58 ["This appeal involves the potential deaths of nursing home residents, which deaths may be hastened by physicians and nursing homes"].) Typically, however, the relevant question for a patient at a skilled nursing or intermediate care facility is, when a problem arises (for example, a cardiac emergency), do you want us to call the paramedics and have you transported to the hospital? That dimension of the issue was explained by the Department's expert witness, Dr. Steinberg. (JA 560-561.) If "Full Treatment" becomes necessary because the patient or the patient's surrogate insists upon it, skilled nursing and intermediate care facilities arrange for the patients to be transported to acute care hospitals. As revealed in the factual record relating to patient Mark H., that means CPR – cardiopulmonary resuscitation. "Full Treatment" means "use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/ cardioversion as indicated," followed by "**Transfer to hospital**, if indicated. Includes intensive care." (JA117. Emphasis in original.)

In any event, analysis of the issue solely in terms of the doctrine of informed consent, as Petitioners propose, can be misleading. The application of informed consent to the context of long term care has been the subject of academic discussion, and some have warned that it is of limited and limiting value. (See, *e.g.,*William M. Altman, Patricia A. Parmalee, and Michael A. Smyer, *Autonomy, Competence, And Informed Consent In Long Term Care: Legal And Psychological Perspectives, supra,* 37 Vill.L.Rev. 1671.)

> We argue that psychology's process orientation and focus on the complex interplay between personal, environmental and social factors can help expand the otherwise rigid and narrow elements of informed consent. Incorporating psychological perspectives may help the law distinguish those situations in which an elderly person's decisions should be implemented and those in which paternalistic intervention is justified.

(*Id.* at 1672-1673.) One of the questions about informed consent that the article attempts to answer is "how does the doctrine apply to those with transient or waning competence?" (*Id.* at 1678.)

The issue of informed consent by long term care patients is particularly significant in the context of refusing life-sustaining treatment. (See, *e.g.*, John J. Regan, *Refusing Life-Sustaining Treatment For Incompetent Patients: New York's Response To Cruzan* (1992) 19 N.Y.U. Rev.L.&Soc.Change 341.) It is even more important in that context to not make a public policy decision based on "the otherwise rigid and narrow elements of informed consent."

Petitioners rely primarily upon the California Supreme Court decision in *Conservatorship of Wendland, supra,* 26 Cal.4th 519 (cited at RB/XAOB, pp. 10, 30, 35, 43, 46, 53, 58, 63-67, 77-80, 83, 90), where the Court observed that "the *competent* adult's right to refuse medical treatment may be safely considered established, at least in California" and "California law has given *competent* adults the power to leave formal directions for health care in the event they later become incompetent[.]" (26 Cal.4th at 533. Emphasis added.) The *Wendland* case involved a different situation, however, where the decision about end-of-life care was by a court appointed conservator. The Court stated the obvious, that "the primary standard" for such is "a decision in accordance with the conservatee's wishes." (26 Cal.4th at 542. Emphasis in heading deleted.) The Court then explained that the "fallback" standard is the "best interest standard." (26 Cal.4th at 552-554.)

Those standards (the patient's "wishes" and the patient's "best interest") are the same standards set forth in Section 1418.8. The difference is that Section 1418.8 is directed at physicians, nurses, other health practitioners, and patient representatives – not at conservators appointed by the court.

E. If This Court Still Has Questions About Antipsychotic Medications Or POLST, The Entire Matter Should Be Remanded Back To The Superior Court For Further Proceedings

If this Court decides to address the issues of antipsychotic medications and POLST that have been raised by Petitioners, *Amici* submit that this Court only should do so based on a full record, about real patient cases, with an opportunity for the physicians and other stakeholders to be heard. For example, with respect to Gloria A., whose complaint was that Dr. McDaniel incorrectly ordered her to receive Seroquel and incorrectly ordered that she was not to leave the facility unattended by skilled personnel, Petitioners should be required to present competent testimony about her mental capacity. For another example, with respect to Mark H., the patient for whom the interdisciplinary team decided that hospice care was best, Petitioners should be required to present competent evidence as to whether he was at risk of a life-threatening event and, if so, whether he wanted to be transferred yet again back to the hospital for full treatment. For still another example, as to the unidentified patient who did not want to be transferred for full treatment (JA098-099), Petitioners should be required to present competent evidence from his physician, nurses, and other health practitioners as to why they decided as they did.

Only then will this Court be able to determine whether there really is a controversy, let alone whether there is a need for judicial intervention into this complex area of competing public policies.

III. THE FACTUAL RECORD IN THIS CASE DOES NOT SUPPORT THE SUPERIOR COURT'S FINDINGS

That is the reason why, if nothing else, the matter should be remanded for further proceedings.

A. The Lower Court Relied Upon Incompetent, Conclusory Evidence Provided By Petitioners, Ignored The Competent Evidence Provided By The Department, And Assumed Unproven Facts About Physicians And Other Health Care Providers

There was no trial. There was no evidentiary hearing in which it was competently established that Gloria A. or any of the other patients about whom Petitioners presented anecdotal evidence had the capacity to make health care decisions.[17] Indeed, there was only one difference between the inadequate evidentiary basis of the challenge in this case and the inadequate evidentiary basis of the challenge in *Rains v. Belshe, supra*.[18] In *Rains,* counsel relied upon "sensational suggestions in popular news articles" (32 Cal.App 4th at 183, fn. 6), whereas here counsel relied upon the hearsay, unqualified opinions, and conclusory statements in the declarations he attached to the Petition. (JA065-102.)

Worse, Petitioners here not only failed to provide competent evidence, but somehow persuaded the lower court to ignore the competent evidence that was provided by the Department, in the declaration of Dr. McDaniel.

Worst of all, Petitioners persuaded the lower court to assume that physicians and other health care providers do not consider the wishes of their patients and do not decide based on the best interests of their patients. (The following two subsections of this brief explain why the lower court ruling in those regards was based on false assumptions.)

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[17] Petitioners did not present any physician or other competent testimony to support their claim of the patients having sufficient mental capacity to make informed health care decisions.

[18] Why the constitutional challenge in this case essentially duplicates that in *Rains* is easily explained. This case is being pursued by the same attorney who unsuccessfully pursued *Rains.* That, in turn, explains why the decision is *Rains* is criticized, both expressly and impliedly, in the Petitioners' brief in this case. (See, *e.g.*, RB/XAOB, pp. 33-34, 45, 62, 62, 67.) And, it is worth noting, prior to *Rains,* that same attorney unsuccessfully pursued a similar challenge. (32 Cal.App.4th at 165, citing case no. A060010.)

Fortunately, the lower court specifically rejected Petitioners' contention that patient representatives are not part of the statutory procedure's interdisciplinary teams. (JA726 ["Petitioners, however, have not provided sufficient evidence to support their contention that a patient representative is not part of the IDT"].) Petitioners misstate that was one of the "facts found by the superior court." (RB/XAOB, p. 27, citing JA726-727.)

Finally, Petitioners misstate the evidence, as where they assert that, with regard to Gloria A., "no attempt was made to have her nephew become her surrogate. JA472." (RB/XAOB, p. 19.) The witness said the opposite. (JA472 ["her cousin did not want to be further responsible" and "a nephew, later was identified and agreed to assist in her affairs"], JA474 ["acted as her surrogate decision-maker at that time and stated that he always had concerns about her decision-making capacity and felt that she received appropriate, quality care"].)

B. There Is No Evidence That California Physicians Assess Patient Incapacity Because Of Conflicts Of Interest

The court's analysis of physician conflicts of interest was based entirely on the conclusory allegations of Petitioners, who argued that physicians are erroneously or even falsely declaring that competent patients are incompetent. For example, in the "Introduction" to their First Amended Petition, CANHR and Chicotel alleged "**misuse**" of the statute in question. (JA632. Emphasis added.) They then alleged that "Respondent has never enforced the statute" and that "[t]he result is widespread **disobedience**[.]" (*Id.* at 637. Emphasis added.) In the

"Statement of Facts" they alleged that "[t]he result is **significant errors** as to capacity determinations." (*Id.* at 648. Emphasis added.) "Additionally, there is **significant inconsistency** in capacity judgments by physicians." (*Id.* at 649. Emphasis added.) Petitioners alternatively characterized the problem as "**[e]rroneous** capacity decisions" (*id.* at 650, emphasis added) or "capacity **errors**[.]" (*Id.* at 651. Emphasis added.)

According to Petitioners, the purported reason for the *problem* of such "errors" and "misuse" is that California physicians are "biased," as where Petitioners alleged that "[t]he determinations also may involve **bias on the part of the clinician**[.]" (JA648. Emphasis added.) Petitioners attributed this to "physician and institutional **conflict in determinations of incapacity** in hospitals and nursing homes[.]" (*Id.* at 657. Emphasis added.)

To be clear, there is no *competent* evidence to support the court's analysis of physician assessments of capacity. That is because Petitioners provided no evidence to support their conclusory arguments about the motivations of physicians.

C. There Is No Evidence That California Physicians Make Decisions Contrary To The Best Interests Of Their Incapacitated, Unfriended Patients

Amici were astonished to read in the Order that the lower court found "that physicians and IDTs are making end of life decisions **without consulting patients and without considering patient's wishes**[.]" (JA744. Emphasis added.) *Amici* understood that to mean that the lower court was critical of California physicians and other health care practitioners who treat this population of patients and participate in the statutory procedure. Any doubt about what the court really intended to say was dispelled when *Amici* read the last section of the court's Order: "the statute is being applied to permit physicians and IDTs to make such end of life decisions for the patients, [1] **irrespective of the patient's instructions** on such health care decisions [2] **without demonstrating that such treatment would be medically ineffective** or [3] **contrary to generally accepted standards**." (*Id.* at 746-747. Emphasis in bold and numbers added.)

There is no competent evidence in the record to support such findings. Certainly, the court cites none. Nor do Petitioners.

Petitioners simply assume that physicians act contrary to the best interests of their patients. This is most apparent in Petitioners' appellate brief, which becomes ever more shrill as the brief progresses. For example, in the introductory section that serves as the "Statement of the Case," Petitioners argue, "[h]aving decided on the need for treatment before making the incompetence and surrogacy decisions, **the physician lacks neutrality**." (RB/XAOB, p. 12. Emphasis added.) By the end of the brief, in pursuit of their cross-appeal from the judgment, Petitioners argue, "[t]his appeal involves the potential deaths of nursing home residents, **which deaths may be hastened by physicians and nursing homes**[.]" (*Id.* at p. 58. Emphasis added.) Petitioners describe "**the role of physicians in disabling people of their fundamental rights** to make medical decisions[.]" (*Id.* at p. 66. Emphasis added.) Petitioners then warn about "**the physician who decides not to obey the legal instructions of the patient**[.]" (*Id.* at p. 85. Emphasis added.)

Petitioners pursue this argument even further, in describing a hypothetical conspiracy between a physician and nurse "to fail to comply with patient wishes" and "then notify the fragile patient that he or she can go to court and try to get a temporary restraining order." (RB/XAOB, p. 86.) Petitioners then predict what the statutory procedure allows a physician to get away with. (*Id.* at p. 89.)

This is the same argument that the petitioner in *Rains v. Belshe, supra* (represented by the same attorney as Petitioners in this case), made over twenty years ago to Division Five of this Court. That argument, as summarized by Division Five, was that,

> the patient's examining physician, to whose judgment the Legislature has entrusted this decision under the statute's guidelines, may be someone possibly interested in finding the patient incompetent. Plainly put, petitioner suggests the patient's own physician cannot be considered a neutral arbitrator on the capacity issue because of the possibility the physician may be financially interested in undertaking income producing medical procedures on a patient powerless to resist because of the physician's incapacity determination.

(32 Cal.App.4th at 180.)

> Petitioner simply argues that a hypothetical possibility exists, which this record does not support, that a physician may misrepresent the mental capacity of a nursing home patient to consent to medical intervention in order to impose that treatment for the financial gain of the physician or an associated institution.

(*Id.* at 181.)

Division Five rejected the argument. So too should this Court.

IV. UNLESS AND UNTIL THE JUDGMENT IS REVERSED, MANY INCAPACITATED AND UNFRIENDED PATIENTS WILL REMAIN IN CALIFORNIA'S ACUTE CARE HOSPITALS FOR THE ASSISTANCE THEY SHOULD RECEIVE IN SKILLED NURSING AND INTERMEDIATE CARE FACILITIES

Yet another reason the Judgment should be reversed is because it adversely impacts California acute care hospitals and their patients.

A. Acute Care Hospitals And Skilled Nursing And Intermediate Care Facilities Serve Different Patient Populations, And They Serve Different Roles In The Rendition Of Health Care

California's acute care hospitals serve seriously ill patients. Acute care — as distinguished from skilled nursing care or long-term care — is a branch of health care where a patient receives active but short-term treatment for a severe injury or episode of illness, an urgent medical condition, or surgery and recovery therefrom. Acute care settings include the emergency departments, intensive care units, coronary care units, cardiology units, and other inpatient areas of a hospital. The average length of stay for an inpatient in a California hospital is 4.6 days.

In contrast, the typical patient stay at a skilled nursing or intermediate care facility is much longer. Many stay for months or even years. The average length of stay for patients currently in nursing homes is 892 days, or 2.44 years. The average length of stay for those patients who are able to be discharged is 272 days, or approximately nine months. The average length of stay for patients who die in a skilled nursing facility is just under two years.

While skilled nursing facilities, as the name implies, provide highly skilled nursing care, they also strive to provide a home-like setting to their patients — which is why persons in those facilities are usually referred to as “residents” rather than “patients.” The facilities provide activities and social opportunities every day for their residents, such as movies, music, group exercises, games, religious services, arts and crafts, animal visits, outings and other events. The residents wear their own clothes, not hospital gowns. Residents in skilled nursing and intermediate care facilities feel at home and know their neighbors and caregivers. The familiar surroundings and daily routine are particularly important to those elderly persons who struggle with cognitive impairment or dementia.

Hospital-based acute inpatient care, on the other hand, typically has the goal of discharging patients as soon as those patients can be appropriately cared for in a non-acute environment, such as at home or, if that is not sufficient, at a skilled nursing or intermediate care facility. Acute care hospitals are not designed to provide long-term or residential care. They typically do not have activity programs. They are busy and noisy 24 hours a day, and patients often find it difficult to sleep at night. While an acute care hospital is absolutely the best place for an acutely ill person, it is not a good place for a chronically ill person to stay indefinitely.

B. As A Result Of This Case, Patients Are Being Forced From Skilled Nursing And Intermediate Care Facilities To Acute Care Hospitals

As a result of this case, incapacitated, unfriended patients are being forced into inappropriate care settings, adding to overcrowding at acute care hospitals. Acute care hospitals in California are increasingly finding it difficult or impossible to transfer such patients to skilled nursing or intermediate care facilities. Although these patients no longer need acute care and can be well cared for in the skilled nursing setting, hospitals are finding in the wake of the Judgment in this case that those facilities are reluctant — or are refusing — to accept the patients.

Unnecessarily retaining such patients in the acute hospital setting results in denial of access to medically necessary post-hospital and community-based care. Ultimately, it compromises patient outcomes. Moreover, housing patients who no longer need acute care services in hospital beds is an inappropriate and costly allocation of resources that may be needed by other patients.

Communities design and build acute care hospitals with the appropriate number of beds and services needed to serve the acute care needs of that community. Acute care hospitals simply do not have extra capacity to care for long-term patients who do not need acute care. The increasing inability of hospitals to discharge unrepresented patients to skilled nursing or intermediate care facilities, combined with the additional patients coming to the acute setting from those facilities, is exacerbating the overcrowding experienced in many hospitals, both in the inpatient units and in the emergency departments. This means that patients who need elective services, *i.e.*, non-emergency, scheduled surgery or other procedures, must wait until a bed becomes available. It also means that emergency patients have a longer wait time.

V. PETITIONERS INCORRECTLY ASSUME THAT PHYSICIANS ASSESS HEALTH CARE DECISION-MAKING CAPACITY IN THE SAME WAY AND TO THE SAME END AS JUDGES ASSESS LEGAL COMPETENCE

One of the many reasons why Petitioners' Cross-Appeal should be rejected is because it is based on another false assumption, that a physician's assessment of his or her patient's health care decision-making incapacity is the same as a judge's assessment of a litigant's legal competency.

A. In Their Cross-Appeal, Petitioners Argue That Only Judges Should Assess Health Care Decision-Making Incapacity

Petitioners assume – and, again, to be sure, it must be pointed out that Petitioners assume incorrectly – that a physician's assessment of his or her patient's decisional capacity is the same as a judge's assessment of a person's legal competence. In other words, Petitioners conflate the two concepts, one of which is a medical concept and the other is a legal concept, to support their argument that physicians are making legal conclusions to deprive patients of their rights. Based on that false assumption and that erroneous argument, Petitioners declare in their cross-appeal that "neither the physician nor the interdisciplinary team may decide decisional incapacity." (RB/XAOB, p. 29.)

For that matter, throughout this case, Petitioners have framed the issue *only* in terms of legal "competence." For example, their Petition began, "Californians have a fundamental right, even as prisoners and if mentally ill, to refuse medical treatment (*Thor v. Superior Court* (1993) 5 Cal.4th 725, 731) unless adjudicated legally incompetent (*In re Qawi* (2004) 323 Cal.4th 1)." (JA024.) The statute that petitioners argued in this case to be unconstitutional, Health and Safety Code section 1418.8, however, was framed by the Legislature in terms of the patient who "lacks capacity to make decisions regarding his or her health care." The statutes that were analyzed by the California Supreme Court in *Thor v. Superior Court* and *In re Qawi* were analyzed in terms of legal "competence." Here, Petitioners conflate the two concepts in order to argue that, under the statutory procedure, physicians should not be allowed to assess the mental capacities of their patients.

Petitioners are wrong. As the Legislature found, "[i]n the absence of a 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 (c).)

B. The Medical Concept Of "Capacity" Is Not The Same As The Legal Concept Of "Competence"

"Capacity" refers to a clinical assessment that a physician makes for purposes of diagnosis and treatment. "Competence" refers to a judicial determination that is made for purposes of a judge's ruling on a legal matter regarding the person. That is why, when judges are called upon to assess a person's legal competence, judges consider a number of things, one of which may be a physician's assessment of the person's mental capacity. But that is not to say that, in doing so, the judge is reviewing the physician's assessment of mental capacity. Rather, the judge is considering the physician's assessment for a separate, judicial purpose.

While it is true that the words "capacity" and "competency" both generally refer to the concept of "ability," there are important differences in the medical and legal definitions of the "ability" in question in this case. One commentator explained it this way:

> The terms "competence" and "capacity" frequently are used interchangeably in common parlance. However, the two terms technically refer to distinct concepts. [Citation.] As used in this essay, "competence" refers to a formal adjudication by a court or other authorized judicial or administrative body regarding the legal authority of an individual to make decisions with legal consequences. By contrast, "capacity" refers to a clinical, extralegal working impression concerning a person's ability to engage in a rational decision-making process. "A capacity assessment is a clinical assessment." [Citation.]

(Marshall B. Kapp, *Older Clients With Questionable Legal Competence*: *Elder Law Practitioners And Treating Physicians* (2010) 37 Wm.MitchellL.Rev. 99, at 99, fn. 2.)

Or, as the Court of Appeal explained in *Riese v. St. Mary's Hospital and Medical Center, supra,* 209 Cal.App.3d 1303, quoting an eminent psychologist, "'[c]ompetence is not a clinical, medical, or psychiatric concept. It does not derive from our understanding of health, sickness, treatment, or persons as patients. Rather, it relates to the world of law, to society's interest in deciding whether an individual should have certain rights (and obligations) relating to person, property and relationships.'" (209 CalApp.3d at 1321, citing R. Michels, *Competence to Refuse Treatment* in A. E. Doudera & J. P. Swazey, *Refusing Treatment in Mental Health Institutions – Values in Conflict* (1982), at p. 115; accord, Paul S. Appelbaum & Thomas G. Gutheil, *Clinical Handbook of Psychiatry and the Law* (1982), at p. 215.)

Perhaps the clearest statement that the two words refer to distinct concepts is Probate Code section 2354, which states that a conservatee – a person found to be legally incompetent – nevertheless may have "the capacity to give informed consent for medical treatment." Correspondingly, Probate Code section 3208 states that even an adult who is not a conservatee – a person who is assumed to be legally competent – nevertheless may be "unable to consent to the recommended care." (Prob. Code, § 3208(a)(3).)

C. The Distinction Between Mental "Capacity" And Legal "Competence" Turns On The *Purpose* For Which The Person's Capacity Is Being Assessed

Probate Code section 813 was enacted in 1995, the same year that *Rains v. Belshe* was decided and a year after Health and Safety Code section 1418.8 was amended. As a result, "*for purposes of a judicial determination*," a judge or other trier of fact must find items (1), (2), and (3) in subsection (a) of Section 813 in order to answer the question of whether “a person has the capacity to give informed consent to a proposed medical treatment[.]”

For purposes of a medical determination, however, a physician does not limit the analysis to the findings required by Probate Code section 813. That is because the answer to the question for purpose of a medical determination is *qualitative*, expressed in varying degrees of mental capacity, as it was explained by the Department’s expert witness in gerontology, Dr. Steinberg. (JA555-556.) That was acknowledged even by Petitioners’ witness, Social Worker Peggy Main. (JA097 [“a form known as History and Physical with boxes at the bottom where the physician may check ‘has capacity’, ‘has no capacity’ or has ‘fluctuating capacity’”].) That terminology is consistent with the Legislature’s use of the word “capacity” in the chapter of the Uniform Health Care Decisions Act entitled “Duties of Health Care Providers.” (Prob. Code, §§ 4730-4736.)

For example, “[a] primary physician who makes or is informed of a determination that a patient lacks or has recovered capacity, or that another condition exists affecting an individual health care instruction or the authority of an agent, conservator of the person, or surrogate, shall promptly record the determination in the patient’s health care record and communicate the determination to the patient, if possible, and to a person then authorized to make health care decisions for the patient.” (Prob. Code, § 4732.)

The assessments vary from individual to individual, of course, and often those assessments are very detailed. A good example is the assessment in this case of Petitioner Gloria A. that was provided by her attending physician Dr. McDaniel. (JA470-475.)

In summary, a physician makes a clinical assessment of his or her patient's mental function for purposes of diagnosis and treatment of disease or trauma, while a judge makes a judicial assessment of a litigant's authority to create relations with other persons for purposes of resolving disputes.

D. The Reason Why Section 1418.8 Refers To "Capacity" And Not "Competence" Is That The Legislature Intended It To Guide Physicians And Other Health Care Practitioners, Not Judges And Other Evaluators Of "Legal Competency"

The "Health Care Decisions Law" (Health & Safety Code, §§ 4600, et seq.) also speaks in terms of "capacity" (§ 4609), not competence. It provides for decision by "surrogate" (§ 4617) and that a health care decision by surrogate does not require "judicial approval." (§ 4750.) By conflating the medical concept of mental capacity with the legal concept of legal competence, however, Petitioners are able to ignore the Legislature's fundamental point about health care decision-making capacity. As it was described by the Department's expert witness Dr. Steinberg:

> Section 1418.8 appropriately leaves capacity determinations to the resident's attending physician rather than the courts. Such physicians generally have significant medical experience caring for this population (including patients suffering from various stages and types of dementia) and are bound by strong ethical standards. Physicians routinely make capacity determinations for their patients, whether or not nursing home residents, as they must determine whether a patient has capacity to provide informed consent when obtaining

> consent for ***any*** medical intervention. In the nursing facility context, more specifically, attending physicians must assess and identify the decision-making capacity of every nursing home resident upon admission.

(JA555. Emphasis in original.) For example, in enacting Section 1418.8, subsection (a), the Legislature used the word "capacity." Nowhere in the statute did the Legislature use the word "competence." Instead of the phrase "legal competence" to decide, the Legislature used the phrase "legal authority" to decide, such that the statute only applies where there is "no person with legal authority to make those decisions on behalf of the resident."[19]

That is not to say Section 1418.8 is inconsistent with Probate Code section 813, which was enacted a few years later. In Section 1418.8, subsection (b), the Legislature defined "capacity" for purposes of the statutory scheme consistently with the medical definition, "a resident lacks capacity to make a decision regarding his or her health care if the resident is unable to understand the nature and consequences of the proposed medical intervention, including its risks and benefits, or is unable to express a preference regarding the intervention" – the same idea reflected in Probate Code section 813.

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[19] In subsection (c), the Legislature defined "authority" for purposes of the statutory scheme, as "a person with legal authority to make medical treatment decisions on behalf of a patient is a person designated under a valid Durable Power of Attorney for Health Care, a guardian, a conservator, or next of kin."

CONCLUSION

By commanding that "the use of Health and Safety Code section 1418.8 is prohibited" (JA853), the Judgment in this case will adversely affect care of this patient population, *i.e.*, the incapacitated and unfriended patients who require assistance and, therefore, who reside in skilled nursing and intermediate care facilities. The goal of the Legislature was to allow California physicians and other health care practitioners to provide timely and efficient care to those patients, but that goal will be frustrated because it will be necessary for physicians to seek judicial approval before providing the recommended care. That goal will be *defeated* in those cases where the time for medical intervention is limited. For those reasons alone, the Judgment should be reversed.

Dated: March 28, 2017

COLE PEDROZA LLP

By: ______________________
Curtis A. Cole
Cassidy C. Davenport
Attorneys for
California Medical Association,
California Dental Association, and
California Hospital Association

CERTIFICATION

Appellate counsel certifies that this document contains 13,960 words. Counsel relies on the word count of the computer program used to prepare the document.

Dated: March 28, 2017

By: ______________________________
Curtis A. Cole

PROOF OF SERVICE

I am a resident of or employed in the County of Los Angeles; I am over the age of eighteen years and not a party to the within action; my business address is: 2670 Mission Street, Suite 200, San Marino, California 91108.

On this date, I served the *AMICI CURIAE* BRIEF OF CALIFORNIA MEDICAL ASSOCIATION, CALIFORNIA DENTAL ASSOCIATION, AND CALIFORNIA HOSPITAL ASSOCIATION IN SUPPORT OF APPELLANT AND CROSS-RESPONDENT on all persons interested in said action in the manner described below and as indicated on the service list:

SEE ATTACHED SERVICE LIST

By United States Postal Service – I am readily familiar with the business's practice for collecting and processing of correspondence for mailing with the United States Postal Service. In that practice correspondence would be deposited with the United States Postal Service that same day in the ordinary course of business, with the postage thereon fully prepaid, in San Marino, California. The envelope was placed for collection and mailing on this date following ordinary business practice.

By TrueFiling – I electronically transmitted the above-referenced documents pursuant to California Rules of Court, rule 8.71(a) and Local Rules of the California Court of Appeal, First Appellate District, local rule 16, through the TrueFiling electronic filing system.

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

Executed this 28th day of March, 2017 at San Marino, California.

Sara Mazzeo

SERVICE LIST

Mark E. Reagan (SBN 143438)
Hooper Lundy & Bookman
575 Market Street, Ste. 2300
San Francisco, CA 94105
Tel: 415-875-8501
Fax: 415-875-8519
mreagan@health-law.com

Counsel for Defendant, Appellant and Cross-Respondent
KAREN SMITH, M.D., MPH, as Director of the California Department of Public Health
(By U.S. Mail)

Joshua N. Sondheimer (SBN 152000)
Office of the Attorney General
455 Golden Gate Avenue, Ste. 11000
San Francisco, CA 94102
Tel: 415-703-5615
Fax: 415-703-5480

Counsel for Defendant, Appellant and Cross-Respondent
KAREN SMITH, M.D., MPH, as Director of the California Department of Public Health
(By U.S. Mail)

Morton P. Cohen (SBN 63644)
Morton P. Cohen Attorney At Law
536 Mission Street
San Francisco, CA 94105
Tel: 415-442-6678
Fax: 415-543-6680
mcohen@ggu.edu

Counsel for Petitioners, Respondents, and Cross-Appellants
CALIFORNIA ADVOCATES FOR NURSING HOME REFORM, GLORIA A., and ANTHONY CHICOTEL
(By U.S. Mail)

Amitai Schwartz (SBN 55187)
Law Offices of Amitai Schwartz
2000 Powell Street, Ste. 1286
Emeryville, CA 94608
Tel: 510-597-1775
Fax: 510-597-0957
attorneys@schwartzlaw.com

Counsel for Petitioners, Respondents, and Cross-Appellants
CALIFORNIA ADVOCATES FOR NURSING HOME REFORM, GLORIA A., and ANTHONY CHICOTEL
(By U.S. Mail)

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