Health Care Decision Making for California’s Unrepresented Nursing Home Residents: Health and Safety Code Section 1418.8

A Guide for California’s Long-Term Care Ombudsman

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About this Guide
This Guide is intended to assist local Ombudsman Programs to address health care decision making by nursing home inter-disciplinary teams ("IDTs") for unrepresented residents pursuant to Health and Safety Code Section 1418.8. While the IDT process is fairly well-defined in the law, the role of the Ombudsman representative is unclear.

No law requires Ombudsman participation in IDT meetings. Although Ombudsman participation was clearly contemplated when the law was adopted and in a subsequent pivotal court case, the inclusion of Ombudsman representatives in IDTs varies among facilities and local programs. Local programs have complete discretion over their participation in IDTs. While Ombudsman participation likely enhances the rights of residents who are the subject of IDTs, local programs should ensure that mandated activities are prioritized, especially given the overwhelming demand for Ombudsman services.

UNREPRESENTED PATIENTS
Many nursing home residents throughout the state are legally considered “unrepresented,” A nursing home resident is considered unrepresented if the resident:

1) lacks capacity as determined by a physician;
2) does not have a legally recognized surrogate decision maker; and
3) does not have an advance directive or other evidence of his or her health care preferences.

The number of unrepresented nursing home residents is estimated nationally at three to four percent while in California the estimate is at nine percent according to a survey conducted in the early 1990s. Regardless of the exact number, there are probably several thousand unrepresented residents in California nursing homes at any given time.

California law requires the informed consent of the patient before any health care treatment may be administered. Unrepresented residents pose significant challenges to nursing home staff because there is no legal surrogate or representative who can give consent on their behalf. California law does allow health care providers to assume consent in emergency situations when the patient is at significant risk of serious bodily injury or death without treatment. However, this emergency care provision does not do much good in nursing homes where most care offered is routine and custodial in nature. Caring for unrepresented patients is a problem throughout the health care system but is particularly challenging in nursing

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1 For discussion about legally recognized surrogate decision makers, please go to “Verifying Lack of Surrogate” on pages 7-8.
homes, where a large number of residents have impaired mental capacity and disengaged or nonexistent family members.

THE DEVELOPMENT OF HEALTH AND SAFETY CODE SECTION 1418.8

In 1991, the legislature considered a bill (AB 1191) concerning the use of restraints in nursing homes. Eventually the bill was amended to address unrepresented residents but the bill was not voted out of the Assembly.

The failed unrepresented residents' bill was reintroduced in the 1992 legislature as AB 3209 by Assemblyman Bob Epple. The bill was motivated by the perceived inadequacy of the contemporary laws to meet the treatment needs of unrepresented residents.

The initial draft of the bill called for a decision-making process that started with a referral to the local public guardian whenever a nursing home was confronted with decision making for an unrepresented resident. Notice of the referral would be sent to the local Ombudsman office. If the resident was truly unrepresented, the public guardian would become his or her decision maker. In order to limit costs to public guardian offices, AB 3209 proposed the creation of a "voluntary surrogate" program by which volunteer community members would be trained and assigned decision-making authority for specific nursing home residents. Despite this attempt at cost reduction, various public guardians' offices claimed the training and supervision of the volunteers would overwhelm their budgets.

When the public guardian option failed, the Legislature turned to nursing home IDTs. The team would be composed of the resident's physician, facility nurses, and other "appropriate staff." The required procedures for IDTs were contained in proposed Health and Safety Code Section 1418.8 (Section 1418.8).

Once the legislature focused on IDTs as decision makers for incapacitated residents, resident advocates, including the California Long-Term Care Ombudsman Association (CLTCOA), formally opposed AB 3209. The opponents claimed that providers make poor surrogates because they have biases and treatment preferences that are not necessarily shared by their patients. In addition, acceptable standards of practice that might be imposed on unwilling residents could include harmful practices such as chemical and physical restraints. Finally, the advocates argued IDTs as decision makers unfairly singled out nursing home residents for provider-based decisions, which is anathema for any other type of health care consumer.

Despite the opposition, AB 3209 was passed by the Legislature and signed into law by Governor Pete Wilson. Shortly thereafter, resident advocates filed a lawsuit arguing that the law was unconstitutional. In an effort to address some of the strongest criticism, the Legislature introduced a clean-up bill in 1994 (AB 1139, authored by Assemblyman Epple). The bill made two additions to Section 1418.8, creating a definition of incapacity and requiring a "patient representative" be part of the IDT. Despite these perceived remedies, the bill was again vigorously opposed by resident advocates including CLTCOA, on constitutional grounds. AB 1139 was passed by the Legislature and signed into law by Governor Wilson. A complete version of Section 1418.8 is included at the end of this Guide.

Despite the legislative amendments to Section 1418.8, the court case filed by resident advocates, Rains v. Belshe, continued its way through the courts. The complete text of the
The First District Court of Appeals ultimately ruled against the resident advocates and held that Section 1418.8 was consistent with the state constitution. Essentially, the court found the law was a common sense response to the "legal conundrum" of medical decision making for unrepresented nursing home residents. Nursing home residents should have lower privacy expectations than other citizens and the state interest in ensuring their care is quite urgent. The court also dismissed the notion that physician biases or preferences would affect the treatment decisions of the IDT. Finally, the court rejected the due process arguments, stating the procedures provided for in Section 1418.8 were sufficiently specific and rigorous to ensure residents were not subjected to undue or ill-advised treatment.

Although Rains v. Belshe struck a blow against resident advocates, the court's interpretation of Section 1418.8 clarified a few of its important provisions. The court relied heavily on the IDT requirement of a "patient representative" in vindicating the constitutionality of the statute. Although Section 1418.8 states a patient representative is included in an IDT "when practical," the court held that patient representatives are "required." In emergencies, a representative may not be available but generally, the law required the routine and ongoing participation of a patient representative. Ombudsman are specifically included by the court as among those likely to serve as patient representatives.

The Rains v. Belshe case requires IDTs to include a patient representative. IDTs that do not include a non-provider patient representative are illegal.

Since the court rendered its decision in Rains v. Belshe, Section 1418.8 has remained unchanged and unchallenged. While many resident advocates still believe the law is unconstitutional, it remains in force although perhaps not with the level of vigor envisioned by the legislature. In practice, IDTs tend to be inconsistently convened with little to no participation of resident physicians. Patient representatives are rarely informed of IDT meetings, leaving facilities to make decisions on behalf of residents without even the minimum due process offered by Section 1418.8.

THE ROLE OF A PATIENT REPRESENTATIVE

While the constitutionality of Section 1418.8 relies on the participation of a patient representative, the law provides no real guidance on the nature of that participation. The law implies, however, that the patient representative should play a role that is distinct from those played by the health care providers who make up the remainder of the IDT. This distinct role contemplates at least two components: 1) providing a layperson's perspective and 2) determining and expressing the patient's wishes. The first component should be relatively easy while the latter poses many challenges.
1. Providing a Layperson's Perspective

Providing a layperson's perspective is the first unique role a patient representative can play in an IDT. As such, the representative should assess the proposed treatment primarily from a quality of life perspective. Health care providers may have a tendency to approach proposed treatment from a pure clinical perspective and unfortunately, may engage in cost-benefit analyses that downplay quality of life considerations. A patient representative should ensure that treatment decisions are not based on financial criteria.

2. Communicating the Resident's Wishes

The second unique role a patient representative plays in an IDT is communicating the resident's wishes regarding the proposed treatment. Determining a resident's wishes will likely pose a significant challenge for IDTs, which should only be convened when a resident has cognitive impairments that render his or her wishes difficult to ascertain. Nonetheless, the first duty of a patient representative should be to consult with the resident to ask him or her how he or she feels about the proposed treatment. If possible, the representative should visit the resident more than once before the IDT meeting to ensure the resident is given ample opportunity to communicate his or her wishes and articulate his or her reasoning.

Besides asking the resident his or her feelings about the proposed treatment, the patient representative should also insist that the resident attend the IDT if at all possible. Engaging the resident from the outset can also give the patient representative an idea of whether the finding of incapacity is accurate and whether an IDT is even necessary for decision making.

If a resident absolutely lacks capacity to provide any indication of preference, the representative may look to the resident's "best interests." Determining the resident's best interests is largely the function of the IDT itself and can be difficult. Determining a resident's best interests is an activity that is typically outside the scope of Ombudsman representation and will not be explored in this Guide.

THE ROLE OF AN OMBUDSMAN

The role of an Ombudsman representative in an IDT is undefined by law or rule, however, this role is distinct from those played by health care providers and surrogate decision makers. Despite this ambiguity, there are several, easily identifiable functions for Ombudsman representatives who participate in an IDT. These functions range from assuring the IDT is properly convened to reviewing the propriety of the decisions being made.

1. Verify Lack of Capacity

a. Background: Legal Capacity and the Due Process in Competency Determination Act

Capacity is an elusive concept that largely depends on medical opinion, functional assessment, and the gravity and complexity of the decision at hand. To assist capacity
determinations, the California legislature passed the Due Process in Competency Determinations Act, codified in Probate Code Sections 810-813. The Act creates a judicial standard for capacity (often referred to as "competency") that begins in Section 810(a) with a presumption of capacity. Thus, every adult in California is presumed by law to have capacity. Incapacity cannot be determined from a mere medical diagnosis of cognitive impairments; rather, incapacity requires the demonstration of an actual "deficit in one or more of the person's mental functions." This presumption in favor of capacity is particularly important in nursing homes, where a resident's mere presence often implies incapacity in the minds of the staff.

The second section of the Act, Probate Code Section 811, includes a list of mental functions to consider in determining a person's capacity. The functions are:

1) alertness and attention;
2) information processing;
3) thought processes; and
4) ability to modulate mood and affect.

Probate Code Section 812, the third section of the Act, shifts the presumption of capacity to one of incapacity if a deficit is found in one of the foregoing list of mental functions. However, capacity may still be proven if the person has the ability to communicate a decision and to understand and appreciate the nature of the decision, including the risks, benefits, and alternatives involved.

The fourth and final section of the Act, Probate Code Section 813, discusses special considerations for decisions involving health care and informed consent. In order to exercise control over such decisions, the principal must be able to respond, participate, and understand proposed treatments, especially their risks, benefits, and alternatives.

While the Act is perhaps the California Legislature's fullest explication of determining capacity for health care decision making, it is also noteworthy for what it does not say. The original version of the Act included a Probate Code Section 810(a)(3) stating "the physicians and family members of patients may determine the capacity of the patient to make medical

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2 Probate Code § 813 states:
(a) For purposes of a judicial determination, a person has the capacity to give informed consent to a proposed medical treatment if the person is able to do all of the following:
(1) Respond knowingly and intelligently to queries about that medical treatment.
(2) Participate in that treatment decision by means of a rational thought process.
(3) Understand all of the following items of minimum basic medical treatment information with respect to that treatment:
(A) The nature and seriousness of the illness, disorder, or defect that the person has.
(B) The nature of the medical treatment that is being recommended by the person's health care providers.
(C) The probable degree and duration of any benefits and risks of any medical intervention that is being recommended by the person's health care providers, and the consequences of lack of treatment.
(D) The nature, risks, and benefits of any reasonable alternatives.
(b) A person who has the capacity to give informed consent to a proposed medical treatment also has the capacity to refuse consent to that treatment.
decisions, in appropriate cases and without judicial authorization — if there are no serious disagreements about the patient's decision making capacity." This statement was not included in the final version of the bill that was eventually passed, indicating that capacity determinations may inherently require some form of judicial determination, particularly when decision-making rights are at stake. The Senate Judicary Committee considered the repercussions of such a statement and concluded that the bill

"...does not address the issue of the disagreement of the patient himself or herself. The right of a competent adult patient to refuse medical treatment is a constitutionally protected right which must not be abridged (Bartling, at p. 195). This bill appears to permit that right to be abridged without the due process protections of a judicial determination."3

Regardless of how a patient's capacity is determined, the process is an inexact science. The law's distinction between competence and incompetence is often strained because it presents capacity as an oversimplified binary measurement. Even physicians experienced in assessing capacity demonstrate significant variation in their evaluation of individual patients that renders the physician's role in capacity judgments quite unreliable.4 Many experts believe capacity is more accurately measured as a continuum that can fluctuate, where the greater the consequences of the decision at issue, the greater the understanding needed by the patient. Thus, the capacity necessary to accept Tylenol for a fever may be less than that needed to consent to surgery to amputate a gangrenous limb.

b. Assessing Capacity for Ombudsman Representatives

A physician's determination that a nursing home resident lacks capacity is sufficient to convene an IDT. Upon such determination, Ombudsman representatives may assert themselves if they believe a resident has at least some capacity to participate in treatment decisions. One assertion an Ombudsman representative can make is seeking a second physician's assessment of capacity. In addition, Ombudsman representatives can insist that medical assessments use some form of universal criteria relying on input from multiple sources. The key to capacity determinations for IDTs is ensuring the determination is the result of a thoughtful, deliberate process designed to produce complete, unbiased, and accurate assessments.

3 S.B. 730, Senate Judiciary Committee Bill Analysis, 16 (May 16, 1995).
4 Marson, Daniel C. et. al., Consistency of Physician Judgments of Capacity to Consent in Mild Alzheimer's Disease, Journal of the American Geriatric Society, Vol. 45 (April 1997), pp. 453-457. (The authors conducted an experiment where five physicians with extensive clinical experience in assessing dementia and capacity were asked to render capacity determinations for 29 patients with mild Alzheimer's disease. The physicians had only 56% agreement regarding the capacity of the patients to make their own medical decisions. The results were deemed by the study's authors as "alarming," substantiating "a long-standing clinical concern, namely, that physician competency assessment is a subjective, inconsistent, and arguably idiosyncratic process. (at 455-456). A subsequent study by many of the same authors found that the use of a specific definition of capacity considerably improved (76%) physician agreement. (Marson, Daniel C., et. al., "Consistency of Physicians' Legal Standard and Personal Judgments of Competency in Patients with Alzheimer's Disease," Journal of the American Geriatric Society, Vol. 48 (August 2000), pp. 911-918.)
2. Verify Lack of Surrogate

Before an IDT may convene pursuant to Section 1418.8, the nursing home must confirm that the resident has no surrogate with the "legal authority to make decisions on behalf of the resident." A series of statutes and court cases can be integrated to form a basic hierarchy of potential surrogates. Examples of surrogates in California are:

a. Conservatorship

Conservators are surrogate decision makers appointed by a court after finding that the conservatee lacks the capacity to make decisions. The powers granted to conservators are traditionally quite broad and deep.

b. Designation Pursuant to Probate Code Section 3201

A designation pursuant to Probate Code Section 3201 is for one-time only medical decisions for persons with no capacity and no surrogates. Much like the conservatorship process, a court makes the determination of capacity and then can authorize any health care treatment, including the withdrawal of artificial life support. 3201 petitions can also be used when there is disagreement about the proper course of health care treatment for an incapacitated patient.

c. Health Care Agent

Health Care Agents are persons in whom authority for health care decision making is formally vested, usually only upon the incapacity of the principal. Health Care Agents are almost always designated in the patient's written Advance Health Care Directive (AHCD). The agent may typically make all health care decisions that the principal could make, but must follow all instructions and limitations written in the AHCD or otherwise made known to the agent.

d. Oral Designee

Probate Code Section 4711 provides for an oral designation of a surrogate health care decision maker. To designate a surrogate, the health care recipient need only tell his or her provider. Thus, the patient must have a minimum capacity to nominate surrogates. Unless otherwise specified, the oral designee is empowered to make decisions on behalf of the patient for the most current course of treatment or illness or for sixty days, whichever is shorter.

e. Spouse

California law does not explicitly give spouses any health care decision making authority for one another by nature of their relationship. In order to act as a fully legally recognized surrogate, a spouse would have to be designated as an agent or surrogate by the principal or appointed as conservator by a court. However, Probate Code Section 4716 indicates that spouses do have decision-making authority based merely on their relationship, but the extent of that power has never been defined. Section 4716(a) states:
"If a patient lacks the capacity to make a health care decision, the patient's domestic partner shall have the same authority as a spouse has to make a health care decision for his or her incapacitated spouse. This section may not be construed to expand or restrict the ability of a spouse to make a health care decision for an incapacitated spouse."

While the section states that it should not be read as an expansion of a spouse's surrogacy powers, the fact that a spousal surrogacy function is formally recognized suggests that spouses do have surrogacy power without a formal designation.

**f. Other Family**

Family members, much like spouses, have no statutory surrogacy status in health care decision making. Nevertheless, case law exists indirectly acknowledging that family members may act as surrogates when there are no other surrogates available. In Cobbs v. Grant (8 Cal. 3d 299), the California Supreme Court briefly reviewed possible exceptions to its rule requiring a patient's informed consent for all forms of health care treatment. The court found that, when a patient lacks capacity to provide informed consent, "the authority to consent is transferred to the patient's legal guardian or closest available relative."

When an IDT is convened, chances are great that the resident at issue does not have any surrogate decision makers from the list; otherwise, there would not be much need for the meeting. Nonetheless, an Ombudsman representative participating in an IDT should critically assess the measures the nursing home staff has undertaken to locate a potential surrogate. Such measures may include discussions with staff at the facility from which the resident came, case managers that may have been involved, and local agencies that provide services to elderly people or dependent adults; as well as web searches or checking with the Secretary of State's AHCD registry.

**3. Encourage Resident's Family or Friends to Participate**

In some cases, a resident without capacity and without a surrogate may actually have known family members or friends. For those who are willing to at least partially participate in decision making, they should be consulted in advance of an IDT and invited to attend. Even if a facility has stated that the family members or friends are not interested in participating, an Ombudsman representative should nonetheless contact them and verify their disinterest. In some cases, family and friends may be willing to help if they are encouraged and educated on how helpful their participation may be.

**4. Advocate for Resident Attendance**

Some nursing homes may be in the habit of not inviting residents to their own care plan meetings, so the likelihood of an unrepresented resident being invited will be slight. Ombudsman representatives should be sure to presume that residents will attend IDT meetings and insist the facility justify not allowing their attendance. Resident attendance, while not required, sends a message that the resident's preferences are still valued. Furthermore, a resident's attendance can offer valuable insight into the wisdom of the proposed treatments.
5. Ensure the IDT Follows the Legally Required Process

Between Section 1418.8 and the Rains decision, the process for IDT decision making is fairly clear. The Ombudsman representative should be sure to review the process and be prepared to demand compliance before health care decisions are made. The process requires, at a minimum:

a. A finding, by the resident's attending physician, that the resident both lacks capacity and has no surrogate decision maker. The physician is required to interview the resident, review his or her medical records, and consult with facility staff and the resident's family members and friends, if any have been identified.
b. Inclusion of the resident's attending physician, a nurse, and other appropriate staff in disciplines as determined by the resident's needs.
c. Review of:

- the resident's condition
- the reason for the proposed use of the medical intervention
- the desires of the patient, where known. This requires a separate interview of the resident, a review of his or her medical records and consultation with family members or friends, if any have been identified
- the type of medical intervention to be used in the resident's care, including its probable frequency and duration
- the probable impact on the resident's condition, with and without the use of the medical intervention
- reasonable alternative medical interventions and reasons for nonuse.

6. Ensure the IDT Acts Within its Authority

The legislature implicitly recognized the significant shortcomings of providers acting as health care decision makers by stating its intent that Section 1418.8 be used only for "on-going" and "day to day" decisions when judicial proceedings are too costly and cumbersome. The Rains Court specifically cited the statute's limitation to "nonintrusive and routine, ongoing" treatment in support of its constitutionality. Clearly, the legislature did not intend to allow treatment providers to make exceptional life and death decisions for their patients.

Given the foregoing, nursing home IDTs may not authorize any treatment that is intrusive or not on-going or day-to-day. Such interventions include:

- The administration of psychoactive drugs;
- The withdrawal of artificial life support;⁵
- Initiating hospice care;
- Surgery;

⁵ See attached California Department of Health Services, Letter to District Administrators, April 27, 1993: "Question: May the [IDT] be used to make a decision regarding withdrawal or withholding of life sustaining treatment on behalf of residents who lack the capacity? Answer: No."
- Executing a DNR or POLST form;
- Overriding a resident's refusal of proposed treatment.

The Ombudsman representative should ensure the IDT remains within its authority by confirming that the proposed treatment is routine and non-invasive. If the unrepresented resident's doctor believes that an extraordinary medical intervention is necessary, he or she must seek authority from a court by seeking court authorization pursuant to Probate Code 3201 or through the appointment of a conservator.

**WHAT THE OMBUDSMAN SHOULD NOT DO**

Participation in an IDT poses some significant challenges to Ombudsman representatives because of their unique dedication to resident advocacy. Ombudsman representatives must refrain from assenting to proposed treatment or otherwise acting as a surrogate decision maker. To do otherwise would undermine the Ombudsman-resident relationship by imposing an Ombudsman representative's professional or personal feelings on the individual. Thus, Ombudsman representatives should avoid “voting” for or against a proposed treatment or otherwise actively approving an IDT decision.

Ombudsman representatives should not convey or advocate for any treatment preferences during the IDT process. Ombudsman representatives must be wary of assuming a "best interest" approach and imposing their own (or someone other than the resident's) notion of what is best for the resident. If a resident cannot express any treatment preferences, the Ombudsman representative should refrain from asserting any.

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**The Role of the Ombudsman Representative in 1418.8 IDTs – Recap**

To do:
1) Verify lack of capacity
2) Verify lack of surrogate
3) Encourage available resident's family members or friends to participate
4) Advocate for resident attendance
5) Ensure the legal process is followed
6) Ensure the IDT is acting within its authority

To avoid:
1) Do not vote for, or otherwise give approval to, a treatment decision
2) Do not express any treatment preference other than those communicated by the resident

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**POST-IDT ISSUES**

1. The Right to Refuse Treatment

Regardless of IDT findings and recommendations, residents can still refuse any treatment proposed – even if they allegedly lack capacity to make decisions. The right to refuse health care interventions is a well-established personal right, based in the state and federal
Constitutional rights of privacy. Case law has demonstrated that the right to refuse medical care can only be abrogated if there is a JUDICIAL determination of incapacity. Thus, a court proceeding is required before a resident can be given treatment against his or her wishes in a non-emergency situation. The Ombudsman representative should be prepared to educate the IDT members and facility staff on the resident's right to refuse treatment and be willing to advocate on the residents behalf.

2. The Right to Judicial Review

Probate Code Section 1418.8 specifically mentions that residents have the right to appeal the findings and recommendations of an IDT to a court of law. The availability of such review was a factor in favor of upholding the law in the Rains case. Nonetheless, very few, if any, court cases are filed by aggrieved residents because of a paucity of access to legal resources. Ombudsman representatives should be ready to supply residents with referrals to Older Americans Act funded or other legal services programs that could assist residents to file an appeal.

3. Change of Condition and Quarterly Review

All IDT decisions must be reviewed by the IDT at least quarterly or whenever there is a change in a resident's condition. One advantage Ombudsman representatives have in IDT participation is their recurrent presence in the facility, affording them the ability to monitor the results of the treatment decision. The Ombudsman representative should insist the IDT reconvene upon a change of condition or when it is timely.

4. Failure to use or the Misuse of IDTs

Unfortunately, it remains to be said that the IDT process is often completely ignored or followed in a haphazard way. Many facilities simply do not have formal IDT meetings for unrepresented residents, instead relying on quarterly care planning conferences that do not include a specific decision-making process. Other facilities hold IDT meetings but rarely include a physician and fail to comply with other important IDT processes. In either case, these facilities are disregarding their residents' rights. Noncompliance with Section 1418.8 is a serious issue and should be investigated as potential violation of residents' rights.

If a local Ombudsman program believes that a facility is not providing legally compliant IDT meetings for its unrepresented residents or is not informed of upcoming meetings, it has several choices for addressing the oversight. Among these choices are: 6

1) Reaching out to the facility administration in order to engage it in formal education about the necessity of IDTs and the appropriate process and makeup.
2) Informing the facility's residents' family or friends about the IDT option and offering guidance to those who wish to participate or learn more.
3) Filing a formal complaint with the Department of Public Health.
4) Referring the matter to a local Older Americans Act funded or other legal services program.

6 *These choices all assume that the resident has been consulted and does not oppose the proposed action.*
This Guide is intended to provide the history of the development of IDTs and direction to local Ombudsman representatives that may participate on an IDT. Ombudsman representatives with questions regarding IDTs should contact their assigned analyst at the OSLTCO.
1418.8. (a) If the attending physician and surgeon of a resident in a skilled nursing facility or intermediate care facility prescribes or orders a medical intervention that requires informed consent be obtained prior to administration of the medical intervention, but is unable to obtain informed consent because the physician and surgeon determines that the resident lacks capacity to make decisions concerning his or her health care and that there is no person with legal authority to make those decisions on behalf of the resident, the physician and surgeon shall inform the skilled nursing facility or intermediate care facility.

(b) For purposes of subdivision (a), 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. To 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.

(c) For purposes of subdivision (a), 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. To determine the existence of a person with legal authority, the physician shall interview the patient, review the medical records of the patient 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.

(d) The attending physician and the skilled nursing facility or intermediate care facility may initiate a medical intervention that requires informed consent pursuant to subdivision (e) in accordance with acceptable standards of practice.

(e) Where a resident of a skilled nursing facility or intermediate care facility has been prescribed a medical intervention by a physician and surgeon that requires informed consent and the physician has determined that the resident lacks capacity to make health care decisions and there is no person with legal authority to make those decisions on behalf of the resident, the facility shall, except as provided in subdivision (h), conduct an interdisciplinary team review of the prescribed medical intervention prior to the administration of the medical intervention. The interdisciplinary team shall oversee the care of the resident utilizing a team approach to assessment and care planning and 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, in accordance with applicable federal and state requirements. The review shall include all of the following:

(1) A review of the physician's assessment of the resident's condition.
(2) The reason for the proposed use of the medical intervention.
(3) 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.
(4) The type of medical intervention to be used in the resident's care, including its probable frequency and duration.
(5) The probable impact on the resident's condition, with and without the use of the medical intervention.
(6) Reasonable alternative medical interventions considered or utilized and reasons for their discontinuance or inappropriateness.

(f) A patient representative may include a family member or friend of the resident who is unable to take full responsibility for the health care decisions of the resident, but has agreed to serve on the interdisciplinary team, or other person authorized by state or federal law.

(g) The interdisciplinary team shall periodically evaluate the use of the prescribed medical intervention at least quarterly or upon a significant change in the resident's medical condition.

(h) In case of an emergency, after obtaining a physician and surgeon's order as necessary, a skilled nursing or intermediate care facility may administer a medical intervention which requires informed consent prior to the facility convening an interdisciplinary team review. If 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.

(i) Physician and surgeons and skilled nursing facilities and intermediate care facilities shall not be required to obtain a court order pursuant to Section 3201 of the Probate Code prior to administering a medical intervention which requires informed consent if the requirements of this section are met.

(j) Nothing 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.

(k) No physician or other health care provider, whose action under this section is in accordance with reasonable medical standards, is subject to administrative sanction 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.

(l) The determinations required to be made 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.
ESTHER E. RAINS, Plaintiff and Respondent, v. S. KIMBERLY BELSHE, as Di-
rector, etc., Defendant and Appellant.

No. A063119.

COURT OF APPEAL OF CALIFORNIA, FIRST APPELLATE DISTRICT, DIVI-
SION FIVE

Op. Service 1044; 95 Daily Journal DAR 1813

February 8, 1995, Decided

PRIOR HISTORY: Superior Court of the City and
County of San Francisco, No. 949165, William J. Cahill,
Judge.

COUNSEL: Daniel E. Lungren, Attorney General,
Charlton G. Holland III, Assistant Attorney General, and
Stephanie Wald, Deputy Attorney General, for Defen-
dant and Appellant.

Lilly T. Spitz as Amicus Curiae on behalf of Defendant
and Appellant.

Morton P. Cohen and Kathleen Lammers for Plaintiff
and Respondent.

Heller, Ehrman, White & McAuliffe, Wayne S. Brave-
man, Meryl Macklin, John H. Bogart, Bet Tzedek Legal
Services, Michael Feuer, William Flanagan and Eric M.
Carlson as Amici Curiae on behalf of Plaintiff and Res-
donant.

JUDGES: Opinion by Peterson, P. J., with King and
Haning, JJ., concurring.

OPINION BY: PETERSON, P. J.

OPINION

PETTERSON, P. J.--The Legislature enacted in
section 1418.8. That amended statute generally allows
certain incompetent patients residing in skilled nursing
facilities or intermediate care facilities to receive medical

treatment, after a physician has determined a patient's
incapacity to give informed consent to such treatment
and an interdisciplinary review team has determined the
treatment is medically appropriate. We find this statute
as amended to be constitutional, and reverse the trial
court's contrary ruling.

I. FACTS AND PROCEDURAL HISTORY

This appeal presents solely legal issues concerning
the facial constitutionality of Health and Safety Code
section 1418.8 as last amended. The lower court's ruling
of unconstitutionality was directed to section 1418.8 as
enacted in 1992. As we explain post, many of petitioner's
arguments in the court below as to the statute's claimed
deficiencies are inapposite to our facial constitutional
review, which must be based upon the provisions of the
amended statute. (See Building Industry Assn. v. City of
Oxnard (1985) 40 Cal. 3d 1, 3 [218 Cal. Rptr. 672, 706
P.2d 285].) The lower court, of course, could not con-
sider the amendments, which were ineffective at the time
of its decision. The parties agree that our decision must
be based on the amended version of the statute, and have
briefed its constitutionality postargument.

1 Unless otherwise indicated, all subsequent
statutory references are to the Health and Safety
Code.

The challenged statute provides, after amendment in
1994 (Stats. 1994, ch. 791, § 1; the amendments to sec-
tion 1418.8, including renumbering, are italicized), as
follows:

"(a) If the attending physician and surgeon of a
resident in a skilled nursing facility or intermediate care
facility 3 (prescribes or orders a medical intervention
that requires informed consent be obtained prior to ad-
ministration of the medical intervention, but is unable to
obtain informed consent because the physician and
surgeon determines that the resident lacks capacity to
make decisions concerning his or her health care and that
there is no person with legal authority to make those de-
cisions on behalf of the resident, the physician and
surgeon shall inform the skilled nursing facility or inter-
mediate care facility.
2. The Legislature has designated both a "skilled nursing facility" and an "intermediate care facility" as a type of "health facility" for purposes of section 1250 et seq.: "'Skilled nursing facility' means a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis." (§ 1250, subd. (c)) "'Intermediate care facility' means a health facility that provides inpatient care to ambulatory or nonambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care." (Id., subd. (d))

In this opinion, we will collectively refer to "skilled nursing facility" and "intermediate care facility" as "nursing home," and sometimes to resident patients of those skilled facilities as "nursing home patients."

"(b) For purposes of subdivision (a), 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. To 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.

"(c) For purposes of subdivision (a), 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. To determine the existence of a person with legal authority, the physician shall interview the patient, review the medical records of the patient 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.

"(d) The attending physician and the skilled nursing facility or intermediate care facility may initiate a medical intervention that requires informed consent pursuant to subdivision (e) in accordance with acceptable standards of practice.

"(e) Where a resident of a skilled nursing facility or intermediate care facility has been prescribed a medical intervention by a physician and surgeon that requires informed consent and the physician has determined that the resident lacks capacity to make health care decisions and there is no person with legal authority to make those decisions on behalf of the resident, the facility shall, except as provided in subdivision (h), conduct an interdisciplinary team review of the prescribed medical intervention prior to the administration of the medical intervention. The interdisciplinary team shall oversee the care of the resident utilizing a team approach to assessment and care planning and 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, in accordance with applicable federal and state requirements. The review shall include all of the following:

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

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

"(3) 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.

"(4) The type of medical intervention to be used in the resident's care, including its probable frequency and duration.

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

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

"(f) A patient representative may include a family member or friend of the resident who is unable to take full responsibility for the health care decisions of the resident, but has agreed to serve on the interdisciplinary team, or other person authorized by state or federal law.

"(g) The interdisciplinary team shall periodically evaluate the use of the prescribed medical intervention at least quarterly or upon a significant change in the resident's medical condition.

"(h) In case of an emergency, after obtaining a physician and surgeon's order as necessary, a skilled nursing or intermediate care facility may administer a medical intervention which requires informed consent prior to the facility convening an interdisciplinary team review.

"(i) Physician[s] and surgeons and skilled nursing facilities and intermediate care facilities shall not be required to obtain a court order pursuant to section 3201 of the Probate Code prior to administering a medical intervention which requires informed consent if the requirements of this section are met.
"(f) Nothing 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.

"(k) No physician or other health care provider, whose action under this section is in accordance with reasonable medical standards, is subject to administrative sanction 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.

"(l) The determinations required to be made 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.

"(m) This section shall remain in effect only until January 1, 1997, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 1997, deletes or extends that date."

If the requirements of section 1418.8 are met, subdivision (i) thereof removes the need to obtain a court order under the provisions of Probate Code section 3201, which reads as follows: "If a patient [who lacks a conservator of the person] requires medical treatment for an existing or continuing medical condition and the patient is unable to give an informed consent to such medical treatment, a petition may be filed under this part for an order authorizing such medical treatment and authorizing the petitioner to give consent to such treatment on behalf of the patient."

Section 1418.8, as originally enacted, became effective on January 1, 1993. A petition for a writ of mandate (No. A060010) was filed in Division One of this court, seeking to invalidate the statute on constitutional grounds and stay its enforcement. The petition and request for stay were denied in an unpublished order.

The lower court then heard the petition generating this appeal, which was filed by Esther E. Rains (petitioner). The trial court's statement of decision concluded that section 1418.8, in its preamended form, was unconstitutional, as violating the constitutional privacy rights and due process rights of nursing home patients who lack capacity to give informed consent to recommended medical intervention. This timely appeal followed from a resulting judgment.

II. DISCUSSION

We conclude section 1418.8 is constitutional. As properly interpreted, 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.

3 This and subsequent references to section 1418.8, unless otherwise indicated, are to the statute as amended.

The Legislature was required to deal here with a very difficult and perplexing problem: how to provide nonemergency but necessary and appropriate medical treatment, frequently of an ongoing nature, to nursing home patients who lack capacity to consent thereto because of incompetence, and who have no surrogate or substitute decision maker with legal authority to consent for them. This was a legal conundrum of long standing; and although it has been held that the consent of the patient will be implied for emergency care, the question of the proper means of securing the consent of such incompetent patient for ongoing, medically necessary care, not rising to the level of an emergency, is one which is not fully addressed or satisfactorily answered by existing case law. (See, e.g., Preston v. Hubbell (1948) 87 Cal. App. 2d 53, 57-59 [196 P.2d 113]; Cobbs v. Grant (1972) 8 Cal. 3d 229, 243-244 [104 Cal. Rptr. 505, 502 P.2d 1]; Crusen v. Director, Missouri Dept. of Health (1990) 497 U.S. 261, 281 [111 L. Ed. 2d 224, 243-244, 110 S. Ct. 2841].) This problem required an effective legislative solution which would allow timely medical treatment of incompetent nursing home patients on an ongoing basis, without the delay of two to six months frequently necessary to secure a ruling on a petition authorizing treatment under Probate Code section 3201. It is highly significant that section 1418.8, subdivision (e) requires a patient representative to be a member of the interdisciplinary team overseeing the patient's care, to consider the need for medical intervention from the patient's point of view. While there may be exigent circumstances in which the participation of such a representative is not practicable, due to temporary unavailability, illness, or similar causes, the Legislature clearly required the routine and ongoing participation of a patient representative in such medical care decisions to ensure that nothing is overlooked from the patient's perspective.

4 Probate Code section 4720 authorizes an attorney in fact, so designated in a durable power of attorney for health care, to make health care decisions for the principal.

Probate Code section 2355 provides for an order allowing a conservator to give informed consent to conservatee's medical treatment.
5 Section 1418.8, subdivision (f) defines a patient representative as "a family member or friend ... or other person authorized by state or federal law [such as a public guardian, ombudsman, attorney in fact under a durable power of attorney, private conservator, private guardian]." (Cf. § 1418.8, subd. (c).)

Petitioner argues that other and arguably better legislative solutions to the problem are possible. That is not a matter for courts to decide. As we will explain, the solution reached by the Legislature in section 1418.8 is facially constitutional.

A. Section 1418.8 Does Not Violate the Privacy Provisions of the California Constitution

1. Recent Relevant Precedents

The trial court, at the time of its ruling in 1993 on the preamendment statute, did not have the benefit of a number of recent cases, in which our Supreme Court has addressed the right of privacy granted by article I, section 1 of the California Constitution, and related issues, in analogous medical contexts.

In Hill v. National Collegiate Athletic Assn. (1994) 7 Cal. 4th 1, 52-57 [26 Cal. Rptr. 2d 834, 865 P.2d 633] (Hill), our high court found no violation of the constitutional right of privacy from a nonconsensual drug testing program, including observation of urination, the medical testing of urine, and the exchange of confidential medical information attendant upon the administration of the drug testing, for persons participating in college athletic programs. The court advanced an analytical framework for deciding questions arising under this constitutional right of privacy, and found that a violation of the constitutional right of privacy is only established where three conditions are shown: "(1) a legally protected privacy interest; (2) a reasonable expectation of privacy in the circumstances; and (3) conduct by defendant constituting a serious invasion of privacy." (Id. at pp. 39-40.)

Further, the high court observed: "No community could function if every intrusion into the realm of private action, no matter how slight or trivial, gave rise to a cause of action for invasion of privacy. ... Actionable invasions of privacy must be sufficiently serious in their nature, scope, and actual or potential impact to constitute an egregious breach of the social norms underlying the privacy right." (Hill, supra, 7 Cal. 4th at p. 37, italics added.) The sharing of confidential medical information resulting from testing athletes' urine for drugs and other substances did not violate this privacy right: "The NCAA's information-gathering procedure (i.e., drug testing through urinalysis) is a method reasonably calculated to further its interests in enforcing a ban on the ingestion of specified substances in order to secure fair competition and the health and safety of athletes participating in the programs." (Id. at p. 54; see also People v. Privitera (1979) 23 Cal. 3d 697, 709-710 [153 Cal. Rptr. 431, 591 P.2d 919, 5 A.L.R.4th 178] [The right of privacy under the California Constitution did not prevent the state from outlawing the actions of physicians who prescribed drugs of unproved efficacy to patients.]; People v. Stitzinger (1983) 34 Cal. 3d 505, 511-512 [194 Cal. Rptr. 431, 668 P.2d 738] [The right of privacy covering a patient's relationship with a psychotherapist did not prevent the state from requiring the reporting of child abuse.].)

In Heller v. Norcal Mutual Ins. Co. (1994) 8 Cal. 4th 30, 42-44 [32 Cal. Rptr. 2d 200, 876 P.2d 999] (Heller), our high court also found no violation of the constitutional right of privacy where the plaintiff's treating physician shared private medical information with an insurer, after the plaintiff-patient filed a medical malpractice action, even though the plaintiff-patient did not consent to the disclosure. Applying the Hill analysis, the court found the patient did not have a reasonable expectation of privacy under these circumstances, because information about her medical history would inevitably have to be disclosed in her malpractice action: "We conclude that, as a matter of law, plaintiff had failed to state a cause of action for invasion of her state constitutional privacy interest. This conclusion is based on the fact that plaintiff did not adequately plead facts supporting a conclusion that any expectation of privacy as to her medical condition would be reasonable under the circumstances of this case." (Heller, supra, 8 Cal. 4th at p. 43.)

In light of the Hill and Heller cases, decided after the trial court ruled in the case at bench, the scope of the state constitutional right of privacy has been considerably clarified. Further, other relevant case law also finds no violation of the state right of privacy in analogous medical contexts. For instance, in Johnetta J. v. Municipal Court (1990) 218 Cal. App. 3d 1255, 1282-1283 [267 Cal. Rptr. 666] (Johnetta J.), this court (Division Five), per Justice Haning, rejected claims that a statute allowing nonconsensual testing of certain persons for the AIDS virus and other communicable diseases, which might have been passed to peace officers by means of exposure to blood or saliva, was unconstitutional under either the state Constitution's right of privacy, or the right of due process: "Petitioner also argues Proposition 96 violates the California [c]onstitutional right of privacy. She correctly notes that the California right of privacy is a fundamental right, explicitly added by the voters to the state Constitution in 1972. [Citations.] As we have previously noted in another context, however, the California right of privacy is 'not absolute' and may be subordinated to a compelling state interest. [Citations.]"
In *Jordan v. Mary K.* (1986) 179 Cal. App. 3d 386, 396-398 [224 Cal. Rptr. 530], this court (Division Five), per Justice King, also found no violation of constitutional privacy rights from the application of a statute which provided that persons desiring to conceive a child through artificial insemination must use a licensed physician to perform the procedure in order to avoid paternity claims by the sperm donor: "Public policy in these areas is best determined by the legislative branch of government, not the judicial."

Also somewhat relevant is our previous decision in *Keyhea v. Rushen* (1986) 178 Cal. App. 3d 526, 540-541 [223 Cal. Rptr. 746] (*Keyhea*), where we declined to rule that the constitutional right of privacy required a judicial finding of incompetency before the administration of psychotropic drugs on state prisoners who were thought to be incompetent and, therefore, could not provide informed consent: "It is settled in California that every person has a right to give or withhold informed consent to a proposed medical treatment, under both the state constitutional guarantee of privacy [citation] and the common law [citation]. No California appellate court, however, has addressed the question whether there is a concomitant constitutional or common law right to a judicial determination of competency before the right to refuse treatment is infringed." We noted that the cases from other jurisdictions were in conflict (id. at p. 540) and declined to base our decision on constitutional grounds: "We need not decide, however, whether there is a constitutional or common law right to a judicial determination of competency [before psychotropic drugs are administered], because that right is provided by statute in California . . . ." (id. at p. 541). Since by statute state prisoners retained the rights accorded to nonprisoners in this area, and since nonprisoners had a statutory right to refuse treatment with psychotropic drugs, we refused to conclude there was any overarching constitutional right to a judicial decision as to competency in implementing the otherwise applicable right to refuse the treatment then in issue: "Thus, regardless of constitutional and common law ramifications, nonprisoners in California have a statutory right to refuse long-term treatment with psychotropic drugs absent a judicial determination that they are incompetent to [refuse treatment]." (*Ibid.*)

Similarly, Division Two of this district, in *Riese v. St. Mary's Hospital & Medical Center* (1987) 209 Cal. App. 3d 1303, 1320-1321 [271 Cal. Rptr. 199] (*Riese*) found that by statute certain California patients had a right to refuse treatment with psychotropic drugs, while noting that this right was not accorded by federal law or constitutional criteria.

Here, of course, unlike the statutory schemes addressed by *Keyhea* and *Riese*, we address a very different statutory setting, in which the Legislature has decided by a newly enacted statute, section 1418.8, to implement the right of privacy and other constitutional rights of certain patients, by providing a particular procedure by which persons in nursing homes who are determined by a physician to lack capacity to make decisions regarding their health care may receive medical treatment, even though they do not have a next of kin, an appointed conservator, or another authorized decision maker to act as their surrogate in making such health care decisions.

We, therefore, must address the constitutional issue we declined to decide in *Keyhea*, considering case law directed to the privacy area since that decision. In so doing, we note there is still no California authority precisely on point, although the issues involved are substantially clarified by the recent decisions of our Supreme Court in *Hill and Heller*.

We note also that the federal Supreme Court has upheld against constitutional challenge a state law procedure for administration of medications to prisoners with mental problems, which is in some ways analogous to section 1418.8 in that such decision is made pursuant to the medical judgment of physicians, without a judicial decision maker. (*Washington v. Harper* (1990) 494 U.S. 210, 231-232 [108 L. Ed. 2d 178, 204-205, 110 S. Ct. 1028] (*Washington*).) Although not wholly determinative, this federal decision also is of help in deciding the privacy and due process issues this case raises.

In assessing the constitutionality of section 1418.8, we are also constrained by the traditionally limited scope of our review of legislative enactments for unconstitutionality. It need hardly be repeated here (although this principle was not mentioned by the trial court in its otherwise exhaustive statement of decision) that a statute is presumed to be constitutional, and the burden is on those asserting its unconstitutionality to demonstrate otherwise; further, the statute will be construed, if possible, in a way that will avoid constitutional infirmities. As Justice Haning has observed: "In determining a statute's constitutionality, we start from the premise that it is valid, we resolve all doubts in favor of its constitutionality, and we uphold it unless it is in clear and unquestionable conflict with the state or federal Constitutions." (*Mounts v. Uyeda* (1991) 227 Cal. App. 3d 111, 122 [277 Cal. Rptr. 730]; accord, *California Housing Finance Agency v. Elliott* (1976) 17 Cal. 3d 575, 594 [131 Cal. Rptr. 361, 551 P.2d 1193]; *County of Sonoma v. State Energy Resources Conservation etc. Com.* (1985) 40 Cal. 3d 361, 368 [220 Cal. Rptr. 114, 708 P.2d 693] (County of Sonoma).)

Since this particular case rests in large part on a claim of unconstitutionality based upon the right of privacy under the California Constitution, we are guided by the observations of Division Three of this district, ap-
proved by our Supreme Court in *Hill, supra*, 7 Cal. 4th at pages 37, 55, footnote 20: "The general concept of privacy can be viewed as encompassing a broad range of personal action and belief. However, that right, much as any other constitutional right, is not absolute. A court must engage in a balancing of interests rather than a deduction from principle to determine its boundaries. Although the Supreme Court stated in *White v. Davis* ([1975]) 13 Cal. 3d 757 [120 Cal. Rptr. 94, 533 P.2d 222], that a compelling interest was necessary to justify any incursion into individual privacy, subsequent cases have made it clear that not every act which has some impact on personal privacy invokes the protections of the state's Constitution and requires such justification. Stated another way, a court should not play the trump card of unconstitutionality to protect absolutely every assertion of individual privacy." (Wilkinson v. *Times Mirror Corp.* (1989) 215 Cal. App. 3d 1034, 1046 [264 Cal. Rptr. 194].)

Aided by these applicable precedents, we will conclude that section 1418.8 does not violate either the right of privacy or the due process rights of affected patients.

2. Privacy Rights

We apply the analytical framework stated in *Hill, supra*, 7 Cal. 4th at pages 39-40, to the claim that section 1418.8 is unconstitutional under the California Constitution's right of privacy. The *Hill* analysis requires us to assess section 1418.8 in terms of whether it will have an unconstitutional result because the following circumstances are present: "(1) a legally protected privacy interest; (2) a reasonable expectation of privacy in the circumstances; and (3) conduct . . . constituting a serious invasion of privacy." (*Hill, supra*, 7 Cal. 4th at pp. 39-40.)

a. Legally Protected Privacy Interest

As to the first of the three prongs of the *Hill* test, we conclude patients in nursing homes, like all other persons, certainly have a legally protected privacy interest in their own personal bodily autonomy and medical treatment, under the rubric of "autonomy privacy." (See 7 Cal. 4th at p. 35.) "Autonomy privacy is also a concern of the Privacy Initiative [which added privacy as an enumerated right under article I, section 1 of the California Constitution]. The ballot arguments refer to the federal constitutional tradition of safeguarding certain intimate and personal decisions from government interference in the form of penal and regulatory laws. [Citation.] But they do not purport to create any unbridled right of personal freedom of action that may be vindicated in lawsuits against either government agencies or private persons or entities. [P] Whether established social norms . . . protect a specific personal decision from public or private intervention is to be determined from the usual sources of positive law governing the right to privacy--common law development, constitutional development, statutory enactment, and the ballot arguments accompanying the Privacy Initiative." (Id. at p. 36.)

We must stress in this context that we deal here with the privacy rights of persons who are initially determined by their physicians to be incompetent to make medical decisions or provide effective informed consent, and who are in need of medical intervention, according to the medical judgment of their treating physicians, yet have no surrogate who can provide a proxy for consent. Nothing said herein affects the rights of other persons who are competent to provide or withhold their consent, or who seek judicial intervention to uphold those rights. (Ct., e.g., *Thor v. Superior Court* (1993) 5 Cal. 4th 725, 749 [21 Cal. Rptr. 2d 357, 855 P.2d 375] [A competent prisoner in a state medical facility had the right to refuse medication or nutrition through a feeding tube]; see also *Bartling v. Superior Court* (1984) 163 Cal. App. 3d 186, 195 [209 Cal. Rptr. 220] ["The right of a competent adult patient to refuse medical treatment has its origins in the constitutional right of privacy." (Italics added).])

Nor do any of the "usual sources of positive law" identified in *Hill, supra*, 7 Cal. 4th at page 36, impose an absolute and inflexible right to refuse treatment for persons determined not to be competent, for obvious reasons; such a rule would lead to unacceptable neglect of the medical needs of incompetent persons. Neither the development of the common law, nor the statutory enactment in issue here, nor the ballot arguments in support of the adoption of the privacy right, purport to prevent medical professionals from administering necessary treatment in these circumstances. Thus, while the patients in issue here have a legally protected privacy interest, this interest is considerably attenuated by the fact they are determined by their physicians to be in need of medical care, yet incompetent to provide the necessary consent for that care. Under these circumstances, patients may also have an important interest in securing treatment, even though unable to provide consent, so as to avoid constant pain, injury, malnutrition, or physical decline. In sum, while there is certainly a legally protected privacy interest here, it is not an "unbridled right" which may be applied in isolation, regardless of the specific circumstances and pressing medical needs of these patients. (See *ibid.*

b. Reasonable Expectation of Privacy

Next, under the *Hill* analysis we must determine whether section 1418.8 would unconstitutionally interfere with the "reasonable expectation of privacy" of these particular nursing home patients. (See *Hill, supra*, 7 Cal. 4th at pp. 36-37.) "Even when a legally cognizable privacy interest is present, other factors may affect a
person's reasonable expectation of privacy." (Id. at p. 36.) "In addition, customs, practices, and physical settings surrounding particular activities may create or inhibit reasonable expectations of privacy. [Citations.]" (Id. at pp. 36-37.) "A reasonable' expectation of privacy is an objective entitlement founded on broadly based and widely accepted community norms. (See, e.g., Rest.2d Torts [(1977)] § 652D, com. c [pp. 387-388] [The protection afforded to the plaintiff's interest in his privacy must be relative to the customs of the time and place, to the occupation of the plaintiff and to the habits of his neighbors and fellow citizens.])" (Id. at p. 37.)

In Heller, supra, 8 Cal. 4th at pages 43-44, our Supreme Court expanded on this point in the context of an alleged privacy violation resulting from the nonconsensual disclosure of the plaintiff's medical condition and other private information, after she brought a medical malpractice action. The high court found the plaintiff could not have had a reasonable expectation of privacy sufficient to establish a privacy violation, because the circumstances were such that her medical history would inevitably have been exposed during the litigation: "By placing her physical condition in issue in the ... litigation, plaintiff's expectation of privacy regarding that condition was substantially lowered by the very nature of the action." (Id. at p. 43.) "Because the information would most likely have been discovered during the ordinary course of litigation, defendants' conduct in revealing information about plaintiff's treatment and physical condition does not violate the state constitutional guarantee against invasion of privacy as a matter of law." (Id. at p. 44.)

Here, as in Heller, the patient's reasonable expectation of privacy over private medical facts is considerably lessened by the circumstances in which this case arises. It is questionable if a person in need of medical care who is incompetent may ever have a reasonable expectation of privacy which would prevent timely medical intervention and treatment. Certainly it is inevitable that such persons residing in nursing homes, who are required to be under the care of a treating physician as a condition of admission (Cal. Code Regs., tit. 22, § 72303, subd. (a)), whose conditions of care and treatment are already extensively regulated by state and federal statutes and regulations, and who are not competent to consent to care will be subject to the decisions of outside professionals (see, e.g., Prob. Code, § 3201). The patient's expectation of privacy is, accordingly, greatly lessened. Indeed, since the providing of necessary medical care to patients residing in nursing homes is the obvious and legitimate purpose of this care in general, it would be surprising to find that a statute passed by the Legislature in furtherance of this purpose was unconstitutional as a privacy violation. (Cf. Hill, supra, 7 Cal. 4th at pp. 41-42 [The high court upheld an involuntary program of drug testing for athletes, in light of the reduced expectation of privacy applicable to a collective enterprise in which participants often observed each other in a state of undress, and medical condition information was disseminated among physicians, trainers, and other persons having a legitimate interest: "As a result of its unique set of demands, athletic participation carries with it social norms that effectively diminish the athlete's reasonable expectation of personal privacy in his or her bodily condition, both internal and external."])

The social norms affecting persons residing in nursing homes are primarily concerned with providing sustenance, shelter, and necessary medical care in a residential setting. While persons residing in nursing homes obviously have a reasonable expectation of privacy relating to aspects of their lives which are not connected to the medical purposes of the facility, it can hardly be doubted that the reasonable expectation of privacy as it relates to medical care must be diminished. Just as persons in need of medical care must sometimes disrobe for an examination, or expose their bodies to observation by medical personnel during needed surgery, certain particular social norms apply to the provision of medical care to patients of nursing homes who are incompetent, in the professional opinion of their physicians. Our currently prevailing social norms obviously find acceptable, in the context of needed medical treatment, much which would otherwise be clearly unacceptable. Here the Legislature, as a reflection of those social norms, enacted section 1418.8 in order to ensure provision of prompt ongoing medical care to incompetent persons in need of that care. This clearly accords with the reasonable expectation of patients: that if they became incompetent they will continue to receive their necessary medical care on a timely basis. The particular nature of this setting, in which nursing homes must continue to provide necessary care to incompetent resident patients on an ongoing and timely basis, indicates section 1418.8 would not unconstitutionally violate reasonable expectations of privacy. (See Hill, supra, 7 Cal. 4th at pp. 42-43; Heller, supra, 8 Cal. 4th at pp. 43-44.)

c. Seriousness of the Invasion of Privacy

The third factor specified by the Hill court was the seriousness of the invasion of privacy rights which would result from the challenged conduct. Once again, consideration of this factor does not support a finding of violation of the constitutional privacy right.

Considered in the abstract, a serious invasion of privacy would seem to result from the provision of medical treatment on a nonconsensual basis. However, as in Heller, supra, 8 Cal. 4th at page 44, the focus cannot be placed in isolation on the fact that medical care is in is-
sue; medical care inevitably implicates the autonomy of the body and concomitant privacy questions. Indeed, as in
Hill, supra, we cannot focus solely on the fact that medical information or personal autonomy is at issue, without also relating this fact to the circumstances in which the case arises in order to decide the seriousness of the privacy invasion in question. Rather, in deciding the question of the seriousness of the invasion on the authority of Hill, we must also focus on the fact that we deal here with persons who, based upon expert medical judgment, are incompetent to provide or obtain consent, and in need of medical care which would ordinarily require such consent. It is inevitable that the medical condition and private medical facts of such patients will be in issue, whether the decision to treat or not to treat these persons is made by a conservator of the person, by a court under Probate Code section 3201, or by a medical interdisciplinary team under section 1418.8. It is very hard to see how the invasion of privacy is more serious when the issue is decided by a medical team, as opposed to a conservator, the holder (frequently a layman) of a patient's durable power of attorney, or a court relying on expert medical reports or testimony, since a decision by some outside person, even if only by default, will "invariably" be made under the circumstances. (See Heller, supra, 8 Cal. 4th at p. 44.)

In sum, consideration of the three factors specified by the analysis in Hill, supra, does not support the claim that the right of privacy attaches here so as to invalidate section 1418.8. Moreover, consideration of the defenses to a privacy violation, such as balancing of the interests at stake, is also relevant under the Hill analysis.

d. Balancing of Interests

"The diverse and somewhat amorphous character of the privacy right necessarily requires that privacy interests be specifically identified and carefully compared with competing or countervailing privacy or nonprivacy interests in a 'balancing test.' The comparison and balancing of diverse interests is central to the privacy jurisprudence of both common and constitutional law." (Hill, supra, 7 Cal. 4th at p. 37.)

"Invasion of a privacy interest is not a violation of the state constitutional right to privacy if the invasion is justified by a competing interest. Legitimate interests derive from the legally authorized and socially beneficial activities of government and private entities. Their relative importance is determined by their proximity to the central functions of a particular public or private enterprise. Conduct alleged to be an invasion of privacy is to be evaluated based on the extent to which it furthers legitimate and important competing interests." (Hill, supra, 7 Cal. 4th at p. 38.)

Although these statements of our Supreme Court, regarding the "proximity" of a legitimate competing interest to an institution's central functions, may be arguably "rather unclear" (cf. Cott Drapery Cleaners, Inc. v. Sequola Ins. Co. (1993) 14 Cal. App. 4th 1595, 1608 [18 Cal. Rptr. 2d 692]), one can hardly deny that the providing of necessary medical care to patients on a timely basis is in very close "proximity" to the central functions of a nursing home and is, in fact, a compelling state interest, i.e., an obviously legitimate and socially beneficial competing interest which must be weighed in the balance.

Moreover, as Hill allows, the alternatives to the conduct in issue must also be considered in the balance as well: "Confronted with a defense based on countervailing interests, the plaintiff may undertake the burden of demonstrating the availability and use of protective measures, safeguards, and alternatives to the defendant's conduct that would minimize the intrusion on privacy interests. [Citations.]") (7 Cal. 4th p. 38.)

In this context, the petitioner and amicus curiae present a variety of alternatives to section 1418.8 which might, in their judgment, provide a better solution to the problem and more protection to nursing home patients. They primarily suggest the Legislature should have enacted an earlier, alternative version of section 1418.8, which gave more power to the system of local public guardians in each county, or other public agencies, to oversee and provide substituted consent for necessary medical procedures to be performed on incompetent nursing home patients; petitioner implicitly assails the Legislature for its failure to fund the relevant bureaucracy to effect this solution. Alternatively, it is suggested that the procedure specified by Probate Code section 3201, which allows a judge to make a medical treatment decision (after the resulting delay of uncertain and varying length to secure a hearing and decision), could exclusively continue to govern these cases.

While we agree that the interposition of another layer of bureaucracy between medical professionals and their patients might have some potential value insofar as it would discourage unnecessary medical treatment, it is far from clear that this would result in better and more timely medical care to nursing home patients as a whole, especially those who suffer more from neglect than from overattention by the medical community. Further, it is not clear that this alternative would be any more sensitive to privacy rights; it would seem to involve a greater number of persons in the decisionmaking process, without necessarily improving it from a privacy standpoint, and without necessarily resulting in a greater likelihood of appropriate treatment. Certainly we cannot say the particular solution sought by petitioner was constitutionally compelled. As the federal Supreme Court has held, in rejecting a similar constitutional challenge to the
treatment of mentally ill inmates without a court order: "Notwithstanding the risks that are involved, we conclude that an inmate's interests are adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge. . . . We cannot make the facile assumption that the patient's intentions, or a substituted judgment approximating those intentions, can be determined in a single judicial hearing apart from the realities of frequent and ongoing clinical observation by medical professionals." (Washington, supra, 494 U.S. at pp. 231-232 [108 L. Ed. 2d at p. 204].)

More fundamentally, the right of privacy does not require the Legislature to enact any particular version of proposed legislation; instead, the Legislature must, as an initial matter, engage in a balancing process in which privacy rights are weighed against other constitutional and public rights. In our own balancing process under Hill, we must also accord the Legislature the initial deference which is due to its judgment as to a solution, since we must approach the subject in light of the relevant legislative pronouncements as well as the common law and societal norms. (See 7 Cal. 4th at p. 38.) This does not mean, of course, that the courts abdicate their function when assessing the merits of a constitutional privacy challenge to legislation; rather, we approach the issue in light of the traditional jurisprudential limits placed upon our judicial review of legislation. (See County of Sonoma, supra, 40 Cal. 3d at p. 368.)

When properly considered under this standard, section 1418.8 does not violate the constitutional right of privacy. The operation of the statute does not constitute an "egregious breach of the social norms underlying the privacy right." (Hill, supra, 7 Cal. 4th at p. 37.) While the nursing home patients in issue certainly have privacy interests which are affected by section 1418.8, consideration of the diminished extent of the reasonable expectation of privacy and the seriousness of the privacy right invasion, in light of the particular circumstances faced by incompetent patients in nursing homes, does not support invalidation of section 1418.8. Finally, consideration of the balancing of interests and alternatives supports the constitutionality of the statute. (See Hill, supra, 7 Cal. 4th at pp. 56-57.)

B. Section 1418.8 Does Not Violate the Due Process Provisions of the California Constitution or the Federal Constitution

Petitioner next contends that section 1418.8 denies due process of law to patients of nursing homes who lack capacity to make decisions regarding their health care where there is no person with legal authority to make such decisions for them.

Petitioner's rationale is based on two interrelated contentions that the procedures established by the Legislature in such circumstances deny procedural due process to the resident patients of such nursing homes. They are:

First, that section 1418.8 permits an initial nonjudicial determination of the patient's incompetence by a physician or surgeon, preceding the subsequent medical intervention decision.

Second, that section 1418.8 unconstitutionally authorizes medical intervention in the case of such a patient without notice, hearing before an independent decision maker, testimony, cross-examination, a written statement by the fact finder, and a surrogate for the patient "whose only allegiances are to the desires or best interests of the patient, rather than to the provider."

In addressing these contentions, we first review the background to, and the legislative purpose in, enacting the original version of section 1418.8 (Stats. 1992, ch. 1303); then we review the current amended version of section 1418.8.

The Legislature in originally enacting section 1418.8 was fashioning a solution to a continuing and significant dilemma: How can necessary health care decisions be made for resident patients in nursing homes who lack capacity to make such decisions and have no surrogate to make such decisions on their behalf?

The legislative findings supporting this statutory enactment were these: "(a) When a skilled nursing facility or intermediate care facility resident loses capacity to make health care decisions, there is a need to identify a surrogate decisionmaker to make health care treatment decisions on his or her behalf. However, in many cases, the skilled nursing facility or intermediate care facility resident may have no family member who is available and willing to make health care decisions, no conservator of the person, and no other health care agent, such as an agent appointed pursuant to a valid Durable Power of Attorney for Health Care. In California, this has been identified by health care providers and others as a significant dilemma. [P] (b) The current system is not adequate to deal with the legal, ethical, and practical issues that are involved in making health care decisions for incapacitated skilled nursing facility or intermediate care facility residents who lack surrogate decisionmakers. Existing Probate Code procedures, including public conservatorship, are inconsistently interpreted and applied, cumbersome, and sometimes unavailable for use in situations in which day-to-day medical treatment decisions must be made on an on-going basis. [P] (c) Therefore, it is the intent of the Legislature to identify a procedure to secure, to the greatest extent possible, health care decisionmakers for skilled nursing facility or intermediate care facility residents who lack the capacity to make these deci-
sions and who also lack a surrogate health care decisionmaker. It is also the intent of the Legislature to ensure that the medical needs of nursing facility residents are met even in the absence of a surrogate health care decisionmaker and to ensure that health care providers are not subject to inappropriate civil, criminal, or administrative liability when delivering appropriate medical care to these residents." (Stats. 1992, ch. 1303, 1st § 1.)

The record below confirms these legislative findings: by evidence, inter alia, that financial constraints had led many public guardians to reject nursing home patients where surrogate decisionmaking was the only need; and in any event, the time lapse accompanying their actual appointment would have rendered them ineffective for nursing home patients with daily or multiple health problems. Overall, that record further confirmed that the number of medical conditions of such patients is frequently in constant fluctuation, requiring prompt medical intervention without the delay engendered by application of the Probate Code sections the Legislature deemed inadequate.

1. Determination of Incompetency by Physician

The amended statute sets forth a clear test for determination by the physician of a resident patient's capacity to make decisions concerning health care: A patient lacks capacity if "unable to understand the nature and consequences of the proposed medical intervention, including its risks and benefits, or . . . unable to express a preference regarding the intervention." (§ 1418.8, subd. (b).) In making this capacity determination, the resident patient's physician must: (1) interview the patient, (2) review the patient's medical records, (3) consult with nursing home staff as appropriate; (4) consult with family members and friends of the patient if such have been identified. (Ibid.)

The addition of subdivisions (b) and (c) to section 1418.8, ante, has resolved petitioner's initial contentions that the preamended version of that statute gave the physician unfettered discretion to determine capacity without a standard to follow; that a physician can deem a patient incompetent without seeing the patient or investigating the patient's medical history or looking into the patient's records. Subdivision (c) resolves the arguments urged below that "no standard" or "definition or description of a person with legal authority" to act as surrogate for such a patient is defined. They now are. The physician is required in making a capacity determination to consult the patient's records; and on admission to the facility, all nursing homes must inform patients of their right to appoint a surrogate, and are required to adopt procedures identifying both a patient's wishes for medical treatment and a surrogate decision maker. Subdivision (c) also disposes of the argument that the capacity-determining physician is not required to investigate or talk to anyone or examine the patient's records. Such requirements are statutorily extant.

Despite the statutory additions, however, petitioner and amicus curiae continue to urge that procedural due process requires the patient capacity determination to be made after "hearing before [and presumably decision by] an independent decision-maker."

Petitioner's major rationale for this position appears to be that a fair hearing on this issue cannot be obtained because 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.

In the face of an analogous contention regarding prescription of drugs for the involuntary treatment of prison inmates, the United States Supreme Court said: "[W]e will not assume that physicians will prescribe these drugs [psychotropic medications] for reasons unrelated to the medical needs of the patients; indeed the ethics of the medical profession are to the contrary." (Washington, supra, 494 U.S. at p. 222, fn. 8 [108 L. Ed. 2d at p. 198].) "Notwithstanding the risks that are involved, we conclude that an inmate's interests are adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge." (Id. at p. 231 [108 L. Ed. 2d at p. 204]).

These decisions are medical decisions. "[W]e agree with those [courts] which have held that requiring judicial intervention in all cases [of alleged] failure of medical providers to continue treatment of a terminally ill patient] is unnecessary and may be unwise. [Citations.]" (Barber v. Superior Court (1983) 147 Cal. App. 3d 1006, 1022 [195 Cal. Rptr. 484, 47 A.L.R.4th 1].)

"We consider that a practice of applying to a court to confirm such decisions [to give or withhold medical treatment to a comatose patient] would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession's field of competence, but because it would be impossibly cumbersome. . . ." ( Matter of Quinlan (1976) 70 N.J. 10 [355 A.2d 647, 669, 79 A.L.R.3d 205], italics added; cf. Youngberg v. Romeo (1982) 457 U.S. 307, 322-323 [73 L. Ed. 2d 28, 41-42, 102 S. Ct. 2452] [There is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions].) Parham
v. J. R. (1979) 442 U.S. 584, 609 [61 L. Ed. 2d 101, 123, 99 S. Ct. 2493] (Farham) [The question of whether a child is mentally or emotionally ill and can benefit from treatment is "essentially medical in character."]

It is common knowledge that the determinate evidentiary factor in court hearings, both civil and criminal, by which the mental capacity of human beings is decided, is the expressed expert views of the medical profession. 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 treatment for the financial gain of the physician or an associated institution.

Petitioner then urges that due process, allegedly lacking under her hypothetical proposition, requires that adversarial hearings must always be held after a physician concludes, following the protocol the Legislature has painfully and carefully constructed, that a patient with no surrogate lacks capacity to consent to medical intervention.

Capacity determination, which must be decided under section 1418.8 before required medical intervention is activated thereunder on potentially thousands of elderly nursing home patients in this state, would thereby be delayed, as would such treatment. No case cited to us, or disclosed by our independent research, has suggested that procedural due process requires postponement of medical intervention for a nursing home patient who is found by a physician to lack capacity to consent thereto until, in each case, the medical capacity issue is separately decided in some adversarial hearing.

To so rule would not only be cumbersome to thousands of these patients and to the courts, it would presume the bias if not dishonesty of physicians opining as to the patient's capacity. We emphatically decline to adopt that presumption. Prompt and effective medical treatment of these unfortunate citizens would be seriously jeopardized.

We believe our elected Legislature is, more than any other single institution, better able to reflect a proper balance of social values at stake in this significant and difficult problem, and that it has done so in enacting section 1418.8. (Cf. Matter of Conroy (1985) 98 N.J. 321 [486 A.2d 1209, 1220, 48 A.L.R.4th 1] ["Perhaps it would be best if the Legislature formulated clear standards for resolving requests to terminate life-sustaining treatment for incompetent patients. As an elected body, the Legislature is better able than any other single institution to reflect the social values at stake."].) We reject adoption of petitioner's suggestion on the rationale proposed. To do otherwise would negate the Legislature's reforming work on a speculative basis, one absolutely contrary to the ethical standards of the medical profession. Nursing home patients are not denied due process because their incapacity to give consent to medical intervention is initially determined by a physician and surgeon, rather than by a judicial or quasi-judicial hearing.

This is particularly true here in view of the provisions of section 1418.8, subdivision (j), ante. As we observe in part II.B.2. and footnote 7, post, of this opinion, due process is assured because there is also the right to secure judicial review of a physician's determination of the patient's incapacity to give informed consent to that medical intervention, which is the predicate condition for the application of section 1418.8.

2. Patient Representative

Petitioner also theorizes that section 1418.8 is unconstitutional because, although the statute requires that a patient representative serve on the interdisciplinary review team which provides the surrogate consent for any medical procedure, there may be some person in a nursing home who lacks any patient representative to serve on the interdisciplinary review team. However, the statutory definition of a patient representative in section 1418.8 is so broad that it is hard to see how this could be true. Even if a patient lacks a spouse and has no surviving next of kin, and even if there is no conservator or person holding a power of attorney, and no public agency such as the ombudsman or public guardian willing to serve in this capacity, the statute still allows any "friend" of the patient to serve in this capacity and represent the patient's interests. This would include patient advocates, legal counsel, and all other persons having an interest in the welfare of the patient. It appears almost impossible to conceive of a patient who could not have a patient representative, under this standard. Certainly petitioner has not presented any convincing proof to the contrary. Moreover, as our Supreme Court observed in County of Nevada v. MacMillen (1974) 11 Cal. 3d 662, 674 [114 Cal. Rptr. 345, 522 P.2d 1345], "We cannot, and need not in this proceeding, pass upon all hypothetical situations and tenuous circumstances which may be presented by counsel. While we recognize that a valid statute may be unconstitutionally applied, the precise limitations to be placed on the words in question can best be specified when actual cases requiring such interpretation are presented. [Citation.]" (Quoting from Stein v. Howlett (1972) 52 Ill.2d 570 [289 N.E.2d 409, 415].)

In this vein, we also need not give any particular credence to those suggestions of counsel, supported by opinions and editorial articles from newspapers, that physicians will abuse their powers and subject patients to unnecessary pro-
procedures under section 1418.8. The parade of horribles conjured up by counsel bears little relation to the prevailing ethics of the medical profession and ignores the need for participation by a patient representative under the statute. Further, we need not, and will not in this case, grant judicial notice or any dispositive weight to sensational suggestions in popular news articles which are not relevant to the statute under consideration, lacking evidentiary foundation. The practice of attempting to bolster an appeal by submitting to this court, under the guise of briefing argument, quotations from such newspaper articles is one we disapprove. (See Mangini v. R. J. Reynolds Tobacco Co. (1994) 7 Cal. 4th 1057, 1063-1065 [31 Cal. Rptr. 2d 358, 875 P.2d 73]; Tanja H. v. Regents of University of California (1991) 228 Cal. App. 3d 434, 440, fn. 1 [278 Cal. Rptr. 918].)

Thus, while we recognize that there may hypothetically be rare instances in which the participation of a patient representative may not be "practicable" under section 1418.8, subdivision (e) because, for instance, a particular conservator of the person or next of kin is out of the country or unavailable, we need not hold the entire statute unconstitutional merely because in rare cases of exigency the designated patient representative is unable to serve. We leave consideration of such hypothetical instances, and the uncertainties they may raise, to the future development of the case law; they do not support a facial challenge to the statute. "In any event, [petitioner] provides no authority to support [her] claim that the remaining uncertainties which may inher in the statute provide a proper basis for striking it down on its face. As with other innovative procedures and doctrines—for example, comparative negligence—in the first instance trial courts will deal with novel problems that arise in time-honored case-by-case fashion, and appellate courts will remain available to aid in the familiar common law task of filling in the gaps in the statutory scheme." (American Bank & Trust Co. v. Community Hospital (1984) 36 Cal. 3d 359, 378 [204 Cal. Rptr. 671, 683 P.2d 670, 41 A.L.R.4th 233].) "It would indeed be undesirable for this Court to consider every conceivable situation which might possibly arise in the application of complex and comprehensive legislation." (Barrows v. Jackson (1953) 346 U.S. 249, 256 [97 L. Ed. 1586, 1595, 73 S. Ct. 1031].) "The delicate power of pronouncing an Act of Congress [or the Legislature] unconstitutional is not to be exercised by this Court to hypothetical cases thus imagined." (United States v. Raines (1960) 362 U.S. 17, 22 [4 L. Ed. 2d 524, 529, 80 S. Ct. 519].)

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. (See In re Marilyn H. (1993) 5 Cal. 4th 295, 307-309 [19 Cal. Rptr. 2d 544, 851 P.2d 826]; Vitek v. Jones (1980) 445 U.S. 480, 495-496 [63 L. Ed. 2d 552, 566-567, 100 S. Ct. 1254] (Vitek).) As such, section 1418.8 passes constitutional muster.

Since California law requires, for good reasons, that the needs of the incompetent should not be neglected, it is only logical to expect that persons having in their care in nursing homes certain incompetent persons who lack any next of kin or other substitute decision maker should be allowed a practical, workable procedure by which consent for needed treatment could be secured. Section 1418.8 is a legislative attempt to deal with this problem without invoking the procedure under Probate Code section 3201, which is plainly unworkable for the routine and ongoing medical care of the incapacitated elderly, since that procedure frequently requires months to produce a court hearing and result, and would require thousands of hearings every year in large metropolitan counties. The resulting gridlock would serve no one's interests—least of all, those of the patients whose medical care would be necessarily delayed. If thousands of persons had to suffer neglect of medical needs for months while awaiting a court decision, those circumstances would appear to be a much more likely candidate for a constitutional challenge based upon due process principles than section 1418.8. Moreover, as the federal Supreme Court observed when rejecting a similar challenge on due process grounds to a state law mandating nonconsensual treatment of the mentally ill in state institutions, there is no reason to expect that interposition of court processes between doctors and their patients will result in better care or any practical benefit; due process certainly does not require that elaborate procedures be followed which have little or no utility, nor does it prevent a state legislature from balancing the interests in question and reaching a workable solution to a particular problem. (See Washington, supra, 494 U.S. at pp. 231-232 [108 L. Ed. 2d at pp. 204-205].)

Moreover, due process does not require that medical decisions be made in the first instance by lawyers and judges. As the federal Supreme Court observed in Parcham, supra, 442 U.S. at pages 607-608 [61 L. Ed. 2d at pages 121-122], "[D]ue process is not violated by use of informal, traditional medical investigative techniques. . . . The mode and procedure of medical diagnostic procedures is not the business of judges." As it also observed, the interposition of judicial norms would be of questionable value where the decision being made is, at bottom, simply a medical diagnosis concerning competency and the need for treatment: "[W]e do not accept the notion
that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing. Even after a hearing, the nonspecialist decisionmaker must make a medical-psychiatric decision. Common human experience and scholarly opinion suggest that the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions . . . may well be more illusory than real.  

More critically, any due process argument fails because it does not take into account the provision of subdivision (j) of section 1418.8, which provides: "Nothing 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." Thus, affected persons or their representatives, such as a friend, public guardian, or other concerned person or entity, are afforded an avenue by which they may obtain "appropriate judicial relief," including a temporary restraining order and other injunctive relief prior to treatment, thereby satisfying due process principles.  

7 After the interdisciplinary committee decides for medical intervention, judicial review of that decision under section 1418.8, subdivision (j) may encompass review of the initial medical determination that the patient lacks capacity to give informed consent (id., subd. (a)), since that incapacity determination is a predicate and triggering condition to the application of section 1418.8. This right to object and seek judicial review meets the requirements of due process under the state and federal Constitutions. (See Vitek, supra, 445 U.S. at pp. 495-496 [63 L. Ed. 2d at pp. 566-567]; Keyhea, supra, 178 Cal. App. 3d at p. 541.)

Here we do not deal with involuntary commitment to a mental hospital, with all the attendant consequences of such a commitment, which would naturally trigger a need for rather extensive due process protections. Instead, we deal with a statutory procedure by which the equivalent of informed consent may be provided, by a patient representative if practicable, and in exigent circumstances by health professionals, so as to allow necessary medical treatment to be afforded to already admitted patients of nursing homes on a routine, ongoing basis. This is consistent with due process, which does not require a judicial officer to make first-line determinations regarding medical treatments. (See Washington, supra, 494 U.S. at pp. 231-232 [108 L. Ed. 2d at pp. 204-205]; see also In re Eric B. (1987) 189 Cal. App. 3d 996, 1001, 1008-1009 [235 Cal. Rptr. 22] [Division Four of this district found no due process violation or other constitutional infirmity in a procedure by which the medical needs of a minor child were to be routinely monitored by a physician for two years, despite the parents' religious objections to medical care.] )

The opportunity to seek a decision by a neutral decision maker as to any particular medical intervention also nullifies petitioner's objection that section 1418.8 violates due process. Even though the statute allows the patient's physician to determine initially whether the patient lacks the capacity to make medical decisions, and the interdisciplinary team assessing the reasons for the treatment under section 1418.8 would also often include the physician who had initially prescribed the treatment under review, this initial decision is not final. Parties seeking to object to such a decision, including the patient, the patient's representative, or a public agency which supervises or investigates the care provided by nursing homes, still retain full access to a neutral determination by a court under subdivision (j) of section 1418.8. This comports with due process principles. (See Washington, supra, 494 U.S. at p. 235 [108 L. Ed. 2d at pp. 206-207].)

Section 1418.8 in its subdivision (f) further contemplates compliance with applicable federal and state requirements designed to protect nursing home patients, such as the standards set and regulations promulgated under 42 United States Code section 1395i-3 and 42 Code of Federal Regulations, section 483.1 et seq. (1993) which both limit and supplement the interdisciplinary team decisionmaking approach by granting certain rights and safeguards to affected residents. In addition, section 1418.8 by its own terms applies only to the relatively nonintrusive and routine, ongoing medical intervention, which may be afforded by physicians in nursing homes; it does not purport to grant blanket authority for
more severe medical interventions such as medically necessary, one-time procedures which would be carried out at a hospital or other acute care facility, as to which compliance with Probate Code section 3200 et seq. would still be required, except in emergency situations. Finally, the protections of state law which apply to any particular medical intervention or procedure would continue to apply. Consideration of these numerous statutory safeguards (see Keyhea, supra, 178 Cal. App. 3d at p. 541) undermines the claim that section 1418.8 violates due process standards.

"In light of the foregoing discussion the due process challenge is without merit." (Johnetta J., supra, 218 Cal. App. 3d at p. 1283, fn. 9.) Considering section 1418.8 in its totality, including the right to seek judicial relief and the other safeguards granted not only by section 1418.8 itself but also in the other state and federal regulatory standards referenced therein, we find the statute affords due process under both the state and federal Constitutions.

C. Conclusion

The Legislature may hereafter arguably craft a different solution to the problem than section 1418.8, which would exceed constitutional minima or provide additional protections to the patients of nursing homes. The opportunity for such legislative consideration has been reserved by the sunset provision of section 1418.8, subdivision (m). However, we are not in the business of reviewing legislation to determine whether it may be improved; we may only determine whether it is constitutional. "[T]he Constitution does not prohibit the State from permitting medical personnel to make the decision [to medicate] under fair procedural mechanisms. . . . [P]. . . . The mode and procedure of medical diagnostic procedures is not the business of judges. . . ." (Washington, supra, 494 U.S. at pp. 231-232 [108 L. Ed. 2d at pp. 204-205].) The procedures provided by section 1418.8 do not violate the constitutional rights of nursing home patients to procedural due process or their right of privacy. (See County of Sonoma, supra, 40 Cal. 3d at p. 368.)

III. DISPOSITION

The judgment is reversed, and the matter is remanded to the trial court with directions to enter a new order denying the petition. Each party shall bear its own costs.

King, J., and Haning, J., concurred.
Memorandum

Date: April 27, 1993
To: District Administrators

From: Licensing and Certification
1800 Third Street, Suite 210
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 445-3054

Subject: Informed Consent Questions and Answers

[ ] Statute Change
   Bill/Chapter___________
   Code___________
   Effective Date___________

[ ] Federal Change
   State Agency Letter #___________
   State Operations Manual #___________
   Regulation #___________
   Program Memo. Transmittal #___________

[ ] State Regulation Change [ ] Court Decision [ ] HQ Initiated [X] Field Requested

BACKGROUND

Now that the district offices (DOs) have had some experience in implementing the informed consent regulations and guidelines, some questions have been raised. In particular, there have been questions about the respective responsibilities of facilities versus physicians and questions about what duties the physician can delegate. The questions and answers are attached.

It has also been brought to our attention that there is an error on the first page (surveyor procedures) where it states that the surveyor must determine whether "the facility has (1) failed to obtain a patient's consent or (2) failed to obtain informed consent for any of the key treatments . . . ." This policy statement can be read incorrectly to mean that the facility has responsibility to obtain informed consent. Section 72528(a) of the regulations makes the physician responsible for obtaining informed consent. This will be discussed at length in the questions and answers which follow. However, the first page of the surveyor guidelines (attached) has been revised to reflect this correction.

TRAINING

District Administrators must ensure that all appropriate office staff receive timely in-service training regarding the provisions of this memo. The preceptors will maintain all in-service/training files in the DO.
District Administrators
Page 2
April 27, 1993

Should you have any questions, please contact Ed Queen, Chief, Long-Term Care Policy Unit, at (916) 327-1277 or ATSS B/467-1277.

[Signature]

Michael L. Rodrian, Chief
Policy and Training Branch

Attachment
INFORMED CONSENT QUESTIONS AND ANSWERS

Question #1

Title 22, California Code of Regulations (CCR), Section 72527(a)(5) establishes that residents have a right to receive all information that is material to the individual resident’s decision, and subsection (a) states that the facility shall ensure that these rights are not violated. Does this mean that when informed consent is not obtained we should conclude that the facility is strictly responsible?

Response

No. This is not a foregone conclusion. Section 72528, which speaks to the physician’s responsibility to provide material information, is a limitation on the facility’s accountability as specified in Section 72527(a). Health and Safety (H&S) Code, Section 1432.1, states “No licensee shall be cited for any violation caused by any person licensed pursuant to the Medical Practice Act . . . .” Therefore, the physician’s responsibility is a limitation on the facility requirement to ensure that resident rights are not violated. However, if the facility initiates any of the key treatments and there is no documentation that the physician obtained informed consent, the facility has violated Section 72528(c).

Question #2

Can a physician delegate the responsibility of obtaining informed consent to a registered nurse (R.N.)?

Response

No. The physician cannot delegate his overall responsibility to provide material information or to obtain informed consent. Title 22, CCR, Section 72528(a) states, in part, “The disclosure of the material information and obtaining informed consent shall be the responsibility of the physician.” Therefore, the physician is directly responsible and accountable for whatever information is received or not received by his/her patient.

Question #3

Can the physician convey the information through another person or health care professional?

Response

Yes, as long as the physician retains overall responsibility as enumerated above. It is important to note that the regulations do not place restrictions on the way the physician provides this information. However, if the physician conveys the information through the R.N. or other health professional, there must be a detailed policy and procedure (see Section 72527(e)(1)) regarding how this exchange of information will occur. This would be a three-way
agreement between the physician, R.N., and facility. Facilities and other health care professionals could enter into these agreements voluntarily with the physician.

Question #4

Can facilities use standard forms for purposes of informed consent?

Response

Yes. These forms are permitted although not required. Title 22, CCR, Section 72528(g) states, in part, "This section does not preclude the use of informed consent forms for any specific treatment or procedure at the time of admission or at any other time. All consent provisions or forms shall indicate that the resident or incapacitated resident's representative may revoke his or her consent at any time." Since the information must originate from the attending physician, there must be evidence that he/she has approved this form. In addition, whether the physician uses another health care professional or a form to convey the required information, the facility's policies and procedures must explain how the physician will accommodate residents with special needs or circumstances. In other words, the information which is required to be communicated to the patient must be tailored to the patient's own needs, and policies and procedures must explain how this (tailored) information, if applicable, will be communicated.

Question #5

Is the Department approving informed consent forms?

Response

No. This is not appropriate. The process of developing, agreeing to, and implementing these policies and procedures is between the facility and the physician. The Department would only be concerned if a form violated a statutory or regulatory requirement or was inconsistent with a facility's policies and procedures.

Question #6

Notwithstanding #5 above, do some forms violate regulations and/or statutory requirements or rules?

Response

Yes. For example, we have seen some forms that blatantly state that residents must waive their rights or that the resident cannot refuse treatment. Also, as mentioned in Section 72528(g), all forms must indicate that the resident or their representative may revoke his or her consent at any time.

Question #7

May the interdisciplinary team (IDT) established in H&S Code, Section 1418.8, Chapter 1303, be used to make a decision regarding withdrawal or withholding of life sustaining treatment (Section 72528(c)) on behalf of residents who lack the capacity?
Response

No. H&S Code, Section 1418.8, authorizes the IDT to make decisions regarding medical interventions. Since withdrawing or withholding life sustaining treatments are not medical interventions, this statute does not authorize the IDT to make these decisions on behalf of residents.

Question #8

Regarding psychotherapeutic drugs and physical restraints, Section 72528(c) requires documentation that informed consent was obtained prior to their initiation. On page 2 of the surveyor guidelines under survey procedure, it states that if the treatment or procedure was initiated prior to the patient entering the nursing facility, the facility should not be cited for not documenting informed consent for continuing the treatment. There are instances when the order was written prior to the patient’s admission to the facility but there is no evidence the patient received the treatment. If there was a prior order but it is not clear that treatment had been initiated, is it still necessary to obtain informed consent?

Response

Yes. A prior order is not the same as "prior initiation" of treatment. The regulations state that prior to initiating the specific treatments, the facility staff must verify that the patient’s health record contains documentation of informed consent to the specific treatments. Thus, if it can not be determined that the specific treatment had been initiated prior to admission, the facility must verify that informed consent was obtained. If informed consent was not obtained previously, it must now be obtained.

The guidelines were written in this manner because there are times when a patient enters the nursing facility with treatments, for example, restraints that are already applied and which were initiated in a hospital. In this example, this regulation would not apply.
<table>
<thead>
<tr>
<th>DEFINITION OF TERMS</th>
<th>REQUIREMENT</th>
<th>DOCUMENTATION</th>
<th>RESPONSIBILITY</th>
<th>SURVEY PROCEDURE</th>
</tr>
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<tbody>
<tr>
<td>CONSENT</td>
<td>72018.1, 72527(a)(4),(5), 72526(a) and 72526(g). Health and Safety Code(H&amp;S) Section 1599.72 (F157,F156,F175) Facilities must develop and implement policies and procedures and ensure that patient's rights are not violated. Among these are: 1) the right to receive all information in advance that is material to a decision to accept or refuse treatment, 2) to consent to or to refuse any treatment of procedure or participation in experimental research, and 3) to participate in care planning.</td>
<td>1. Facility policies and procedures must include a description of all patients' rights and state that the facility shall ensure these rights are not violated. 2. Admission agreements may have a general consent provision. This provision must be limited to consent for emergency care or routine nursing care only. Routine nursing care is a treatment or procedure that does not require informed consent or does not require disclosure (as determined by the physician) of information material to the patient. It includes, but is not limited to, bathing, feeding, turning the patient, etc. A blanket consent clause for all treatment is not permitted. There must be included in any written consent document a statement that a patient can refuse treatment at any time.</td>
<td>Facility</td>
<td>During an OBRA Standard Survey, if the surveyor has discovered that the facility has (1) initiated or continued any treatment contrary to the patient's wishes or (2) failed to verify and document that informed consent was obtained for any of the key treatments.</td>
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</table>

1. Review facility policies and procedures to see if all patient rights are described and listed and a procedure is developed to ensure rights are not violated.

2. Review admission agreement for general consent and check to see whether the patient or the patient's representative signed it.

3. Interview patient or incapacitated patient's representative to determine their understanding of consent provisions and facility's policies and procedures.
Health and Safety Code Section 1418.8:
Snapshot Guide for Long-Term Care Ombudsman Representatives

Summary of Health & Safety Code § 1418.8:

When a resident in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), who is no longer capable of providing informed consent, has been prescribed a medical intervention in which informed consent is required, and there is no legal surrogate decision maker and/or Advance Directive, the facility’s Interdisciplinary Team (IDT), along with the attending physician and surgeon, can make health care decisions on behalf of the resident.

The IDT shall include the resident’s attending physician, registered professional nurse with responsibility for the patient, other appropriate staff in disciplines as determined by the resident’s needs, and a patient representative, in accordance with applicable federal and state requirements. The IDT shall oversee the care of the resident utilizing a team approach to assessment and care planning and shall conduct an interdisciplinary team review of the prescribed medical intervention prior to the administration of the prescribed medical intervention.

The 1418.8 IDTs may not authorize any treatment that is intrusive or not ongoing or day to day such as the administration of psychoactive drugs, the withdrawal of artificial life support, initiating hospice care, surgery, executing a DNR or POLST form, or overriding a resident’s refusal of proposed treatment. If the attending physician believes that an extraordinary medical intervention is necessary, he or she must seek court authorization pursuant to Probate Code section 3201, or through the appointment of a conservator.

The Role of the Ombudsman in Health & Safety Code § 1418.8 IDTs:

1) Verify the lack of capacity- Ensure the capacity determination is current, accurate, and the result of a thoughtful, deliberate process.
2) Verify the lack of surrogate- Make certain the SNF or ICF staff have followed an adequate process to determine that there is no surrogate with the legal authority to make decisions on behalf of the resident.
3) Encourage the resident’s family or friends to participate- Provide education and encouragement to family or friends to participate in the IDT process.
4) Advocate for resident attendance- Require the resident to be in attendance and/or be provided the opportunity to express treatment preference.
5) Ensure the legal process is followed- Insist that those required to attend and those deemed appropriate to attend are present and that they conduct a team review of the prescribed medical intervention.
6) Ensure the treatment contemplated is routine or day-to-day- Verify that the proposed medical intervention is routine and not outside the authority of the IDT.
7) Do not vote for, or give approval to, a treatment decision- Refrain from imposing either professional or personal feelings and do not take on the role of a health care provider or surrogate decision maker.
8) Do not express treatment preference other than those communicated by the resident- Refrain from asserting any treatment preference other than what is conveyed by the resident.