MEDICAL DECISION-MAKING IN CALIFORNIA LONG-TERM CARE FACILITIES: HEALTH AND SAFETY CODE SECTION 1418.8, A MANDATED ALTERNATIVE TO CONSERVATORSHIP

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I. INTRODUCTION

In long-term care (LTC) settings, the statutory authority for the interdisciplinary team (IDT) – Health and Safety Code section 1418.8 (hereafter "section 1418.8") – is not well known or understood. In the context of the requirement to employ the least restrictive reasonable alternative for decision-making, the authors posit that section 1418.8 is a mandatory alternative to conservatorship. As such, we must be prepared to consider this option with a clear understanding of the powers it authorizes and the responsibilities it entails.

Diminished judicial financing makes the relevance of alternatives to conservatorship increasingly significant. While the formalities of court-supervised conservatorships provide needed protection for vulnerable individuals, there are often available alternatives left unconsidered. Some of these alternatives promote safe and supportive decision making that results in better representation of the individual's known wishes and best interests.

This article discusses the mechanism for making medical decisions for incapacitated individuals in LTC facilities, specifically the "unbefriended," those residents with no known family or friends. The authors take the position that section 1418.8 sets a mandate that, in applicable cases, medical decision-making shall be done according to its terms, thereby eviscerating many cases otherwise destined for conservatorship.

Before filing for a conservatorship in California, a petitioner must explore all viable alternatives.[1] Alternatives include (1) the proposed conservatee's voluntary acceptance of informal assistance, assuming they have some degree of decision-making capacity remaining to do so, (2) the use of durable powers of attorney, (3) activation of other estate planning instruments that permit a fiduciary to act on behalf of the individual in a time of incapacity, or (4) appointment of a surrogate decision-maker, if available.[2]

For medical decisions, a petition can be filed applying to a single medical procedure or an on-going course of treatment. Hospitals probably have the resources to bring such petitions. If ongoing, comprehensive care would require repeated use of this mechanism, however, it rapidly becomes impractical. Typically, nursing homes do not have ready access to attorneys for day-to-day operations. Even if such support were available, filing repeated petitions would be overly cumbersome for managing a resident's medical care.

Placement in an LTC facility is a medical decision. Hospitals seeking placement for incapacitated and unbefriended patients must move quickly to pursue such a petition because a potential discharge to an LTC facility often depends on the immediate availability of an open bed. Open beds are not held to give time for a possible or eventual admission following court action since LTC facilities are paid based on filled beds.

Finally, since the LTC facility standard admission agreement is focused on routine care, the standard of simple consent may be applied. Some residents unable to provide informed consent for non-routine medical treatment may still be able to self-admit. If the potential resident cannot even meet this standard, an IDT approach may be the best remaining option to obtain consent for admission. Informed consent will still be needed for treatment beyond admission, but an IDT should still be available.

A. Informed Consent

1. The Legal Standard

Informed consent is the standard for consenting to or refusing medical treatment. It requires understanding the risks, expected benefits, and alternative treatment modalities for a patient's medical condition.[3] The legal standard is that a patient must be able to:

1. Respond knowingly and intelligently to queries about the proposed medical treatment;
2. Participate in the treatment decision by means of a rational thought process;
3. Understand:
    a. The nature and seriousness of the patient's illness, disorder or defect;
    b. The nature of the medical treatment that is being recommended by the patient's health care providers;
    c. The probable degree and duration of any benefits and risks of any medical interventions that are being recommended by the patient's health care providers, and the consequences of lack of treatment; and
    d. The nature, risks and benefits of any reasonable alternatives.[4]

Related to this legal standard is the need for clinical assessment of decision-making capacity (DMC). Probate Code section 4732 requires terms like "knowingly and intelligently," "rational," and the elements of being able to "understand" to be documented

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in the medical record by the primary physician. A model for accomplishing this is outlined and discussed in publications by Grisso and Appelbaum, 1998,[5] and by Gibson and Ferrini, 2010.[6]

Capacity is variable. It must be assessed based on the patient's current ability to consent to a particular procedure. Procedures also vary with the complexity of the information necessary for an informed decision. Given that both the patient's ability and the complexity of procedures are "moving targets," a mechanism is needed for assessing and charting this in the context of the informed consent standards.

2. U-CARE

Gibson and Ferrini suggest a simple framework for documenting discussion of the medical issues and assessment of a patient's abilities, expressed by them via the acronym U-CARE: Understanding, Consistency, Appreciation, Reasoning and Expression.[7] *Understanding* of the relevant information may be documented through quotes by the patient, questions, or other appropriate manipulation and use of the information. *Consistency* is discussed in the next paragraph. *Appreciation* of the significance of the information as it applies to the patient's own situation may also be captured with questions, both by the patient and via responses to questions posed by the professional. *Reasoning* reflects the ability to engage in a logical process of weighing options. *Expression* reflects any manner of communicating the above. [8]

Consistency is a dimension of assessment involving examination of a patient's responses both within a single interview and across several interviews. Reversal of questions during an interview, such that a consistent response would require "yes" at one point, and "no" at another, is helpful to rule-out an all "yes" or all "no" pattern related to cognitive impairment. When possible, more than one interview will also provide greater support for a capacity conclusion, particularly when the patient exhibits cognitive impairment but retains the ability to consistently express his or her values and process information per the informed consent requirements.

Routine medical treatment in skilled nursing and intermediate care facilities is addressed by the California Standard Admission Agreement from the California Department of Public Health. Upon admission, the patient or his or her representative "consents to routine nursing care provided by this facility, as well as emergency care that may be required." As with informed consent, decision-making capacity should be reviewed, though a standard of simple consent would apply.

3. Reality Check

In the past, when an arriving patient appeared incapacitated, a solution to the lack of an agent or conservator was "double doctoring" to sign admission papers or to authorize treatment. According to the California Hospital Association (CHA) Consent Law Manual,[9] there is no provision in California or federal law permitting two doctors to consent to a patient's medical procedure or admission. Section 1418.8 supplants this gimmick by allowing informed consent by an IDT, once the patient has been admitted. Arguably, it may not apply pre-admission, but absent its application, some new statutory mechanism would need to be created to address the gap between inpatient placement and admission to an LTC facility. Informal discussion with attorneys presenting on the topic of consent and hospital providers have suggested that the community standard for resolving this conundrum, in practicality, is use of an IDT approach for the admission itself, when no other option is available. This seems reasonable.

The well-developed statutory scheme in California for supporting the decision-making of cognitively-impaired persons spreads throughout the Probate, Welfare and Institutions, and Health and Safety Codes. It is augmented by federal and state regulations, especially Title 42 of the Code of Federal Regulations and Title 22 of the California Code of Regulations, which provide for continuous oversight of activities within LTC facilities. These are mere frosting on a cake. The bedrock of support for the incapacitated patient comes from the Hippocratic Oath. Physicians, by the foundational ethic "Do no harm," strive for their patient's health and well-being.

In court, a lawyer is required to speak the truth. In making factual representations, he or she will be believed by the judge because the attorney is presumed to be acting ethically. In much the same way, doctors are presumed to be acting in their patient's best interests. Consequently, doctors should be presumed to make ethical decisions for their incapacitated patients without another person's input. Like the distrusted attorney, however, doctors can suffer from our society's prejudice that members of the profession are "in it for the money" and may subrogate ethics to the "almighty dollar." While there are instances of abuse, creation of a policy to address provision of care to unbefriended and incapacitated patients based on potential bad behavior of an unethical minority is not required. Protections are needed, but in the LTC industry, state and federal laws and regulations already provide them.

B. The Inter-Disciplinary Team

Legislators, who have their own societal biases with which to contend, naturally favor team approaches to decision making. When resolving conundrums like balancing individual autonomy with allocation of limited resources, there is a tendency to rely on groups of people empowered to discuss and decide, rather than a single person. IDTs, like those formulated in section 1418.8, are used successfully in many contexts.

Multidisciplinary teams (MDTs) and IDTs are found in the contexts of elder abuse remediation, supported decision making for the developmentally disabled, and in the bio-ethics committees of every major hospital. Although similar, MDTs are composed of professionals from diverse fields and often different agencies, while the professionals working in IDTs are usually with the same institution and the focuses of their fields intersect. For example, doctors, social workers, and facility administrators all work with a

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geriatric population. These teams work, not just because "it takes a village" and "more heads are better than one," but because a synergy exists when differently trained perspectives and practical experience are brought to problem-solving. These teams increase transparency when properly functioning and documented. The downside is that privacy, a constitutionally-protected right in California, is compromised.

The potential for compromise of privacy may be related to the degree of protection provided. If disclosure of private information is limited to the direct care team, which already has access to the information in question, privacy is impacted minimally, if at all. Protection of privacy comes at a cost. If we wish to increase oversight and broaden the perspective of the team, then persons who would not otherwise have access to the patient's information may need access. If we wish to include someone from the patient's religious faith, the Ombudsman, a community member, or outside medical or ethical consultant, for example, the patient's privacy might be "compromised." There is no comparison to the near-complete compromise of personal privacy by a public conservatorship proceeding, presumed the provider of greatest protection.

II. ALTERNATIVES TO CONSERVATORSHIP

Conservatorship by its nature is an infringement of an individual's civil liberties. Authority to make fundamental decisions like what to eat, what to wear, where to reside, and who will be allowed to touch the patient can be taken away and given to another; to be exercised in the patient's best interests, of course. Someone will take title to the patient's property, intercept the patient's mail and pension payments, and manage the patient's investments; in strict accordance with prudent practices, of course. Complete compliance with all applicable laws is practiced by competent fiduciaries, and strictly enforced by bevies of attorneys and an ever-watchful court; at the patient's expense. Conservatorship is such a serious and expensive invasion that it must be the last resort.

Probate Code section 1800.3(b) states: "No conservatorship of the person or of the estate shall be granted by the court unless the court makes an express finding that the granting of the conservatorship is the least restrictive alternative needed for the protection of the conservatee." To establish a probate conservatorship, a petitioner must show by clear and convincing evidence, the civil equivalent of "beyond reasonable doubt," that the proposed conservatee cannot properly provide for their basic needs of food, clothing, shelter and health care.[10] If there is any reasonable alternative to conservatorship, the court would be unable to make the affirmative finding necessary to appoint a conservator.

A. Voluntary Acceptance of Informal Assistance

The most common alternative to conservatorship is for an incapacitated person to be helped by someone else. In the medical decision-making context, California Probate Code sections 4700-4701 provide for the creation of an Advance Health Care Directive (AHCD). The AHCD documents healthcare preferences and the appointment of an agent to serve as the decision-maker for medical issues, if the principal becomes incapacitated. For the unbefriended and incapacitated patient, if an AHCD were present and valid, it might specify treatment preferences. If the appointment of an agent were effective, however, the patient would not be unbefriended. As such, an LTC facility would review any AHCD to ascertain the patient's treatment preferences, and if present, take reasonable steps to locate any listed potential agent.

Although it is a requirement under the Patient Self-Determination Act of 1990 to discuss with incoming patients their treatment preferences and choice of agents,[11] this may seem less relevant with unbefriended and incapacitated persons. As discussed below, however, incapacity is often not "all-or-nothing" but a matter of degree. An individual suffering from a traumatic brain injury might have severe short-term memory loss but have sufficient long-term memory to know he does not want "the government" making medical treatment decisions for him. Is this a paranoid delusion or life-long belief in self-sufficiency? To help such a patient often leads facilities to seek assistance from non-medical professionals.

The Professional Fiduciary Act[12] enacted in 2007 created licensure requirements for professional fiduciaries. The Professional Fiduciaries Bureau, a licensing entity within the State of California's Department of Consumer Affairs,[13] monitors approximately 600 professional fiduciaries. The Professional Fiduciary Association of California (PFAC), an affiliate of the National Guardianship Association, has over 500 members.[14] Attorneys and Certified Public Accountants acting as fiduciaries are not required to be licensed, but their malpractice insurance may not cover fiduciary services.[15]

To fall under the enforcement provisions of the Professional Fiduciary Act, an individual must be serving as the agent, trustee, or conservator of two or more persons not related to her or him. It is part of the Professional Fiduciaries Bureau's strategic plan to encourage professionals in related fields to become licensed. Most fiduciaries, however, are family members acting without supervision and, more often than not, without legal counsel. From the passage of the Elder and Dependent Adult Civil Protection Act,[16] we infer that more than a few "friends" and family act improperly.

Given California's population in 2012 of over 4,000,000 elders (12.1% of more than 41,041,430 persons),[17] if only 1% are unbefriended (an optimistic assumption), there are at least 40,000 elders without a non-professional to assist them. It is safe to say there is a dearth of available agents. Add to this sad state a reality of the professional fiduciary industry: limited pro bono services aside, hired agents are only an option if the person has a sizable estate. When medical decisions need to be made for an incapacitated and impoverished person, the odds worsen.

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B. Probate Code section 3200: Medical Decision Making for Incapacitated Adults without a Conservator.

A petition pursuant to Probate Code section 3200 can be filed by any interested person. This means that a hospital or LTC facility could, if it wanted, obtain court authority to treat an incapacitated patient if the circumstances warranted. The section 3200 petition is best used to obtain authorization for medical treatment when the condition to be treated presents "a probability that the condition will become life-endangering or result in a serious threat to the physical or mental health of the patient." The patient must be unable to consent to the recommended treatment. The recommended health care must be in accordance with the patient's best interests and take into consideration the patient's personal values, to the extent known to the petitioner.

Rule 4.18.5.C of the San Diego County Superior Court Rules requires that if a conservatorship petition is premised on the need to exercise medical authority, the petitioner must explain why a Probate Code section 3200 petition is not the least restrictive alternative. Often, if a single, non-imminent (though still potentially life-endangering or serious) condition is of concern, even with the delay inherent in a petition for an order for a single medical procedure/treatment, it may be the least restrictive alternative. But in the case of long-term, ongoing care that requires the ability to more quickly address multiple medical concerns, this may rapidly become impractical.

A potential wrinkle is that Probate Code section 3208(a)(2) requires a finding by the court that, "[i]f untreated, there is a probability that the condition will become life-endangering or result in a serious threat to the physical or mental health of the patient." One might argue that section 3200 does not apply to placement from hospital to LTC, since if the patient remains in hospital the above conditions are unlikely. Consider, however, that the hospital is probably mandated to discharge the patient and the appropriate level of care may be LTC. If restriction of a person's liberty interests was not important to both physical and mental health, it would not be both a presumption and legal requirement of our present system that placement of a conservatee should be in the least restrictive, appropriate placement. We conclude, therefore, that section 3200 does apply to discharge from acute care to LTC.

Is it less expensive to pay legal counsel to file a section 3200 petition to discharge and place a recovered but incapacitated patient in a skilled nursing facility, or to hire a professional fiduciary to prepare, file and pursue a conservatorship proceeding with its attendant expense and delay? This question might reasonably be asked of an inpatient health care facility's utilization review committee. There is probably a savvy young attorney in California, hungry for work, ready to ask the same question. After a proposed conservatee has been kept in an acute hospital bed for thousands of dollars a day, instead of having been placed in a less restrictive Skilled Nursing Facility costing only hundreds, the pursuit of a section 3200 petition for appropriate placement may be the most cost effective option.

Facilitating appropriate placement is one function of a petition under Probate Code section 3200, which includes in the definition of medical decisions in subsection (b)(1): "[s]election and discharge of health care providers and institutions." Instead of suing hospitals, we suggest that our hypothetical enterprising young attorney become proficient with section 3200 petitions and contract instead to seek the discharge of incapacitated patients to LTC. It would be a conflict of interest for a hospital to bring (or hire an agent to bring) a conservatorship petition because of its status as a creditor. However, this is probably not an impediment to a petition under section 3200.

C. Involuntary Provision of On-Going Formal Assistance

It is no wonder health care providers and the public in general look to government agencies to assist with the incapacitated, unbefriended patient. While the courts have had budget cuts of over a billion dollars in the past four years, human services programs are also feeling the economic pinch. For example, funding for the Long-Term Care Ombudsman Program, despite providing 'watch over' care for more 1,200 skilled nursing facilities and 7,500 residential care facilities, had its funding reduced by over two million dollars between Fiscal Years 2010/2011 to 2011/2012.[18] There may never be enough money, but there will be no end to referrals. The Alzheimer's Association estimates that the likelihood of developing Alzheimer's doubles about every five years after age 65, and that after age 85 the risk of developing Alzheimer's reaches nearly 50 percent.[19] With the aging of the Boomer generation, this demographic is the fastest growing in the state.

Due to the absence of a mechanism for establishing a probate conservatorship of the person without an interested party, LPS conservatorship is sometimes employed as a "last (and only) resort." The Lanterman-Petris-Short Act was passed in 1967 and went into full effect in 1972.[20] LPS addresses the cyclic nature of many mental illnesses. Significant due process protections are built into the law, which provides for a mental health conservatorship that terminates automatically after one year.[21] To establish an LPS conservatorship, the proposed conservatee must be "gravely disabled," meaning that due to the presence of a mental illness, the person is unable to provide for the basic needs of food, shelter or clothing, and these cannot be provided by another.[22] If the criteria for the grave disability standard are met, then the LPS conservatorship may be established, but it must be re-established annually on a showing of continued grave disability.

The use of LPS conservatorships is dubious in many cases, as the person is hardly gravely disabled if his needs are being met by the facility in which he is being treated. On the other hand, if there is a risk of flight or for some other reason an inpatient's access to food, shelter or clothing is in jeopardy, then even with dementia as the Axis I DSM diagnosis, an LPS conservatorship may be appropriately obtained. Finally, there is probate conservatorship.

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Probate Code section 2920(a) states that if any person domiciled in the county requires a conservator, and there is no one else who is qualified and willing to act whose appointment as guardian or conservator would be in the best interests of the person, then the Public Guardian shall apply for appointment if there is an imminent threat to the person's health or safety or the person's estate. The court may also *sua sponte* order the Public Guardian to petition for conservatorship under limited circumstances.[23]

At present, there is no known Public Guardian's office in California which undertakes to manage an incapacitated individual's affairs with only a power of attorney. In theory, this would be possible. Many people who need assistance, perhaps because of some short-term memory impairment, still have the mental capacity to understand and execute legal documents. Public Guardians, however, benefit from court supervision of their activities. The settlement of each account further limits governmental liability. The individual's right to privacy ends up being sacrificed to the compelling state interest of protecting him or her from abuse, and to the reality of limited public resources.

III. SECTION 1418.8

Section 1418.8 was enacted in 1992 and amended in 1994. The California Supreme Court held this statute to be constitutional and consistent with California's right to privacy and procedural due process in *Rains v. Belshe*.[24] The Court found that the purpose of the statute was consistent with other cases in which invasions of privacy had been upheld and that it contained sufficient due process protection. *Rains* has been cited often. It has not been overturned, nor does it appear to have been criticized in any subsequent case.

A. Functional Structure

The key requirements of section 1418.8 are that 1) the physician orders a medical intervention, 2) the physician is required to interview the patient, 3) the patient must be unable to understand the nature and consequences of the proposed medical intervention, including its risks and benefits, or be unable to express a preference regarding the intervention, and 4) no other substitute decision-maker is available. The section then identifies the members of the IDT tasked with decision-making. The IDT includes the physician, a registered nurse with primary care responsibilities for the patient, and practitioners of other disciplines as appropriate. Most significant, however, is the inclusion of a patient representative whenever practicable.[25]

> It is highly significant that section 1418.8, subsection (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.[26]

Section 1418.8(f) states that the patient representative may include a family member or friend that cannot accept full responsibility for the patient but is willing to participate as a member of the IDT to make medical decisions. For the unbefriended patient, the statute continues by stating other persons may be authorized by state or federal law to serve.

To meet the statute's requirements, a review of the prescribed medical intervention must be done no less than quarterly. To continue, there must be a significant change in the patient's condition. Documentation for the review must include the physician's current assessment, the reason for the intervention or continuation of the intervention, review of any known desires of the patient, and the type and impact of reasonable alternatives to the intervention.[27] This is essentially the same information used to make the initial determination concerning treatment.

B. *Rains v. Belshe*

Rains v. Belshe involves a suit filed against the Department of Health Services (DHS) in August 1993, challenging the validity of section 1418.8.[28] At trial, the judge ruled that the statute was unconstitutional.[29] The California Attorney General appealed. Less than a month before the matter was set for oral argument, section 1418.8 was amended by the state legislature, addressing most of the issues cited by the trial court. The Court of Appeal in *Rains* stated:

> The Legislature enacted in 1992, and amended in 1994, Health and Safety Code 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.[30]

In making its decision, the Court of Appeal considered only post-amendment positions.[31] The Court of Appeal had an advantage over the trial court, in that precedents had recently been set defining the limits of California's constitutional right to privacy. Between 1993 and 1995, the California Supreme Court determined that college athletes could be observed urinating for drug tests, that their confidential medical information could be shared,[32] and that there was no expectation of privacy of medical information when suing a physician for medical malpractice.[33]

In earlier decisions, the Court of Appeals addressed due process concerns similar to those raised in *Rains*. The court pointed out that it had previously determined that prisoners[34] and certain patients[35] had the right to refuse administration of psychotropic medications without adjudication of their incapacity to refuse medical treatment. The court distinguished those cases from *Rains* by observing that, by enacting section 1418.8, the legislature "implement[s] 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

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regarding their health care may receive medical treatment,"[36] even though they have no agent or conservator.

Rains is explicit that due process is satisfied by access to the courts. Section 1418.8(j) states, "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."

When determining a statute's constitutionality on appellate review, the statute is presumed to be valid.[36] The Supreme Court had already determined that the right to privacy is not without limit.[37] Keeping medical decision-making for incapacitated persons out of the courts is a compelling state interest.[38] Section 1418.8 meets that need. At the same time, it lays out a specific procedure to be used: a procedure that states how incapacity is to be determined, how decisions are to be made, and how the patient's interests are to be protected.

IV. ROOM FOR IMPROVEMENT

Here is where it gets complicated. Section 1418.8 is designed for skilled nursing facilities, so it is assumed it relates to the kinds of medical decisions ("medical interventions") made in those facilities. These might involve a restraint, use of a medical device, a minor or major medical procedure, consent for administration of psychotropic medications, and change of code status.

May an IDT complete a Physician Orders for Life-Sustaining Treatment (POLST)? The POLST is approved by the Emergency Medical Services Authority.[39] A POLST can specify that paramedics are not to attempt resuscitation, allowing natural death if a person is found without a pulse and is not breathing. It can provide for comfort care only, allow limited interventions, or request full treatment to include mechanical ventilation and intensive care. This document might follow an individual to another facility, if the level of treatment needed to sustain the person changes, and may be reviewed by any receiving physician.

Some advocates do not want Section 1418.8 to be used to make end-of-life decisions. The *Rains* court's opinion is at odds with their position.[40] The *Rains* court observed that applying to a court to confirm a decision such as to give or withhold medical treatment to a comatose patient would generally be inappropriate.[41]

May an IDT consent only to an affirmative action but not to refusal of care, such as withholding or withdrawal of treatment? This controversy may arise from the statutory wording "prescribes or orders a medical intervention" in section 1418.8 but runs counter to the intent of providing medical decision-making for unbefriended patients. If this view is accepted, it would effectively remove the only active decision-making entity, the IDT, from discussions of refusing futile or non-beneficial treatment. It would eliminate the IDT from input on end-of-life decision-making because it could only order more care. By default, unbefriended patients would be subjected to care that might run counter to good or in some cases even humane practice, such as feeding tubes and restraints for an advanced dementia patient. Unlike persons with capacity or incapacitated persons with an AHCD and willing agent, the remaining option is to "do everything," regardless of the consequences or return to courts that are less equipped to make these decisions. Presumably, this is why the legislature adopted the statute.

The scope of section 1418.8 remains uncertain without case law addressing a specific application. The previously-noted discussion of *Quinlan* goes well beyond day-to-day care.

The court said in *Rains* that section 1418.8 intends that "the equivalent of informed consent may be provided ... so as to allow necessary medical treatment to be afforded to already admitted patients of a nursing home on a routine, on-going basis." This does not limit the IDT to "day-to-day" or "routine" decisions only, but allows necessary medical treatment to be provided on the noted routine and on-going basis. Routine or day-to-day decisions are likely those covered and authorized in the admission agreement for an LTC facility, and there would be no need for section 1418.8.

The *Rains* court noted that the legislature intended to deal with "the very difficult and perplexing problem: How to provide non-emergency but necessary and appropriate medical treatment, frequently of an on-going nature, to nursing home patients who lack capacity to consent."[42] The court balanced moral, ethical, legal and practical aspects of meeting the medical needs of unbefriended and incapacitated LTC residents. The court acknowledged that "other and arguably better legislative solutions are possible," but concluded that at present no such alternative exists.

V. CONCLUSION

There is an undeniable trend toward supported or patient-centered decision-making – applying the individual's stated preferences and known values, rather than vesting authority in another individual to make decisions believed to be in the incapacitated patient's best interests. In fact, it appears to be a presumption of the status quo that the IDT makes better decisions than an agent acting alone, unless close to the patient.

The IDT model works and is used successfully in many contexts. For Regional Center clients without family, the Director of Developmental Services or a designee can also make medical decisions without a limited conservatorship.[43] California law requires application of the least restrictive mechanism for making medical decisions for incapacitated patients. If an agent has been designated under an AHCD or there is a duly-appointed conservator, that person makes the decisions, relying on medical advice and the known wishes of the patient. If there is no agent and only a medical decision to be made, the decisions are made by an IDT after investigation of and in accordance with the known wishes of the patient.

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While there is time needed to employ section 1418.8, it is less cumbersome and better suited to the needs of most LTC facility residents than conservatorship. Regular review is required, and documentation must be sufficiently detailed to survive scrutiny by an Ombudsman or other state agency.

Until some of the controversies discussed above are definitively resolved, the options may remain to "do everything" or for care providers to document their reasoning and focus on "doing the right thing." Whoever has the misfortune of being a test case regarding the limits of section 1418.8, we all have to hope that the ambiguities are resolved in a manner allowing the patient's wishes, values and best interests to be acted upon, while supporting care providers' ability to practice in a manner consistent with reasonable standards of care.

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1. Prob. Code section 1800.3(b) provides: "No conservatorship of the person or of the estate shall be granted by the court unless the court makes an express finding that the granting of the conservatorship is the least restrictive alternative needed for the protection of the conservatee."
2. *Cobbs v. Grant* (1972) 8 Cal.3d 229, 244.
3. Prob. Code, section 813.
4. California Hospital Association, *Consent Law Manual*, 39th Ed. (2012), pp. 2.1-2.2.
5. Grisso and Appelbaum, *Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals* (1998).
6. Gibson and Ferrini, *You Let Them Do What??!!* Decision-Making Capacity and the Exercise of Patient Autonomy in LTC. Annals of Long-Term Care, Vol. 18, Issue 10, pp. 25 to 30 (October 2010).
7. Gibson and Ferrini, *You Let Them Do What??!!*, *supra*, pages 27 to 29. Gibson and Ferrini's discussion of U-CARE is presented in a series of case studies that apply the principles stated succinctly here.
8. Gibson and Ferrini, *You Let Them Do What??!!*, *supra*, page 26 (citing Grisso and Appelbaum, *Assessing Competence to Consent to Treatment*: A Guide for Physicians and Other Health Professionals (1998) and Appelbaum, *Assessment of Patients' Competence to Consent to Treatment,* N Engl J Med (2007) 357:1834-1840).
9. California Hospital Association, *Consent Law Manual*, *supra*, p. 1.8 (E).
10. Prob. Code, section 1801(a).
11. Patient Self Determination Act of 1990, 42 C.F.R. 489, parts 100 and 102.
12. Bus. & Prof. Code, sections 6500 et seq.
13. <www.fiduciary.ca.gov>
14. <www.pfac-pro.org>
15. Bus. & Prof. Code, section 6530. The exemption for CPAs is limited to actions taken within the scope of practice of CPAs. Bus. & Prof. Code, section 6530(c).
16. Welf. & Inst. Code, sections 15600 et seq.
17. U.S. Census Bureau, <http://quickfacts.census.gov/qfd/states/06000.html>, states there were approximately 38,041,430 people in California, 12.1% of which were elders over the age of 65, i.e., approximately 4,100,000 (38,041,430 x .121 = 4,119,013).
18. State of California, Department of Aging, Long-Term Care and Aging Services Division, Statistical Fact Sheets and Program Narratives. Sacramento, California, March 2012.
19. Alzheimer's Association®, <http://www.alz.org/alzheimers_disease_causes_risk_factors.asp>.
20. Welf. & Inst. Code, sections 5000 - 8000.
21. Welf. & Inst. Code, sections 5000 - 8000.
22. *Conservatorship of Davis* (1981) 124 Cal.App.3d 313.
23. Prob. Code, section 2920(b).
24. *Rains v. Belshe* (1995) 32 Cal.App.4th 157.
25. Health & Saf. Code, section 1418.8(e).
26. *Rains v. Belshe* (1995) 32 Cal.App.4th 157, 166.
27. Health & Saf. Code, section 1418(g).
28. *Rains v. Belshe* (1995) 32 Cal.App.4th 157.
29. *Id.*
30. *Id.*
31. *Id.*
32. *Id.* at pp. 167-168 (citing *Hill v. National Collegiate Athletic Assn* (1994) 7 Cal.4th 1, 52-57).
33. *Id.* at p. 168 (citing *Heller v. Norcal Mutual Ins. Co.* (1994) 8 Cal.4th 30, 42-44).
34. *Id.* at p. 169 (citing *Keyhea v. Rushen* (1986) 178 Cal.App.3d 526, 540-541).
35. *Id.* (citing *Riese v. St. Mary's Hospital & Medical Center* (1987) 209 Cal.App.3d 1303, 1320-1321).
36. *Id.* at p. 170.
37. *Id.* at p. 170 ("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 constitution.") (citing *Mounts v. Uyeda* (1991) 227 Cal.App.3d 111, 122).
38. *Hill v. National Collegiate Athletic Assn.* (1994) 7 Cal.4th 1, 52-57.
39. *Rains v. Belshe, supra,* 32 Cal.App.4th at pp. 180-181 (citing *Barber v. Superior Court* (1983) 147 Cal.App.3d 1006 and *In re Quinlan* (1976) 70 N.J. 10, 355 A.2d 647).
40. Prob. Code, section 4780.
41. *Rains v. Belshe, supra,* 32 Cal.App.4th 157 (citing *In re Quinlan*, *supra,* 70 N.J. 10); *Barber v. Superior Court* (1983) 147 Cal.App.3d 1006; *Conservatorship of Wendland* (2001) 26 Cal.4th 519.
42. *Rains v. Belshe, supra,* 32 Cal.App.4th at pp. 157, 181. ("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. …") (citing *In re Quinlan, supra*).
43. Welf. & Inst. Code, section 4655(b).

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