

Case No. S276545

**IN THE SUPREME COURT
OF THE STATE OF CALIFORNIA**

CHARLES LOGAN,
Plaintiff and Respondent,

v.

COUNTRY OAKS PARTNERS, LLC et al.,
Defendants and Appellants.

ON REVIEW OF A JUDGMENT BY THE COURT OF APPEAL,
SECOND APPELLATE DISTRICT, DIVISION FOUR, CASE NO. B312967

LOS ANGELES SUPERIOR COURT, CASE NO. 20STCV26536

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Plaintiff/Respondent Charles Logan respectfully submits this Consolidated Answer to the amicus curiae briefs filed by the California Association of Health Facilities, the California Medical Association, and the Association of Southern California Defense Counsel.

INTRODUCTION

The California Association of Health Facilities (“CAHF”), the California Medical Association (“CMA”), and the Association of Southern California Defense Counsel (“ASCDC”) (collectively, “Amici”) have submitted amicus briefs in support of Petitioner that mainly restate Petitioner’s arguments. In the few instances where they offer new arguments, Amici either misconstrue the Court of Appeal’s decision or offer policy arguments that have no bearing on the question before this Court.

CAHF argues that the Court of Appeal’s view of what constitutes a health care decision is flawed because various health care decisions, such as selecting a physician or pharmacy, are not included in the Standard Admission Agreement for nursing facilities. (CAHF Br. at pp. 7-8, 15.) This argument attacks a straw man. The term “health care decision” is defined in Section 4617 of the Probate Code to include (a) the selection of providers, (b) the approval of tests and procedures, and (c) directives to withhold nutrition and resuscitation. The Court of Appeal reasoned that, because receiving care cannot be conditioned agreeing to arbitrate, signing an arbitration clause is not part of selecting a nursing facility.

Many important health care decisions, such as the right to refuse treatment—the reason the Advance Health Care Directive was created—are not in the Standard Admission Agreement, but still meet the statutory definition in the Probate Code. Other decisions, such as agreeing to pay a security deposit (Section V(B) of the Standard Admission Agreement), may be required as part of selecting a facility, and are, in those cases, within the

scope of a Health Care Power of Attorney’s agency as part of selecting a provider. The Court of Appeal correctly recognized that arbitration is neither: It does not fall within the plain language of Probate Code Section 4617—which Amici avoid discussing—and it is, by law, not part of the facility-selection process.

Amici’s “policy” arguments are not based on the plain language of the statute, the statutory structure, or the purpose of the law. They assert that arbitration (1) benefits residents and (2) lowers costs for nursing facilities. (CAHF Br. at pp. 8-9; CMA Br. at p. 11.) Neither argument is compelling. First, under the Court of Appeal’s decision, authorized decision makers remain free to agree to arbitrate legal claims, both pre- and post-dispute, so residents who want to arbitrate their claims may do so. Second, there is no policy that favors compelling people to arbitrate simply because doing so would benefit the industry. Arbitration is a contractual arrangement that requires mutual assent. Amici seek to strip away rights from hundreds of thousands of people who executed the Advanced Health Care Directive to make end-of-life decisions, but who had no reason to believe that they were giving up their rights to a jury trial, discovery, and public redress for legal wrongs.

ARGUMENT

I. AMICI ATTACK LEGAL POSITIONS THAT NEITHER THE COURT OF APPEAL NOR MR. LOGAN ESPOUSED

The few unique arguments Amici offer target legal positions the Court of Appeal did not adopt and Mr. Logan did not defend. Those arguments mainly try to define the powers of a Health Care Power of Attorney based on what is in the Standard Admission Agreement for nursing facilities. This flawed reasoning offers little guidance in resolving this case.

A. Selecting a Service Provider Is a “Health Care Decision” Under the Plain Language of the Probate Code

CAHF and CMA argue that, if the Court of Appeal’s holding is affirmed, Health Care Power of Attorneys will no longer be able to make certain health care decisions for their principals. CAHF claims, for instance, that “many health care decisions ... not covered by the SAA [Standard Admission Agreement]”—such as selecting a physician or selecting a pharmacy—would “lose their status as health care decisions” and so fall outside a Health Care Power of Attorney’s decision-making authority. (CAHF Br. at pp. 7-8, 15.) CMA claims, similarly, that “non-necessary but nevertheless helpful decisions”—such as whether to utilize treatments like acupuncture or reflexology—“would be excluded” from the Health Care Power of Attorney’s ambit, leaving principals without care that could benefit them. (CMA Br. at p. 13.)

These arguments are red herrings. What constitutes a “health care decision” is defined in the Probate Code, not the Standard Admission Agreement, and nothing in the rulemaking history of the Standard Admission Agreement cited by Amici purports to define or interpret, much less negate, this clearly defined term.

As the Court of Appeal held, and as Mr. Logan argued, the Advance Health Care Directive empowers Health Care Power of Attorneys to make “health care decisions.” (*Logan v. Country Oaks Partners, LLC* (2022) 82 Cal.App.5th 365, 371; Answering Brief (“AB”) § I.A) A “health care decision” is a decision that relates to “care for the general health of a person” or that must be made to effectuate such a decision. (See *id.* at p. 372; AB 12-13 [concerning plain language of statutory text]; I.B.1 [concerning language in Probate Code].) Selecting a physician, a pharmacy, or a course of treatment (including acupuncture or reflexology) are quintessential health care decisions, whether or not they are mentioned in

the Standard Admission Agreement.¹ Probate Code section 4615 defines “health care” to include “any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a patient’s physical or mental health condition,” and section 4617 lists “[s]elect[ing] ... health care providers” as a “health care decision.” Affirming the Court of Appeal’s decision will not prevent Health Care Power of Attorneys from making these or other health care decisions.

B. Health Care Power of Attorneys Can Make Decisions Necessary to Effectuate Health Care Decisions

CAHF argues that the Standard Admission Agreement—which Health Care Power of Attorneys can execute on behalf of their principals—includes “a number of clauses ... that are not directly related to health care,” such as a choice of law provision, a photography provision, and a theft and loss prevention policy. (CAHF Br. at p. 20.) But as CAHF itself notes, these decisions—unlike the decision to arbitrate—are “necessary for admission into a [Skilled Nursing Facility].” (*Ibid.*) They therefore fall

¹ CAHF assumes throughout its brief that, on the Court of Appeal’s view, “agreeing to arbitration is not part of a health care decision” because of “the separation of the arbitration agreement from the SAA.” (CAHF Br. At p. 14.) That is why CAHF summarizes the rulemaking history that ultimately led to arbitration’s removal from the Standard Admission Agreement. (See *id.* at § II.B, III.A.) But CAHF misreads the Court of Appeal. The court held that arbitration is not a health care decision, not because arbitration agreements were excised from the Standard Admission Agreement, but because whether to arbitrate is a purely legal decision that an agent need not make to gain admission to a skilled nursing facility. (See *Logan, supra*, 82 Cal.App.5th at p. 374) [court could not infer that “Harrod had authority to enter into an optional arbitration agreement from the fact he had express authority to make ‘health care decisions’ and ‘[c]hoose ... health care facilities,’” neither of which required signing arbitration agreement].) For this reason, the point CAHF emphasizes throughout its brief—that “documents related to health care decisions will exist outside the SAA” (CAHF Br. at p. 15)—is both unexceptional and consistent with the Court of Appeal’s holding.

within the narrow allowance for decisions “necessary” to obtain medical care, even if they are not, in themselves, health care decisions. (See AB § I.C.1.)²

C. Signing an Agreement for Skilled Nursing Services Is a Health Care Decision

CAHF argues that, in distinguishing “between ‘legal decisions’ and ‘health care decisions,’” the Court of Appeal “fail[ed] to appreciate ‘that signing a contract for health care services, even one without an arbitration provision, is itself a ‘legal decision.’” (CAHF Br. at p. 19 [quoting *Owens v. National Health Corp.* (Tenn. 2007) 263 S.W.3d 876, 884].) This argument ignores the plain language of Probate Code Section 4617(a), which expressly states that “health care decisions” include “selection and discharge of health care providers and institutions.”

Moreover, CAHF again misconstrues the Court of Appeal’s holding. The court did not hold that the decision to arbitrate is outside the scope of a Health Care Power of Attorney’s authority solely because it is a legal decision; it held that it is outside the scope of a Health Care Power of Attorney’s authority because it is neither a health care decision nor a decision an agent must make to effectuate a health care decision. (See *Logan*, 82 Cal.App.5th at p. 373 [explaining that “the ‘health care decision’ (whether to consent to admission into the skilled nursing facility) has been expressly decoupled”—that is, causally detached—“from the decision whether to enter into the optional arbitration agreement”].) Obtaining health care services is a “health care decision,” even though it involves executing

² Some of these decisions may, in fact, be health care decisions. (See, e.g., Standard Admission Agreement § IX [“You agree that we may take photographs of you for identification and health care purposes. We will not take a photograph of you for any other purpose, unless you give us your prior written permission to do so.”].)

a contract, because the Probate Code says so, and because signing a contract for health care services is necessary to obtain those services. Contracting to arbitrate legal claims, by contrast, is not a health care decision because it does not fall within the definition in Probate Code Section 4617, and because signing such a contract is unnecessary to effectuate the health care decision (i.e., selection of a provider).

D. The Structure of the Probate Code Supports Mr. Logan, Not Petitioners

ASCDC argues that Health Care Power of Attorneys must be allowed to agree to arbitration because the general power of attorney described in Probate Code section 4450 expressly permits a general power of attorney to “submit to arbitration.” (ASCDC Br. § II.B.) As Mr. Logan explained in his Answering Brief (at § I.B.1), this observation proves the opposite. That the Health Care Decisions Law (Prob. Code, § 4600 et seq.) limits the scope of the Health Care Power of Attorney to “health care decisions” (*id.*, § 4683), while the Power of Attorney Act (*id.*, §§ 4400-4465) provides a “broad and sweeping” “Uniform Statutory Form Power of Attorney” that empowers an agent to make legal decisions (*id.*, § 4401), only demonstrates that the Advance Health Care Directive (which includes a Health Care Power of Attorney form) is not the place to appoint an agent to make non-health-care related legal decisions like whether to arbitrate.

E. The Cases Amici Cite Do Not Say, or Even Suggest, That a Health Care Power of Attorney Can Decide to Arbitrate Legal Claims

ASCDC cites four decisions from the California Court of Appeal that, it claims, “readily accept an agent’s authority to enter into arbitration agreements where the power to make ‘health care decisions’ has been expressly conferred.” (ASCDC Br. at p. 19 fn. 1.) These cases say nothing of the sort.

Hutcheson v. Eskaton FountainWood Lodge (2017) held that a personal care power of attorney could not enter an arbitration agreement as part of a principal’s admission into a residential care facility because choosing such a facility is a health care decision and a personal care power of attorney cannot make health care decisions. (17 Cal.App.5th 937, 941, 951, fn. 7.)

Goldman v. Sunbridge Healthcare (2013) and *Flores v. Evergreen at San Diego* (2007) are no better. Both held that a resident’s spouse does not have inherent authority to bind him or her to arbitration. (See 220 Cal.App.4th 1160, 1169, 1171 [“[T]here is no policy compelling persons to accept arbitration of controversies which they have not agreed to arbitrate. [Citations.]”]; 148 Cal.App.4th 581, 594 [“[T]he decision whether to agree to an arbitration provision in a nursing home contract is not a necessary decision that must be made to preserve a person’s well-being.”].) And *Buckner v. Tamarin* (2002) held that a patient’s agreement to arbitrate disputes with his doctor did not require his adult children to arbitrate following his death. (98 Cal.App.4th 140, 142.)

Not one of these cases even suggests that a Health Care Power of Attorney has “authority to enter into arbitration agreements,” as ASCDC maintains. (ASCDC Br. at p. 19 fn. 1.)

II. AMICI’S POLICY ARGUMENTS ARE FACTUALLY INACCUARATE AND, IN ANY CASE, IRRELEVANT

In their remaining arguments, Amici advance policy arguments that, in addition to relying on factual inaccuracies, are irrelevant to the legal questions in this case.

CAHF claims that affirming the Court of Appeal’s decision would “[e]ffectively eliminat[e] arbitration as an option” for residents, or “vastly reduce[] the number of residents who could resolve disputes via arbitration.” (CAHF Br. at pp. 9, 10.) But CAHF does not explain why this

would be so. The lower court’s decision does not prohibit residents from agreeing to arbitrate claims or from appointing an agent to decide whether to do so. It held only that Mr. Logan’s nephew—who was authorized as a Health Care Power of Attorney to make “health care decisions”—could not, in virtue of that authority, make decisions that are not related to health care.

CAHF then argues, along with CMA, that the Court should allow Health Care Power of Attorneys to execute arbitration agreements because arbitration agreements, Amici claim, are good for both residents and nursing homes. (See, e.g., CAHF Br. at pp. 8-9 [claiming that arbitration reduces “strain” on “an already overburdened long-term care industry” and benefits residents because it is “a less costly and more expeditious approach to dispute resolution”]; CMA Br. at p. 11 [claiming that “litigation costs will strain an already overburdened system, while offering no meaningful benefit to patients”].)

These allegations, even if they were true, would not permit an agent to make decisions that fall outside the scope of his or her authority. There is, as the Court of Appeal observed, “no public policy favoring arbitration of disputes which the parties have not agreed to arbitrate.” (*Logan*, 82 Cal.App.5th at p. 370 [quoting *Metters v. Ralphs Grocery Co.* (2008) 161 Cal.App.4th 696, 701].) To the extent that residents’ properly authorized agents believe that arbitration is beneficial, they remain free to agree to arbitrate their principals’ claims pre- or post-dispute.

And while the costs and benefits of arbitration are not relevant to this case, CAHF offers no support for its claim that arbitration benefits nursing home residents. In fact, the evidence demonstrates the opposite. As CMS noted when it considered barring nursing homes from requiring arbitration as part of their admissions process, academic articles and court opinions involving arbitration reveal “that pre-dispute arbitration agreements [are] detrimental to the health and safety of [long term care]

facility residents.” (Fed. Register 81, No. 192 (October 4, 2016), 68793 [collecting authorities³].) Even “organizations whose members conduct nursing home arbitrations (including the American Bar Association, the American Health Lawyers Association, and the American Arbitration Association) have expressed concerns about the fairness of pre-dispute arbitration clauses in the [long term care] context.” (*Id.* at 68792.) It is no surprise, then, that “34 senators urged [CMS] to ban pre-dispute arbitration clauses” altogether, and another “16 state attorneys-general stat[ed] that pre-dispute arbitration agreements were harmful to residents in [long term care] facilities and should be prohibited.” (*Id.* at 68790.)

What Amici’s “policy” argument really amounts to is this: Residents who did not agree to arbitrate should be forced to do so because arbitration lowers costs for nursing facilities. But this would strip away rights from hundreds of thousands of people who executed the Advanced Health Care Directive to make end-of-life decisions, who had no reason to believe that they were giving a proxy the ability to waive their rights to a public jury trial and discovery.

Amici claim that facilities ought to be able to rely on Health Care Power of Attorneys to execute arbitration agreements, but they make no effort to address that consumers execute the Advance Health Care Directive to maintain autonomy over end-of-life decisions without any clue about arbitration. (See AB 5-7 [explaining that the extensive instructions for filling out the Advance Health Care

³ The cited authorities include Tripp, Lisa, *A Senior Moment: The Executive Branch Solution to the Problem of Binding Arbitration Agreements in LTC facilities Admission Contracts* (2009) 31 Campbell L.Rev. 157; Tripp, Lisa, *Arbitration Agreements Used by LTC facilities: An Empirical Study and Critique of AT&T Mobility v. Concepcion* (2011) 35 *Am. J. Trial Advoc.* 87; and Bagby, K. and Souza, S., *Ending Unfair Arbitration: Fighting Against the Enforcement of Arbitration Agreements in Long-Term Care Contracts* (2013) 29 *J. Contemp. Health L. & Pol’y.*

Directive say nothing about arbitration].) The State’s website makes no mention of arbitration. (See <https://oag.ca.gov/consumers/general/care>.) Nor do other common resources, such as the National Institute on Aging. (See <https://www.nia.nih.gov/health/advance-care-planning-advance-directives-health-care>.) Even the websites of Amici, such as the Kaiser Permanente or the California Hospital Association, which enable users to execute the Advance Health Care Directive, fail to explain that the Directive gives the agent the power to bind the principal to arbitration. (See <https://healthy.kaiserpermanente.org/content/dam/kporg/mhc/life-care-plan/pdfs/advance-health-care-directive/advance-directive-scal-en-2022.pdf>; <https://calhospital.org/file/advance-health-care-directive/>.)⁴ All these resources say the same thing—that executing the form “allows you to choose a health care agent (decision maker) to make health care decision on your behalf if you are unable to do so AND/OR express your values, beliefs, and health care preferences.” (See <https://healthy.kaiserpermanente.org/content/dam/kporg/mhc/life-care-plan/pdfs/advance-health-care-directive/advance-directive-scal-en-2022.pdf>.) Nobody reading that would believe that they are giving up their right to litigate claims if they are wronged.

In sum, Amici offer little guidance to the Court. Their primary arguments are based either on a misunderstanding of the decision below or on policy considerations that lack factual support and are, in any case, irrelevant to the legal issues here.

⁴ The same is true for Sutter Health, Kindred Hospitals, and all the other major medical providers in the State. (See, e.g., <https://www.sutterhealth.org/for-patients/advance-health-care-directive>; <https://www.kindredhospitals.com/resources/blog-kindred-continuum/2014/01/09/what-you-need-to-know-about-advance-directives>.)

CONCLUSION

For the foregoing reasons, the decision below should be affirmed and all inconsistent decisions, including *Garrison*, should be overruled.

Dated: July 27, 2023

Respectfully submitted,

/s/ Matthew Borden

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[Cal. Rules of Court, Rule 8.504(d)(1)]

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Dated this 27th day of July 2023, at San Francisco, California.

/s/ Matthew Borden

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Supreme Court of California

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PARTNERS**

Case Number: **S276545**

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