**House Legislative Analysis Section**

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# AUTHORITY TO MAKE MED. DECISIONS

## House Bill 4016 as enrolled
Second Analysis (12-17-90)

**Sponsor: Rep. David Hollister**
**House Committee: Judiciary**
**Senate Committee: Human Resources and Senior Citizens**

## *THE APPARENT PROBLEM:*

When important medical decisions have to be made, the patient is consulted and his or her preferences are followed so far as the law and medical ethics allow. However, when a patient is incapacitated by illness or injury medical decisions can be made which may be contrary to the wishes of the patient. Many people are concerned that decisions regarding such matters as institutionalization and blood transfusions might be made for them during a period of incapacity without regard for their views, but the most common fear is that of mistaken judgments about the continuation or termination of medical treatment when death seems imminent.

Advances in medical technology have made it possible to preserve the vestiges of life in patients whose condition makes recovery impossible. Heart and lungs can be made to function even after all brain activity has ceased. For many patients in critical condition medical intervention constitutes not so much the preservation of life as the prolongation of death. When death is imminent and inevitable a conscious and capable patient can inform physicians as to the extent of treatment he or she wishes to receive. When the patient is unconscious or incapacitated, however, the family and physicians are faced with a painful decision. People generally want to respect the views of the sick person, but family members have heavy emotional investments of their own in the patient's life, and doctors have to consider both the duty to preserve life and the threat of civil or criminal liability for their actions. Reluctance to give up hope is natural and proper, yet examples of people being kept alive well past the point of any hope of recovery are familiar. To most people the prospect of being so artificially sustained is dreadful, and many would like to have some assurance that when they have reached such a point someone will be authorized to order the termination of medical treatment in accordance with their specific wishes.

Michigan's Revised Probate Code contains a section which has been used to provide for such delegation of authority; this is the section creating the durable power of attorney. The traditional common law power of attorney loses its effect when the person who had delegated the power (the principal) becomes incapacitated. The statutory durable power of attorney, however, can be written so as to have effect despite the incapacity of the principal or only in the event of such incapacity. This section allows a principal to confer unspecified authority upon the "attorney in fact." Lawyers commonly draw up written instruments which specify what decisions the attorney in fact is authorized to make in the event of the principal's incapacitation, including decisions as to medical treatment. While the durable power of attorney is sufficiently general to include authority to make medical decisions, its very generality creates some problems. Doctors and hospital staff are often doubtful of the attorney in fact's authority, and the statute contains no specific safeguards against liability for following his or her instructions. Also, the present statute does not make as clear as some would like the limits of the attorney in fact's authority with regard to medical decisions. Some people think that the Revised Probate Code should be amended to provide specifically for a durable power of attorney which gives the attorney in fact authority to make decisions regarding the person of the principal.

## *THE CONTENT OF THE BILL:*

The bill would add a new section to the Revised Probate Code to allow a person 18 years of age or older who is of sound mind to designate another adult as a patient advocate, who could exercise powers concerning care, custody, and medical treatment decisions for the person making the designation (the "patient").

Designation of a patient advocate. A designation of a patient advocate would have to be voluntarily executed in writing, and witnessed by two persons who were not the patient's spouse, parent, child, grandchild, sibling, heir, physician, or patient advocate, an employee of the patient's life or health insurance provider, an employee of the health facility treating the patient, or an employee of a home for the aged. A witness could not sign the designation unless the patient appeared to be of sound mind and under no duress, fraud or undue influence.

A designation of a patient advocate would be made part of the patient's medical record. It would include a statement that the patient advocate's authority could be exercised only when the patient was unable to participate in medical treatment decisions. A designation could include a statement of the patient's desires on care, custody, and medical treatment, and could authorize the advocate to exercise powers concerning the patient's care that the patient could have exercised on his or her own behalf. The person designated would receive a copy of the document before its implementation and would have to sign an acceptance of the designation. A patient could designate a successor to act as an advocate if the first person named did not accept or could not serve as advocate.

Implementation of a designation. The determination of when a patient was unable to participate in medical treatment decisions would be made by the patient's attending physician and another physician or licensed psychologist. The determination would have to be in writing and made a part of the patient's medical record, and would have to be reviewed at least annually. If the patient's religious beliefs prohibited an examination to make the determination, the patient could state in the designation how the determination would be made.

A patient advocate would be required to act in accordance with the standards of care that apply to fiduciaries, and act consistent with the patient's best interests. The known desires of the patient

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would be presumed to be in the patient's best interest. A patient advocate could not delegate his or her powers to another person without the patient's consent. A decision to withhold or withdraw treatment that would allow the patient to die could be made only if the patient had expressed in a clear and convincing manner that the patient advocate was authorized to make such a decision, and the patient acknowledged that such a decision could allow the patient's death.

A patient advocate could not receive compensation for the performance of his or her responsibilities, but could be reimbursed for actual and necessary expenses.

Disputes. Disputes over whether a patient was unable to participate in a medical treatment decision, whether a patient advocate was failing to comply with the patient's desires or the bill, or whether the patient intended to revoke a designation of a patient advocate would be resolved by the probate court.

Pregnant women. A patient advocate could not make a medical decision to withhold or withdraw treatment from a patient who was pregnant that would result in a pregnant patient's death.

Revocation of a designation. A designation of a patient advocate would be suspended when the patient regained the ability to participate in medical treatment decisions, and for as long as the patient was so able. A designation would be revoked upon the death of the patient, a court order, the resignation of the advocate, or the revocation of the designation by the patient. The bill would specify that the patient could revoke a designation in any manner by which he or she was able to communicate such an intent, even if he or she was unable to participate in medical decisions. Further, if the patient's spouse has been named as advocate, the designation would be revoked if the marriage ended. An advocate who, in good faith, made a treatment decision on behalf of a patient without knowing that the designation had been revoked would still be acting as an agent of the patient, and the decision would be binding on the patient and his or her heirs.

Health care provider responsibilities. Medical personnel acting to provide or withdraw care as a result of a patient advocate's decision would be liable in the same manner and to the same extent as if the patient had made the decision. A health care provider would be bound by sound medical practice and by the patient advocate's instructions if the advocate complied with the bill, but would not be bound by the instructions of an advocate who did not comply with the bill. A health care provider could not require a designation to be executed as a condition of medical treatment.

Insurance requirements. A life or health insurer could not refuse to provide or continue coverage to the patient, limit the coverage, charge a different rate, consider the terms of an existing policy to have been breached or modified, or invoke a suicide exclusion in a policy covering a patient because of the execution of a patient advocate designation or the refusal to execute a designation.

Existing designations. A designation executed before the bill took effect would be valid but subject to the bill's provisions, other than those prescribing procedures for witnessing.

Suicide, homicide. The bill would state that a designation executed under it could not be construed to condone or allow suicide or homicide.

Religious beliefs. The bill would specify that it could not be considered to authorize or compel care, custody or medical treatment decisions for a patient who objected on religious grounds.

MCL 700.496

## *FISCAL IMPLICATIONS:*

According to the House Fiscal Agency, the bill would result in an undetermined amount of savings for the state. (12-4-90)

## *ARGUMENTS:*

### *For:*

There is great need for a clear statutory procedure whereby a person can be assured that his or her lawful desires with regard to medical decisions will be observed if he or she should be unable to communicate them. Whether a person dreads being kept alive in a vegetative state or fears that medical efforts may not be continued as long as possible, the person should be able to feel that his or her wishes will be given the same respect during a period of incapacity that they would be accorded if he or she were capable. The bill would guarantee personal autonomy in the determination of medical treatment; people would not have patient advocates acting on their behalf unless they made an active choice to appoint one. Further, the bill contains a great number of safeguards that would guard against abuse of patients for the convenience of others.

### *Against:*

The bill would fail to prohibit the withdrawal of food and water, to ensure that death is by disease rather than by starvation and dehydration And it would fail to protect against the withdrawal of medication that would prevent death (and not just prolong the natural dying process), such as insulin for a diabetic. Further, the bill does not adequately distinguish between temporary and permanent disability, or between a major medical catastrophe and mental incompetence. This opens the way to "passive euthanasia," a course of action where the patient advocate allows the principal to die by withholding medical care because the advocate has made the determination that the principal's life is not worth living.

*Response:* The bill is intended to give force to the principal's wishes when he or she is incapacitated, whether or not death is imminent. There are medical decisions short of life and death decisions which may be of great importance to an individual. The bill would allow the patient advocate to make only decisions which would be legal for the principal to make if he or she were not incapacitated. Further, a designation under the bill would have force only while a patient was unable to participate in medical treatment decisions; the designation would have no effect on a patient who regained the ability to participate. The bill contains language to prohibit a decision to withdraw treatment that would allow the patient to die unless the patient had expressed in a "clear and convincing manner" that the advocate was authorized to make such a decision, the standard approved by the U.S. Supreme Court in Cruzan v. Missouri Department of Health (110 S.Ct. 2841). To further narrow the scope of allowable medical decision making would render the bill meaningless.

### *Against:*

The bill is dangerous in that it would give an individual the power to make life or death decisions for someone else. It is impossible to predict where the adoption of this principle might lead. Given the opportunity to examine the bill's provisions, there is no telling how far the courts might expand such authority. Approval of this legislation will contribute to a general diminution of respect for human life.

***Response:*** The bill is a clarification of a procedure already in use in this state. It more clearly limits the authority of an attorney in fact in making medical decisions than does the current durable power of attorney statute. The bill strives to eliminate all ambiguity as to the powers and duties of the attorney in fact. It does not expand those powers.

### *Against:*

The bill does not specify any qualifications for a patient advocate, nor does it require that either the physician or the family be consulted before the patient advocate makes a decision. The bill ought to address the matter of who is to make such weighty decisions or who ought to participate in their making.

***Response:*** These decisions are being made now without any regulation. When a medical decision must be made for a person who is incapacitated, hospital staff, in consultation with whomever they deem to have responsibility for the patient, reaches the decision. This bill would help assure that the preferences of the patient himself or herself were given primary importance. It is not likely that a person would appoint an agent in whom he or she did not have confidence, nor that agent would fail to consult the attending physician before making a decision.

### *Against:*

The bill would discriminate against women by prohibiting the exercise of a patient advocate's authority over a pregnant woman. It could lead to the absurdity of pregnancy testing virtually every woman for whom a designation was being exercised, and, worse, it would establish in the law a procedure allowing the rights of an embryo of any term to supersede those of an adult woman. Rather than allowing a pregnant woman the same death with dignity afforded others, the bill would equate a woman with a womb.