SFA BILL ANALYSIS

Senate Fiscal Agency • Lansing, Michigan 48909 • (517) 373-5383

House Bill 4016 (as enrolled)
Sponsor: Representative David Hollister
House Committee: Judiciary
Senate Committee: Human Resources and Senior Citizens

PUBLIC ACT 312 of 1990

Date Completed: 12-12-90

RATIONALE

"'Medical technology has effectively created a twilight zone of suspended animation where death commences while life, in some form, continues. Some patients, however, want no part of a life sustained only by medical technology. Instead, they prefer a plan of medical treatment that allows nature to take its course and permits them to die with dignity'" (Cruzan v Missouri Department of Health, 110 S.Ct. 2841, Brennan dissent).

As a rule, when important medical decisions must be made, the patient is consulted and his or her preferences are followed to the extent allowed by law and medical ethics. When a patient is incapacitated by illness or injury, however, others must make the medical decisions, which might at times be contrary to the patient's wishes. Though many are concerned that decisions regarding such matters as institutionalization and blood transfusions may be made for them mistakenly, the most common fear is of erroneous judgments about the continuation or termination of medical treatment when death seems imminent.

This fear is especially prevalent because of advances in medical treatment that have made it possible to preserve the vestiges of life in patients whose condition makes recovery impossible. For example, the heart and lungs can be made to function even after all brain activity has ceased. To many people, the prospect of being artificially sustained is abhorrent, and they would like some assurance that when they have reached such a point someone will be authorized to order the termination of medical treatment on their behalf. Conversely, others would like the assurance that medical treatment will be continued as long as possible.

CONTENT

The bill would add a new section to the Revised Probate Code to allow a person 18 years of age or older and 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"), when the patient was unable to participate in medical treatment decisions.

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, patient advocate, or known devisee at the time of the witnessing, or 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 if the patient resided in the home. 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 have to be made part of the patient's medical record. It would have to state 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 have to be given 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 would have to state in the designation how the determination would be made.

A patient advocate would be required to act consistently with the patient's best interests and in accordance with the standards of care that apply to fiduciaries, and take reasonable steps to follow the desires, instructions, or guidelines--whether oral or written--given by the patient while he or she was able to participate in treatment decisions. 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 that the patient acknowledged that such a decision could or would allow the patient's death. A current desire, regardless of a previously expressed or evidenced desire, by a patient to have provided, and not withheld or withdrawn, a specific life-extending care, custody, or medical treatment would be binding on the patient advocate, if known, regardless of the patient's competency or ability or inability to participate in care, custody, or medical treatment decisions.

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

If a dispute arose as to whether the patient was unable to participate in medical treatment decisions, a petition could be filed with the probate court in the county in which the patient resided or was found requesting the court's determination as to whether the patient was unable to participate in medical treatment decisions. If a petition were filed, the court would be required to appoint a guardian ad litem to represent the patient. The court would have to conduct a hearing on a petition as soon as possible and within seven days of receiving the petition. As soon as possible and within seven days after the hearing, the court would have to determine whether the patient was able to participate in medical treatment decisions. If the court determined that the patient was unable to participate in medical treatment decisions, the patient advocate's authority, rights, and responsibilities would become effective. If the court determined that the patient was able to participate in medical treatment decisions, the patient advocate's authority, rights, and responsibilities would not become effective.

Disputes over 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, also 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 the pregnant patient's death.

Marital Status

If a designation were made during a patient's marriage naming the patient's spouse as the patient advocate and the parties were subsequently divorced or the marriage was annulled, the designation would terminate upon the divorce or annulment and would be suspended while an action for divorce, annulment, or separate maintenance was pending, unless the patient had designated a

successor individual to serve as a patient advocate. If a successor patient advocate were named, that individual would act as the patient advocate.

Voluntary Revocation of a Designation

A patient could revoke a designation at any time and in any manner by which he or she was able to communicate that desire, even if he or she were unable to participate in medical treatment decisions. If the revocation were not in writing, a witness would have to sign a written description of the circumstances of the revocation and notify the patient advocate if possible. If the patient's physician or health facility had notice of the revocation, the physician or facility would be required to note the revocation in the patient's medical records and bedside chart, and notify the patient advocate.

The patient advocate could revoke his or her acceptance of the designation at any time and in any manner sufficient to communicate an intent to revoke.

Automatic Revocation of Designation

A patient advocate designation would be revoked automatically under any of the following conditions:

- -- The death of the patient.
- -- An order of dissolution by the probate court.
- -- Resignation or removal of the patient advocate unless a successor patient advocate had been designated.
- -- Revocation of the patient advocate designation by the patient.
- -- The occurrence of a provision for revocation contained in the patient advocate designation.
- -- A subsequent patient advocate designation that revoked the prior designation either expressly or by inconsistency.
- -- The return of the patient's ability to participate in medical treatment decisions. If the patient subsequently were determined to be unable to participate in medical treatment decisions, the patient advocate's authority, rights, and responsibilities would again become effective.

The revocation of a designation of a patient advocate would not revoke or terminate the agency as to the patient advocate or other person who acted in good faith under the designation and without actual knowledge of the revocation. An action taken without knowledge of the revocation would bind the patient and his or her heirs, devisees, and personal representatives unless the action was otherwise invalid or unenforceable. In the absence of fraud, an affidavit executed by the patient advocate stating that he or she did not have actual knowledge of the revocation at the time he or she took an action would be conclusive proof that the patient advocate did not have actual knowledge of the revocation.

Health Care Provider Responsibilities

Medical personnel acting to provide or withdraw care as a result of a decision by a person who was reasonably believed to be a patient advocate acting within the authority granted by the designation 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 providing or withholding care, custody or 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 states that a designation executed under it could not be construed to condone or allow suicide or homicide.

Religious Beliefs

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

Patient Rights

The bill specifies that a patient admitted to a health facility or agency would have the rights enumerated in provisions of the Public Health Code pertaining to the rights and responsibilities of patients and residents in health facilities.

Proposed MCL 700.496

FISCAL IMPACT

The bill would have an indeterminate fiscal impact on the State judicial system. Increased caseload in probate courts would depend on the number of cases brought under the bill. Court intervention would be needed to resolve a dispute as to whether the patient was unable to participate in medical treatment decisions, and a dispute as to whether a patient advocate was acting consistently with the patient's best interests. The number of such cases cannot be anticipated.

ARGUMENTS

Supporting Argument

There is a great need for a clear statutory procedure under which a person could be assured that his or her lawful desires with regard to medical decisions would be observed if he or she should be unable to communicate them. For many patients in critical condition, medical intervention constitutes not so much the preservation of life as the prolongation of dying. The issue is not whether a patient has the right to refuse medical treatment--a right that the U.S. Supreme Court clearly recognized in the Cruzan decision--but how that right is to be effectuated when the patient is incapable of exercising it. When death is imminent and inevitable, a conscious and capable patient can inform physicians as to the extent of the treatment he or she wishes to receive. When the patient is unconscious or incapacitated, however, the family and physicians may be faced with a difficult decision. Though people generally want to respect the views of a sick person, family members usually have their own heavy emotional investments in the patient's life, while doctors have to consider both their duty to preserve life and the potential threat of civil or criminal liability for their actions. Reluctance to give up hope is natural and proper, yet examples of patients' being kept alive well past the point of any hope of recovery are familiar. "[D]ifficult, indeed agonizing, questions...are presented by the constantly increasing power of science to keep the human body alive for longer than any reasonable person would want to inhabit it" (Cruzan v Missouri Department of Health, Scalia concurrence).

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 reassured that his or her wishes will be given the same respect during a period of incapacity that they would receive if he or she were capable. While not allowing a patient advocate to make any decisions the patient could not make himself or herself, the bill would protect the patient's right both to make decisions and have them carried out, and not to have other decisions made on his or her behalf. Reportedly, Michigan is one of only six states without a law of this type. Enacting the bill would send a progressive and positive statement to everyone.

Supporting Argument

The bill is necessary despite the section of Michigan's Revised Probate Code that allows the creation of a durable power of attorney. Unlike a traditional common law power of attorney, which loses its effect when the person who delegated the power (the "principal") becomes incapacitated, a durable power of attorney can be written to take effect or continue in effect when the principal becomes incapacitated. Under this section, a principal can confer authority upon an "attorney in fact", and a written instrument can specify what decisions the attorney in fact is authorized to make in the event of the principal's incapacititation, including decisions as to medical treatment. While a durable power of attorney is sufficiently

general to grant authority to make medical decisions, its very generality can create problems. Doctors and hospital staff often doubt the authority of the attorney in fact, and the statute contains no specific safeguards against liability for following his or her instructions. Also, the law does not make as clear as some would like the limits of authority regarding medical decisions. Under the bill, however, instead of appointing an attorney in fact whose authority might be questioned and decisions disregarded, an individual could designate a patient advocate specifically for the purpose of making medical decisions if the patient became incapacitated. At the same time, the bill would validate designations--such as a durable power of attorney--that were executed before the bill took effect.

Supporting Argument

The bill would require a patient to have authorized, "in a clear and convincing manner", the patient advocate to make a decision that could or would allow the patient to die, before the advocate made such a decision. This would be consistent with the June 25, 1990, decision of the United States Supreme Court in Cruzan v Missouri Department of Health. In that case, the Court concluded that "a State may apply a clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a persistent vegetative state". This opinion upheld a decision of the Missouri Supreme Court articulating the clear and convincing standard of proof, and finding that it was not satisfied by testimony concerning previous statements the patient had made to a housemate expressing her desire not to be kept alive "unless she could live at least halfway normally". ("Clear and convincing evidence" is a more stringent standard of proof than the "preponderance of the evidence" standard normally applied in civil cases. Although some courts view "clear and convincing evidence" as an intermediate level of proof, the standard generally may be considered the civil equivalent of the "proof beyond a reasonable doubt" required in criminal cases.)

Supporting Argument

The patient advocate approach would provide more flexibility than would be available under a so-called "living will", in which a person would have to spell out explicitly what he or she wanted done or not done under specific circumstances and which would limit the appointed person to making only those decisions. In the case of a patient advocate designation, on the other hand, the patient could but would not be required to state his or her desires on care, custody, and medical treatment, and the advocate would be required to follow the desires, instruction, or guidelines given by the patient either orally or in the designation. If the patient did not spell out his or her wishes, however, the advocate still could make decisions on behalf of the patient as long as the advocate acted consistently with the patient's best interests and did not make any decision that the patient could not make himself or herself if competent. As the O'Connor concurrence in Cruzan pointed out, "Few individuals provide explicit oral or written instructions regarding their intent to refuse medical treatment should they become incompetent... States which decline to consider any evidence other than such instructions may frequently fail to honor a patient's intent. Such failures might be avoided if the State considered an equally probative source of evidence: the patient's appointment of a proxy to make health care decisions on her behalf."

Opposing Argument

The bill would give too much power to a patient advocate--such as a patient's spouse or child--who could have an interest in the patient's death.

Response: Although it is true that a family member could be designated a patient advocate, relatives could not be witnesses to the designation. If a spouse were, in fact, the patient advocate, the designation would automatically terminate if the parties were divorced or the marriage annulled. Additional protections are found in the bill's provisions for voluntary or automatic revocation of a designation. Finally, a patient advocate's authority would take effect only when two unrelated individuals--the patient's attending physician and another physician or a licensed psychologist--determined that the patient was unable to participate in medical treatment decisions.

Opposing Argument

The bill would discriminate against women by prohibiting a patient advocate from making a medical decision to withhold or withdraw treatment from a pregnant woman if doing so

would result in the woman's death. Rather than allowing a pregnant woman the same death with dignity afforded others, the bill would give an embryo or fetus rights that superseded those of an adult woman.

Response: To provide otherwise would mean the loss of both an existing human life and a potential human life.

Opposing Argument

The bill should specify that it would not preclude a wrongful death action or a homicide prosecution in the event that a patient advocate, against the wishes of the patient, made a decision that allowed the patient to die. Otherwise, if a patient advocate had an interest in the patient's estate or were in league with someone who did, the patient advocate could prematurely "pull the plug".

Response: A patient advocate could not make a decision that would allow the patient to die unless the patient had given the advocate that authority in a clear and convincing manner.

Legislative Analyst: S. Margules
Fiscal Analyst: F. Sanchez

H8990\S4016EA