SFA BILL ANALYSIS

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

Senate Bill 293 (Substitute S-2 as reported)
Sponsor: Senator Frederick Dillingham
Committee: Human Resources and Senior Citizens

Date Completed: 4-24-89

RATIONALE

When important medical decisions have to be made, the patient usually is consulted and his or her preferences are followed to the extent that the law and medical ethics will allow. When a patient is incapacitated by illness or injury, however, certain medical decisions 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 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. 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 dreadful, and they 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.

The section of Michigan's Revised Probate Code that creates the durable power of attorney has been used to provide for such delegation of authority. 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 that 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 grant 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 provide specifically for a durable power of attorney that gives the attorney in fact authority to make decisions regarding the person of the principal.

CONTENT

The bill would add a new section to the Revised Probate Code to regulate a power of attorney that confers authority to make care, custody, and medical treatment decisions for the principal.

Further, the bill would amend the Code's current durable power of attorney section

to provide that it would apply only to matters having to do with the estate or financial affairs of the principal. In addition, the bill would make specific provision for the revocation of a power of attorney and would specify fiduciary duties for someone designated as an attorney in fact under this section. The bill would repeal a section saying that other powers of attorney are not revoked until the attorney in fact is notified of the death, disability, or incompetence of the principal. A more detailed description of the proposed section follows.

Designation of a Patient Advocate

An adult of sound mind could designate in writing any other adult, to be known as the patient advocate, to make care, custody, and medical treatment decisions for the person who made the designation. A designation would have to be signed by two witnesses, neither of whom could be the patient's spouse, immediate family member, presumptive heir, known devisee, physician, or patient advocate, or an employee of an entity providing health care or health or life insurance to the patient or of a home for the aged where the patient resided. 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 could include a statement of the patient's desires on care, custody, and medical treatment, and could authorize the patient advocate to exercise one or more powers concerning the patient's medical treatment, care, and custody that the patient could have exercised on his or her own behalf. The designation would be made a part of the patient's health record with the patient's attending physician and, if applicable, with the facility where the patient was located. A patient could designate a successor individual as a patient advocate who could exercise powers concerning care, custody, and medical treatment decisions for the patient if the first designated patient advocate did not accept, were incapacitated, resigned or were removed. Before acting as patient advocate, the proposed patient advocate or successor advocate would have to fulfill the requirements of the bill and sign an acceptance document.

A designation executed before the bill took effect would be valid but subject to the bill's provisions other than those pertaining to the witnessing of the documents.

Duties/Compensation of a Patient Advocate

A patient advocate would have to act in accordance with the standards of care applicable to fiduciaries in exercising his or her powers, and consistent with the patient's best interests. The known desires of the patient expressed or evidenced while competent would be presumed to be in the patient's best interest. The patient advocate would have to 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 current 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 delegate his or her powers to another individual without prior authorization from the patient. (These provisions concerning duties and delegation of power also would apply to an attorney in fact or agent acting for a principal.)

The bill would prohibit a patient advocate from receiving compensation for the performance of his or her authority, rights, and responsibilities but a patient advocate could be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibilities.

Exercise of Authority

The authority under the patient advocate designation could be exercised only during a period when the patient was unable to participate in medical treatment decisions. The patient's attending physician and another physician or licensed psychologist would have to make the determination that a patient was no longer able to participate in medical treatment decisions, file the determination in the patient's medical record, and review this determination annually. A patient whose religious beliefs prohibited the necessary examination would have to indicate in the designation how the

determination was to be made. None of the bill's provisions would be considered to authorize or compel care, custody or medical treatment decisions for a patient who objected on religious grounds.

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. 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. A revocation would be made a part of the patient's health records, and the physician or health facility would notify the patient advocate. (These provisions concerning voluntary revocation also would apply to revocation of a power of attorney by a principal.)

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 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 power of attorney 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 designation 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. (These provisions for automatic revocation also would apply to power of attorney designations with the additional specification that a power of attorney would be revoked upon the disability of the principal unless the designation was a durable power of attorney.)

Disputes

If a dispute arose as to whether a patient advocate was acting consistent with the patient's best interests or otherwise not complying with the bill, a petition could be filed with the probate court requesting the court's determination as to the continuation of the designation or the removal of the patient advocate. Disputes over whether the attorney in fact or agent was acting in the principal's best interests and in compliance with the bill would be resolved in the same manner. Disputes as to whether a patient was unable to participate in medical treatment decisions would also be resolved by the probate court.

Health Care Provider Responsibilities

A person providing, performing, withdrawing, or withholding care, custody, or medical treatment due to the decision of someone reasonably believed to be a patient advocate and acting in 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 on his or her own behalf. A care provider would be bound by sound medical practice and by the instructions of a patient advocate if he or she complied with the bill,

and would not be bound by the instructions of a patient 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, withholding, or withdrawing care, custody, or medical treatment.

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 or separate maintenance was pending, unless the patient had executed a separate written designation naming a successor individual to serve as a patient advocate. If a successor patient advocate were named, that individual, and not the patient's former spouse, would act as the patient advocate.

Unborn Children

If a patient were pregnant, a patient advocate's decision to withhold or withdraw medical treatment would first have to be reviewed by the probate court if that decision would be detrimental to the embryo or fetus. The court would have to appoint a guardian ad litem to represent the best interests of the embryo or fetus, which would include its survival.

Deprivation of Nutrition

A patient advocate could authorize decisions to withhold or withdraw treatment that would allow the patient to die only if there were a pre-existing disease or injury that would lead to the patient's death whether or not the treatment were used and the decision was based on the patient's best interests and sound medical judgment and was subject to the provisions of the bill. A patient advocate could not authorize a decision that would deprive the patient of nutrition and hydration if the purpose were to cause the patient's death.

Insurance Matters

A life or health insurer would be prohibited from doing any of the following because of the execution or implementation of a designation or because of the failure or refusal to implement or execute a designation: refuse or limit coverage, charge a different rate, consider the terms of an existing policy to have been breached or modified, or invoke a suicide or intentional death exclusion in a policy covering the patient.

Suicide, Homicide

The bill states that a designation executed under it could not be construed to condone, allow, permit, authorize, or approve suicide or homicide.

MCL 700.495 et al.

FISCAL IMPACT

The bill would have no fiscal impact on the State. Costs to local units of government would be due to the probate court's increased workload and administrative duties.

These costs to local courts would result from new filing and notification requirements, appointment of guardians ad litem, and hearings to be conducted if certain circumstances outlined under this bill arose.

ARGUMENTS

Supporting Argument

There is a 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. For many patients in critical condition medical intervention constitutes not so much the preservation of life as the prolongation of dying. 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 may be faced with a difficult 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 their 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 patients' being

kept alive well past the point of any hope of recovery are familiar. 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 be accorded if he or she were capable.

Opposing Argument

Allowing the withdrawal of food and water, if there were a pre-existing disease or injury that would lead to the patient's death, would be wrong. The withdrawal of nutrients and water from a seriously ill person is all too likely to increase suffering and cause death. A compassionate respect for life demands that nutrients and fluids continue to be administered, especially when it is impossible to determine whether withholding food and water would allow death or cause it.

Response: Testimony from physicians and others experienced in hospice care indicates that the very ill differ from the healthy in their need or desire for food and water. It is natural and common for the dying to reduce or stop their intake of foods and fluids. Artificially-provided nutrition and hydration can greatly increase a dying person's discomfort, not only by the use of tubes but also by taxing an altered digestive system or exacerbating problems with secretions in the throat or lungs. Discomfort created by drying tissues can at least to some degree be relieved by moisturizing the mouth and skin. Nutrition and hydration decisions are best made on a case-by-case basis, to ensure that an individual's wishes and comfort are paramount. The bill should not prohibit the withdrawal of nutrition or hydration, any more than it should prohibit the withdrawal of artificial respiration or heartbeat.

Opposing Argument

The bill would discriminate against women by limiting 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 or fetus of any term to supercede 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. The dehumanization and the possible consequences of this way of thinking are dramatically illustrated by recent reports of a case in which a terminally ill woman's pain apparently was increased and death hastened by a court-ordered Caesarian section.

Response: The bill would not imbue a fetus with rights that superceded a woman's. Rather, it would require an examination of each individual case in which the withdrawal or withholding of treatment could be detrimental to a fetus. To do otherwise would mean the loss of two lives, one of which had no say in the execution of the durable power of attorney.

Opposing Argument

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. Should this proposed statute ever become an issue before the courts there is no telling how far the courts could expand such authority. Approval of this legislation would contribute to a general diminution of respect for human life.

Response: The bill represents a clarification of a procedure already in use in this state. It would more specifically limit 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 ambiguity as to the powers and duties of the attorney in fact. It would not expand those powers.

Opposing Argument

The bill does not specify any qualifications for a patient advocate, nor would it require that either the physician or the family be consulted before the patient advocate made a decision. The bill ought to address the matter of who would 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 members, in consultation with whomever they deem to have responsibility for the patient, reach 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 that agent would fail to consult the attending physician before making a decision.

Opposing Argument

The bill does not adequately distinguish between temporary and permanent disability, or between a major medical catastrophe and mental incompetence. This would open the way to "passive euthanasia", a course of action in which 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 designed 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 that may be of great importance to an individual. The bill would allow the patient advocate to make only decisions that 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.

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