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BILL ANALYSIS

Senate Bill 1102 (Substitute S-4 as reported)
Sponsor: Senator Dale L. Shugars
Committee: Families, Mental Health and Human Services

Date Completed: 11-6-96

RATIONALE

According to a June 1994 report by the Michigan Commission on Death and Dying, many people, during the last phase of life, undergo intense suffering--both physical and emotional--as a result of a physical condition or disease. Further, the report states, it is now well established that a competent adult has the right to self-determination with regard to choosing or refusing medical treatment, including life-sustaining therapy. This, according to the report, is based on the constitutional right to privacy and supported by the ethical principle of autonomy. Although foregoing treatment may conclude with the patient's death, it is a course of action that relieves a patient of therapy that he or she may consider more burdensome than beneficial. Foregoing life-sustaining therapy, providing adequate administration of medication, and adopting other strategies for the relief of pain and suffering are standard responses to the needs of a person at the end of life.

Ignorance about their rights concerning these treatment options and other medical information, however, may lead some patients to believe that they are destined to a painful death or an existence ravaged by the overuse of medical technology. Many believe that it is this ignorance and fear that prompt some patients to resort to suicide to relieve their suffering. Once empowered with knowledge and a sense of control, some state, it would be unlikely that many patients would find suicide a necessary escape from the impositions of medicine and disease. It has been suggested, therefore, that provision be made in statute to ensure that terminally ill patients are informed of all the different treatment options and support services, such as pain management and hospice, that are available to them and of their right to forego any and all treatments.

CONTENT

The bill would amend the Public Health Code to add Part 56A, to be known as the "Michigan Dignified Death Act", which would require that physicians inform terminally ill patients of alternative medical treatments, palliative care services, and their rights to designate a patient advocate and to make an informed decision concerning medical treatment; require physicians to inform terminally ill patients that neither they nor any other individuals may assist a patient in committing suicide; require the Department of Community Health to publish a written summary of required information; and prohibit certain conduct by life and health insurers and benefits plans.

The bill contains the following legislative findings:

-- "That patients face a unique set of circumstances and decisions once they have been diagnosed as having a terminal illness."
-- "That published studies indicate that terminally ill patients fear that in end-of-life situations they could receive unwanted aggressive medical treatment."
-- "That terminally ill patients are often unaware of their legal rights, particularly with regard to controlling end-of-life decisions."
-- "That the free flow of information among health care providers, patients, and patients' families can give patients and their families a sense of control over their lives, ease the stress involved in coping with a terminal illness, and provide needed guidance to all involved in determining the appropriate variety and degree of medical intervention to be used."

Further, the bill provides that: “In affirmation of the tradition in this state recognizing the integrity of patients and their desire for a humane and dignified death, the Michigan legislature enacts the "Michigan dignified death act". In doing so, the legislature recognizes that a well-considered body of common law exists detailing the relationship between health care providers and their patients. This act is not intended to abrogate any part of that law, but is intended to be read in conjunction with the common law. This act is intended to increase terminally ill patients’ awareness of their right to make decisions to receive, continue, discontinue, or refuse medical treatment. It is hoped that by doing so, the legislature will encourage better communication between terminally ill patients and health care providers to ensure that a terminally ill patient’s final days are meaningful and dignified.”

"Patient" would mean an individual who was under the care of a physician. "Patient advocate" would mean that term as defined in the Revised Probate Code, which specifies that “...a person who is named in a designation to exercise powers concerning care, custody, and medical treatment decisions shall be known as a patient advocate”. "Medical treatment" would mean a treatment including, but not limited to, palliative care treatment, or a procedure, medication, surgery, or diagnostic test that could be ordered, provided, or withheld or withdrawn by a health professional or a health facility under generally accepted standards of medical practice and that was not prohibited by law. “Physician” would refer to an individual licensed to practice medicine or osteopathic medicine and surgery. “Patient surrogate” would mean the parent or legal guardian of a patient who was a minor or a member of the immediate family, the next of kin, or the legal guardian of a patient who had a condition other than minority that prevented the patient from giving consent to medical treatment. “Terminal illness” would mean a disease or condition due to which, in a physician’s opinion, a patient’s death was anticipated within six months after the date of the physician’s opinion.

The bill would require a physician who was recommending medical treatment for terminal illness to a patient who had been diagnosed as having a terminal illness to inform orally the patient, the patient’s patient surrogate, or, if the patient had designated a patient advocate and were unable to participate in medical treatment decisions, the patient advocate about the recommended medical treatment for the terminal illness and about the alternatives to the recommended medical treatment for the terminal illness. The physician also would have to inform orally the patient, patient surrogate, or patient advocate about the advantages, disadvantages, and risks of the recommended medical treatment and of each alternative medical treatment and the procedures involved in the recommended and each alternative medical treatment. The information required would not limit or modify the information concerning HIV testing and breast cancer treatment that physicians are required to provide to patients. The bill specifies that the physician’s duty to inform a patient, patient surrogate, or patient advocate would not require disclosure of information beyond that required by the applicable standard of practice and beyond what a reasonably well qualified licensed physician would disclose.

In addition to these disclosure requirements, beginning 120 days after the effective date of the bill, a physician who was recommending medical treatment for terminal illness to a patient who had been diagnosed as having a terminal illness would have to inform the patient, the patient’s patient surrogate, or the patient advocate, orally and in writing, of all of the following:

- -- If the patient had not designated a patient advocate, that the patient had the option of designating a patient advocate to make medical treatment decisions for the patient if he or she were not able to participate in his or her medical treatment decisions because of his or her medical condition.
- -- That the patient, the patient’s patient surrogate, or the patient advocate, acting on behalf of the patient, had the right to make an informed decision regarding receiving, continuing, discontinuing, and refusing medical treatment for the patient’s terminal illness.
- -- That under Michigan law, the physician, another health professional, or any other individual could not assist the patient in committing suicide.
- -- That the patient, the patient’s patient surrogate, or the patient advocate, acting on behalf of the patient, could choose palliative care treatment including, but not limited to, hospice care and pain management.

If a disciplinary subcommittee found that a physician had failed to disclose the specified information to a patient, patient advocate, or patient surrogate, the subcommittee would have to impose a reprimand and a fine.

The bill would require the Department of Community Health to develop and publish a standardized, written summary containing all of the additional required information within 60 days after the effective date of the bill. The summary would have to be developed in consultation with appropriate professional and other organizations and would have to be drafted in nontechnical terms that a patient, patient surrogate, or patient advocate could easily understand. Further, the Department would have to make the summary available to physicians through the Michigan Board of Medicine and the Michigan Board of Osteopathic Medicine and Surgery. The boards would have to provide to each physician subject to the bill written notification of the requirements of the bill and the availability of the summary within 10 days after the summary was published. If a physician gave a copy of the summary to a terminally ill patient, the patient's patient surrogate, or the patient advocate, he or she would be in full compliance with the additional disclosure requirement.

A physician could make available to a terminally ill patient, or to the patient's patient surrogate or patient advocate a form indicating that the patient, patient surrogate, or patient advocate had been given a copy of the standardized, written summary and had received the oral information. If a physician made such a form available, he or she would have to request the recipient to sign it, and would have to place a copy of the signed form in the patient's medical record. A patient, a patient surrogate, or a patient advocate who signed a form would be barred from subsequently bringing a civil action against the physician providing the information contained in the standardized, written summary based on failure to obtain informed consent, but only in regard to the information contained in the summary.

If a physician, as part of a medical treatment plan for a terminally ill patient, prescribed for the patient a controlled substance that was a narcotic drug included in Schedules 2 to 5 under Part 72 of the Public Health Code, the physician would be immune from administrative, civil, and criminal liability based on prescribing the controlled substance if all of the following were met:

- -- The prescription was for a legitimate and professionally recognized therapeutic purpose.
- -- The prescription conformed to the applicable standard of practice.
- -- Prescribing the controlled substance was within the physician's scope of practice.
- -- The physician held a valid license under Article 7 of the Public Health Code to prescribe controlled substances.

A life insurer, a health insurer, or a health care payment or benefits plan could not do any of the following because a terminally ill patient, his or her surrogate, or his or her patient advocate had made a decision to refuse or discontinue a medical treatment as a result of information received under the bill:

- -- Refuse to provide or continue coverage or benefits to the terminally ill patient within the scope and level of coverage or benefits of an existing policy, certificate, or contract.
- -- Limit the amount of coverage or benefits available to a terminally ill patient within the scope and level of coverage or benefits of an existing policy, certificate, or contract.
- -- Charge the terminally ill patient a different rate for coverage or benefits under an existing policy, certificate, or contract.
- -- Consider the terms of an existing policy, certificate, or contract to have been breached or modified.
- -- Invoke a suicide or intentional death exemption or exclusion in a policy, certificate, or contract covering the terminally ill patient.

The bill specifies that it would not:

- -- Impair or supersede a legal right that a parent, a patient, an advocate, a legal guardian, or any other individual could have to consent to or refuse medical treatment on behalf of another.
- -- Create a presumption about a terminally ill patient's desire to receive or refuse medical treatment, regardless of the ability of the patient to participate in medical treatment decisions.
- -- Limit the ability of a court making a determination about a terminally ill patient's medical treatment decisions to consider all of the following State interests: the preservation of life, the prevention of suicide, the protection of innocent third parties, and the preservation of the integrity of the medical profession.
- -- Condone, allow, permit, authorize, or approve suicide, assisted suicide, mercy killing, or euthanasia.

The bill would prohibit an individual from causing or attempting to cause a patient, patient surrogate, or patient advocate, by fraud or coercion, to make a medical treatment decision that resulted in the death of the patient with the intent to benefit financially from the outcome of the medical treatment decision. "Fraud" would mean a false representation of a matter of fact, whether by words or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed, that deceived or was intended to deceive another so that he or she acted upon it to his or her legal injury. A violation of this prohibition would be a felony, punishable by imprisonment for up to four years, a fine of up to $2,000, or both.

MCL 333.16221 et al.

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

The bill would help ensure that terminally ill patients had treatment options at the end of their lives, and were properly informed of those options, by requiring increased and improved communications between patients and medical treatment staff. Perhaps the greatest challenge that terminally ill patients face comes not from pain and suffering, but from fear and ignorance. Physicians' ignorance of pain management techniques, and fear of using what they do know, leaves many patients to die in pain. Current medical practice, not medical capability, is failing patients. Ignorance about their rights, and fear, leads many patients to believe that they are destined to a painful death or an existence ravaged by the overuse of medical technology. And, as the news media report, some of those patients believe that suicide, specifically physician-assisted suicide, is the only option they have left to ensure a fast end to their suffering. Requiring physicians to inform their terminally ill patients about the advantages, disadvantages, and risks of the recommended medical treatment and alternative treatments would help alleviate patients' fears about dying and banish any thoughts of assisted suicide.

Supporting Argument

There is a presumption, indeed a prejudice, that persons facing chronic illness or impending death from terminal illness, could "rationally" desire suicide. There is no clinical evidence, however, to support this presumption. In fact, the weight of clinically based evidence indicates that nearly all instances of suicidal desire can be traced to diagnosable psychiatric morbidity. Moreover, studies of suicide have found that 90% to 100% of victims die while they have a diagnosable psychiatric illness. This is disturbing considering that physicians often are not trained to recognize the depressed and the mentally ill. The presence of terminal illness does not automatically warrant a "rational" desire to die. The bill would help ensure that terminally ill patients who were overwhelmed by depression and fear did not succumb to the desire for assisted suicide, but rather were made aware of the vast array of treatments and services available to them.

Response: If society is going to define any contemplation of, or attempt at, suicide as an irrational thought or action, then the terminally ill who wish to end their suffering will never be considered to be rational, but will always be diagnosed as having severe depression or some other psychiatric illness. Perhaps it is time to examine the rationality of suicide in some cases.

Supporting Argument

Among other things, a physician would have to inform a patient that neither the physician nor anyone else could assist the patient in committing suicide. Assisted suicide subverts the traditional role of the physician as healer and creates a conflict of interest and an atmosphere of distrust for physicians in their practice. Assisted suicide also involves physicians in making inappropriate value judgments about quality of life. Allowing physicians, as trusted authority figures in our society, to provide suicide assistance could remove the natural ambivalence that stays the hand of most who contemplate suicide.

Response: The trust between physician and patient has already been compromised by repeated failure of the medical community to respect the wishes of elderly and terminally ill patients. For example, according an article in *State Legislatures* (July/August 1996), an 85-year old woman in Florida, Estelle Browning, prepared for her medical future by drawing up a living will. It stated that, in the event of incapacity, she did not want to receive artificial nutrition or hydration. When a stroke later left Ms. Browning paralyzed and unable to communicate, she nonetheless was put on a feeding tube. It took more than two years and a ruling by the state supreme court before the patient's original directive was carried out.

Although most states have some type of advance directives law that allows individuals to specify an array of end-of-life medical instructions, lawsuits like the Browning case can occur because many doctors resist any action that is not life-sustaining. Indeed, it may be that physicians and other medical personnel feel a paternalistic obligation to protect the perceived "vulnerable" elements of society from their own perhaps uninformed and emotional choice of suicide in the face of the possible suffering and difficulties expected from crippling disease and terminal illness. Instead of requiring physicians to inform patients that assisted suicide is unlawful, the bill should allow assisted suicide under certain conditions. Indeed, according to the article, no doctor, to date, has been held liable for withdrawing life support. Earlier this year, however, a jury reportedly levied a judgment of $16 million against a Michigan hospital for maintaining a severely brain-damaged woman on life support against her stated wishes.

Supporting Argument

Including family members and next of kin in the definition of "surrogate" would avoid the problem of unnecessary and unwanted legal action to obtain a court-appointed legal guardian in every instance in which a patient became unable to make medical treatment decisions for himself or herself, for the purpose of receiving information under the bill.

Supporting Argument

Often, physicians want to help alleviate the pain and suffering of their patients by prescribing pain-killing narcotics but fear losing their licenses under State laws that strictly regulate the administration of these drugs. The bill, therefore, would give a physician immunity from administrative, civil, and criminal liability for prescribing a controlled narcotic drug if certain conditions were met.

Opposing Argument

The bill would do more than just require physicians to inform their terminally ill patients about treatment options. It would require physicians to tell their patients that, under Michigan law, no one may help the patient commit suicide. Currently, however, there is no State statute in force that bans assisted suicide. The bill, in effect, would codify court decisions concerning assisted suicide. It would be far less ambiguous if a law specifically banning assisted suicide were enacted, although the majority of the State's citizens evidently support assisted suicide and juries consistently have acquitted one physician who has attended the suicide of a number of patients.

Response: The bill would not prohibit assisted suicide. It merely would require that patients be informed that it is unlawful. After all, Michigan law consists of both statutory law and court decisions, more commonly known as common law. In December 1994, the Michigan Supreme Court made it clear that assisting in a suicide may be prosecuted as a common law felony (*People* v *Kevorkian*).

Opposing Argument

While knowledge of impending death can be seen as an element of a person's desire for death, many other aspects of suffering may be central to a person's request for "aid-in-dying". Suffering is unique to the individual and cannot be defined narrowly by medical diagnosis, or predicted length of life remaining. Those who endure unending physical suffering without having a terminal illness may actually suffer more than those who are terminal and know that the end is near.

The medical system has developed techniques for managing suffering to a greater or lesser degree in various cases. In some situations, however, it is said that dying is merely being prolonged rather than life being sustained. In any event, there is a small but irreducible number of cases in which suffering cannot be alleviated at all or can be alleviated only by the induction of a comatose or near-comatose state. In addition, there also are persons who would prefer death to continued life with suffering or with the treatment necessary to relieve suffering.

Current law, however, ignores the needs, autonomy, and dignity of acutely suffering individuals. A modification of the law that would encourage individuals to explore all possible alternatives to aid-in-dying, but that would reserve it as a legal, well-regulated option of last resort, would provide considerable peace of mind to those who suffer or fear suffering. Aid-in-dying for the purpose of hastening death for a willing, competent adult should be permitted when standard treatment fails to have its intended and usual effect, the relief of pain and suffering. Knowing the option was available should suffering become unbearable would help most individuals cope with their conditions and go on living.

Response: Most people now acknowledge that some patients suffer pain that could be effectively relieved. The implication that there are thousands of persons who are destined to suffer excruciatingly painful deaths is simply untrue. Advances in pain and symptom management in the last decade alone have dramatically reduced the number of cases in which pain relief is problematic. Cases in which pain is difficult to manage without compromising mental clarity are becoming increasingly rare. The final resort of sedation is always available. Suicide as a means of relieving physical suffering is absolutely unnecessary. The bill would ensure that patients knew that suicide was unnecessary.

Opposing Argument

One of the most important principles developed in biomedical ethics is the principle of respect for persons, from which the concept of patient autonomy is derived. The physician is no longer a paternalistic figure telling the patient what should be done. Instead, informed consent of the competent patient is now necessary before any treatment or procedure is done. Many believe that this principle of patient autonomy should extend to the terminal phase of life and that the person should be able to determine whether death is preferable to the life that lies ahead. Indeed, court decisions have favored the person's right to make decisions in a case of terminal illness and minimized the state's interest in preserving human life at all costs. For example, according to the *Detroit Free Press* (10-2-96), in March 1996, the U.S. Ninth Circuit Court of Appeals struck down a Washington state law that barred doctor-assisted suicide, ruling that the law violated due process rights. The ruling affects nine states. The article states that by an 8-3 vote, the appeals court said the ban was unconstitutional because it "prohibits physicians from prescribing life-ending medication for use by terminally ill, competent adults who wish to hasten their own deaths". According to the article, the court was ruling on "the most basic of human concerns--the mortality of self and loved ones" and its decision was an attempt "to balance the interest in preserving human life against the desire to die peacefully and with dignity".

The article also states that in New York, the U.S. Second Circuit Court of Appeals in April struck down two laws that barred doctor-assisted suicide, ruling that they unconstitutionally failed to treat people equally. The ruling affects three states. According to the article, the Second Circuit judges said that it was discriminatory to refuse to let terminally ill patients end their lives with medication while allowing other dying patients to end their lives by granting their requests that life-support systems be disconnected.

Response: Numerous factors justify and make rational, if not compelling, the exercise of the state's police powers to ban assisted suicide. It is vital that seriously ill patients be protected from the immediate risk of fallible judgments and irreversible error. Not everyone has access to the most up-to-date medical technology and experienced, informed medical personnel. Requiring physicians to inform patients that suicide is unlawful and provide them with alternative information could save the life of a patient who otherwise might become despondent over an erroneous diagnosis of terminal illness or from lack of knowledge of treatment options.

The bill also would protect society's most vulnerable members--the elderly, infirm, developmentally disabled, and mentally ill--from what some perceive as an obligation to die. According to an article in *State Legislatures* (July/August 1996), a rapidly aging population and shrinking health care funds have raised the issue of economics of end-of-life medical care as often as the issue of bioethics. The article states that according to the 1995 White House Conference on Aging, the nation's elderly population, now 33 million, is expected to reach 77 million by 2030; one in five U.S. citizens will then be over 65. The fastest growing segment of the population is over age 85 and will number nearly 9 million by 2030. The Federal government currently spends nearly 10 times as much on every person over 65 as it spends on those under age 18.

Bias against the elderly, the ill, the severely disabled, and the poor, especially those dependent on society, is frequent. The stated desire of the elderly not to become a "burden" demonstrates how deeply inculcated is the belief that an elderly, dependent person is less valuable. People with disabilities often do not receive the support and accommodations they need to live a full life. In fact, given sufficient economic pressure, many patients get the message that they are using up precious health care and other resources and that they are a financial, physical, and emotional burden. Further, physician's perception of patients' cultural, social, and economic status, has been shown in studies to result in inadequate care to certain groups (e.g., women, minorities, and handicapped persons). Assisted suicide thus would be accommodated suicide. In essence, the state would be willing to accommodate certain groups of people in dying, but not in living. The communication requirements of the bill, particularly those concerning assisted suicide, would help ensure that no segment of society was considered more dispensable than another. Without this protection, there could be a compulsion for some to commit suicide, in order to escape a life that has been made intolerable more by social circumstances than by physical conditions.

Opposing Argument

The bill could be problematic. Some could interpret removing a person from equipment or denying food or medication to a patient as assisted suicide, instead of a right now protected by the courts, and refuse to remove feeding tube or other life support systems. The bill would leave the right to be removed from equipment in an ambiguous position.

Legislative Analyst: L. Burghardt

FISCAL IMPACT

The bill would require the Department of Consumer and Industry Services to make the required written summary available to all physicians through their licensing boards. It is estimated that meeting this requirement could cost the Department as much as $10,000 for postage.

Additionally, the Department would be responsible for investigating any complaints of health providers who violated the bill. Although it is difficult to predict the actual number of complaints that could be filed, the Department estimates that an investigation of this type costs an average of $5,000 and can cost as much as $20,000 depending on the extent of the investigation.

There would be no fiscal impact on the Department of Community Health.

Fiscal Analyst: M. Tyszkiewicz
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