

How Long Can Michigan Tread Water Without a Family Consent Law?

By Constance L. Brigman

If a mentally incompetent patient has neither a guardianship nor an advance directive, what is his or her healthcare provider left with? A patient in a boat without paddles.

A patient may live on artificial life support for a long time, given the many life-sustaining treatments available.¹ Some are hard to endure² or selectively effective,³ and if one survives⁴ treatment, the outcome may be difficult to accept.⁵

If emergency medical treatment is given to a patient, the patient's consent to the treatment is *implied*. To override implied consent, a patient must offer an informed *refusal*.⁶ Again, emergency medical treatment does not require informed consent. It requires an informed refusal.

Query: The patient is unconscious and not breathing. How can she *refuse* a lifesaving medical treatment?

Response: The patient executes and maintains an advance directive in her medical records.

Query: CPR saved the patient's life but she is in a persistent vegetative state and does not have advance directives. The physician and family want to remove her life support. The court did not authorize removal because there is insufficient proof of the individual's wishes.⁷ This is a problem.⁸

Response: A patient who cannot make her own healthcare decisions occupies a legal position similar to that of a minor; the state will protect this individual from harm.⁹ If the patient's family members seek to remove life support for this individual, they are implementing a decision the patient already made for herself when she still had the mental capacity to make it. The evidentiary standard for proof of the patient's wishes is not the same for every state.¹⁰

Generally, a patient's family is in the best position to know his or her wishes, but not all families are alike. Therefore, a state may impose a higher burden of proof on families seeking to remove



life support from a formerly competent adult. It is a difficult burden to meet, and imposing it means that some individuals who failed to express their wishes will get caught in the crossfire. To avoid a harsh result, it is permissible to impose a lower evidentiary standard if the patient is permanently unconscious, suffering pain that cannot be relieved, or near death.¹¹ There is no bright-line test, but in Michigan the clear and convincing evidentiary standard generally applies to formerly competent, conscious adults on life support.¹²

Discussion

In Michigan, the leading case regarding end-of-life medical decisions for conscious, formerly competent adults is *Martin v Martin*.¹³ In this 1995 opinion, a guardian was not allowed to terminate life-sustaining treatment for a conscious, formerly competent patient because her proofs failed to meet the clear and convincing evidentiary standard. The patient was healthy and conscious, and it was not clear what he presently wanted. Absent solid confirmation of his wishes past and present, the court did not remove his feeding tube.

While competent, the patient had said he never wanted to live hooked up to a machine. However, the court passed over these statements, requiring proof that the patient's statements were part of a serious, thoughtful, consistent decision to refuse medical treatment under the exact or similar circumstances. The patient in *Martin* was healthy and conscious. The proofs may have been sufficient had the patient been terminally ill and experiencing great pain that could not be relieved.

The leading Michigan case regarding the objective standard is *In re Rosebush*.¹⁴ In this case, the patient, a minor, never had the capacity to make her own healthcare decisions. According to the opinion, removal of the patient's life support did not require a court order as long as her healthcare providers and parents agreed on what was in her best interest. This opinion suggests that not every end-of-life decision requires a court order authorizing the guardian's decision.

Notably, *Martin* dealt with a spouse who was her husband's guardian. In Michigan, spouses are not natural guardians as parents are for minors. Note that the court specifically asked her for *proof of the patient's treatment preferences*. Elsewhere, a spouse might be able to inform a healthcare provider about her husband's wishes without seeking a guardianship. In Michigan, there is no appellate decision specifically authorizing a spouse to act as the patient's agent in a healthcare decision-making capacity.

Two Michigan statutes, the Social Welfare Act¹⁵ and the Michigan Dignified Death Act,¹⁶ include family members in certain medical treatment decisions. The Social Welfare Act authorizes next of kin to provide consent to medical treatment for an indigent patient needing essential medical care. The Dignified Death Act allows a physician to communicate with family members about a terminally ill patient's treatment choices. Of the two, the Social Welfare Act gives family members greater authority.

The Dignified Death Act does not grant family members the authority to make decisions about end-of-life treatment. Instead,

FAST FACTS

Family consent laws in other states address the priority of a patient's family members to convey to a medical provider the patient's wishes regarding treatment.

The family's authority is limited in scope and inapplicable when a guardian or agent has been appointed under a healthcare power of attorney.

Increasingly, Michigan needs a family consent law.



If a patient does not have a patient advocate or guardian, a family consent law determines who may make medical treatment decisions on the patient's behalf.

it requires physicians to inform terminally ill patients about patients' rights and treatment options, including the right to appoint a patient advocate.

Like the Patient Self-Determination Act,¹⁷ the Dignified Death Act informs patients and their families of the patients' right to choose medical treatment. However, it is primarily concerned with the timing of the information.¹⁸

Importantly, if a terminally ill patient is incompetent, the Dignified Death Act allows a physician to give information to the patient's guardian, patient advocate, or family.¹⁹ One could conclude that the legislature would not have included the patient's family in this list unless it believed the family had the authority to make medical treatment decisions. Alternatively, the legislature may have assumed the family would act on the information and petition for guardianship if the proper party refused to act. The most reasonable conclusion is that the purpose of the Dignified Death Act is to get information to those who know the patient's wishes and empower them with timely information about treatment choices.

In summary, Michigan does not have a family consent law authorizing families to make end-of-life medical treatment decisions for patients using an objective standard or to communicate the patient's treatment preferences using a subjective standard. Some Michigan hospitals, however, allow families to communicate the patient's treatment preferences without seeking guardianship.²⁰ Likewise, some nursing homes are implementing a pilot program allowing the patient's family to communicate his or her wishes in an informal capacity.²¹ This program follows the paradigm of the Physician's Order for Life-Sustaining Treatment²² (POLST) program.

A POLST is a physician's order intended for patients near death. The patient's participation is voluntary. The validity of accepting

an incompetent person's voluntary participation in the program is an important legal question.

A POLST is written at the hospital and follows the patient after discharge, meaning it continues to have legal effect after the patient leaves the physician's care. If the patient's medical condition changes, the POLST must be revoked or revised. Although it sounds like a POLST is an advance directive, it is not. Unlike an advance directive, a POLST takes effect immediately. It guides medical care in light of the patient's current condition. Taking that into consideration, it clearly is a document that solves the problem of incompetent patients lacking advance directives. Only competent patients may execute an advance directive.²³

The POLST paradigm relies on the legal authority of the family to communicate end-of-life medical treatment decisions for incompetent patients.²⁴ Since Michigan does not have a family consent law, the POLST paradigm is difficult to understand and implement fairly in Michigan.

Here is the situation in Michigan: our population curve is tilting toward aging baby boomers, guardianships are not popular because they are burdensome, healthcare providers would like to simply ask the families what the patients want, and many patients would prefer to let their families speak for them without filling out any paperwork. It appears that whether one likes the POLST paradigm programs or not, they are here to stay, and they seem to do for patients what patients want done. Therefore, it makes sense to enact a family consent law to lay down some guidelines for a practice likely to continue regardless of any lack of legal authority it may have in Michigan.



Family consent laws provide an order of priority for selecting a surrogate decision maker. They also limit the medical treatment decisions a surrogate may make. For example, if a patient does not have a patient advocate or guardian, a family consent law determines who may make medical treatment decisions on the patient's behalf. It also specifies which treatment decisions the family may make. For all other decisions, a guardianship is required. The family consent law includes a list of interested parties who have a right to object to the surrogate's decisions. The same procedures that protect a patient in the patient advocate designation law ought to be present in a family consent law. Healthcare providers have an incentive to follow family consent laws because they are protected from liability if they do so.

In 1993, the Uniform Law Commission promulgated an act that included a family consent law for adults and emancipated minors.²⁵ Like previous acts, it has a priority list to determine who should be designated as the surrogate decision maker. It gives highest priority to a surrogate decision maker orally designated by the patient.

If a patient does not name a surrogate, a family member may assume authority according to a governing order of priority. The priority list begins with the patient's spouse followed by, in order, an adult child, a parent, and an adult brother or sister. If there is no available person related to the patient, "an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, and who is willing and able to make a health-care decision for the patient" is allowed to assume authority. In the event that nobody is qualified and willing to serve, the healthcare provider may ask the probate court to appoint a guardian.

The surrogate decision maker is last in line in a hierarchy of healthcare decision makers as follows:

- The patient makes his or her own decisions regarding medical treatment as long as he or she is competent to provide informed consent to treatment.
- If the patient cannot provide informed consent to medical treatment, the patient's appointed agent in an advance directive must be notified.
- If there is no validly appointed agent qualified and reasonably available to make decisions regarding medical treatment, a court-appointed guardian must be notified if one has been appointed.
- If there is no court-appointed guardian, the healthcare provider may select a default surrogate decision maker according to the priority list provided in the act.

Michigan needs a family consent law. Healthcare providers have developed policies to cope with the issue of family consent, but the result is a patchwork of inconsistencies. For any individual, the outcome will differ depending on the hospital and location in which the individual dies. This is not a satisfactory result, and why guidance from a family consent law is needed. ■



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ENDNOTES

1. Life-sustaining treatment consists of all treatment having the potential to postpone the patient's death and includes cardiopulmonary resuscitation, artificial ventilation, specialized treatments for particular conditions such as chemotherapy or dialysis, antibiotics when given for a potentially life-threatening infection, and artificial nutrition and hydration.
2. Gorenstein, *How Doctors Die: Showing Others the Way*, The New York Times, November 20, 2013, p F-1.
3. Jones, *Public expectations of survival following cardiopulmonary resuscitation*, 7 *Academic Emergency Med* 48 (2000); see also Diem, *Cardiopulmonary resuscitation on television—Miracles and misinformation*, 334 *N Eng J Med* 1578 (1996).
4. De Vos, *Quality of survival after cardiopulmonary resuscitation*, 159 *Arch Int Med* 249 (1999).
5. Colby, *From Quinlan to Cruzan to Schiavo: What have we learned?*, 37 *Loy U Chi LJ* 286 (2006).
6. "The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment." *Cruzan v Mo Dep't of Health*, 497 US 261, 270; 110 S Ct 2841; 111 L Ed 2d 224 (1990). Quoted in *Martin and Rosebush*.
7. *Martin v Martin*, 450 Mich 204; 538 NW2d 399 (1995).
8. Fagerlin & Schneider, *Enough: The Failure of the Living Will*, 34 *Hastings Center Report* 30 (2004).
9. *Cruzan*, n 6 *supra*.
10. *Id.* at 284.
11. *Martin*, n 7 *supra* at 223.
12. *Id.* at 234.
13. *Id.*
14. *In re Rosebush*, 195 Mich App 675; 491 NW2d 633 (1992).
15. MCL 400.1 *et seq.*
16. MCL 333.5651 *et seq.*
17. 42 USC 1395cc(f). If a provider participates in Medicare and Medicaid, it must inform patients in writing of their rights under state law regarding advance directives. CFR § 489.102(3) allows a medical provider to give information about advance directives to the patient's family or surrogate if the patient is incapacitated. This communication satisfies the act's requirements.
18. MCL 333.5652(1)(e).
19. MCL 333.5655(b).
20. See Edward W. Sparrow Hospital, *Medical Staff: General Policies and Procedures Manual*, revised March, 2013, pp 49–60.
21. Michigan Dep't of Community Health, *Emergency Services Training*, State Emergency Medical Services Coordination Committee Meeting Minutes Approved, September 28, 2012, p 3, presented by Carolyn Stramecki, director of the Michigan Coalition for Honoring Healthcare Choices.
22. <<http://www.polst.org>>. All websites cited in this article were accessed March 25, 2014.
23. 42 USC 1395cc(f)(3).
24. See Oregon POLST Task Force, *Physician Orders for Life-Sustaining Treatment (POLST): Use for Persons with Significant Physical Disabilities, Developmental Disabilities and/or Significant Mental Health Condition who are Now Near the End of Life*, available at <http://www.polst.org/wp-content/uploads/2013/02/POLSTPersonswithDisabilitiesLongDocument.Final_.pdf>.
25. See Uniform Healthcare Decisions Act of 1993, available at <<http://www.uniformlaws.org/Act.aspx?title=Health-Care%20Decisions%20Act>>.