



End-of-Life Care

Legislation removes barriers for the terminally ill

By Robert C. Anderson

In December of 2001 and January of 2002, the Michigan legislature enacted 15 bills comprising what has been called the “End-of-Life Care Amendments” of 2001.¹ All of these amendments were effective in 2002. The intent of this legislative package is to remove barriers to pain management, increase citizen access to end-of-life care, and improve end-of-life curricula and education for health care professionals. The legislation was enacted without any substantial opposition in response to the final report issued in August of 2001 of the Michigan Commission on the End-of-Life Care, a 12-member group appointed by then Michigan Governor John Engler.²

The commission’s report found that the way Michigan statutes defined two medical terms created an unreasonable barrier in providing adequate end-of-life care. The first is the definition that a

“terminal illness” is a disease that limits life expectancy to less than six months. This definition is problematic because the causes of death are shifting to chronic longer term conditions, such as heart disease, stroke, diabetes, and Alzheimer’s disease. It can be difficult to determine when patients with these diagnoses are “terminally ill.”

Because more residents are dying at home, limiting end-of-life care and attention to the last six months of life prevents many chronically ill patients from receiving hospice care. As a result, the Michigan Dignified Death Act was amended to expand required physician discussion of end-of-life issues. Prior law required such discussion for a “terminal illness when death is anticipated within six months.” Instead, the new law requires such physician discussion when the patient has “limited life expectancy due to advanced illness.”

Fast Facts

New laws require physician discussion of end-of-life issues when the patient has "limited life expectancy due to advanced illness."

A patient or resident of a licensed health care facility shall be entitled to "adequate and appropriate pain and symptom management as a basic and essential element of his or her medical treatment."

A sticker indicating who is designated as a patient advocate can now be placed on a driver's license or senior citizen identification card.

The Michigan Dignified Death Act, as amended, requires the physician treating a patient with "limited life expectancy due to advanced illness" to inform the patient that he or she (1) may designate a patient advocate to make medical treatment decisions, (2) has the right to make an informed decision regarding receiving, continuing, discontinuing, and refusing medical treatment, and (3) may choose *palliative* care treatment, including hospice care and pain management.³ This amended act further provides that a physician who prescribes a narcotic drug for a patient with "a limited life expectancy due to advanced illness" to alleviate a patient's pain is immune from civil, criminal, and administrative liability.⁴

The second statutory definition limiting access to adequate end-of-life care is the reference to "intractable pain." Before aggressive pain medication could be ordered under prior law, a finding of "intractable pain" was needed. The new legislation only requires a finding that a patient is in "pain" as a requirement for prescribing pain-relieving medication.⁵

Another major statutory change responds to the commission's finding that "the management of patient pain and symptoms is inadequate in Michigan." The new legislation provides that a patient or resident of a licensed health care facility shall be entitled to "adequate and appropriate pain and symptom management as a basic and essential element of his or her medical treatment."⁶ This new right must be stated in a posted policy statement at all health care facilities. This new statutory right should improve access to palliative and hospice care.

Another major statutory amendment requires hospitals, upon request, to inform patients of the availability of hospice care in the area, even if not available at that hospital.⁷ Nursing homes will similarly be required to inform new admissions of the availability of hospice care.⁸ This provision will provide needed information on the availability of hospice care to patients and their families.

Additional statutory changes help reduce the barriers to the use of narcotic drugs needed for patients in substantial pain. The cumbersome prescription form program for narcotics has been replaced with an electronic reporting system for the prescription of narcotics.⁹ The acceptance of electronic signatures on prescriptions will speed the access of narcotics to those truly in pain, while not compromising drug diversion.

Next, responding to the need to better inform health care providers and emergency care workers of the existence of a designated patient advocate and advance directives, a sticker indicating who is designated as a patient advocate can now be placed on a driver's license.¹⁰ This new statutory amendment also provides for a new

emergency medical card to be kept personally. For people without a driver's license, the same sticker can be placed on a special senior citizen's identification card.¹¹

This new legislation is an important first step in improving end-of-life care, but the legislation is not self-executing. It will require the concerted effort of sensitive and compassionate professionals providing services to those in end-of-life settings. Attorneys who practice in this area can play an important part in making sure clients receive the medical services they need at the end of their lives. We can assist by mailing a copy of a client's medical power of attorney to his or her regular physician and providing clients with the new sticker disclosing patient advocate in-

formation on a driver's license or special ID card. We can assist a client in seeking active pain management by informing clients and family members of the new law changes and contacting the client's health care providers directly about this new law. ♦

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Footnotes

1. Public Act 216 of 2001 (House Bill 5148) approved on December 27, 2001; Public Act 219 of 2001 (House Bill 5255) approved on December 27, 2001; Public Act 231 (House Bill 5260) approved on January 3, 2002; Public Act 232 (House Bill 5261) approved on January 3, 2002; Public Act 233 (House Bill 5262) approved on January 3, 2002; Public Act 234 (House Bill 5263) approved on January 3, 2002; Public Act 235 (Senate Bill 662) approved on January 3, 2002; Public Act 236 (Senate Bill 827) approved on January 3, 2002; Public Act 237 (Senate Bill 781) approved on January 3, 2002; Public Act 238 (Senate Bill 828) approved on January 3, 2002; Public Act 239 (House Bill 5258) approved on January 7, 2002; Public Act 240 (House Bill 5259) approved on January 7, 2002.
2. Commission's Report, Michigan Commission on End-of-Life Care was formed under Executive Order 1999-4.
3. MCL 333.5652 et al. as amended by PA 239 of 2001.
4. MCL 333.5652 et al. as amended by PA 239 of 2001 and PA 237 of 2001.
5. MCL 333.16204a et al. as amended by PA 234 of 2001; MCL 550.1402a.
6. MCL 333.20201 as amended by PA 240 of 2001.
7. MCL 333.25211 as amended by PA 219 of 2001.
8. MCL 333.21766 as amended by PA 243 of 2001.
9. MCL 333.7333 as amended by PA 231 of 2001; MCL 333.16204b et al. as amended by PA 241 of 2001; and MCL 333.7104, 333.7107, & 333.7109 as amended by PA 233 of 2001.
10. MCL 257.310 as amended by PA 216 of 2001.
11. MCL 28.292 as amended by PA 238 of 2001.