

STATE OF MICHIGAN
COURT OF CLAIMS

DR. VIKTORIA KOSKENOJA, SAMUEL
HOLCOMB, JAMIE AIRD, NICOLE SAPIRO
VINCKIER, MARK VINCKIER, MADALYN
KNUTSON, DR. LAURA LOZIER, DR. JEROME
WINEGARDEN, and DR. LISA HARRIS,

Plaintiffs,

v

Case No. 25-000165-MM

GRETCHEN WHITMER, in her official capacity
as Governor of the State of Michigan, DANA
NESSEL, in her official capacity as the Attorney
General of the State of Michigan, JOCELYN
BENSON, in her official capacity as Secretary of
State of the State of Michigan, ELIZABETH
HERTEL, in her official capacity as Director of the
Michigan Department of Health and Human
Services, and MARLON BROWN, in his official
capacity as Director of the Michigan Department of
Licensing and Regulatory Affairs,

Hon. Sima G. Patel

Defendants.

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JUDGMENT ON STIPULATED FACTS

This case represents a challenge to the constitutionality of various provisions of the Estates and Protected Individuals Code (EPIC), MCL 700.1101 *et seq.*, which limit the rights and powers of women to execute advanced directives based on the contingency of pregnancy and limit the rights and powers of a designated patient advocate to follow the advanced directives of the patient when the subject patient is pregnant. The parties agreed to proceed to judgment on stipulated facts

pursuant to MCR 2.116(A). The parties also agreed that the subject statutory provisions violate the Reproductive Freedom Amendment of Const 1963, art 1, § 28.¹

The Court finds that despite the current agreements, there is an actual case or controversy for the Court’s resolution. The Court accepts the parties’ stipulated joint statement of facts. Upon review of the applicable law, the Court DECLARES unconstitutional MCL 700.5507(5)(3), MCL 700.5509(1)(d), and MCL 700.5512(1). The Court DIRECTS that these provisions be struck from the EPIC and ENJOINS all future enforcement of these provisions.

I. CASE OR CONTROVERSY

MCR 2.605(A)(1) provides that in order for a court to enter a declaratory judgment, there must be an actual controversy within the court’s jurisdiction. “An actual controversy exists when a declaratory judgment is needed to guide a party’s future conduct in order to preserve that party’s legal rights.” *League of Women Voters of Mich v Secretary of State*, 506 Mich 561, 586; 957 NW2d 731 (2020). “[A] court is not precluded from reaching issues before actual injuries or losses have occurred, [but] there still must be a present legal controversy, not one that is merely hypothetical or anticipated in the future.” *Id.* (cleaned up). The law liberally provides for a case-and-controversy when a declaratory judgment is necessary to guide a plaintiff’s future conduct and preserve his or her legal rights. *Shavers v Kelley*, 402 Mich 554, 588; 267 NW2d 72 (1978).

¹ Plaintiffs contended that these provisions also violate the substantive due process right to privacy, autonomy, and bodily integrity in Const 1963, art 1, § 17; the right to procedural due process in Const 1963, art 1, § 17; the right to equal protection in Const 1963, art 1, § 2; and freedom of speech in Const 1963, art 1, § 5. The parties proceed under Const 1963, art 1, § 28 alone.

The Court of Claims recently found an actual case and controversy in a matter where the government defendants agreed with the plaintiffs that a statute was unconstitutional. In *Planned Parenthood v Attorney General*, Docket No. 22-000044-MM, the plaintiffs challenged the constitutionality of MCL 750.14, which outlawed abortion but had not been upheld since before *Roe v Wade*. The Attorney General concurred that the statute was unconstitutional and vowed not to enforce it. However, the Attorney General argued that without a defendant with an actual competing interest, the Court would not be presented both sides with partisan zeal and therefore could not fulfill its duty as a neutral arbiter. The plaintiffs, on the other hand, argued that the Attorney General’s personal views regarding the validity of the statute and promise not to enforce it did not divest the Court of jurisdiction because that position could change when a new Attorney General took office. Moreover, a court decision was required to bind county prosecutors from enforcing the statute.

The Court found the Attorney General’s position problematic because it permitted the Attorney General to derail any constitutional challenge against a statute simply by expressing even a general and nonspecific concurrence with a plaintiff’s position. “ ‘[I]t would be a curious result if, in the administration of justice, a person could be denied access to the courts because the Attorney General of the United States agreed with the legal arguments asserted by the individual.’ ” Opinion and Order, May 17, 2022, Docket No. 22-000044-MM, p 10, quoting *INS v Chadha*, 462 US 919, 939; 103 S Ct 2764; 77 L Ed 2d 317 (1983). Citing 3 Longhofer, Mich Court Rules Practice, the Court stated, “[I]f a case has progressed to the point where a traditional action for damages or for an injunction could be maintained, declaratory relief will not be denied for lack of an actual controversy.” And that decision can be made before an injury actually occurs. Opinion and Order, May 17, 2022, Docket No. 22-000044-MM, p 11.

Although defendants in this case concur with plaintiffs regarding the constitutionality of the subject EPIC provisions, a new governor, attorney general, and secretary of state will be elected in November 2026. The newly elected governor will then appoint new directors for the state departments. There is no promise that the newly installed government officials will agree with the current defendants' position and could insist on the enforcement of the challenged statutory provisions. Further, as long as the challenged provisions remain within the statutes, hospitals are bound to follow them. These are real harms that will impact patients and their designated patient advocates. Accordingly, the Court finds an actual case and controversy permitting the Court's action.

II. JOINT STIPULATED FACTS

The Court has reviewed the parties' stipulated facts and adopts them for purposes of this action. Those facts are reproduced with nonsubstantive edits below:

The parties stipulate to the following facts:

1. Plaintiffs Dr. Viktoria Koskenoja, Samuel Holcomb, Jamie Aird, Nicole Sapiro Vinckier, Mark Vinckier, Madalyn Knutson, Dr. Laura Lozier, Dr. Jerome Winegarden, and Dr. Lisa Harris together challenge the constitutionality of a subsection of Michigan's EPIC, specifically MCL 700.5507(5)(3), 700.5509(1)(d), 700.5512(1) (collectively "the Pregnancy Exclusion"), that restricts enforcement of otherwise legally recognized advance decisions about end-of-life care for pregnant individuals, but no others.

2. EPIC establishes the right of an individual (the "patient") to designate another individual as their "patient advocate." Once designated, EPIC empowers a patient advocate to

“exercise powers concerning care, custody, and medical or mental health treatment decisions” in the event the designating individual is incapacitated. MCL 700.5506(1).

3. Despite its purpose of empowering patients to maintain control of their personal, end-of-life decisions through their designated patient advocate, EPIC’s Pregnancy Exclusion prohibits a patient advocate from honoring a patient’s decision to withhold or withdraw life-sustaining treatment if they are pregnant. MCL 700.5507(5)(3) (“This patient advocate designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient’s death.”); MCL 700.5509(1)(d) (“The designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient’s death.”); and MCL 700.5512(1) (“A patient advocate cannot make a medical treatment decision under the authority of or under the process created by this section and sections 5506 to 5511 to withhold or withdraw treatment from a pregnant patient that would result in the pregnant patient’s death.”).

4. EPIC further requires that all advance directives include the following statement: the “patient advocate designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient’s death.” MCL 700.5507(5)(3) (the “Pregnancy Addendum”).

5. EPIC nevertheless creates an exception to the Pregnancy Exclusion for those who object to treatment on religious grounds, stating that “nothing in sections 5506 or 5515 shall be considered to authorize or compel care, custody, or medical or mental health treatment decisions for a patient who objects on religious grounds.” MCL 700.5512(6).

6. The Pregnancy Exclusion operates categorically and applies regardless of the patient's own documented decisions or any individualized medical considerations. It conditions the advance directives of all patients capable of pregnancy on whether they are pregnant in the moment the directive needs to be carried out, denying them the certainty EPIC was intended to provide to patients and their loved ones.

7. As a result of the Pregnancy Exclusion, Michigan law overrides the decision of a pregnant patient who has executed a valid patient advocate designation expressing their decision to refuse life-sustaining treatment.

a. Further, Michigan's Pregnancy Exclusion renders ineffective all refusals of life-sustaining treatment, other than those based on religious grounds, in the directives of all pregnant, incapacitated individuals; it prevents their patient advocates from communicating such refusals; and it prevents their healthcare providers from honoring such refusals.

b. The Pregnancy Exclusion also creates an exception to the well-settled rule that healthcare providers cannot provide treatment to a patient without informed consent, and it subjects pregnant, incapacitated individuals to a lower standard of medical care than that available to similarly situated individuals, i.e., incapacitated individuals with advance directives that are not pregnant.

c. Finally, the Pregnancy Exclusion creates untenable uncertainty for Michigan healthcare providers, patients and patient advocates.

d. As a further result of the Pregnancy Exclusion, healthcare providers must either abide by the Pregnancy Exclusion and disregard their patients' clearly expressed decisions and right to informed consent, or honor their patients' advance directives and risk potential legal liability.

e. As a further result of the Pregnancy Exclusion, patient advocates, who are bound to follow "the desires, instructions, or guidelines given by the patient," MCL 700.5509(1)(b), must either affirmatively consent to the Pregnancy Addendum that they will disregard a patient's decisions if pregnant, or risk invalidation of the patient's designation and decisions documented therein.

f. As a further result of the Pregnancy Exclusion, patients are unable to plan for their end-of-life care in the same manner as all others. They have potentially ineffective advance directives, and they face uncertainty as to whether their deeply personal end-of-life and pregnancy-related care decisions will be honored.

8. In 2022, Michigan voters amended the Michigan Constitution to expressly guarantee "the right to make and effectuate decisions about all matters relating to pregnancy." Const 1963, art 1, § 28. This constitutional right also protects individuals from adverse action for "aiding or assisting a pregnant individual in the exercising of their right to reproductive freedom with their voluntary consent." *Id.*

9. Defendant Gretchen Whitmer is the Governor of Michigan. Under the Michigan Constitution, the executive power is vested in Governor Whitmer.

10. Defendant Dana Nessel is the Michigan Attorney General and Michigan's chief law enforcement officer.

11. Defendant Jocelyn Benson is the Michigan Secretary of State.

12. Defendant Elizabeth Hertel is the Director of the Michigan Department of Health and Human Services (DHHS).

13. Defendant Marlon Brown is the Director of the Michigan Department of Licensing and Regulatory Affairs (LARA).

Plaintiffs further assert the following facts that are not disputed by defendants in this case only and for purposes of the Court's consideration of the legality of MCL 700.5507(5)(3), MCL 700.5509(1)(d), and MCL 700.5512(1) under Const 1963, art 1, § 28:

14. Physician Plaintiffs are all physicians licensed to practice medicine in the State of Michigan. All regularly treat patients who are pregnant or capable of becoming pregnant, including patients who experience emergency or life-threatening health conditions. All are required by law and professional ethics to treat their patients in accordance with their medical expertise and with each patient's informed consent. Given their medical specialties, all physicians either have provided, or are likely to provide, end-of-life treatment or clinical consultation and treatment to a pregnant, incapacitated patient.

15. Physician Plaintiffs' pregnant and pregnancy-capable patients are Michiganders who either are or could become pregnant, who have an advance directive or would have an advance directive but for the Pregnancy Exclusion.

16. Patient Advocate Plaintiffs are the designated spokespersons for their Patient Plaintiff loved ones. They are spouses and co-parents with their loved ones, and they are knowledgeable about their loved ones' decisions for pregnancy, family formation, and end-of-life care. Patient Advocate Plaintiffs reasonably wish to be able to freely speak for their loved ones and effectuate their responsibilities as patient advocates based on their loved ones' expressed decisions and best interests.

17. Dr. Viktoria Koskenoja is both a Patient Plaintiff and a Physician Plaintiff. Dr. Koskenoja is a woman of childbearing age and an emergency medicine physician who regularly provides end-of-life treatment to incapacitated patients as part of her medical practice. Dr. Koskenoja resides in Skandia, Michigan. She has two children—aged four and six—and drafted her advance directive in 2020 after giving birth to her first child because, as a physician, she has personally witnessed how individuals can unexpectedly suffer life-threatening conditions. Dr. Koskenoja did not include pregnancy-related instructions in her original advance directive, even though she wanted to do so, because an attorney advised her that those pregnancy-related instructions would not be effective. Dr. Koskenoja updated her directive in 2025, to include additional instructions related to pregnancy, despite them being ineffective under current law, because of how strongly she feels about having her pregnancy-related end-of-life decisions honored. Dr. Koskenoja designated her husband, Samuel Holcomb, as her patient advocate. Dr. Koskenoja's advance directive makes clear that she would not consent to life-extending care if she has no chance of recovery or any quality of life. As a result of the Pregnancy Exclusion, Dr. Koskenoja reasonably fears that her end-of-life decisions will not be honored, causing her to receive unnecessary and invasive medical treatment, while prolonging the suffering and compounding the grief of her husband and young children.

18. Dr. Koskenoja is an emergency medicine physician at a hospital in L'Anse, Michigan, and the Assistant Medical Director at an urgent care clinic in Marquette, Michigan. In those practices, she routinely treats patients, including pregnant patients, who are in emergency, life-threatening situations. She reasonably fears that because of the Pregnancy Exclusion, she will be forced to substitute the Pregnancy Exclusion's one-size-fits-all standard for her own medical expertise, act in violation of her patients' informed consent, and provide potentially invasive and unnecessary treatment against her professional judgment. Dr. Koskenoja often counsels patients' families through the end of a patient's life and has witnessed the suffering that uncertainty about end-of-life care adds to their grief. As a result, she reasonably fears that the Pregnancy Exclusion's requirement that she provide unwanted life-extending care will only extend a grieving family's suffering. Both outcomes—providing unwanted care to her patients and worsening their families' grief—are directly at odds with Dr. Koskenoja's medical judgment and the reasons she became a doctor.

19. Mr. Samuel Holcomb is a Patient Advocate Plaintiff. Mr. Holcomb is Plaintiff Koskenoja's husband and designated patient advocate. He resides in Skandia, Michigan. Mr. Holcomb and Dr. Koskenoja have been partners since they were teenagers and have had many conversations about their values and end-of-life plans. Mr. Holcomb is very familiar with the decisions in Dr. Koskenoja's advance directive, and he understands the values, desires, and experiences motivating her decisions. He understands Dr. Koskenoja's decision to forego life-sustaining treatment in a situation where there is no possibility of recovery or quality of life, and, as her patient advocate and life partner, he is able to freely speak on her behalf. Mr. Holcomb reasonably fears that the Pregnancy Exclusion will not allow him to speak on his wife's behalf and voice her end-of-life decisions if she is pregnant. He reasonably fears that this will lead to invasive,

unnecessary, and unwanted life-extending care that would only extend Mr. Holcomb's and his family's grief and impede his ability to help his children process the loss of their mother.

20. Dr. Koskenoja's patient advocate designation of Mr. Holcomb does not include the Pregnancy Addendum because he fundamentally disagrees with the government-mandated script requiring him to affirm that he will ignore any of his wife's end-of-life decisions if she is pregnant. Both Mr. Holcomb and Dr. Koskenoja reasonably believe that the Pregnancy Exclusion infringes on Dr. Koskenoja's rights and are appalled that Mr. Holcomb's advance directive has more force than Dr. Koskenoja's solely because he is not capable of becoming pregnant. They are aware that failing to include the Pregnancy Addendum in the patient designation acceptance invalidates Mr. Holcomb's designation. Understanding this, Mr. Holcomb fears that he will not be able to act as Dr. Koskenoja's patient advocate and voice her treatment decisions if needed.

21. Ms. Jamie Aird is a Patient Plaintiff. Ms. Aird is a woman of childbearing age who resides in Rochester, Michigan. She has appointed her neighbor and close friend to be her patient advocate. Ms. Aird's advance directive is clear that she does not wish to receive life-extending care in the event she has no chance of recovery or quality of life. Ms. Aird has spoken at length with her designated patient advocate about her decisions and values, and she is confident that her patient advocate will honor her decisions and act accordingly on her behalf if lawfully permitted to do so. However, the Pregnancy Exclusion does not allow her patient advocate to fully speak on her behalf or honor all of her decisions. Ms. Aird's decisions, memorialized in her advance directive, are driven by her values, including her belief in bodily autonomy, and her strong desire to reduce her family's pain and suffering in the event she is incapacitated and near death. Ms. Aird's understanding of what end-of-life autonomy looks like, and the peace it provides a loved one's family to know that their decisions are respected, comes from observing both her grandfather

and grandmother refuse life-extending care at the end of their lives when she was a teenager. Watching them pass on their own terms motivated her to think about what she would want at the end of life and to memorialize those decisions in her advance directive. Absent the State's compulsion through the Pregnancy Exclusion, Ms. Aird would not have included a Pregnancy Addendum.

22. Ms. Aird is a survivor of sexual assault and had to seek emergency abortion care as a result of that assault. After these events, it took Ms. Aird many years to regain her sense of bodily autonomy. The Pregnancy Exclusion undermines Ms. Aird's hard-fought battle to reclaim her autonomy. She feels re-violated knowing she has less force under the law to dictate her pregnancy-related and end-of-life treatment and that she may be forced to undergo unnecessary, invasive and unwanted treatment if she is pregnant. Ms. Aird reasonably fears that her end-of-life decisions will not be honored if she is pregnant, worsening her family's suffering, and undermining the very autonomy she has fought so hard to reclaim.

23. Ms. Nicole Sapiro Vinckier is a Patient Plaintiff. Ms. Sapiro Vinckier is a woman of childbearing age who resides in Birmingham, Michigan. She is a trained OB-GYN physician assistant, and her professional experience motivated her to enact an advance directive to plan for her pregnancy-related and end-of-life treatment. Ms. Sapiro Vinckier has three children—aged seven, five, and three—and enacted her advance directive during her first pregnancy due to concerns regarding complications during pregnancy. She selected her husband, Mark Vinckier, to be her patient advocate. The two have had extensive conversations regarding Ms. Sapiro Vinckier's decision to forego life-extending care if there is no chance of recovery or quality of life, and her advance directive instructs Mr. Vinckier to withhold or withdraw medical treatment in those circumstances. Yet, Michigan law compelled Ms. Sapiro Vinckier to include a Pregnancy

Addendum in her advance directive. Ms. Sapiro Vinckier is deeply distressed that her advance directive has less force and that she has less autonomy over her decisions than others in Michigan because she is capable of pregnancy. She reasonably fears that her decisions will not be honored because of the Pregnancy Exclusion, which would undermine her bodily autonomy, cause her to undergo unnecessary procedures, and extend her family's pain and suffering.

24. Mr. Mark Vinckier is a Patient Advocate Plaintiff. He is Plaintiff Sapiro Vinckier's husband and designated patient advocate. He resides in Birmingham, Michigan. Mr. Vinckier is well aware of his wife's values and decisions regarding her end-of-life and pregnancy-related care. Mr. Vinckier was compelled to include the Pregnancy Addendum and agree to the Pregnancy Exclusion to ensure his wife's advance directive was valid, even though it neither reflects Ms. Sapiro Vinckier's carefully considered decisions and values, nor his own. Mr. Vinckier fundamentally disagrees with the Pregnancy Addendum he was forced to include and understandably wants to honor and effectuate his wife's decisions regardless of her pregnancy status. Mr. Vinckier reasonably fears that the Pregnancy Exclusion will impede his ability to speak on his wife's behalf in the event she is incapacitated, causing her to receive unnecessary and invasive treatment and making the situation more challenging and painful for him and their children.

25. Ms. Madalyn Knutson is a Patient Plaintiff. Ms. Knutson is a woman of childbearing age who resides in Traverse City, Michigan. Ms. Knutson enacted her advance directive in 2023, and chose her husband, Justin Pippel, as her patient advocate. The two have had extensive conversations about Ms. Knutson's values and decisions regarding life-extending care. Consistent with those values, her advance directive instructs that, while she wants her healthcare providers to prolong her life for a period of time, if the treatments are not improving her conditions

or are causing pain and suffering, she would choose to cease the treatments. Yet Ms. Knutson felt compelled by Michigan law to include a Pregnancy Addendum in her advance directive that she would not otherwise have included. Ms. Knutson's biggest concern in enacting her advance directive was that prolonging her dying process with life-sustaining care would merely extend her family's suffering. Ms. Knutson feels violated because she has less autonomy than other Michiganders to memorialize and have honored her end-of-life decisions, and she fears that the Pregnancy Exclusion will result in forced treatment in violation of her expressed decisions, undermine her bodily autonomy, cause her to suffer unnecessary and invasive procedures, and extend her family's suffering.

26. Dr. Laura Lozier is a Physician Plaintiff. Dr. Lozier is a trauma surgeon who regularly provides end-of-life treatment to incapacitated patients as part of her medical practice. Dr. Lozier resides in Marquette, Michigan. She practices medicine as a member of the Surgical Associates of Marquette. Dr. Lozier regularly treats trauma patients and has significant experience treating patients with advance directives. Dr. Lozier treats all patients who come through the emergency room needing surgery, which includes pregnant patients. Based on Dr. Lozier's medical and medical ethics training and experience, she believes that a patient's decisions, including those in their advance directives, must be followed and that forcing a pregnant patient to receive unwanted, life-extending care runs counter to medical best practices and harms the patient and their loved ones. Dr. Lozier reasonably fears she will have to subject pregnant patients who have declined life-sustaining treatment to unnecessary, unwanted, and invasive care solely because of the Pregnancy Exclusion's threat of liability and sanctions. Dr. Lozier also reasonably fears that the Pregnancy Exclusion risks straining finite resources, as it can result in intensive care

resources and medical attention being diverted to patients who do not want or need such care while depriving other critical patients of potentially life-saving treatment.

27. Dr. Jerome Winegarden is a Physician Plaintiff. Dr. Winegarden is a Michigan-licensed hematologist/oncologist who regularly provides end-of-life treatment to incapacitated patients as part of his medical practice. Dr. Winegarden resides in Ann Arbor, Michigan. In addition to practicing medicine, Dr. Winegarden oversees a hematology and oncology fellowship at a community hospital. Dr. Winegarden regularly treats patients in end-of-life situations, including pregnant patients diagnosed with cancer or other life-threatening illnesses. He reasonably believes that the Pregnancy Exclusion undermines his ability to exercise his best medical judgment, since best practice requires careful, individualized evaluation of a patient's conditions and personal desires, and the Pregnancy Exclusion diminishes his ability to properly weigh these considerations. He reasonably fears that the threat of liability for following a pregnant patient's expressed decision to decline life-sustaining treatment may force him to unnecessarily prolong care and inflict significant pain on the patient and their family. As a doctor at a community hospital with limited capacity, one of Dr. Winegarden's primary responsibilities is triaging resources as efficiently as possible. He reasonably fears that the Pregnancy Exclusion risks requiring him to provide unwanted treatment in contravention of a patient's expressed decisions and informed consent, consuming valuable hospital resources that could be allocated toward treating patients in critical need. Even if Dr. Winegarden were to decide that he should discontinue treatment, the ambiguous threat of liability would force him to consult the ethics board at his hospital to confirm that he is in compliance with state law. This deliberation would unnecessarily delay the decision-making process, potentially prolong unwanted treatment, and prevent other patients from receiving the care they need.

28. Dr. Lisa Harris is a Physician Plaintiff. Dr. Harris is an obstetrician and gynecologist who provides emergency gynecological care as part of her medical practice. Dr. Harris resides in Ann Arbor, Michigan. Dr. Harris is regularly called in to treat emergencies in pregnancy, including miscarriage. She also treats pregnant patients who face terminal or life-threatening conditions. Dr. Harris reasonably fears that the Pregnancy Exclusion, and its threat of liability or professional sanction, would supersede her best judgment as a doctor and force her to violate her duty of informed consent to administer unnecessary, unwanted, and invasive life-extending care to her pregnant patients. Dr. Harris further reasonably fears that her patients facing terminal or life-threatening conditions will feel compelled to have an abortion they otherwise would not want in order to have their end-of-life decisions carried out. Dr. Harris believes that this outcome would not only subject her patients to unnecessary treatment and violate their rights, but it would also force their families to face the pain of both the demise of a pregnancy and the death of a loved one, rather than having to say goodbye to both together, as the pregnant individual would have wanted. Such an outcome runs counter to Dr. Harris's best medical judgment.

29. Defendant Gretchen Whitmer is the person ultimately responsible for enforcement of Michigan law. Governor Whitmer, further, has the authority to appoint and oversee the heads of the various agencies that enforce the Pregnancy Exclusion. Exercising that authority, Governor Whitmer issued Executive Directive 2022-13, which directed all Michigan departments and agencies to review, align, and update their policies and practices to fully protect and uphold Michigan's newly enshrined constitutional right to reproductive freedom. *Executive Directive 2022-13: Constitutional Right to Reproductive Freedom*, available at <<https://www.michigan.gov/whitmer/news/state-orders-and-directives/2022/12/14/executive-directive-2022-13>> (accessed April 16, 2026).

30. AG Nessel is responsible for defending Michigan law against constitutional challenges and prosecuting any civil or criminal actions in which the state is a party or has an interest. Attorney General Nessel, therefore, has the power to bring both criminal and civil actions against any physicians or patient advocates who are suspected of having violated EPIC.

31. Alongside the Michigan DHHS, Secretary Benson is responsible for maintaining the Peace of Mind Registry—a statewide registry where individuals can store and access their advance directives. MCL 333.10301.

32. Director Hertel is responsible for health policy, regulation, and provider compliance, including overseeing advance directive regulations and enforcement in hospitals and long-term care settings. MCL 333.2226. Director Hertel also jointly oversees the Peace of Mind Registry. MCL 333.10301.

33. Director Brown’s agency is responsible for both licensing and disciplinary actions against physicians in Michigan. LARA also publishes a list of disciplined physicians in Michigan. Michigan Public Health Code PA 368.

34. LARA is authorized to bring disciplinary action against physicians who are accused of having acted contrary to the law, including violating the rules of informed consent. If found to have committed the charged offenses, discipline for such licensees can result in significant penalties, including the suspension or loss of licensure. LARA publishes the Disciplinary Action Report—a list of disciplinary actions taken against health and occupational licensees. Any disciplinary action taken against a physician for failure to comply with EPIC’s vague prescription of using “sound medical” judgment with incapacitated patients who are diagnosed as pregnant

would result in publication on this list. Such publication undermines the provider’s professional reputation and may hinder their ability to attract new patients or obtain gainful employment.

35. The Pregnancy Exclusion is incompatible with prevailing standards of medical ethics.

a. The American College of Obstetricians and Gynecologists (ACOG) opposes Pregnancy Exclusions and has stated that “[p]regnancy is not an exception to the principle that a decisionally-capable patient has the right to refuse treatment, even treatment needed to maintain life.” ACOG, *Position Statement on Life-Sustaining Care and Advance Directives for Pregnant Patients*, available at <<https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2025/life-sustaining-care-and-advance-directives-for-pregnant-patients>> (accessed April 16, 2026). ACOG affirms that “[t]he standard of medical care when a patient loses the capacity to make medical decisions is to rely on advance directives and proxy decision-makers to guide clinical care. Deviation from this standard for pregnant patients is not ethically justified.” *Id.* ACOG has called for the repeal of all laws, such as pregnancy exclusions, that interfere with the autonomous decision-making of pregnant people.

b. The American Medical Association (AMA) has stated that physicians should not face liability for honoring a pregnant patient’s informed decision to refuse medical treatment, including treatment to sustain a pregnancy. AMA, *Pregnancy and Childbirth, Legal Interventions During Pregnancy H-420.969*, available at <<https://policysearch.ama-assn.org/policyfinder/detail/pregnant?uri=%2FAMADoc%2FHOD.xml-0-3712.xml>> (accessed April 16, 2026).

36. Since 2023, the Uniform Health-Care Decisions Act has not contained a Pregnancy Exclusion. Uniform Law Commission, *Health-Care Decisions Act*, available at <<https://www.uniformlaws.org/committees/community-home?CommunityKey=3df274d6-776b-4780-8e4e-018a850ef44e>> (accessed April 16, 2026).

a. States that have adopted the Uniform Health-Care Decisions Act are eliminating the Pregnancy Exclusion, and states such as Washington and Colorado—recognizing the discriminatory burden pregnancy exclusions place on pregnant people’s right to autonomy and medical decision-making—have passed legislation to remove pregnancy exclusions from their advance-directive laws. See Compassion & Choices, *Pregnancy Exclusions*, available at <<https://compassionandchoices.org/resource/pregnancy-exclusions/>> (accessed April 16, 2026); see also Diaz-Tello, *If When How: Lawyering for Reproductive Justice, Pregnancy Exclusion Laws Deny Pregnant People End-of-Life Decision-Making*, July 14, 2025, available at <<https://ifwhenhow.org/resources/pregnancy-exclusion-laws-deny-pregnant-people-end-of-lie-decision-making/>> (accessed April 16, 2026).

37. Pregnancy exclusion laws have forced unwanted and invasive life-sustaining treatment on pregnant people, including those without advance directives.

a. In 2014, Marlise Munoz—who was 14 weeks pregnant when she was declared brain-dead—was kept on life support for months in a Texas hospital against her previously expressed wishes because of a pregnancy exclusion in Texas’s advance-directive law, even though she had no advance directive and was legally dead. Fernandez & Erik Eckholm, *Pregnant, and Forced to Stay on Life Support*, NY Times, available at

<https://www.nytimes.com/2014/01/08/us/pregnant-and-forced-to-stay-on-life-support.html>> (accessed April 16, 2026).

b. Similarly, in 2025, Adriana Smith was kept on life support for months in a Georgia hospital without her family's consent and after she was declared brain dead when she was about 9 weeks pregnant. The hospital cited Georgia law, which includes restrictive abortion provisions and a pregnancy exclusion in its advance directive law, as requiring the forced treatment, despite the fact that Ms. Smith did not have an advance directive and was legally dead. Somasundaram, *Brain-Dead Pregnant Woman's Case Spurs Questions About Medical Consent*, available at <https://www.washingtonpost.com/nation/2025/05/19/georgia-mother-pregnant-brain-dead/>> (accessed April 16, 2026).

38. The Pregnancy Exclusion disparately impacts people of color, economically disadvantaged people, and people living in rural areas. The United States has the highest rate of maternal mortality among high-income countries. Hill et al, *Racial Disparities in Maternal and Infant Health: Current Status and Key Issues*, December 3, 2025, available at <https://www.kff.org/racial-equity-and-health-policy/racial-disparities-in-maternal-and-infant-health-current-status-and-key-issues/>> (accessed April 16, 2026).

a. This rate is much higher for people of color, with Black pregnant people more than three times as likely to experience a pregnancy-related death than their white counterparts, *id.*, and Native American pregnant people four times as likely. Center for Disease Control and Prevention, *Data from the Pregnancy Mortality Surveillance System: Pregnancy-Related Deaths by Race-Ethnicity*, December 18, 2025, available at

<<https://www.cdc.gov/maternal-mortality/php/pregnancy-mortality-surveillance-data/index.html>> (accessed April 16, 2026).

b. The risks of mortality and severe morbidity pregnant people face are not only related to conditions stemming from the pregnancy: pregnancy can increase the risk associated with other conditions. For instance, seasonal illnesses, such as COVID-19 and flu, can be especially dangerous to pregnant people, who are at a higher risk of developing life-threatening complications. See Fromson, *Pregnant Women Hospitalized for COVID-19, and Their Newborns, Have Higher Complication Risk*, Michigan Medicine, December 30, 2025, available at <<https://www.michiganmedicine.org/health-lab/pregnant-women-hospitalized-covid-19-and-their-newborns-have-higher-complication-risk>> (accessed April 16, 2026); see also Osheghale et al, *Influenza Virus Infection during Pregnancy as a Trigger of Acute and Chronic Complications*, available at <<https://pubmed.ncbi.nlm.nih.gov/36560733/>> (accessed April 16, 2026).

c. Having a chronic health condition before pregnancy also increases the likelihood of pregnancy complications. March of Dimes, *Where You Live Matters: Maternity Care Access in Michigan*, available at <<https://www.marchofdimes.org/peristats/reports/michigan/maternity-care-deserts>> (accessed April 16, 2026). 42.6% of pregnancy-capable individuals in Michigan have chronic health conditions, a rate higher than the national average of 37.8%. *Id.*

d. In addition, limited access to maternity care increases the risk of both negative health outcomes and health disparities. *Id.* at 1. 21.7% of Michigan counties are classified

as maternity care deserts (areas without birthing facilities or prenatal care providers), with an almost 3% decrease in the number of birthing hospitals between 2019 and 2020. *Id.*

e. People of color are more likely to live in places where various factors in the environment, including lack of access to transportation, create barriers to access to prenatal care. *Id.* at 3. Lack of access to prenatal care increases the risk of adverse pregnancy outcomes. *Id.* In Michigan, 13% of all women receive inadequate prenatal care. *Id.*

f. Taken together, these factors mean that pregnant people are at a greater risk of a condition that may suddenly render them terminally ill and unable to communicate, forcing them to rely on an advance directive to make their decisions for end-of-life care.

III. LEGAL CONCLUSIONS

The Court agrees that the challenged provisions of the EPIC infringe the fundamental right to reproductive freedom granted by Const 1963, art 1, § 28. The Reproductive Freedom Amendment states, in full:

(1) Every individual has a fundamental right to reproductive freedom, which entails the right to make and effectuate decisions about all matters relating to pregnancy, including but not limited to prenatal care, childbirth, postpartum care, contraception, sterilization, abortion care, miscarriage management, and infertility care.

An individual's right to reproductive freedom shall not be denied, burdened, nor infringed upon unless justified by a compelling state interest achieved by the least restrictive means.

Notwithstanding the above, the state may regulate the provision of abortion care after fetal viability, provided that in no circumstance shall the state prohibit an abortion that, in the professional judgment of an attending health care professional, is medically indicated to protect the life or physical or mental health of the pregnant individual.

(2) The state shall not discriminate in the protection or enforcement of this fundamental right.

(3) The state shall not penalize, prosecute, or otherwise take adverse action against an individual based on their actual, potential, perceived, or alleged pregnancy outcomes, including but not limited to miscarriage, stillbirth, or abortion. Nor shall the state penalize, prosecute, or otherwise take adverse action against someone for aiding or assisting a pregnant individual in exercising their right to reproductive freedom with their voluntary consent.

(4) For the purposes of this section:

A state interest is “compelling” only if it is for the limited purpose of protecting the health of an individual seeking care, consistent with accepted clinical standards of practice and evidence-based medicine, and does not infringe on that individual’s autonomous decision-making.

“Fetal viability” means: the point in pregnancy when, in the professional judgment of an attending health care professional and based on the particular facts of the case, there is a significant likelihood of the fetus’s sustained survival outside the uterus without the application of extraordinary medical measures.

(5) This section shall be self-executing. Any provision of this section held invalid shall be severable from the remaining portions of this section. [Const 1963, art 1, § 28.]

Plaintiffs raise a facial challenge to the constitutionality of the subject EPIC provisions. A statute may have been constitutional when enacted by the Legislature but rendered invalid by a later amendment to the Constitution. See *Gaylord v Gaylord City Clerk*, 378 Mich 273, 321; 144 NW2d 460 (1966). See also Const 1963, art 1, § 7 (“The common law and the statute laws now in force, not repugnant to this constitution, shall remain in force until they expire by their own limitations, or are changed, amended or repealed”). “The party challenging the facial constitutionality of an act must establish that no set of circumstances exists under which the act would be valid. The fact that the act might operate unconstitutionally under some conceivable set of circumstances is insufficient.” *League of Women Voters of Mich v Secretary of State*, 508 Mich 520, 534-535; 975 NW2d 840 (2022) (cleaned up). “Our task, then, is to determine whether [the

statute] is unconstitutional in the abstract, rather than to analyze the statute ‘as applied’ to the particular case.” *Id.*

Const 1963, art 1, § 28(1) states that “[e]very individual has a fundamental right to reproductive freedom, which entails the right to make and effectuate decisions about all matters relating to pregnancy.” This provision continues by providing a nonexclusive list of “matters relating to pregnancy” that are constitutionally protected. The Court concludes that the personal decision whether to forego life-extending care in the face of an incapacitating condition and to designate a patient advocate to protect one’s wishes in this regard while incapacitated, even if pregnant, is a fundamental right to make and effectuate a decision related to pregnancy.

Const 1963, art 1, § 28(1) continues, “An individual’s right to reproductive freedom shall not be denied, burdened, nor infringed upon unless justified by a compelling state interest achieved by the least restrictive means.” And Const 1963, art 1, § 28(4) provides, “A state interest is ‘compelling’ only if it is for the limited purpose of protecting the health of an individual seeking care, consistent with accepted clinical standards of practice and evidence-based medicine, and does not infringe on that individual’s autonomous decision-making.” Through this language, the Reproductive Freedom Amendment requires courts to apply a strict scrutiny standard of review to assess the constitutionality of a statute. The challenged laws only pass constitutional muster if they: (1) do not deny, burden, or infringe upon an individual’s fundamental right to make and effectuate decisions about reproductive care, or (2) if the laws do deny, burden, or infringe upon that right, they do so in the least restrictive means possible (a) only to achieve the purpose of protecting the health of an individual seeking care, (b) consistent with accepted clinical standards of practice and evidence-based medicine, and (c) do not infringe on that individual’s autonomous decision-making.

The challenged provisions of the EPIC deny, burden, and infringe upon an individual's fundamental rights. MCL 700.5507 permits individuals to provide instructions and state their desires "on care, custody, and medical treatment and mental health treatment, or both" and to appoint a patient advocate to fulfill these instructions in the event the individual becomes incapacitated. MCL 700.5507(1), (2). MCL 700.5507(5) outlines various requirements for the patient advocate designation acceptance document, including a statement that the patient advocate's powers are limited to situations in which the patient is unable to personally participate in making medical decisions. MCL 700.5507(5)(4) requires a statement within the acceptance document that "A patient advocate may make a decision to withhold or withdraw treatment that would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death." But MCL 700.5507(5)(3) requires the acceptance form to state: "This patient advocate designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death."

MCL 700.5509 outlines the "authority, rights, responsibilities, and limitations" on a patient advocate. MCL 700.5509(1). Subsection (1)(b) requires the patient advocate to "take reasonable steps to follow the desires, instructions, or guidelines given by the patient while the patient was able to participate in decisions regarding care, custody, medical treatment, or mental health treatment." Subsection (1)(e) grants a patient advocate authority to decide "to withhold or withdraw treatment that would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death." But MCL

700.5509(1)(d) prevents a patient advocate from making that same decision, even if the patient advocate designation clearly states the patient would choose to withhold or withdraw life-extending care under the circumstances, if the patient is pregnant: “The designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient’s death.”

MCL 700.5512 imposes restrictions on patient advocate designations. Subsection (1) reiterates that “[a] patient advocate cannot make a medical treatment decision under the authority of or under the process created by this section and sections 5506 to 5511 to withhold or withdraw treatment from a pregnant patient that would result in the pregnant patient’s death.”

By their plain and unambiguous language, MCL 700.5507(5)(3), MCL 700.5509(1)(d), and MCL 700.5512(1) infringe an individual’s autonomous decision-making about essential healthcare decisions. They prevent a patient from making an informed decision about the removal of life-extending care and having their wishes effectuated by the patient advocate in the event of pregnancy. These provisions do not protect the health of an individual seeking care. Rather, they prevent individuals who are capable of becoming pregnant of making autonomous decisions about the type of healthcare they will receive in the event they are incapacitated. These provisions prevent the patient advocate selected by the patient from effectuating the informed healthcare decisions made by the individual. And these provisions invalidate an individual’s patient advocate designation if the individual is capable of becoming pregnant and even if they intentionally declined to include language limiting their advanced directives in the event of pregnancy.

Moreover, the challenged provisions do not regulate by the least restrictive means possible, are not only for the purpose of protecting the patient’s health, are not consistent with accepted

clinical standards of care, and actively infringe on autonomous decision-making. The statutory provisions create a blanket exception to an individual's authority to make autonomous medical decisions on a single criterion: pregnancy. These provisions prevent an individual's carefully selected patient advocate from securing the type of care and custody desired by the patient. These provisions prevent individuals from making personal, informed decisions about the conditions under which they would withhold or withdraw life-extending care. Similar statutory provisions have been used to prolong the suffering of patients and their families by requiring patients who have been pronounced brain dead by qualified medical professionals or who have been diagnosed as having no possibility of recovering with any quality of life to remain on invasive life support simply because they are pregnant.

There are no circumstances under which the pregnancy-related restrictions on patient advocate designations could comply with Const 1963, art 1, § 28. Preventing individuals who are capable of becoming pregnant from making informed advanced decisions about their healthcare runs afoul of the fundamental right to reproductive freedom enshrined in the Michigan Constitution. Those provisions are unconstitutional and invalid and must be struck from the EPIC.

IV. JUDGMENT

The Court DECLARES that MCL 700.5507(5)(3), MCL 700.5509(1)(d), and MCL 700.5512(1) are unconstitutional and invalid. The Court DIRECTS that these provisions must be struck from the statutes and given no force or effect. This is a final decision resolving all issues in and closing this case.

It is so ordered.

Date: April 16, 2026



Sima G. Patel
Judge, Court of Claims