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The Right to Refuse Medical Treatment in Ohio after Cruzan: The Need for A Comprehensive Legislative Solution

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THE RIGHT TO REFUSE MEDICAL TREATMENT
IN OHIO AFTER CRUZAN: THE NEED FOR
A COMPREHENSIVE LEGISLATIVE SOLUTION

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I. INTRODUCTION

The United States Supreme Court has implicitly recognized the right to refuse medical treatment as a constitutionally protected liberty interest.¹ Ohio common law also recognizes a person's right to refuse medical treatment based upon the doctrine of informed consent.² To avoid receiving certain types of life-sustaining treatment, Ohioans may authorize an attorney in fact to make health care decisions under the Durable Power of Attorney for Health Care statute.³ While the statute is designed to give the attorney in fact the authority to make health care decisions, this authority does not extend to the refusal of life-sustaining treatment in non-terminal cases, nor does it extend to the refusal or withdrawal of nutrition and hydration except in very limited circumstances.⁴ At present, an Ohioan wishing to provide an advance directive regarding the termination of treatment in non-terminal cases and/or the provision of nutrition and hydration has no other statutory mechanism to do so since neither a natural death act⁵ nor living will statute⁶ has yet been passed by the Ohio legislature.⁷

This paper will first review the development of Ohio case law prior to the Supreme Court's decision in *Cruzan v. Director, Missouri Department of Health*⁸ along with the *Cruzan* decision and Ohio's Durable Power of Attorney for Health Care statute. Next, the constitutionality of the limitations in the Durable Power of Attorney Health Care statute will be discussed. The standard of evidence which must be met in Ohio in order to implement an incompetent's wishes regarding medical treatment in the absence of a durable power will be analyzed. Recommendations will be presented regarding what Ohioans should do in order to increase the

¹ *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841 (1990).

² *Estate of Leach v. Shapiro (Leach II)*, 13 Ohio App.3d 393, 469 N.E.2d 1047 (Summit Cty. 1984).

³ OHIO REV. CODE ANN. §§ 1337.11-17 (Baldwin 1990).

⁴ *Id.* at § 1337.13.

⁵ These are statutes which establish certain requirements for providing a directive to physicians regarding future medical treatment choices. See, e.g., CAL. HEALTH & SAFETY CODE §§ 7185 - 95 (West Supp. 1990) which provides a statutory form that a competent person may sign to refuse medical treatment at a time when the person is no longer competent and in a terminal condition. However, this statute provides that if a person executes a directive *prior* to being diagnosed as terminal, the directive is not binding on health care providers.

⁶ A living will is a statutory mechanism which permits a competent person to execute a formal, witnessed legal document to direct future health care at a time when the person becomes incompetent. See, e.g., ARK. STAT. ANN. §§ 20-17-201-214 (1990). A living will applies in a greater variety of situations than a directive executed pursuant to a natural death act, and living will statutes often allow the appointment of a surrogate decision-maker.

⁷ Three different pieces of living will legislation recently have been introduced in the Ohio legislature. See *infra* notes 166 thru 192 and accompanying text for a discussion of these.

⁸ 110 S. Ct. 2841 (1990).

likelihood that their choices regarding all forms of medical treatment, including nutrition and hydration, are carried out. Ohio's proposed living will legislation will be examined along with representative legislation from other jurisdictions. Finally, a legislative solution to the multifaceted issues regarding the right to refuse treatment in Ohio will be suggested.

II. OHIO LAW PRIOR TO CRUZAN

A. *The Leach Cases*

Grounding their holdings on either a constitutional right to privacy or the common law doctrine of informed consent, Ohio courts have permitted the termination of life-sustaining medical treatment.^{9,10} Ohio courts have recognized a surrogate's authority to exercise this right.¹¹ Further, surrogates frequently exercise this right in Ohio without judicial intervention.

In *Leach I*, a court allowed a patient's guardian to discontinue his wife's ventilator. Mrs. Leach was a seventy-two year old woman who was diagnosed in June, 1980, with amyotrophic lateral sclerosis, a progressively debilitating, terminal disease of the nervous system which would result in her death within the next three to five years. The following month, she was admitted to Akron General Medical Center with respiratory distress and in a "stuporous" condition.¹² She arrested two days later and was placed on life support which included a ventilator, a nasogastric tube and a foley catheter.¹³ She was later diagnosed as being in a chronic vegetative state and was non-responsive to external stimuli. However, she did react to deep pain by grimacing and her brain wave test demonstrated a very low brain activity.¹⁴ She could not be weaned from the ventilator.¹⁵

Her husband requested that the ventilator be discontinued. Her doctor refused stating that the life support could only be terminated by a court order which Mr. Leach then sought. Mr. Leach was appointed legal guardian of Mrs. Leach and a guardian ad litem was also appointed.¹⁶

⁹ *Leach v. Akron Gen. Medical Center (Leach I)*, 68 Ohio Misc. 1, 426 N.E.2d 809 (Summit Cty. 1980).

¹⁰ *Estate of Leach v. Shapiro (Leach II)*, 13 Ohio App.3d 393, 469 N.E.2d 1047 (Summit Cty. 1984).

¹¹ *Leach I*, 68 Ohio Misc. at 1, 426 N.E.2d at 809.

¹² *Id.* at 2, 426 N.E.2d at 810. "Stuporous" is defined as partial or nearly complete unconsciousness. SLOAN-DORLAND ANNOTATED MEDICAL-LEGAL DICTIONARY 676 (West 1987).

¹³ *Leach I*, 68 Ohio Misc. at 3, 426 N.E.2d at 810. A ventilator is used to provide artificial, mechanical ventilation of the lungs. A nasogastric tube is inserted through the nose and extends into the stomach. It may be used to provide artificial nutrition and/or hydration or to remove the gastric contents from the stomach. A foley catheter drains urine from the bladder outside the body.

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

An evidentiary hearing was held during which a total of seventeen witnesses testified as to numerous conversations with Mrs. Leach concerning life support systems.¹⁷ The last of these conversations took place only two days before she entered the hospital, at which time Mrs. Leach expressed a desire that she not be placed on life support systems.¹⁸

The court framed the issue not as a decision between life or death, but rather:

[t]he basic question is how long will society require Mrs. Leach and others similarly situated to remain on the threshold of certain death suspended and sustained there by artificial life supports.¹⁹

Concluding that a constitutional right of privacy allowed a terminally ill but competent person to choose medical treatment, the court determined that "the terminally ill should be treated equally, whether competent or incompetent."²⁰ The court then examined what compelling state interests would outweigh the individual's right.

The court reviewed the four potential interests generally advanced by states in these types of cases: the preservation of life, the protection of third parties, the maintenance of the ethical integrity of the medical profession, and the prevention of suicide.²¹ The court concluded that there was no benefit to the State of Ohio in preserving Mrs. Leach's life under the circumstances and also that no third party would suffer from her death.²² The court concluded that the termination of an extraordinary life support system for a terminally ill patient in an irreversible coma was not inconsistent with the current state of medical ethics. Finally, the court determined that the withdrawal of the ventilator was not suicide, but rather "evinces only an intent to forego extraordinary measures, and allows the processes of nature to run their course."²³ Thus, the court concluded the state's interests did not outweigh Mrs. Leach's constitutional right, as exercised through her guardian, to choose to forego medical treatment.²⁴

In determining Mrs. Leach's intent regarding treatment, the court adopted a clear and convincing evidence standard.²⁵ Mrs. Leach had made

¹⁷ *Id.*

¹⁸ *Id.* at 4, 426 N.E.2d at 811. One witness recalled that Mrs. Leach had stated "[t]hat's the one thing that terrifies me. I don't want to be put on life support systems. I don't want to live if I have to be a vegetable." *Id.*

¹⁹ *Id.* at 6, 426 N.E.2d at 812.

²⁰ *Id.* at 8, 426 N.E.2d at 813 (quoting *In re Eichner*, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980)).

²¹ *Id.* at 9, 426 N.E.2d at 814-15.

²² *Id.* at 9, 426 N.E.2d at 814. Moreover, the court recognized that there were a number of detriments to the state, the patient and her family which would result from attempting to delay her death. *Id.*

²³ *Id.* at 10, 426 N.E.2d at 815.

²⁴ *Id.*

²⁵ *Id.* at 11, 426 N.E.2d at 815.

no advance written directive regarding her wishes to refuse or terminate medical treatment if she became incompetent. Recognizing that the burden of proof normally used in a civil matter is a preponderance of the evidence standard, the court stated that "because of the nature and importance of the issues involved, this court would be remiss if it did not adopt the highest possible civil standard of clear and convincing."²⁶

A doctor and neurologist were ordered to examine and certify that Mrs. Leach was in a permanent vegetative state and that there was no "reasonable medical possibility" that Mrs. Leach would "regain a sapient or cognitive function."²⁷ It is notable that the authorization to remove life support extended only to the removal of the ventilator and to no other life supports so that the feeding tube was not discontinued.²⁸

After the ventilator was removed and Mrs. Leach died, her husband and family again brought suit against the attending physician and the hospital. In *Leach II*,²⁹ the family claimed that Mrs. Leach was wrongfully placed on life support systems on August 1, 1980 and maintained on life support without her or her family's consent. The plaintiffs sought compensatory damages for pain, suffering and mental anguish for both themselves and the decedent for the time Mrs. Leach was continued on life support systems, as well as punitive damages. Additionally, the plaintiffs claimed that the defendants' failure to inform the family of Mrs. Leach's condition, prognosis, and course of treatment for two months constituted malpractice and/or a misrepresentation amounting to fraud. They also claimed that experimental drugs were administered without consent and that the removal of Mrs. Leach's ventilator on January 6, 1981, constituted an unreasonable delay in complying with the probate court's December 18, 1980 order to terminate her life supports. The trial court dismissed all of the claims. In affirming the dismissal of the invasion of privacy claim, but reversing the trial court's dismissal of most of the plaintiff's other claims,³⁰ the court of appeals discussed several points of law.

First, the court stated that an incompetent patient's life support could only be disconnected pursuant to a court order³¹ and noted that this

²⁶ *Id.* citing *Ayres v. Cook* 140 Ohio St. 281, 43 N.E.2d 287 (1942) and *Flax v. Williams*, 25 Ohio Law Abs. 680 (1937). The court rejected the arguments of the guardian ad litem and the hospital who requested even higher burdens of proof.

²⁷ *Leach I*, 68 Ohio Misc. at 12, 426 N.E.2d at 816.

²⁸ *Id.* at 13, 426 N.E.2d at 816. The court's order of December 18, 1980 also granted both civil and criminal immunity to the patient's guardian, the hospital, physician or other person who participated in the act of discontinuing the ventilator. Mrs. Leach was disconnected from the ventilator on January 6, 1981 and died the same day. *Id.*

²⁹ *Estate of Leach v. Shapiro (Leach II)*, 13 Ohio App.3d 393, 469 N.E.2d 1047 (Summit Cty. 1984).

³⁰ The case was eventually settled.

³¹ Court orders have *not* regularly been sought before discontinuing life support. Commonly, when a consensus among family members regarding treatment is reached, ventilators are disconnected consistent with the medical judgment of the physician. In the experience of the authors, a pronouncement such as this

holding was in accord with other states that had addressed this issue.³² The court also stated that "absent legislation to the contrary, the competent patient's right to refuse treatment is absolute until the quality of the competing interests [are] weighed in a court proceeding."³³ The court stated that this right was a logical extension of the requirement that a patient must consent to treatment and concluded that a patient could recover for battery if his refusal was ignored.³⁴ While the court made no distinction between the rights of competent and incompetent patients to refuse treatment, Mrs. Leach had apparently expressly advised her doctors while competent "that she did not wish to be kept alive by machines."³⁵ The court added that "general statements by the patient could still be considered by a court, of course, in determining the wishes of a patient in a chronic vegetative condition."³⁶ The court also recognized the right of a terminally ill, competent patient to refuse treatment which prolonged suffering.³⁷

The two *Leach* cases illustrate the "Catch-22" that exists for health care providers. In *Leach I*, the guardian had petitioned for the removal of the patient's life support systems which apparently included the ventilator, nasogastric tube and foley catheter.³⁸ In granting the request, the court limited the termination of the life support systems to include only the ventilator.³⁹ Since the *Leach II* decision would have apparently per-

raises many questions and reinforces the need for comprehensive legislation in this area. For example, legislation would resolve the issue of whether a court order is needed in every case prior to terminating life supports or only in cases where a disagreement exists. At present, no clear guidance is available for health care providers. Further, requiring court orders in every case is directly contrary to the position taken by the National Center for State Courts and State Justice Institute in the *Draft Guidelines for State Court Decision Making in Authorizing or Withholding Life-Sustaining Medical Treatment* 1, 8 (Draft No. 7) (November 1990) [hereinafter *Guidelines*]. According to the *Guidelines*: "Judicial involvement should occur only when there are irresolvable disagreements among the primary decision-makers, or there are serious grounds for believing there is a need for protective services." *Id.* Notwithstanding a patient's status, nutrition and hydration have generally not been discontinued.

³² *Leach II*, 13 Ohio App. 3d at 396, 469 N.E.2d at 1053 citing, *inter alia*, Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977). As pointed out by one commentator, the *Leach II* court was incorrect in its conclusion since the Massachusetts courts had modified the requirement for court orders in subsequent cases decided prior to *Leach II*. See *In re Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978); *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980), in Miller, *Right-to-Die Damage Actions: Developments in the Law*, 85 Den. U.L. Rev. 181, 201 (1988).

³³ *Leach II*, 13 Ohio App.3d at 395, 426 N.E.2d at 1051-52.

³⁴ *Id.*

³⁵ *Id.* at 396, 469 N.E.2d at 1053.

³⁶ *Id.* at 397, 469 N.E.2d at 1053.

³⁷ *Id.* As previously noted, the trial court's dismissal was reversed and the case eventually settled.

³⁸ 68 Ohio Misc. 1, 3, 426 N.E.2d 809, 810 (Summit Cty. 1980) ("The life support system consists of a respirator, a nasogastric tube and a catheter. . . . Mr. Leach instituted an action for an order to discontinue life supports of Edna Marie Leach.") (emphasis added).

³⁹ *Id.* at 13, 426 N.E.2d at 816.

mitted recovery on a battery theory for the unconsented to application of all life supports,⁴⁰ the health care providers could have incurred liability for the continued nasogastric tube feedings had Mrs. Leach lived without the ventilator, even though the *Leach I* court did not permit nasogastric tube to be discontinued. This anomalous situation points out the need for adequate, comprehensive guidelines for the refusal or termination of all types of life support systems.

B. The Durable Power of Attorney for Health Care Statute

In order to allow Ohioans to designate a proxy to make health care decisions in advance of any future incompetency, the Durable Power of Attorney for Health Care statute was passed in June of 1989.⁴¹ This statute allows a competent person to plan for future incompetency through the designation of an attorney in fact as a health care decision-maker.⁴² The instrument becomes effective if and when the principal loses the capacity to make informed health care decisions for himself.⁴³ The statute provides that the authorization may include the right to give informed consent, or to refuse to give consent, or to withdraw consent to "any health care"⁴⁴ that is being or could be provided to the principal.⁴⁵

Subject to any express limitations in the instrument or as otherwise provided in the statute, the attorney in fact may make health care decisions for the principal "to the same extent as the principal could make those decisions for himself if he had the capacity to do so."⁴⁶ However, this is contradicted by a later section which provides that an attorney in

⁴⁰ *Leach II*, 13 Ohio App. 3d at 395-96, 469 N.E.2d at 1052. "The complaint alleges that Mrs. Leach was placed on life support systems on August 1, 1980, without the consent of Mrs. Leach or her family." *Id.* The life support systems had previously been described by the court as including a ventilator, nasogastric tube and foley catheter. *Leach I*, 68 Ohio Misc. at 3, 426 N.E.2d at 810.)

⁴¹ OHIO REV. CODE ANN. §§ 1337.11-17 (Baldwin 1990).

⁴² OHIO REV. CODE ANN. §§ 1337.11-17 (Baldwin 1990). To be valid, the durable power must be written, signed and dated by the principal. It must either be witnessed by two disinterested individuals (the statute excludes those providing health care to the principal, as well as persons who would benefit in any way from the death of the principal) or acknowledged by the principal before a notary public. *Id.* at §§ 1337.12(A), (C). The statute also provides that a durable power of attorney for health care expires after seven years unless re-executed by the principal. *Id.* at § 1337.12(A)(3).

⁴³ *Id.* at § 1337.13(A)(1).

⁴⁴ *Id.* at § 1337.12(A)(1).

⁴⁵ OHIO REV. CODE ANN. § 1337.11(B) (Baldwin 1990) defines health care as "any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition."

⁴⁶ *Id.* at § 1337.13(A)(1). See Feibel, *Health Care Law Helps-A Little*, Business First, Oct. 30, 1989, at 7, col. 1. "The new law provides a partial solution for terminating life-support for the terminally ill, but it does not give a non-terminal but incapacitated patient the same right to avoid life-saving treatment that the patient would possess were he or she competent." *Id.*

fact does *not* have the authority "to refuse or withdraw informed consent to health care that is necessary to maintain the life of the principal, unless the principal is in a terminal condition."⁴⁷

An attorney in fact also does not have the authority to refuse or withdraw informed consent to health care necessary to provide "comfort care."⁴⁸ An attorney in fact may refuse or withdraw informed consent to the provision of nutrition and hydration only when two physicians concur that (1) the provision of nutrition and hydration would not provide comfort, and that either (2) death is imminent whether or not nutrition or hydration is provided and the non-provision of such is not likely to result in the death of the principal by malnutrition or dehydration, or (3) nutrition or hydration could not be assimilated or would shorten the principal's life.⁴⁹

In addition, if a principal has previously consented to health care, an attorney in fact may not withdraw such consent unless (1) the principal's condition has changed resulting in a significant decrease in the benefit of health care or (2) the health care is not significantly effective in achieving the purposes for which the principal's consent was originally given.⁵⁰

Notably, there is no provision in the statute regarding alternative decision-making for an incompetent patient who has not executed a valid durable power. In addition, the limitations on the powers of an attorney in fact are counterproductive since they severely restrict a principal's ability to control the type and amount of health care provided if incompetency occurs. While Ohio has joined other states in limiting the ability

⁴⁷ OHIO REV. CODE ANN. § 1337.13(B) (Baldwin 1990) (emphasis added). Terminal condition is defined in OHIO REV. CODE ANN. § 1337.11(I) (Baldwin 1990) as "any illness or injury that is likely to result in *imminent* death, regardless of the type, nature, and amount of health care that is provided." This section places an affirmative obligation on the attorney in fact to consent to certain types of care.

⁴⁸ *Id.* at § 1337.13(C). The term "comfort care" is not defined.

⁴⁹ *Id.* at § 1337.13(E)(1)-(3). It will be the rare occasion when an attorney in fact will be able to terminate nutrition and/or hydration under the statute. Limiting the withdrawal or refusal of treatment to situations where death is "imminent," whether or not medical treatment is used, greatly reduces the potential of an advance directive. See President's Commission for the Study of Ethical Problems in Medicine, *Deciding to Forego Life-Sustaining Treatment* 1, 143 (1983) [hereinafter *Deciding to Forego*]. Further, the statute also grants blanket immunity from liability to the physician and health care facility potentially resulting from non-compliance with an attorney in fact's decision regarding treatment. For example, if the patient's condition meets the statutory criteria for termination of nutrition and hydration and the attorney in fact requests such termination pursuant to the patient's previously expressed wishes, the health care providers risk no liability for non-compliance with this choice. See OHIO REV. CODE ANN. §§ 1337.15(B), (D) (Baldwin 1990) "A physician is not . . . liable in damages . . . for providing or failing to withdraw health care that is necessary to keep the principal alive." One commentator has suggested that this "safe harbor" provision could "induce the medical community to provide life-sustaining treatment in *all* events." Feibel, *supra* note 46, at 7, col. 2.

⁵⁰ OHIO REV. CODE ANN. § 1337.13(F) (Baldwin 1990).

to terminate nutrition and hydration,⁵¹ Ohio's statute goes even further in that it may even prevent the attorney in fact from withholding this in the first instance.⁵² These limitations prevent the incompetent principal from enjoying the same privilege as a competent person to refuse or terminate all forms of life-sustaining medical treatment.

C. Couture's Interpretation of the Durable Power for Health Care Statute

As if all the limitations in the Durable Power for Health Care statute weren't enough, an Ohio appellate court⁵³ has held that those limitations apply to a guardianship situation even in the absence of a durable power. Daniel Couture was a twenty-nine year old who became comatose on April 20, 1989, as a result of medication he had received.⁵⁴ He was placed on a ventilator and a feeding tube was inserted. His divorced parents each filed applications for guardianship which was eventually awarded to his mother. Based upon the advice of Daniel's physician, as well as other family members, his mother decided that it was in Daniel's best interest to terminate the use of the ventilator and the feeding tube. His father objected and instituted legal proceedings to prevent the withdrawal of these treatments and to remove the mother as guardian. At the hearing before the probate court on June 26, 1989, a medical expert testified that Daniel's underlying condition had created "fluid on the brain" and that he would continue to live only one or two more months.⁵⁵ The expert stated that under these circumstances, medical ethics and procedures would permit the withdrawal of nutrition and hydration.⁵⁶ It was the position of the hospital, Daniel's physician and his mother that withdrawal of treatment was appropriate. In denying the father's requests for injunctive and declaratory relief, the probate court stated that the guardian was entitled to make decisions regarding treatment and care after consultation with the ward's doctors, which were in the ward's "best interests."⁵⁷

On June 28, 1989, Daniel's father appealed these decisions to the court of appeals. The same day, the court issued a temporary restraining order to prevent the removal of any life support system pending further court

⁵¹ See, e.g., Health Care Surrogate Act of Kentucky, KY. REV. STAT. ANN. § 311.978 (Baldwin 1990) (with certain exceptions "nutrition and hydration shall always be provided").

⁵² For example, if the principal is non-terminal, then the attorney in fact cannot withhold consent to health care necessary to maintain the principal's life. OHIO REV. CODE ANN. § 1337.13(B) (Baldwin 1990). See generally Kapp, *Ohio's New Durable Power of Attorney*, 14 U. DAYTON L. REV. 541 (1989).

⁵³ *Couture v. Couture*, 48 Ohio App. 3d 208, 549 N.E.2d 571 (Montgomery Cty. 1989).

⁵⁴ *Id.* at 209, 549 N.E.2d at 572.

⁵⁵ *Id.* at 210-11, 549 N.E.2d at 573.

⁵⁶ *Id.* at 210-11, 549 N.E.2d at 573.

⁵⁷ *Id.* at 209, 549 N.E.2d at 572.

order and later granted an injunction while the father appealed. In the interim, Daniel was weaned from the ventilator, but continued to receive hydration and nutrition through his feeding tube. Subsequently, the mother voluntarily withdrew as guardian and the father was appointed. A guardian ad litem was also appointed. The issue in the case was whether nutrition and hydration could be withdrawn.

Even though no durable power had been executed in this case, the court of appeals looked to Ohio's Durable Power of Attorney for Health Care statute in making its decision.⁵⁸ The court determined that this statute had announced a public policy forbidding the withdrawal of hydration and nutrition in a case of this kind. Even though this was a case involving a guardianship and not an attorney in fact under the statute, the court stated that the public policy of Ohio as evidenced by the statute is "opposed to the withdrawal of nutrition or hydration under these circumstances, notwithstanding the wishes of the patient or his surrogate."⁵⁹

In reaching its decision, the court reasoned that if it could not give effect to a person's express written direction to withdraw nutrition or hydration because it was not generally permitted under the new statute, then the same prohibitions applied to a guardian's decision.⁶⁰ The court concluded that even if the withdrawal of nutrition or hydration had been permitted by the statute, the guardian's decision, made in reliance upon the ward's casual oral remarks, was even less compelling than a person's express written directions to terminate nutrition and hydration.⁶¹ The court ordered that no party was permitted to take any steps to withdraw nutrition or hydration from Daniel.

In refusing to permit the withdrawal of nutrition and hydration, the court determined that although Daniel was "terminally ill,"⁶² his death was not "imminent"⁶³ since he could survive one to two months. Addi-

⁵⁸ OHIO REV. CODE ANN. §§ 1337.11-17 (Baldwin 1990). The *Couture* decision was rendered on August 21, 1989. The statute was not effective until September 27, 1989.

⁵⁹ *Couture*, 48 Ohio App.3d at 213, 549 N.E.2d at 575-76.

⁶⁰ *Id.* Evidently, the court reasoned that because an attorney in fact was required to act "in the best interest" of the principal when the principal's desires regarding treatment were unknown, and that as a matter of law, nutrition and hydration could not be terminated by an attorney in fact, a guardian acting under the same standard, the "best interest" of the ward, was prohibited from refusing or terminating nutrition and hydration. See OHIO REV. CODE ANN. § 2111.13 (Baldwin 1990).

⁶¹ *Couture*, 48 Ohio App. 3d at 213, 549 N.E.2d at 576.

⁶² See *supra* note 47, for definition of terminal.

⁶³ OHIO REV. CODE ANN. § 1337.13(E) (Baldwin 1990) states that nutrition and hydration may only be discontinued by an attorney in fact when death is *imminent*. The term "imminent" is not defined in the statute. One commentator has noted: "[i]f the medical certainty of death within 30 days is not considered imminent by the courts, then what is, and what use is such a shortened span to the grieving family?" Jenkins, *Durable Power of Attorney for Health Care*, 4 OHIO LAWYER 26, 31 (May-June 1990).

tionally, the court concluded that the non-provision of nutrition and hydration would result in his death by malnutrition and dehydration and, thus, was not permitted under the statute.

Although moot in light of the court's interpretation of the statute, the court discussed the "substituted judgment" standard. Under this standard, a guardian would attempt to reach the decision that the incapacitated person would make were he able to choose.⁶⁴

Ironically, the court stated that Daniel did make legally significant statements since: (1) his remarks were made on several occasions, (2) over a period of four to five years, and (3) were clearly articulated and made with knowledge that his own medical problems posed a risk that he would be placed on life support systems.⁶⁵ Thus, the court concluded that these statements were "legally sufficient" to support the substituted judgment of the guardian to discontinue nutrition and hydration had it been permitted by law.⁶⁶ Noting that an advance directive would have the most probative value in determining a person's wishes regarding medical treatment because it would clearly reflect a prior competent choice, the court stated that it was not necessary that the evidence show exactly what the ward would do in the precise circumstances at hand since application of such a standard would impose an impossible evidentiary burden.⁶⁷

A strong argument can be made that the *Couture* court misinterpreted the legislative intent behind the limitations in the Durable Power of Attorney for Health Care statute. Given that the statute permits the attorney in fact to terminate treatment without any evidence of what the patient would have desired in the given circumstances, the Ohio legislature was understandably reluctant to permit decisions by an attorney in fact in the "hardest" cases (i.e., cases where death is not "imminent" and/or those involving hydration and feeding) absent such evidence. In light of the then current state of the common law in Ohio (i.e., *Leach I* and *Leach II*), the legislature likely preferred a court determination in a guardianship setting based on clear and convincing evidence of the patient's wishes before permitting termination of life support in such extreme cases. However, there is nothing to indicate the legislature meant to reverse the prior common law in this area.⁶⁸ Unfortunately, the absence of comprehensive legislation in this area has led at least one Ohio court to refuse termination of treatment even where clear and convincing evidence demonstrated the patient's desire for the same.

⁶⁴ *Couture*, 48 Ohio App. 3d at 214, 549 N.E.2d at 576.

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ See *infra* note 171, regarding proposed legislation which will articulate the legislative intent underlying this statute.

III. THE CRUZAN DECISION

A. *The Majority Decision*

The long awaited decision of the United States Supreme Court in *Cruzan*⁶⁹ did little to resolve this area of the law and is more significant for the issues it leaves unanswered than for those it answers.

Nancy Beth Cruzan had been in a hospital since the night of January 11, 1983, when she suffered irreversible brain damage as a result of an automobile accident. Nancy's condition was described as a "persistent vegetative state," in which a person exhibits motor reflexes but evinces no indications of significant cognitive function.⁷⁰ She was oblivious to her environment except for reflexive responses to sound and painful stimuli. Although not terminally ill nor clinically dead, loss of oxygen to Nancy's brain for several minutes following the accident caused cerebral cortical atrophy which was determined to be "irreversible, permanent, progressive and ongoing."⁷¹ Although unable to swallow food or water, medical experts testified that with artificial hydration and feeding she could live another thirty years.⁷²

When it became apparent that Nancy had virtually no chance of recovering her cognitive faculties, her parents asked the hospital to terminate the artificial feeding and hydration procedures, which all agreed would certainly cause her death. When this request was refused, Nancy's parents sought a court order directing withdrawal of the artificial feeding and hydration.

The Missouri trial court granted the order, concluding that a person in Nancy's condition has a fundamental right under both the state and federal constitutions to refuse or direct withdrawal of "death prolonging procedures."⁷³ The trial court concluded that Nancy's expressed thoughts at the age of twenty-five in a conversation with her housemate that if she were injured she would not wish to continue her life unless she could live "at least half-way normally," provided sufficient evidence that given her present condition she would not wish to continue with her nutrition and hydration.⁷⁴

Although the court-appointed guardian ad litem agreed with the trial court's decision, the guardian felt compelled to appeal the order to the Missouri Supreme Court. That court, by a divided vote, ruled that the Missouri Living Will statute⁷⁵ embodied a state policy strongly favoring

⁶⁹ 110 S. Ct. 2841 (1990).

⁷⁰ *Id.* at 2845. See generally Cranford, *The Persistent Vegetative State: The Medical Reality*, 18 HASTINGS CTR. REP. 27 (1988).

⁷¹ *Cruzan*, by *Cruzan v. Harmon*, 760 S.W.2d 408, 411 (Mo. en banc 1988).

⁷² *Id.*

⁷³ *Cruzan*, 110 S. Ct. 2846.

⁷⁴ *Id.*

⁷⁵ MO. REV. STAT. § 459.010-.055 (1986).

the preservation of life and that "clear and convincing evidence" as to what Nancy's wishes would be under the circumstances was required before an order terminating artificial feeding and hydration could be granted.⁷⁶ The court acknowledged a right to refuse treatment based upon the common law doctrine of informed consent but declined to read a broad right of privacy into the Missouri Constitution which would support the right of a person to refuse medical treatment in every circumstance.⁷⁷ The court found that the lifetime remarks of Nancy to her roommate were insufficient to satisfy this requirement and, therefore, reversed the order of the trial court. Nancy's parents then appealed to the United States Supreme Court on the grounds that the refusal to withdraw artificial feeding and hydration violated Nancy's rights of privacy and due process under the federal Constitution. The United States Supreme Court affirmed the decision of Missouri Supreme Court.⁷⁸

In the majority opinion written by Justice Rehnquist, the Court reviewed a number of state supreme court decisions regarding right-to-die issues, which were based on various combinations of common law and/or state and federal constitutional principles. The issue for the Supreme Court, according to the majority, was "simply and starkly whether the United States Constitution prohibits Missouri from choosing the rule of decision which it did."⁷⁹ The majority acknowledged that "this is the first case in which we have been squarely presented with the issue of whether the United States Constitution grants what is in common parlance referred to as a 'right to die'."⁸⁰

The Court recognized that the principle that a competent person has a constitutionally protected liberty interest under the Due Process Clause of the Fourteenth Amendment to refuse unwanted medical treatment could be inferred from the Supreme Court's prior decisions.⁸¹ But the majority also indicated that determining that a person has a liberty interest under the Due Process Clause does not end the inquiry, and the

⁷⁶ *Cruzan, by Cruzan v. Harmon*, 760 S.W.2d 408, 419-20 (Mo. en banc 1988).

⁷⁷ *Id.* at 417.

⁷⁸ *Cruzan*, 110 S. Ct. at 2856. Subsequent to the decision of the United States Supreme Court, Nancy's parents repeticioned the probate court for termination of their daughter's life support based on new evidence. On December 14, 1990, Probate Judge Charles Teel ruled that there was clear and convincing evidence of Nancy Cruzan's wishes to terminate treatment and that the feeding tube could be discontinued. At the hearing, two former co-workers and one former employer testified about conversations during which Nancy indicated that she would not wish to be kept alive in a vegetative state. The State of Missouri withdrew from the case in September, 1990, announcing that it no longer had "a recognizable legal interest" in the case. *Chicago Tribune*, Dec. 15, 1990, at 1, col. 2; *Washington Post*, Dec. 15, 1990, at A1, col. 1; *UPI*, Dec. 14, 1990, Domestic News (BC Cycle) (LEXIS, NEXIS library, Omni file). Nancy's life support was terminated on December 14, 1990, and she died on December 26, 1990. Proprietary to the *UPI*, Dec. 27, 1990, Domestic News (BC Cycle) (LEXIS, NEXIS library, Current file).

⁷⁹ *Cruzan*, 110 S. Ct. at 2851.

⁸⁰ *Id.*

⁸¹ *Id.* at 2852.

issue of whether an individual's constitutional rights have been violated must be determined by balancing the individual's liberty interests against the relevant state interests.⁸² The State of Missouri had asserted an "unqualified interest" in the preservation of life.⁸³

For purposes of its decision, the majority "assumed" that the federal Constitution would grant a competent person a constitutionally protected right to refuse life-saving hydration and nutrition. The issue presented in this case was the right of a surrogate to exercise such a right on behalf of an incompetent.

The Court found that Missouri has established its own procedures for determining whether a surrogate may elect to have hydration and nutrition withdrawn on behalf of an incompetent person, in a way to assure that the action of the surrogate conformed to the wishes expressed by the patient while competent. The majority concluded that Missouri may legitimately seek to safeguard the personal element of this choice by requiring "clear and convincing evidence" as to the intent of the patient when competent.⁸⁴ The majority noted that the purpose of a clear and convincing standard of proof is to instruct the fact-finder concerning the degree of confidence the state requires in the correctness of a factual conclusion in light of the gravity of the issue. The Court concluded it was permissible for Missouri to place an increased risk of an erroneous decision on those seeking to terminate an incompetent individual's life-sustaining treatment, in light of the fact that an erroneous decision not to terminate would result in the maintenance of the status quo and the possibility that subsequent developments (such as advancements in medical science, the discovery of new evidence regarding the patient's intent, changes in law, or the unexpected death of the patient) created the potential that a wrong decision not to terminate would eventually be corrected or its impact mitigated. On the other hand, an erroneous decision to withdraw life-sustaining treatment is irreversible.

The Court specifically rejected the argument that the federal Constitution requires a right of substituted judgment in immediate family members or court-appointed surrogates, holding that the Due Process Clause requires the state to repose judgment on these matters with no one but the patient herself.⁸⁵ However, the majority specifically left open the issue of whether a state would be required to follow the decision of a surrogate if there were competent and probative evidence to establish that the patient had expressed a desire that if she became incompetent the decision as to whether to terminate life-sustaining treatment be made for her by that surrogate.⁸⁶

⁸² *Id.* at 2851-52. The majority held that a right to refuse treatment is more properly analyzed in terms of a Fourteenth Amendment liberty interest, rather than a generalized right of privacy.

⁸³ *Id.* at 2853.

⁸⁴ *Id.*

⁸⁵ *Id.* at 2855.

⁸⁶ *Id.* at 2856.

In her concurring opinion, Justice O'Connor agreed with the majority in finding that Missouri did not unconstitutionally interfere with Nancy Cruzan's liberty interest by refusing to order the termination of artificial hydration and feeding. However, Justice O'Connor emphasized that whatever right to refuse treatment does exist, it should extend not only to medical treatment, but should also include the provision of artificial hydration and feeding.⁸⁷ Justice O'Connor also emphasized that a state may be constitutionally required to give effect to the decisions of a surrogate decision-maker appointed by the patient when competent.⁸⁸ Since forced medical treatment "may burden [an] individual's liberty interests as much as any state coercion," states should consider "equally probative source[s] of evidence" of a patient's intent, specifically "the patient's appointment of a proxy to make health care decisions on her behalf."⁸⁹ While the states were charged with developing "appropriate procedures" for protecting incompetents' liberty interests, these statements suggest that states should defer to the decisions of a proxy decision-maker when one has been appointed by a prior competent person.⁹⁰

Justice Scalia in his concurring opinion, rejected the notion that the federal Constitution protected a right to refuse medical treatment. He reasoned that since ordinary suicide is not protected by the Fourteenth Amendment, and ordinary suicide and the right to refuse medical treatment are indistinguishable for constitutional purposes, there was no substantive due process issue presented under the federal Constitution by a state's interference in the decision to refuse treatment.⁹¹

B. The Dissent

Justice Brennan⁹² unequivocally recognized that the Due Process Clause of the Fourteenth Amendment provides a significant liberty interest in avoiding unwanted medical treatment. He agreed with Justice O'Connor that there was no reason for distinguishing between artificial hydration and feeding and other forms of medical treatment with respect to the constitutional right to refuse treatment.

While recognizing that no constitutionally recognized individual right is absolute, Justice Brennan concluded that Nancy Cruzan's right to re-

⁸⁷ *Id.* at 2856-57. "The liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water." *Id.*

⁸⁸ *Id.* Justice O'Connor noted that thirteen states and the District of Columbia had adopted durable power of attorney statutes expressly authorizing the appointment of proxies for making health care decisions, and another thirteen states had living will statutes which authorized the appointment of health care proxies. In her view, the majority's decision that *one* state's practice did not violate the constitutional liberty interest in refusing treatment. *Id.*

⁸⁹ *Id.* at 2856-57 (O'Connor, J., concurring).

⁹⁰ *Id.* at 2859 (O'Connor, J., concurring).

⁹¹ *Id.* at 2859-60 (Scalia, J., concurring).

⁹² Justices Marshall and Blackmun joined Justice Brennan's dissent. *Id.* at 2867.

fuse treatment was fundamental and outweighed any possible state interest in this case.⁹³ He also stated that the state had no interest simply in prolonging an individual's life, as evidenced by the fact that Missouri had adopted a living will statute which allows and encourages pre-planned termination of life. The only legitimate state interest, according to Justice Brennan, is a *parens patriae* interest in providing an incompetent patient with an accurate as possible determination of how she would have exercised her rights under these circumstances had she been competent to do so. Only if there is a determination that the patient would want to continue treatment in such circumstances, does the state have an interest in providing such treatment.

Justice Brennan found that Missouri's intrusion into the decision-making process went beyond its only legitimate interest of ensuring accurate fact-finding. He concluded that the clear and convincing standard as interpreted by the Missouri Supreme Court apparently required the execution of a living will before treatment could be terminated on behalf of an incompetent patient in that state.⁹⁴ Because so few people execute living wills, requiring the execution of a living will as a condition of being able to refuse treatment if one later becomes incompetent, constituted an unwarranted intrusion on the constitutional right to refuse treatment. He acknowledged that states remained free to fashion procedural protections to safeguard the interest of incompetents under these circumstances, noting that nothing in the federal Constitution in his view prevented states from reviewing the advisability of a family decision by requiring a court proceeding or the appointment of an impartial guardian *ad litem*.

In his separate dissent, Justice Stevens criticized the majority for recognizing a state interest in preserving life for a patient in a chronic vegetative state, rather than in determining what is in the best interests of such a patient given the quality of life available to them. The effect of the majority opinion, according to Justice Stevens, is to deprive the incompetent patient of the constitutional right to be free from unwanted medical treatment unless such patient has had the foresight to make an unambiguous statement of their wishes while competent. Justice Stevens felt that it went beyond the state's legitimate interest to, in effect, attempt to define life by insisting Nancy Cruzan's physical existence be perpetuated without regard to the quality of life available to her and the consequences for herself and her loved ones.

C. Conclusions

The narrow holding of a deeply divided court was merely that the State of Missouri could properly require clear and convincing evidence, beyond

⁹³ *Id.* at 2864-65.

⁹⁴ *Id.* at 2875.

prior remarks to acquaintances, that a patient in a persistent vegetative state would have wanted life support efforts to be terminated. Such a narrow holding only affects a small fraction of the life support withdrawal decisions being made every day in this country since, according to the majority, only two states (New York and Missouri) so narrowly interpret that standard of proof in this type of case. As stated previously, the *Cruzan* decision is more significant for the questions it leaves unanswered.

IV. THE EFFECT OF THE CRUZAN DECISION ON EXISTING OHIO LAW

A. Constitutional Issues

A competent person has a constitutionally protected liberty interest to refuse life-saving medical treatment, including hydration and nutrition.⁹⁵ The liberty interest in being free from unwanted medical treatment has been variously described as "significant"⁹⁶ or "substantial."⁹⁷

Although the *Cruzan* court avoided a discussion of "either the measure of the liberty interest or its application"⁹⁸ as to incompetent patients, in his dissent, Justice Brennan openly asserted that this liberty interest is a "fundamental"⁹⁹ right. Nothing in the majority opinion would detract from this conclusion.¹⁰⁰ In fact, the majority never disputed and, apparently assumed for purposes of its decision, the trial court's conclusion

⁹⁵ *Cruzan*, 110 S. Ct. at 2852.

⁹⁶ See *Washington v. Harper*, 110 S. Ct. 1028, 1036 (1990) (a prisoner "possesses a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment").

⁹⁷ *Id.* at 1041. ("The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty."); *Washington*, 110 S. Ct. at 1045 (Stevens, J. concurring and dissenting) ("The liberty of citizens to resist the administration of mind altering drugs arises from our Nation's most basic values."); *Parham v. J. R.*, 442 U.S. 584, 600 (1979) (Both children and adults have "a substantial liberty interest in not being confined unnecessarily for medical treatment."); *Breithaupt v. Abram*, 352 U.S. 432, 439 (1957) (Concluding that an individual has a right "that his person be held inviolable").

⁹⁸ *Cruzan*, 110 S. Ct. at 2865 (Brennan, J., dissenting).

⁹⁹ *Id.* at 2865 (Brennan, J., dissenting) quoting *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934) ("Thus, freedom from unwanted medical attention is unquestionably among those principles 'so rooted in the traditions and conscious of our people as to be ranked as fundamental.'"). The fundamental nature of the liberty interest at stake is recognized by Ohio law which holds that freedom from unconsented treatment is so important that one can sue for battery even if "the procedure is harmless or beneficial." *Estate of Leach v. Shapiro (Leach II)*, 13 Ohio App. 3d 393 at 395, 469 N.E.2d 1047, 1051 (Summit Cty. 1984) citing *Lacey v. Laird*, 166 Ohio St. 12, 139 N.E.2d 25 (1956).

¹⁰⁰ However, the difficulty with this decision is that as Justice Stevens indicated, the Court might be stating that "chronically incompetent persons have no constitutionally cognizable interest." *Cruzan*, 110 S. Ct. at 2891 (Stevens, J., dissenting).

that Nancy Cruzan had a "fundamental right" under both the state and federal constitutions to refuse life-saving treatment.¹⁰¹ Regardless of whether the liberty interest is fundamental, it encompasses the right to refuse nutrition and hydration since this form of medical treatment cannot readily be distinguished from other forms of treatment.¹⁰² However, to protect this interest, due process only requires that a state "repose judgment on these matters" with the patient and does not require it to "confide the decision to close family members."¹⁰³

Any liberty interest recognized under the Constitution is not absolute; the determination of whether the deprivation of this interest is constitutionally permissible requires application of a balancing test to weigh the competing interests at stake.¹⁰⁴ Four potential state interests are generally asserted when an individual chooses to terminate or forego medical treatment.¹⁰⁵ Foregoing a discussion of other three state interests,¹⁰⁶ the Supreme Court recognized that a state could "assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interest of the individual."¹⁰⁷

Acknowledging that there was "no gainsaying" the state of Missouri's interest in the protection and preservation of human life,¹⁰⁸ Justice Brennan articulated the majority's unstated but implicit proposition that until an incompetent's wishes are determined, the only legitimate state interest

¹⁰¹ The *Cruzan* majority also suggested that the liberty interest at stake was fundamental when it stated that "[w]e think it's self-evident that the interests at stake in the instant proceedings are more *substantial*, both on an individual and societal level, than those involved in a run-of-the-mine (sic) civil dispute." *Cruzan*, 110 S. Ct. at 2854. While it is reasonable to conclude that this interest is fundamental, the majority's conspicuous failure to expressly articulate this conclusion suggests that it may not be.

¹⁰² *Cruzan*, 110 S. Ct. at 2852 ("[T]he forced administration of life-sustaining medical treatment, and even of artificially-delivered food and water essential to life would implicate a competent person's liberty interest."); see also *Id.* at 2857 (O'Connor, J., concurring) ("Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water.").

¹⁰³ *Id.* at 2855-56.

¹⁰⁴ *Id.* at 2851-52.

¹⁰⁵ *Leach v. Akron Gen. Medical Center (Leach I)*, 68 Ohio Misc. 1, 9, 426 N.E.2d 809, 814-15 (Summit Cty. 1980) (These include the preservation of life, protection of third parties, the maintenance of the ethical integrity of the medical profession, and the prevention of suicide.).

¹⁰⁶ The Missouri Supreme Court determined that the only state interest implicated in this case was the preservation of life. *Cruzan v. Harmon*, 760 S.W.2d 408, 419 (Mo. en banc 1988).

¹⁰⁷ *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, 2853 (1990); see also *Cruzan v. Harmon*, 760 S.W.2d at 420 ("[T]he state's interest is in life; that interest is unqualified."). However, the Missouri Supreme Court noted that in "striking the balance between a patient's right to refuse treatment . . . and the state's interest in life, we may not discount either side of the equation in order to reach a result." *Id.* at 422.

¹⁰⁸ *Cruzan*, 110 S. Ct. at 2852.

is one that safe-guards the "accuracy of that determination."¹⁰⁹ For both the Missouri Supreme Court as well as the United States Supreme Court, the state's interest in the preservation of life predominated "in the face of the uncertainty of Nancy's wishes."¹¹⁰ The state's legitimate interest is in determining what the patient's choice would be if competent. Had there been sufficient evidence of Nancy's wishes, it is likely that both courts would have permitted the guardians to exercise substituted judgment on Nancy Cruzan's behalf.¹¹¹ What *Cruzan* appears to be saying is that the four state interests are not to be considered as part of the balancing test when evidence of a previously competent person's choice satisfies the state's evidentiary standard.¹¹²

The Supreme Court's failure to set any clear parameters as to the degree or level of the state's interest suggests that any distinctions between different types of medical treatment or a patient's status, whether terminal or otherwise, are in essence factors in the patient's decision whether to terminate treatment, and not part of the state's interest. The bottom line is if the incompetent patient has made a prior competent choice and left evidence of his or her wishes sufficient to satisfy the state's legitimate evidentiary standard, the state has no further legitimate interest to assert.

For example, in determining the extent of the state's interest in preserving the life of a patient in a permanently vegetative state, the *Leach I* court first concluded that clear and convincing evidence (in the form of oral statements to family and friends) regarding Mrs. Leach's wish to terminate treatment existed. The court then examined whether there was any benefit to the state in preserving Mrs. Leach's life. The court held that not only was there no benefit to the state from preserving Mrs. Leach's life but that it was detrimental to the state to do so.¹¹³ Although the *Leach I* court was balancing the state's interests with Mrs. Leach's fundamental right to privacy, which required a compelling state interest to overcome, it is likely that the outcome of the case would be the same if the right to refuse had been predicated on the liberty interest articulated by the *Cruzan* majority. The key to the *Leach I* decision was that the evidentiary standard was satisfied and there were simply no countervailing state interests to override that determination.

¹⁰⁹ *Id.* at 2871 (Brennan, J., dissenting). The only clear evidence of the majority's acceptance of this proposition is the statement that "Missouri may legitimately seek to safeguard the personal element of this choice. . . ." *Id.* at 2853.

¹¹⁰ *Id.* at 426 (emphasis added).

¹¹¹ *Id.*

¹¹² See *infra* notes 117-20 and accompanying text. Justice O'Connor strongly suggests that the federal Constitution may require a state to defer to the choices of surrogate. In the context of a previously competent person, state interests other than those related to making an accurate determination of how the patient would choose are simply irrelevant.

¹¹³ *Leach v. Akron Gen. Medical Center (Leach I)*, 68 Ohio Misc. 1, 9, 426 N.E.2d 809, 814 (Summit Cty. 1980); accord *Cruzan*, 110 S. Ct. at 2869 (Brennan, J., dissenting) ("Missouri does not claim, nor could it, that society as a whole will be benefitted by Nancy's receiving medical treatment.")

Acknowledging that the *Cruzan* decision was not a case requiring a determination of whether a state is "required to defer to the decision of a surrogate if competent and probative evidence establishes that the patient herself had expressed a desire that the decision to terminate life-sustaining treatment be made for her by that individual,"¹¹⁴ Justice O'Connor strongly suggested that a state's decision whether to give effect to the decisions of a surrogate decision-maker may well have constitutional dimensions.¹¹⁵ Mindful that as yet there is no constitutional requirement for a state to defer to the decisions of a surrogate decision-maker, Justice O'Connor stated: "[a] duty may well be constitutionally required to protect the patient's liberty interest in refusing medical treatment."¹¹⁶

If a state's legitimate interest is limited to an accurate determination of how the incompetent would choose, then statutory restrictions on the right to choose treatment must be reasonably related to determining the patient's desires.¹¹⁷ If a person, while competent, appoints a surrogate decision-maker and clearly indicates that decisions regarding life-sustaining treatment should be made for him or her by that proxy, the limitations in the Ohio Durable Power of Attorney for Health Care statute impinge upon that individual's right to refuse treatment. Under the statute, an attorney in fact cannot refuse medical treatment necessary to sustain the principal's life unless death is "imminent."¹¹⁸ In addition, an attorney in fact cannot refuse or withdraw informed consent to the provision of nutrition or hydration unless death is imminent *and* the non-provision of either would not likely result in the principal's death by malnutrition or dehydration.¹¹⁹ The statutory limitations would seem to preclude the refusal or withdrawal of nutrition and hydration in all but the most extreme circumstances. One problem posed by these restrictions is the inherent difficulty in making this kind of medical determination. Moreover, sophisticated medical technology may prevent a person from reaching a state of existence consistent with the statute's requirements for termination or refusal of medical treatment necessary to sustain the principal's life.

¹¹⁴ *Cruzan*, 110 S. Ct. at 2856.

¹¹⁵ *Id.* at 2857 (O'Connor, J., concurring).

¹¹⁶ *Id.* at 2857 (O'Connor, J., concurring).

¹¹⁷ The difficulty with this conclusion is that an entire group of people, those who are never competent, apparently have no *constitutional* right to be free of unwanted treatment since they can never clearly articulate their choices.

¹¹⁸ "Imminent" has been judicially defined as death within less than one month. See *Couture v. Couture*, 48 Ohio App.3d 208 at 213, 549 N.E.2d 571, 575-76 (Montgomery Cty. 1989). The term "imminent" may be interpreted differently by various Ohio courts.

¹¹⁹ OHIO REV. CODE ANN. § 1337.14(E)(2)(a) (Baldwin 1989). A determination that the administration of nutrition and hydration would not provide comfort to the principal is also required prior to refusing or withdrawing nutrition and hydration. *Id.*

Although the statutory limitations would appear to be a reflection of the state's interest in the preservation of life,¹²⁰ Ohio's prohibition on terminating medical treatment unless death is imminent, and nearly absolute prohibition against terminating nutrition and hydration, even when that is the choice made by a previously competent person and exercised by the attorney in fact, does not appear to comport with due process requirements. As previously stated, when a person exercises a right to refuse treatment through an attorney in fact, any asserted state interest is limited to whether there is clear and convincing evidence of the principal's choice of a decision-maker.

This determination need not be judicial.¹²¹ The proper inquiry in a case where the attorney in fact is exercising the patient's choice regarding a decision to terminate life-sustaining treatment as determined by Ohio courts, is whether clear and convincing evidence of that person's intent exists.¹²² Once this standard is satisfied, then the person's constitutional right to choose, as exercised through the attorney in fact, must be given effect.¹²³ Given that an attorney in fact is merely exercising a previously

¹²⁰ It has also been suggested that "at some point new constitutional interests may be asserted - those of the physician and the health care facility. Can the state compel a health care provider to administer treatment that the provider considers inappropriate, against the will of the patient? *** If the state determines that it has an overriding interest in preserving the lives of persons in a persistent vegetative state, against their will, the burden may be on the state to find the practitioners to provide this life-sustaining treatment." Witherell, *In Open Court, Withholding Treatment: Couture v. Couture*, 1 HEALTH LAW J. OF OHIO, 74-76 (Nov.-Dec. 1989) (emphasis added).

¹²¹ *Parham v. J.R.*, 442 U.S. 584, 607 (1979) ("Due Process has never been thought to require that the neutral and detached trier of fact be law trained or a judicial or administrative officer."); accord *Washington*, 110 S. Ct. 1028, 1042 (1990).

¹²² *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, 2856 n. 12, 2857 (1990) (O'Connor, J., concurring). Clear and convincing evidence is "more than a mere preponderance, but not to the extent of such certainty as is required beyond a reasonable doubt as in criminal cases. It does not mean clear and unequivocal." *Cross v. Ledford*, 161 Ohio St. 469, 477, 120 N.E.2d 118, 123 (1954).

¹²³ It has been suggested that the policy underlying the limitations to the attorney in fact's powers is to preserve a court's ability to protect an incompetent person's rights and balance them against the state's interest. See Note, *Nutrition and Hydration under Ohio's DPAH: Judicial Misconstruction Threatens the Right to Choose Death with Dignity*, 30 CLEV. STATE L. REV. 279 (1990). Historically, courts have not been involved in a competent person's determination of whether to forego life sustaining treatment absent circumstances where important interests of third parties were involved. Thus, prior to *Leach II*, court intervention had not been required for the termination of life sustaining treatment. Similarly, an attorney should not be subject to judicial scrutiny absent unusual circumstances. See *infra* notes 212-14 and accompanying text. However, prior to *Leach II*, court intervention had not been required for the termination of life sustaining treatment.

If the suggestion is that whenever an attorney in fact chooses to terminate or withhold nutrition and hydration court review is required, this will be an additional burden upon the court system and judges who may not be best situated to make these decisions. This conclusion is in accord with the *Guidelines'* position that few of these decisions should come before the court. *Guidelines, supra* note 31. The court system should take administrative steps to "forestall the routine use of the judicial system to review [life-sustaining medical treatment] decisions." *Id.* at 6.

competent person's right to choose, the statutory limitations regarding nutrition and hydration are unconstitutional since they deprive a person, without process, of his constitutionally protected liberty interest.¹²⁴

Similarly, the sweeping pronouncement in *Couture* that Ohio's Durable Power of Attorney for Health Care statute, even in the absence of an executed durable power, prevents the withdrawal of nutrition and hydration from a ward by a guardian would probably not survive constitutional challenge under the principles enunciated in *Cruzan*.¹²⁵ It is well settled that a state cannot arbitrarily restrict the exercise of constitutional rights.¹²⁶ Although the guardian is acting under the state's *parens patriae* power and must act in the ward's best interests, when the ward has evidenced an intent that life-sustaining measures not be used or continued, this factor should be given great weight in determining what course of conduct is in the ward's best interests. If evidence of the ward's intent satisfies the clear and convincing standard, the federal Constitution appears to require that the ward's choice be given effect.

B. Standards of Review for Decisions to Terminate Treatment in Absence of Durable Power

Evidence of a patient's intent to forego or terminate medical treatment must be established by clear and convincing evidence in Ohio.¹²⁷ This was the same standard adopted by the Missouri Supreme Court in *Cruzan*. Thus, the United States Supreme Court's analysis of Ohio law if confronted with facts similar to those in *Cruzan* would be the same.

In the absence of a durable power or living will, satisfaction of this standard generally requires testimony regarding a person's expressed

¹²⁴ This is distinguishable from a guardian/ward relationship which is a state-created relationship in which the state asserts its *parens patriae* power (the state's power to protect the health, comfort and welfare of citizens under a disability). In Ohio, a guardian has statutory authority to "authorize or approve the provision to [the] ward of medical, health, or other professional care, counsel, treatment, or services. . . ." OHIO REV. CODE ANN. § 2111.13(C) (Baldwin 1990). However, the guardian's authority may be limited by the probate court. *Id.* Thus, in a guardianship situation, it may be necessary to require judicial review to determine whether clear and convincing evidence of the ward's intent regarding treatment exists. See *infra* section IV (D) (7) of this article.

¹²⁵ *Couture's* interpretation of the statute would be nullified if proposed legislation were to pass. See *infra* note 171.

¹²⁶ *Wolff v. McDonnell*, 418 U.S. 539, 558 (1974) (Due process protects the individual against arbitrary governmental action); *Meyer v. Nebraska*, 262 U.S. 390, 400 (1923) ("liberty may not be interfered with, under the guise of protecting the public interest, by legislative action which is arbitrary or without reasonable relation" to a legitimate public purpose); *Corbett v. D'Alessandro*, 487 So. 2d 368 (Fla. App. 1986), *review denied*, 492 So. 2d 1331 (Fla. 1986).

¹²⁷ *Leach v. Akron Gen. Medical Center (Leach I)*, 68 Ohio Misc. 1, 11, 426 N.E.2d 809, 815 (Summit Cty. 1980); *Couture*, 48 Ohio App.3d at 214, 549 N.E.2d at 576.

preferences to forego or terminate life-sustaining treatment.¹²⁸ The Missouri Supreme Court stated that “[a] decision to refuse treatment, when that decision will bring about death, should be as informed as a decision to accept treatment.”¹²⁹ Informed consent or refusal requires that a patient possess the capacity to consent, that consent be voluntary and that the patient have a clear understanding of the risks and benefits of treatment or non-treatment, and the nature of the disease and the prognosis.¹³⁰ Thus, in Missouri the standard of evidence to establish a patient’s intent to refuse or forego treatment is exacting and appears to be the same as that required for informed consent.¹³¹ In light of this, according to the Missouri Supreme Court, Nancy Cruzan’s “informally expressed reactions to other people’s medical condition and treatment” did not constitute clear proof of her intent regarding nutrition and hydration.¹³² By comparison, an Ohio court has stated that under the appropriate circumstances a patient’s “general statements” may be considered by a court in determining the intent of a person in a chronic vegetative condition.¹³³

For example, in determining whether to discontinue a ventilator, the court in *Leach I* held that the clear and convincing standard was satisfied in that case.¹³⁴ A total of 17 witnesses testified regarding Mrs. Leach’s preference not to be placed on life support systems in light of her prognosis.¹³⁵ Close relatives, including her husband, sister and a cousin, recalled numerous conversations in which she expressed her desire not to be placed on life support systems. Several of these conversations occurred after Mrs. Leach was informed that she was afflicted with a progressively deteriorating, disabling disease of the nervous system. In fact, the last of these conversations occurred only two days prior to her entering the hospital and a full six weeks after she was initially informed of her fatal diagnosis. One witness was able to recall the exact words of a conversation in which Mrs. Leach had stated that being placed on life support systems terrified her and that “‘I don’t want to live if I have to be a vegetable.’”¹³⁶

¹²⁸ See generally *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, 2854-55 (1990); *Leach I*, 68 Ohio Misc. at 3, 4, 426 N.E.2d at 815. A durable power of attorney for health care is clear expression of person’s treatment preferences. See *Cruzan*, 110 S. Ct. at 2857 (O’Connor, J., concurring) (Probative evidence of a patient’s choices includes the appointment of a proxy health care decision maker.)

¹²⁹ *Cruzan*, by *Cruzan v. Harmon*, 760 S.W.2d 408, 424 (Mo. en. banc. 1988).

¹³⁰ *Id.* at 417.

¹³¹ The same standard apparently applies in Ohio as well. See *Estate of Leach v. Shapiro (Leach II)*, 13 Ohio App.3d 393, 397, 469 N.E.2d 1047, 1053 (Summit Cty. 1984). “Before this refusal [of medical treatment] can controvert the implied consent of a medical emergency, however, it must satisfy the same standards of knowledge and understanding required for informed consent.” *Id.* In a non-emergent situation, the same standard would apply.

¹³² *Cruzan*, 110 St. Ct. at 2855.

¹³³ *Leach II*, 13 Ohio App.3d at 397, 469 N.E.2d at 1053.

¹³⁴ 68 Ohio Misc. 1, 426 N.E.2d 809 (Summit Cty. C.P. 1980).

¹³⁵ Mrs. Leach was expected to die within three to five years.

¹³⁶ *Leach v. Akron Gen. Medical Center (Leach I)*, Ohio Misc. 1, 4, 426 N.E.2d 809, 811 (Summit Cty. 1980).

Similarly, the court in *Couture*¹³⁷ determined that the decedent, Daniel Couture, had made "legally significant" statements regarding his intent to forego life support. Evidence regarding Daniel's intent was found to be clear and convincing because there were numerous conversations over a significant period of time, which were made with knowledge of the risk of his then existing health problems. Although the only testimony came from his mother and brother, the court determined that as witnesses they were inherently reliable since "their desire to act scrupulously in a matter of this kind is natural and obvious."¹³⁸ The brevity of Daniel's statements did not detract from their legal significance particularly in light of the fact that no contrary evidence was presented. The court held that it was not necessary that the evidence show precisely what Daniel would do in the present circumstances since:

[a]pplication of such a standard would impose impossible burdens as it could almost never be shown that the precise circumstances were anticipated.¹³⁹

Other Ohio courts faced with similar issues may attempt to limit the application of these cases since the patients in both *Leach I* and *Couture* were aware of their fatal prognosis prior to the time they made statements regarding their desire to forego life support systems.¹⁴⁰ In a situation where a person does not have a fatal illness, evidence of a more exacting nature may be required. Particularly in light of *Cruzan*, it would seem that more than general statements regarding life support could be constitutionally required by a state to satisfy the evidentiary standard. While *Couture* suggests that the evidence not need precisely show what a person would do under a set of circumstances since the precise circumstances can never be anticipated, it may be necessary that a person's expressions clearly evidence an intent to forego or terminate life-sustaining treat-

¹³⁷ 48 Ohio App.3d 208, 549 N.E.2d 571 (Montgomery Cty. 1989).

¹³⁸ *Id.* at 214, 549 N.E.2d at 576. In fact, one noted ethicist observed that state legislatures "would do well to recognize that most families can and do speak for their loved ones" and suggests that the evidentiary burden be placed "on the state to prove by clear and convincing evidence that the family's wishes are inconsistent with the wishes of the patient before removing decision making authority from the family." Annas, *Nancy Cruzan and the Right to Die*, 323 NEW ENG. J. MED. 670, 672 (Sept. 6, 1990).

¹³⁹ *Couture v. Couture*, 48 Ohio App.3d 208, 549 N.E.2d 571, 576 (Montgomery Cty. 1989).

¹⁴⁰ It could be argued that in these two cases, the patients' decisions to forego met all the elements for informed consent or in their cases, informed refusal. With equal persuasiveness, these cases may be cited for the proposition that in Ohio, casual oral remarks constitute clear and convincing evidence of a person's intent regarding life-sustaining treatment. Alternatively, they may represent the position that oral statements only constitute clear and convincing evidence when made *after* a person becomes aware of a fatal prognosis, thus excluding a large percentage of those who are suddenly injured or taken ill. Either interpretation would be constitutional under *Cruzan*. However, the interpretation chosen would have a significant impact on the outcome of these types of cases.

ment. Although Ohio courts appear to be willing to accept that a person's prior statements may constitute clear and convincing evidence, there remains a great deal of uncertainty regarding what type and amount of evidence satisfies this burden¹⁴¹ and whether an evidentiary hearing by a court is necessary to determine if the clear and convincing standard has been met.¹⁴² This uncertainty could lead to the adoption of different evidentiary and judicial review requirements by different lower courts in Ohio. This reinforces the need for a legislative solution so that all Ohio citizens, similarly situated, will be able to exercise their constitutional right to refuse treatment equally, without regard to the county in which they reside.

C. What Can Ohio Residents Do to Ensure that Under No Circumstances Will They be Maintained in a Persistent Vegetative State?

Although there does not appear to be anything an Ohio resident can do under current law to guarantee that their life will not be artificially prolonged, there are steps one can take in Ohio which may increase the chances of achieving that result.

First, a durable power of attorney for health care directive should be executed. However, the present statute effectively denies the attorney in fact the power to terminate care in cases where death is not imminent or to terminate nutrition and hydration, even if that is the choice of the principal.

Even though no living will statute has been enacted as yet in Ohio, a living will should also be executed, either as a separate document or as part of a durable power.¹⁴³ The living will should set forth the type of

¹⁴¹ In light of *Cruzan*, one commentator has stated that "many observers are hard-pressed to imagine the kind of oral testimony that would satisfy a court in a state with a clear-and-convincing-evidence standard" in the absence of a specific writing. Apfel, *Cruzan Leads Courts, Legislators To Rethink Right-to-Die Issues*, 13 NAT'L LAW J. 22 (Nov. 19, 1990).

¹⁴² As previously noted, *Leach II* held that judicial authority is required before life-prolonging treatment may be terminated from an incompetent. 13 Ohio App.3d at 396, 469 N.E.2d at 1052-53. This is contrary to the position taken in the *Guidelines* which states that "judicial involvement should occur only when there are irresolvable disagreements . . . or there are serious grounds for believing there is a need for protective services." *Guidelines*, *supra* note 31, at 8. See also *Deciding to Forego*, *supra* note 49, at 160 ("Routine judicial oversight is neither necessary nor appropriate."). However, Justice Brennan agreed that "states are free to fashion procedural protections" including judicial review to ensure that decisions are made "commensurate with the will of the patient." *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, 2876 (1990) (Brennan, J., dissenting).

¹⁴³ Justice Brennan noted that most American's do not execute advance directives. *Cruzan*, 110 S. Ct. at 2875 n. 21 (a recently conducted study found that only 9% of people had executed an advance directive). However, the publicity surrounding the *Cruzan* decision has resulted in a 500% increase in living will requests to the Society For the Right to Die. As of October 1990, more than 400,000 requests for living wills and durable powers of attorney had been filled. *Concern For Dying/Society for the Right to Die*, Newsletter, Fall 1990, at 1.

treatment that the person would or would not want and the circumstances under which the withdrawal or withholding of treatment should occur, including the termination of treatment where death is not yet and the withdrawal of hydration and feeding. Again, although a living will is not yet statutorily authorized in Ohio, it will assist the family and health care providers in ascertaining a person's intent regarding life-sustaining treatment and will provide an additional piece of evidence in meeting the clear and convincing standard.¹⁴⁴

Finally, clear and detailed statements of a person's choices regarding life-sustaining treatment should be made to family and/or significant others. For those who feel strongly about this subject, it would be helpful to have documentary evidence of such statements in the form of a videotape, audiotape or other method of recording.

As noted, most people will not take the time to implement any of these recommendations. Even for those willing to take the time, at present, there is nothing a person can do to guarantee that life will not be maintained in a technological limbo if incompetency occurs. A system to make treatment decisions for those who leave insufficient evidence of their intent is clearly needed.

V. THE NEED FOR COMPREHENSIVE LEGISLATION IN OHIO ON THE RIGHT TO DIE

A. *Deficiencies and Limitations in the Current Durable Power of Attorney for Health Care Statute Itself*

1. Problems with the Statute

Although the statute represents a step forward for Ohio, its problems are numerous.¹⁴⁵ The real problem with the statute stems from the fact that it does not go far enough to preserve for all Ohioans the constitutional right to forego or terminate all forms of life support through the making of an advance directive. The power must be re-executed every seven years to remain effective. The termination of medical care is limited to situations where death is imminent, and the termination of nutrition and hydration is limited to the occasion where death is imminent or the nutrition and hydration could not be assimilated or would shorten the

¹⁴⁴ One commentator suggests that "anyone interested in expressing oneself on this [withdrawal or refusal of treatment] subject should do so in the most detailed manner possible. The assumption is that if a certain kind of treatment is *not* addressed in the *writing*, such treatment could well be imposed by a court in the event of litigation similar to *Cruzan*." Apfel, *supra* note 141.

¹⁴⁵ For a brief discussion of the statute's limitations see Feibel, *supra* note 46; Brown, *Durable Power of Attorney for Health Care*, 61 CLEVE. BAR 50 (December 1989); Jenkins, *supra* note 63.

principal's life.¹⁴⁶ Thus, the statute fails to completely allay the classic fear of being maintained in a permanent vegetative state,¹⁴⁷ because the statute does not give to the attorney in fact all of the health care discretion that the principal would otherwise have under Ohio law.¹⁴⁸

Further, the law provides absolute immunity to health care providers who provide treatment "necessary to keep the principal alive" when the patient is incompetent, even if such treatment is contrary to the principal's previously expressed intent and the express direction of the attorney in fact. This far-reaching immunity may provide an impetus to provide care under any circumstances and effectively thwart the principal's desires to terminate or forego treatment as expressed through the attorney in fact.¹⁴⁹ This contravenes the purpose of the statute which is to effectuate a principal's choices through the appointment of a statutory decision-maker.¹⁵⁰ Thus, a more comprehensive statutory scheme is required to assure that a person's express wishes regarding treatment are carried out.

Proposed Senate Bill 1 would implement several needed modifications to this statute.¹⁵¹ It adds a definition of "comfort care" and greatly expands

¹⁴⁶ OHIO REV. CODE ANN. § 1337.13(E) (Baldwin 1990). There is no authority to refuse or withdraw care necessary to provide comfort to the principal. *Id.* at § 1337.13(C).

¹⁴⁷ Jenkins, *supra* note 63, at 29. Indeed, many people feel that life as a permanently unconscious patient is more horrible than death. *Deciding to Forego*, *supra* note 49, at 193.

¹⁴⁸ Although no Ohio case expressly recognized the right of a competent person to refuse nutrition and hydration, as *Cruzan* suggests this would seem to be encompassed in the right to self-determination. See 110 S. Ct. at 2856 (O'Connor, J., concurring) ("[T]he refusal of artificially delivered food and water is encompassed" with a person's liberty interest and these interests "are inextricably entwined with our idea of physical freedom and self-determination"); *Id.* at 2866-68 (Brennan, J., dissenting) ("No material distinction can be drawn between . . . artificial nutrition and hydration - and any other medical treatment. *** The right to be free from unwanted medical attention is a right to evaluate the potential benefit of treatment and its possible consequences according to one's own values and to make a personal decision whether to subject oneself to the intrusion.") Further, application of unconsented to medical treatment constitutes a battery. See also *Guth v. Huron Road Hosp.*, 43 Ohio App.3d 83, 539 N.E.2d 670 (Cuyahoga Cty. 1987) (continued administration of drug therapy after consent withdrawn constitutes a battery).

¹⁴⁹ Feibel, *supra* note 46, at 7, col. 2.

¹⁵⁰ In general, health care providers cannot overrule a competent person's choice regarding treatment without risking liability for battery. See *Lacey v. Laird*, 166 Ohio St. 12, 139 N.E.2d 25 (1956) (In the absence of proper consent, even a beneficial or harmless treatment is an assault and battery). An additional problem with the statute is that a durable power of attorney for health care is only valid for seven years from its execution. It is likely that persons who execute a durable power will inadvertently fail to re-execute it. The effect, if any, of an expired durable power of attorney for health care is uncertain.

¹⁵¹ S.B. No. 1, 119th Gen. Assembly, Reg. Sess. § 1337.11-.17 (1991) (Montgomery, et al.) (introduced 1/22/91 and referred to Reference and Oversight Committee on 1/3/91; passed by the Senate as amended 2/5/91). See also House Bill 70 which proposes essentially the same changes to the Durable Power of Attorney for Health Care statute. H.B. No. 70, 119th Gen. Ass., Reg. Sess. (1991) (Guthrie, et al.) (introduced 1/24/91 and referred to Civil and Commercial Law Committee on 1/30/91). For a discussion of the living will provisions proposed by these bills, see *infra* notes 166-91 and accompanying text.

the definition of "terminal condition."¹⁵² While an agent does not have the authority to withdraw consent to "comfort care," an agent may withdraw health care necessary to keep the principal alive when a principal is in a "terminal condition" and the decision is either (1) "consistent with the desires" of the principal or (2) is in the "best interest" of the principal.¹⁵³

In addition to expanding the authority of the agent, this bill would remove the limitations on who could be designated as an agent.¹⁵⁴ In addition, the witness requirements would be greatly reduced.¹⁵⁵ Importantly, this bill would remove the present seven year re-execution requirement and, thus, a validly executed durable power for health care would not expire unless the document expressly provided for this.¹⁵⁶ Adoption of the modifications set forth in Senate Bill 1 would be a vital step in ensuring the rights of all Ohioans to decline all forms of medical treatment at any time their condition is terminal where they lack the capacity to make such a decision.

¹⁵² S.B. No. 1, *supra* note 151, at § 1337.11(C) defines "comfort care" as "any medical or nursing procedure, treatment, intervention, or other measure that is taken principally to diminish the pain or discomfort of a patient not to postpone his death." "Terminal condition" is "a condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined by a patient's attending physician, both of the following apply:

(1) There can be no recovery.

(2) There is a permanently unconscious state, or death is likely to occur within a relatively short time if life-sustaining treatment is not administered."

Id. at § 1337.11(P). A "permanently unconscious state" means that "the patient is irreversibly unaware of himself or his environment" and that there is "a total loss of cerebral cortical functioning, resulting in the patient having no capacity to experience pain or suffering." *Id.* at § 1337.11(N).

¹⁵³ *Id.* at §§ 1337.13(C), 1337.17. Health care includes "any care, treatment, service or procedure to maintain, diagnose or treat individual's physical or mental condition." *Id.* at § 1337.11(B).

In the version passed by the Senate on February 5, 1991, a principal must give express authorization to an agent to refuse or withdraw informed consent to the provision of nutrition and hydration by: (1) including a statement in capital letters to this effect and (2) initialling or signing underneath or adjacent to this statement. *See* Am. Sub. S.B. No. 1 § 1337.13(C), (E). While the "as introduced" version of this bill deleted all references to nutrition and hydration, they were reinserted by the Senate Reference and Oversight Committee.

¹⁵⁴ An attending physician or an employee or agent of any health care facility in which the principal is being treated may be designated as an agent if related to the principal by blood, marriage, or adoption. S.B. No. 1, *supra* note 151, at § 1337.12(A)(2).

¹⁵⁵ *Id.* at § 1337.12(B). In the version passed by the Senate, persons ineligible to be witnesses are limited to those who are "related to the principal by blood, marriage, or adoption," and the agent and attending physician of the principal. Am. Sub. S.B. No. 1 § 1337.12(B). It removes the prior limitation which prevented a person from being a witness if "entitled to benefit in any way" from the principal's death.

¹⁵⁶ OHIO REV. CODE ANN. § 1337.12(A)(3) (Baldwin 1990).

2. Problems With the Statute As Interpreted By *Couture*

The *Couture* decision extends the problems and limitations of the Durable Power of Attorney for Health Care statute into the guardianship area.¹⁵⁷ A guardian's ability to exercise a ward's right to refuse medical treatment had been previously recognized in Ohio.¹⁵⁸ While the *Leach I* case based this right on the patient's right of privacy, *Leach II* based this on the common law doctrine of informed consent and its necessary corollary, that of the right to refuse treatment.¹⁵⁹

As one commentator has observed, "[t]he fundamental error in *Couture* is that it ignores a fairly clear indication that the General Assembly did not intend to make the powers of other surrogates as limited as those of an attorney in fact"¹⁶⁰ under the Durable Power of Attorney for Health Care statute. This is supported by express language in the statute:

This section does not affect, and shall not be construed as affecting, any right that the person designated as attorney in fact in a Durable Power of Attorney for Health Care may have, apart from the instrument, to make or participate in the making of health care decisions on behalf of the principal.¹⁶¹

Thus, there was no intent that the limitations contained in the Durable Power of Attorney statute be applied where no power has been executed.¹⁶²

The *Couture* court erred when it determined that the limitations in the statute defined the entire spectrum of patient rights that could be exercised by a guardian.¹⁶³ Additionally, the *Couture* court's holding that death was not "imminent" for purposes of the statute when Daniel Couture's death was expected within one to two months severely restricts the application of the statute.¹⁶⁴ Finally, there was no legislative intent to prevent the withdrawal of nutrition and hydration from patients in a persistent vegetative state.¹⁶⁵ Thus, in light of *Couture*, the state can

¹⁵⁷ *Couture v. Couture*, 48 Ohio App. 3d 208, 549 N.E.2d 571 (Montgomery Cty. 1989).

¹⁵⁸ See *Leach v. Akron Gen. Medical Center (Leach I)*, 68 Ohio Misc. 1, 426 N.E.2d 809 (Summit Cty. 1980); see also *Estate of Leach v. Shaprio (Leach II)*, 13 Ohio App.3d 393, 469 N.E.2d 1047 (Summit Cty. 1984).

¹⁵⁹ *Leach II*, 13 Ohio App. 3d at 393, 469 N.E.2d at 1047; see also *Guth v. Huron Rd. Hosp.*, 43 Ohio App. 3d 83, 539 N.E.2d 670 (1987).

¹⁶⁰ Witherell, *supra* note 120, at 75.

¹⁶¹ OHIO REV. CODE ANN. § 1337.13(A)(2) (Baldwin 1990).

¹⁶² In fact, proposed substitute House Bill 56 expressly states that *Couture* clearly misinterpreted the statute. See *infra* note 171.

¹⁶³ See *Corbett v. D'Alessandro*, 487 So.2d 368 (Florida App. 1986). (Living will statute did not encompass every circumstance under which treatment living will could be discontinued. Further, constitutional and common law rights could not be limited by statute.)

¹⁶⁴ *Couture v. Couture*, 48 Ohio App.3d 208, 213, 549 N.E.2d 571, 575 (Montgomery Cty. 1989) ("Though Daniel Couture is terminally ill, death is not 'imminent.'"). The failure of the statute's drafters to define this term has resulted in the attorney in fact being foreclosed from terminating nutrition and hydration in most cases.

¹⁶⁵ OHIO REV. CODE ANN. § 1337.13(E) (Baldwin 1990).

successfully override clear and convincing evidence of a patient's contrary wishes even though the patient has not executed a Durable Power of Attorney Health Care and his right to refuse treatment could have been properly exercised by a guardian under prior common law.

B. Proposed Legislation in Ohio

Two bills were been introduced into the Ohio Senate¹⁶⁶ and one into the Ohio House of Representatives¹⁶⁷ which would authorize living wills in Ohio. The simplest, Senate Bill 17, would allow a person to execute a written document to decline "medical measures" when a person lacks capacity to make decisions regarding medical treatment and is either (a) terminal, (b) permanently unconscious or (c) conscious but irreversibly brain damaged.¹⁶⁸ It also provides immunity for compliance or noncompliance with the terms of a living will, as well as criminal penalties for "interference" with another's living will.¹⁶⁹

Of more importance is the comprehensive living will legislation proposed by Senate Bill 1 and House Bill 70.¹⁷⁰ Not only does the proposed legislation authorize living wills, but as previously noted, it amends the Durable Power of Attorney for Health Care statute and clarifies the intent of the legislature in enacting the original Durable Power of Attorney for

¹⁶⁶ S.B. No. 1, *supra* note 151; S.B. No. 17, 119th Gen. Assembly, Reg. Sess. (1991) (Zimmers, et al.) (introduced 1/22/91 and referred to Reference and Oversight Committee on 1/30/91).

¹⁶⁷ H.B. No. 70, *supra* note 151.

¹⁶⁸ "Medical measures" are defined as "any medicines, procedures, or devices that a physician prescribes, administers, performs, or authorizes." S.B. No. 17, *supra* note 166, at § 2108.31(K). "Terminal" is not defined. This bill parallels that introduced last session by Senator Zimmers. See S.B. No. 380, 118th Gen. Assembly, Reg. Sess. (1990) (introduced 7/10/90 and referred to Judiciary Committee). Since the Assembly adjourned *sine die* in December 1990, bills introduced last session must be reintroduced to receive further consideration.

Three other living will bills were also introduced last session. However, none made it out of Committee. See S.B. No. 379, 118th Gen. Assembly, Reg. Sess. (1990) (Nettle) (introduced 7/10/90 and referred to Judicial Committee); S.B. No. 383, 118th Gen. Assembly, Reg. Sess. (1990) (Hobson-Zimmers) (introduced 8/2/90 and referred to Judiciary Committee); H.B. 56, 118th Gen. Assembly, Reg. Sess. (1990) (Guthrie-Sawyer) (introduced 1/30/90 and referred to Civil and Commercial Law Committee).

¹⁶⁹ S.B. No. 17, *supra* note 166, at §§ 2108.33(E), 2108.34(A)-(C).

¹⁷⁰ See S.B. No. 1 and H.B. No. 70, *supra* note 151. In their original versions, these bills were very similar. Significant differences in House Bill 70 will be highlighted where appropriate.

Health statute.¹⁷¹ The living will portion of the legislation would allow a person to execute a written document indicating the declarant's intent regarding the use of "life-sustaining treatment."¹⁷²

A declaration would be effective when an attending physician in "good faith" and to a "reasonable degree of medical certainty" determines that the declarant is (1) terminal and (2) lacks the capacity to make informed decisions regarding the administration of life-sustaining treatment.¹⁷³ Both bills also provide sample documents, however, Senate Bill 1 requires every document to use the terms "terminal condition" and "permanently unconscious state" and to define the terms in a manner "substantially consistent" with the definitions set forth in the legislation itself.¹⁷⁴

¹⁷¹ See *supra* notes 151-56 and accompanying text for a discussion of the proposed changes to the Durable Power of Attorney for Health Care statute.

In setting forth the legislative intent underlying the original Durable Power of Attorney for Health Care statute, Senate Bill 1 expressly provides that:

[The] General Assembly did not include any intent to effect the ability of competent adults or the guardians of incompetents or minors to make informed health care decisions for themselves or their wards, including, but not limited to, the refusal or withdrawal of informed consent to the provision of nutrition or hydration to competent adults and wards. S.B. No. 1, *supra* note 151, at § 5(B).

This would legislatively overrule the *Couture* decision.

¹⁷² "Life-sustaining treatment" is defined as "any medical procedure, treatment, intervention, or other measure that, when administered to a qualified patient or other patient, will serve principally to prolong the process of dying." S.B. No. 1, *supra* note 151, at § 2133.01(O); see also H.B. No. 70, *supra* note 151, at § 2133.01(M). This definition is broad enough to encompass the withholding or withdrawal of nutrition and/or hydration. Neither bill would permit the withdrawal of "comfort care," defined as "any medical or nursing procedure, treatment, intervention, or other measure that is taken principally to diminish the pain or discomfort of a patient, not to postpone his death." S.B. No. 1, *supra* note 151, at § 2133.01(C); see also H.B. No. 70, *supra* note 151, at § 2133.01(C).

Before passage, the Senate Reference and Oversight Committee added a provision that requires a declarant to (1) expressly include a statement that nutrition and hydration may be withheld and (2) to initial or sign underneath or adjacent to this statement, in order to refuse nutrition and hydration. Sub. S.B. No. 1, *supra* note 151, at § 2133.02(A)(1)(2).

¹⁷³ S.B. No. 1, *supra* note 151, at § 2133.01(A); see also H.B. No. 70, *supra* note 151, at § 2133.03(A). A "terminal condition" is defined as a "disease, illness, or injury from which . . . (1) there can be no recovery, [and] (2) there is a permanently unconscious state, or death is likely to occur within a relatively short time if life-sustaining treatment is not administered." S.B. No. 1, *supra* note 151, at § 2133.01(X); see also H.B. 70, *supra* note 151, at § 2133.01(V). In S.B. No. 1 as passed by the Senate, terminal status must be determined by two physicians. See Am. Sub. S.B. No. 1 § 2133.01(Y). A "permanently unconscious state" includes a persistent vegetative state. S.B. No. 1, *supra* note 151, at § 2133.01(R)(2); see also H.B. No. 70, *supra* note 151, at § 2133.01(P)(1), (2) (permanently unconscious state means that the declarant is "irreversibly unaware of himself or his environment" and that there is "a total loss of cerebral cortical functioning" which results in the declarant or patient having "no capacity to experience pain or suffering.").

¹⁷⁴ S.B. No. 1, *supra* note 151, at § 2133.02(A). H.B. No. 70, *supra* note 151, does not require that these words be used.

An attending physician's determinations that a person is terminal and lacks capacity to make informed decisions are deemed "conclusive."¹⁷⁵ However, both bills also provide a mechanism for persons to object to the attending physician's determination that a person is (1) terminal or (2) that the "course of action proposed" is not authorized by the declaration.¹⁷⁶ An objection may also be raised that the document is invalid because (1) the declarant was not of sound mind or otherwise lacked the capacity to execute a declaration, or (2) the declaration does not comply with the requirements set forth in the legislation.¹⁷⁷

Persons having standing to raise an objection are those (1) designated in a living will as a person to be notified prior to the time that the terms of a living will are given effect¹⁷⁸ or (2) a member of a list of individuals provided in a descending order of priority in another section of the legislation (if no one is listed by the declarant as a person to be notified).¹⁷⁹ A person who chooses to object must advise the attending physician within forty-eight hours after receipt of notice.¹⁸⁰ A complaint must also be filed within two business days in the probate court.¹⁸¹ If, after the required hearing,¹⁸² the court finds, by clear and convincing evidence, that a factual

¹⁷⁵ S.B. No. 1, *supra* note 151, at § 2133.03(C); *see also* H.B. 70, *supra* note 151, at § 2133.03(C).

¹⁷⁶ S.B. No. 1, *supra* note 151, at § 2133.05(A)(3); *see also* H.B. No. 70, *supra* note 151, at § 2133.05(A)(3) (an objection may be raised to the attending physician's "determination" or that the proposed course of action is "not authorized" by the declaration).

¹⁷⁷ *Id.*

¹⁷⁸ Before complying with the terms of a living will, an attending physician must, among other things, make a "good faith effort" and use "reasonable diligence" to (1) give notice of same to persons designated by the declarant or to one of the persons specified in another section of the legislation, (2) record in the medical record the names and manner in which notice was provided or the reason the requisite notice was not provided, and (3) "afford time" for persons so notified to object. S.B. No. 1, *supra* note 151, at § 2133.05(A); H.B. No. 70, *supra* note 151, at § 2133.05(A).

¹⁷⁹ S.B. No. 1, *supra* note 151, at §§ 2133.05(A)(2)(a) (ii), 2133.08(B) (priority is given in the following order: (1) the guardian, if any (2) the patient's spouse, (3) a majority of the patient's adult children who are available within a "reasonable period of time," (4) the patient's parents, (5) an adult sibling of the patient or a majority of this class, and (6) the nearest adult blood relative available within a "reasonable period of time."); H.B. 70, *supra* note 151, at § 2133.05(A)(2)(a), (b) (giving first priority to the patient's spouse; the guardian's priority, if any, is not addressed).

¹⁸⁰ S.B. No. 1, *supra* note 151, at § 2133.05(B)(1); *see also* H.B. No. 70, *supra* note 151, at § 2133.05(B)(1).

¹⁸¹ *See* S.B. No. 1, *supra* note 151, at § 2133.05(B)(1) (the failure to file a complaint renders any objection void), and § 2133.05(B)(4) (requiring the probate court to conduct a hearing after the complaint and notice of the hearing have been served upon (1) the attending physician, (2) any health care facility in which the declarant is confined, and (3) any other persons notified by the attending physician although not joining in the complaint as plaintiffs); H.B. No. 70, *supra* note 151, at § 2133.05(B)(1) (does not require that the health care facility be named as a defendant).

¹⁸² A hearing must be held by the probate court within three business days after service has been completed. S.B. No. 1, *supra* note 151, at § 2133.05(B)(4).

basis exists for the objections raised, the court may issue an order. The court's jurisdiction is limited to (1) an order requiring the attending physician to reevaluate the proposed course of action and/or the determination that the patient is terminal or (2) an order invalidating the declaration.

Of great importance and utility is the inclusion of a surrogate decision-making provision in the original versions of both bills.¹⁸³ This establishes a statutory decision-making mechanism when no declaration or Durable Power of Attorney for Health Care exists.¹⁸⁴ Both require that surrogate decisions be made in good faith¹⁸⁵ and that consent given by a surrogate is not valid if it conflicts with the previously expressed intention of the patient. However, absent actual knowledge of the patient's contrary intent, health care providers may rely on a consent given as authorized by this section.¹⁸⁶

Both bills include a grandfather clause which would give legal effectiveness to living wills executed prior to the adoption of a living will statute.¹⁸⁷ Various immunities are also included for health care providers and facilities.¹⁸⁸ In addition, both bills also provide that physicians, health

¹⁸³ *Id.* at § 2133.08(D); H.B. No. 70, *supra* note 151, at § 2133.08(D). Unfortunately, the Ohio Senate deleted the entire surrogate decision-making section. This greatly reduces the utility of the bill since the majority of people will not execute either a durable power of attorney for health care or a living will. See *supra* note 142.

¹⁸⁴ A surrogate may also become the decision-maker when a declaration or Durable Power of Attorney for Health Care is not legally effective. S.B. No. 1, *supra* note 151, at § 2133.08(A); H.B. No. 70, *supra* note 151, at § 2133.08(A).

¹⁸⁵ S.B. No. 1, *supra* note 151, at § 2133.08(D); H.B. No. 70, *supra* note 151, at § 2133.08(D).

¹⁸⁶ *Id.*

¹⁸⁷ S.B. No. 1, *supra* note 151, at § 2133.14. However, all living wills must "substantially" comply with the statute to be legally effective. This condition probably requires inclusion of the statutory definitions of terminal condition and permanently unconsciousness state somewhere in the declaration. Thus, most living wills executed in Ohio prior to the new legislation becoming effective will probably have to be rewritten. See *supra* note 172. See also H.B. No. 70, *supra* note 151, at § 2133.13-14. In addition, living wills validly executed under the laws of another state that "substantially" comply with Ohio's law are valid under this statute. S.B. No. 1, *supra* note 151, at § 2133.13; H.B. No. 70, *supra* note 151, at § 2133.13.

¹⁸⁸ S.B. No. 1, *supra* note 151, at § 2133.10 (civil, criminal and immunity from professional disciplinary action is provided for attending and consulting physicians, health care facilities, and health care personnel acting under the direction of an attending physician); H.B. No. 70, *supra* note 151, at § 2133.10 (providing similar immunities). However, neither bill grants immunity for "actions that are outside the scope" of authority. See S.B. No. 1, *supra* note 151, at § 2133.10(D); H.B. No. 70, *supra* note 151, at § 2133.10(D).

In addition, both provide that the death of a patient from the withholding or withdrawal of life-sustaining treatment does not constitute a "suicide, aggravated murder, murder, or any other homicide offense for any purpose." S.B. No. 1, *supra* note 151, at § 2133.11(A); H.B. No. 70, *supra* note 151 at, § 2133.11(A).

care personnel and health care facilities are not required to "take action that is contrary to reasonable medical standards."¹⁸⁹

There is also a provision in both which provides that the rights enumerated are cumulative to those rights existing at common law so that the statutory provisions are not the exclusive mechanisms to direct the withholding or discontinuation of medical care.¹⁹⁰ This is an important provision, particularly in states like Ohio where the restrictions in the current statutory mechanism for surrogate decision-making have been held applicable to a guardianship situation.¹⁹¹ It clearly preserves both the constitutional and common law right to refuse medical treatment.

While both bills are an excellent effort at a statutory solution of the issues that currently exist in this area, there are several problems with the proposed legislation. First, the deletion of the surrogate decision-making section would greatly reduce the utility of this legislation since, as noted, most persons will not take the time to execute either a living will or Durable Power of Attorney for Health Care. Additionally, standing to challenge a decision is limited to certain enumerated family members (in the absence of an express designation in a living will), thus excluding other persons who may be more intimately acquainted with the patient. Also, the legislation does not address whether the designation of a particular surrogate, or the decision of the surrogate, may be challenged. Further, the priorities between the terms of a living will and those of a Durable Power of Attorney for Health Care are not clearly articulated. Finally, the proposed definition of "permanently unconscious state" as one in which a person has "no capacity to experience pain or suffering" may give too much latitude to Ohio courts confronting the issue of whether a person is "terminal" and provide courts with the opportunity to reject a physician's determination that a person's condition satisfies this definition.¹⁹² However, the comprehensive approach to addressing termination of treatment issues reflected in this legislation represents a positive step for Ohio.

¹⁸⁹ S.B. No. 1, *supra* note 151, at § 2133.11(C)(4); H.B. No. 70, *supra* note 151, at § 2133.11(C)(4).

¹⁹⁰ S.B. No. 1, *supra* note 151, at § 2133.11(C)(3); H.B. No. 70, *supra* note 151, at § 2133.11(C)(3).

¹⁹¹ *Couture v. Couture*, 48 Ohio App.3d 208, 549 N.E.2d 571 (Montgomery Cty. 1989).

¹⁹² For example, Edna Leach was described as grimacing in reaction to deep pain although non-responsive to external stimuli. See *Leach v. Akron Gen. Medical Center (Leach I)*, 68 Ohio Misc. 1, 3, 426 N.E.2d 809, 810 (Summit Cty. 1980). Similarly, Nancy Cruzan exhibited reflexive responses to sound and painful stimuli. See *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, 2845 (1990). Although both were considered to be in permanently unconscious or persistent vegetative states, it is conceivable that an Ohio court confronted with the issue of whether such persons lack the "capacity to experience pain or suffering" could conclude that they do experience pain or that it cannot be ruled out that they do not experience pain and thus, would not meet the statutory definition of "terminal." Although both bills provide that a physician's determination of "terminal" status is "conclusive," the potential exists to override a physician's determination.

C. Legislative Solutions From Other Jurisdictions

Forty states and the District of Columbia have living will acts.¹⁹³ Thirty states have durable power of attorney statutes which permit an attorney in fact to consent to medical treatment.¹⁹⁴ Several of the living will statutes expressly permit the withdrawal of nutrition and hydration.¹⁹⁵ A growing number of durable power statutes either explicitly or implicitly permit an agent to direct that life support be withdrawn.¹⁹⁶

In formulating policies and drafting legislation, an examination of representative legislation from other jurisdictions illustrates the various approaches taken by other states in this area. Although the different types of legislation have been separated for purposes of discussion, the best approach for solving the myriad of problems in this area is a comprehensive statutory scheme which includes not only a durable power of attorney for health care but also a living will alternative, as well as a mechanism for surrogate decision-making in the absence of an advance directive.¹⁹⁷ A unified approach is best because it can coordinate the interaction and authority of the various types of directives as well as avoid potential gaps or conflicts between same.

A compromise to the near total ban in some states on the withdrawal or withholding of nutrition and hydration is evidenced in two recent statutes. In Maine, the statutory definition of life-sustaining treatment does not include artificially administered nutrition and hydration.¹⁹⁸ However, a declarant may elect in the living will to include artificially administered nutrition and hydration in the definition of life-sustaining treatment.¹⁹⁹ Thus, in Maine the presumption is that nutrition and hydration will generally be administered unless the declarant directs otherwise.²⁰⁰

In Florida, the term "life-sustaining treatment" does not include the provision of sustenance or any medical treatment. These measures are termed "comfort care."²⁰¹ Nutrition or hydration will be permitted to be

¹⁹³ Society For the Right to Die, *Artificial Nutrition and Hydration, Update on Artificial Nutrition and Hydration* 1, 5 (Sept. 1990) (available from the Society For the Right to Die, 250 West 57th St., New York, NY 10107).

¹⁹⁴ *Id.* at 6.

¹⁹⁵ *Id.* at 5.

¹⁹⁶ *Id.* at 6; see also Society for the Right to Die, *Update on Tube Feeding in the United States* 1 (Aug. 30, 1990).

¹⁹⁷ See, e.g., Texas Natural Death Act, TEX. HEALTH & SAFETY CODE ANN. §§ 672.001-.021 (Vernon 1990) and Durable Power of Attorney for Health Care Act, TEX. REV. CIV. STAT. ANN. art. 4590h-1 (Vernon 1989).

¹⁹⁸ 1990 Me. Legis. Serv. 830, § 5-701(4)(A).

¹⁹⁹ *Id.*

²⁰⁰ *Id.* at § 5-702(b). Although the definition of life-sustaining is broad enough under Senate Bill 1 to include nutrition and hydration, unless the declarant expressly provides that it may be withheld or withdrawn, it will continue to be administered.

²⁰¹ 1990 Fla. Laws 223, § 765.03(3)(b).

withdrawn or withheld as a life-prolonging procedure if (1) the living will expressly authorizes this, and (2) it is medically determined that the provision of sustenance is not comfort care but rather, a life-prolonging procedure for a patient.²⁰² These types of statutes offer some protection to the incompetent whose wishes cannot be reasonably ascertained and err on the side of preserving life.

In the instance where a declarant has left instructions regarding his or her future treatment wishes, health care providers should be able to implement the patient's wishes, since artificial distinctions between nutrition and hydration and other forms of medical treatment appear to have been rejected by the Supreme Court.²⁰³ However, evidence of the patient's wishes must meet the clear and convincing standard. A broadly drafted statute such as these would likely survive constitutional challenge while protecting those whose future wishes were not as clearly stated.

In attempting to address the concerns surrounding the provision of nutrition and hydration to incompetents, New York's sweeping new health care proxy statute²⁰⁴ sets forth a workable compromise. Case law in New York requires that clear and convincing evidence of an incompetent patient's wishes regarding the provision of nutrition and hydration must be satisfied in order to withdraw or withhold these measures.²⁰⁵ This statute allows the agent to make a decision regarding nutrition and hydration if the principal's wishes are "reasonably known."²⁰⁶ The principal must affirmatively instruct the agent regarding future treatment choices since another section of the statute, providing a recommended form for the health care proxy, states: "unless your agent knows your wishes about artificial nutrition and hydration, your agent will not have the authority to decide about artificial nutrition and hydration."²⁰⁷

²⁰² *Id.* at § 765.075(1). The use of the term "sustenance" also appears to be somewhat ambiguous since it is unclear whether it is limited to the provision of nutrition (food) or would also include fluids. Since a subsection of the statute provides that nutrition or hydration artificially administered may be withdrawn or withheld, it would seem that sustenance would include both. However, it would have been better to avoid the use of the term "sustenance" in § 765.075(B), which states that nutrition or hydration, artificially administered, may be withdrawn if "the provision of sustenance is a life-prolonging procedure for the patient." *Id.*

²⁰³ *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, 2852 (1990).

²⁰⁴ 1990 N.Y. Laws 752. This statute is based upon a proposal of the New York Task Force on Life and the Law entitled *Life Sustaining Treatment: Making Decisions and Appointing a Health Care Agent* (1987). The 26 member task force included physicians, nurses, lawyers, philosophers and clergy from different religious sects.

²⁰⁵ *In re Eichner*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981); *In re Westchester County Medical Center*, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988).

²⁰⁶ 1990 N.Y. Laws 752, § 2982(2)(a) (an agent "shall make health care decisions: (a) in accordance with the principal's wishes, including the principal's religious and moral beliefs.")

²⁰⁷ *Id.* at § 2981(5)(d). This will also be the rule in Ohio if Am. Sub. S.B. No. 1 becomes law in its present form. *See supra* note 153.

Alternatively, treatment decisions may be made in accordance with the principal's best interests, however "if the principal's wishes regarding the administration of artificial nutrition and hydration are not reasonably known and cannot with reasonable diligence be ascertained, the agent shall not have the authority to make decisions regarding these measures."²⁰⁸ This is similar to the provision in the Wisconsin durable power of attorney for health care statute which allows an agent to consent to the withholding or withdrawal of "non-orally ingested nutrition or hydration" if the instrument expressly authorizes the agent to do this.²⁰⁹

The New York statute also identifies the priorities between a designated agent and other decision-makers. Generally, the principal's designated agent should have priority over all other decision-makers²¹⁰ since the agent is acting pursuant to the principal's express choice. Further, in Tennessee, a subsequently appointed guardian of the estate does not have any power to revoke, amend or replace a designated attorney in fact.²¹¹

Anticipating challenges to an agent's priority or authority, New York has included a dispute resolution mechanism within the statute.²¹² Deference to the principal's choice is evident in that an agent's selection can only be overridden if (1) the agent is not "reasonably available" or (2) is acting in bad faith.²¹³ An agent's decision may only be overridden if it was (1) made in bad faith or (2) not in accord with the patient's reasonably known wishes or in the patients best interests.²¹⁴ This is similar to the Tennessee statute which provides that an attorney in fact has priority over any other person in making health care decisions unless clear and convincing evidence demonstrates that the attorney in fact is acting in bad faith.²¹⁵ It is important in drafting these statutes to clearly identify the priorities of decision-makers between agents named in a durable power, surrogate decision-makers named in a living will, family or other surrogates and a guardian, if one is appointed.²¹⁶

The priorities between different documents must also be clearly iden-

²⁰⁸ 1990 N.Y. Laws 752, § 2982(2)(b). The clear and convincing evidence standard appears to have been displaced by negative inference, since if a principal's wishes are "reasonably known" then the agent can act in accordance with them. Failure to provide affirmative instructions would preclude the agent from making nutrition and hydration treatment decisions, as well as move the evidentiary requirement up to the clear and convincing standard.

²⁰⁹ 1990 Wis. Legis. Serv. 200 (West 1990) codified at WIS. STAT. § 155.20(4) (1990) (the agent's power may be limited by a physician's determination that the withholding or withdrawal of nutrition or hydration would cause the principal pain or reduce the principal's comfort.).

²¹⁰ 1990 N.Y. Laws 752, § 2982(4).

²¹¹ 1990 Tenn. Pub. Acts 831, § 5(b)(2).

²¹² 1990 N.Y. Laws 752, § 2992.

²¹³ *Id.* at § 2992(2).

²¹⁴ *Id.* at § 2992(3).

²¹⁵ 1990 Tenn. Pub. Acts 831, § 5(a)(1).

²¹⁶ For example, in West Virginia, if the appointment of a guardian is sought after the execution of a valid medical power of attorney, the statute provides that the agent should be designated the guardian of the person for medical decision-making in the absence of good cause weighing against such a designation. W. VA. CODE § 16-30A-4 (1990).

tified.²¹⁷ In Georgia, a living will is inoperative when an agent has been appointed pursuant to a durable power of attorney for health care.²¹⁸ Georgia also recognizes the agent's priority over any other person including any guardian of the person.²¹⁹

Of equal importance is the provision of an adequate dispute resolution mechanism. This is vital in view of the reluctance and possible inability of the judicial system to resolve disputes surrounding these types of treatment decisions.²²⁰ The best approach to this issue would be to require judicial review as a last resort only when there is a dispute as to the patient's desires. Even in that event, an institutional review mechanism should be required prior to court intervention.²²¹ As a check on the agent's authority, Wisconsin provides that any person can petition for a determination of competency and request the appointment of a guardian.²²² Thus, the court can review whether the health care agent is acting in accordance with the terms of the power. If the court finds that the agent is not acting according to the terms of the power it may (1) direct the agent to do so, (2) order court supervision of the agent and require the agent to report to the court, or (3) terminate the powers of the health care agent.²²³ However, a judicial determination that the principal is incompetent or partially incompetent, operates as a revocation of the agent's authority in favor of the appointed guardian unless the court finds that the agent's power should remain in effect.²²⁴

The aforementioned Illinois proposal provides a model for surrogate decision-making without judicial intervention in the absence of an advance directive.²²⁵ The Act's provisions would take effect when a patient is terminal, permanently unconscious or in an incurable or irreversible condition.²²⁶ Surrogate decision-makers are listed in decreasing order of

²¹⁷ Where the provisions of a declaration (living will) and special directives in a medical power of attorney are in conflict in West Virginia, the provisions of the document executed later in time controls. *Id.* at § 16-30A-(4)8.

²¹⁸ 1990 Ga. Laws 1259 (codified at GA. CODE ANN. § 31-36-11 (1990)).

²¹⁹ *Id.*

²²⁰ See *Guidelines*, *supra* note 31, at 14.

²²¹ See S.B. No. 2213, 86th Ill. Gen. Assembly (1989-90) (would create the Decisions to Forego Life-Sustaining Treatment Act). Section 7 of this proposed act would require every Illinois health care facility to establish a "mechanism for the purpose of mediating and resolving, whenever possible, disputes over the selection of the surrogate decision maker or life-sustaining treatment decisions." *Id.* Further, a person challenging the selection or decision of a surrogate must show by clear and convincing evidence that the decision was contrary to the patient's wishes or best interests.

²²² WIS. STAT. § 155.60(1) (1990).

²²³ *Id.* at § 155.60(4)(a)(1-3).

²²⁴ *Id.* at § 155.60(2). No standards are set forth in the statute for making this determination. Any legislation should address the interaction of the various decision-makers, and provide for an adequate dispute resolution prior to any redress to the courts.

²²⁵ Decisions to Forego Life-Sustaining Treatment Act, S.B. 2213, 86th Ill. Gen. Assembly (1989-90) (failed 6-8-90).

²²⁶ *Id.* at § 3. These conditions constitute qualifying conditions. When two physicians determine that a patient lacks "decisional capacity" and meets one of the conditions, the decision making mechanisms of the Act are triggered.

priority. These include: (1) the patient's guardian; (2) an individual(s) "clearly identified" by the patient when the patient had capacity; (3) the spouse; or (4) a majority of the patient's adult children.²²⁷ If no surrogate can be found, a health care facility's ethics committee would be permitted to make a decision for an adult patient.²²⁸

Other states use a similar sequence of priority decision-makers.²²⁹ However, provisions for non-family members to be recognized as decision-makers should be included since these persons may have a closer relationship with the patient than the family. For example, in New York, a "close friend" is authorized to challenge the appointment of a proxy decision-maker.²³⁰ A comprehensive statute should mirror the Illinois proposal and include a "close friend" as a person who could be named as a surrogate.

Some statutes also allow a person to disqualify potential health care decision-makers. South Dakota allows any person to disqualify a family member by a signed writing.²³¹ In addition, the authority of a higher priority or class of decision-makers may be delegated to a lower class.²³² This allows for shared decision-making because it removes the burden where there is only one decision-maker. If several persons are members of a lower class, a consensus of surrogates will determine what the health care decision should be. This is in accord with the generally accepted past practices of medical decision-making.

²²⁷ *Id.* at § 6. The statute also identifies several other more distant family members as decision makers. However, it does not indicate when someone is "clearly identified."

²²⁸ *Id.* at § 5(c)(2). Alternatively, if no surrogate can be found, it may be wise to petition a court to appoint a guardian. *See, e.g.*, 1990 Fla. Laws 232, § 15(2)(a)(b) (to eliminate the possibility of bias, the Florida statute states that the health care facility may obtain a person who is "willing and competent" and "not employed or otherwise associated with the health care facility" to act as the surrogate in an enumerated order of preference. However, if no person can be found from those enumerated, the health care facility may petition for the appointment of a guardian.)

²²⁹ *See* D.C. CODE ANN. § 221-2210 (1989); 1990 Fla. Laws 232, § 15(2)(a); 1990 Me. Legis. Serv. 830 (to be codified at ME. REV. STAT. ANN. tit. 18-A, § 5-707(B)); S.C. CODIFIED LAWS ANN. § 34-12C-1 (1990); VA. CODE ANN. § 54.1-2986 (1990).

²³⁰ 1990 N.Y. Laws 752, § 2992. A "close friend" is defined as a person eighteen or older who presents an affidavit which states that "he has maintained such regular contact with the patient as to be familiar with the patient's activities, health, and religious or moral beliefs," along with the inclusion of sufficient facts or circumstances which demonstrate this familiarity. N.Y. PUB. HEALTH LAW § 2961(5) (Consol. Supp. 1990); *accord* Decisions to Forego Life-Sustaining Treatment Act, S.B. No. 2213, 86th Ill. Gen. Assembly, § 3 (1989-90).

²³¹ S.D. CODIFIED LAWS ANN. § 34-12C-3 (1990). Only family members are statutorily permitted to provide consent when no guardian or attorney in fact is available. Further, a spouse who is legally separated from the patient cannot consent under the statutory scheme. *See also* 1990 Me. Legis. Serv. 830, § 5-707(G).

²³² *See* 1990 Me. Legis. Serv. 830, § 5-707(C); S.D. CODIFIED LAWS ANN. § 34-12C-3 (1990).

A health care decision should be made in accordance with the patient's wishes. A more flexible standard has been adopted in Maine which states that decisions should be made in the "best interest of the individual consistent with the individual's desires, if known, and in good faith."²³³ An invalid directive may be used as evidence of those wishes.²³⁴ Regardless of the standard used, an attorney in fact is required to use "due care when acting for the benefit of the principal" and may be liable for the negligent exercise of the power.

Judicial review of the surrogate's appointment and decisions is not limited to particular persons in some states. Others limit standing to those persons enumerated in the statute.²³⁵ For example, the Florida statute provides that review of a surrogate's decisions or appointment may be sought by the patient,²³⁶ health care professionals, the patient's family, the health care surrogate or "other interested party."²³⁷ In Maine, any person with a "significant personal relationship" may petition to court.²³⁸

One question raised by these statutes is whether a lower priority decision-maker can petition the court for the appointment of a guardian. Generally, a guardian enjoys the highest priority in the decision-making ladder, in the absence of a surrogate named in an advance directive.²³⁹ It seems conceivable that a disgruntled family member could attempt to control the decision-making by becoming the patient's appointed guardian. Thus, any statutory scheme should address this circumstance, possibly requiring the appointment of an independent decision-maker.²⁴⁰

D. The Need for a Comprehensive Legislative Solution

Given the serious constitutional issues presented by Ohio's limited Durable Power of Attorney for Health Care statute and case law, the current common law and statutory scheme is unsatisfactory. Adoption of Senate Bill 1 "as introduced" would resolve many of the issues presented by Ohio's current common law and statute in light of the *Cruzan* decision.

²³³ 1990 Me. Legis. Serv. 830, § 5-707(5)(D).

²³⁴ See, e.g., 1990 Ga. Laws 1259 § 31-36-10. It is noteworthy that Wisconsin law provides that a durable power of attorney for health care that does not conform to the statutory formalities "has no force or effect." 1990 Wis. Legis. Serv. 200, § 243.07 (6m).

²³⁵ See, e.g., D.C. CODE ANN. § 21-2210(e) (1989).

²³⁶ This would occur if the patient regained capacity.

²³⁷ 1990 Fla. Laws 232, § 18(1). In Florida, the petition for review must simply "state facts showing why the relief requested better reflects the patient's desires" with regard to the appointment of a decision maker or the decision to be made. *Id.* § 18(2).

²³⁸ 1990 Me. Legis Serv. 830, § 5-707(F). However, this is limited to a determination of whether the health care decision was made in the best interests of the individual. It does not grant standing to challenge the appointee named to make decisions.

²³⁹ See, e.g., D.C. CODE ANN. § 21-2210(a) (1989).

²⁴⁰ See *Guidelines*, *supra* note 31, at 16 (recommending the use of trained, court appointed guardians to make life-sustaining medical treatment decisions).

This issue has brought to the forefront with the passage of recent federal legislation which requires health care facilities and health maintenance organizations receiving Medicare or Medicaid funds to provide written information to adult patients regarding their rights under state law to accept or refuse medical care and to formulate advance directives.²⁴¹ Such Medicare and Medicaid providers must develop written policies and procedures regarding the implementation of advance directives, as well as to inform patients of these policies.²⁴² Given the current lack of clarity and inconsistency in Ohio law, health care providers in this state will have a hard time complying with this new law. The difficulty will not only be in determining what the law is, but conveying it coherently to patients and their families and friends. Since the federal law will take effect in December of 1991, the Ohio legislature must address this problem in the near future.

While the statutory schemes of certain other states have some desirable features, none of them completely resolves these issues. What is really needed is a comprehensive statute, such as that proposed by Senate Bill 1, to replace Ohio's current limited durable power statute. This statute should include not only provisions for a durable power and/or a living will, but also provisions for how treatment decisions on behalf of incompetent patients are to be handled in the absence of a durable power or living will.

The essential elements of such a comprehensive legislative solution would include:

1. The option of executing of a durable power of attorney for health care should be expanded. As suggested by Justices O'Connor and Brennan in the *Cruzan* decision, persons should be given the opportunity to expressly authorize an attorney in fact to withhold medical treatment even where death is not imminent and to authorize the attorney in fact to refuse and/or terminate artificial hydration and feeding. This would eliminate the constitutional issues presented by the current statute in light of the *Cruzan* decision and would also avoid the issue of what constitutes a "terminal" condition or "imminent" death. The statute should expressly authorize the principal to consent to organ donation, a post-mortem examination, and disposition of the body.²⁴³ Also, the statute should allow for the designation of an alternate agent if the named agent is unwilling or unable to serve.

²⁴¹ Omnibus Budget Reconciliation Act of 1990, 101st Cong., end Sess., Pub. L. No. 101-508, § 4751, 104 Stat. 1388 (1990) (to be codified at 42 U.S.C. §§ 1395cc(a)(1) and 1396(a)). See also Wagner, *New Law Will Require Providers to Inform Patients of Living Wills*, MOD. HEALTHCARE 20 (Dec. 1990).

²⁴² *Id.*

²⁴³ See, e.g., 1990 Tenn. Pub. Acts 831, § 5(b).

2. A second option of executing a living will should also be authorized. A person should be given the right in such a document to expressly authorize withholding of medical treatment in non-terminal cases, as well as withholding of artificial hydration and feeding. Living wills executed prior to the adoption of the statute or in conformity with the laws of other states should be given legal effect in Ohio.

3. The effect of the passage of time after execution of a living will should be made clear. Without guidance, it is troublesome for health care providers to determine what weight to accord a directive in a particular set of circumstances. The statute should clearly articulate that either: (a) the passage of time has no effect on the validity and weight to be accorded an advance directive or (b) that an advance directive must be reexecuted within a specified number of years.²⁴⁴ Although the first alternative seems preferable, the primary aim of any statute should be clarity.

4. It should be made clear that the absence of a durable power or living will in no way limits the ability of the next of kin or a court-appointed guardian to refuse treatment on behalf of an incompetent person. Limitations in the Durable Power of Attorney for Health Care statute should not apply to guardianship cases. This would legislatively overrule the *Couture* decision.

5. There should be statutory authority for the closest next of kin or a "close friend" to refuse treatment based upon a statutory prioritization. An agent designated in a valid durable power or living will should be given the highest priority. Where such authorization is obtained, the termination of care should be permitted without having to resort to judicial review. This would clear up the confusion caused by the indication in *Leach II* that the termination of life support can only be carried out pursuant a court order.

6. An interested party should be given standing to seek judicial review of surrogate decisions, including the decision to appoint a particular surrogate. Judicial review should be a last resort and an institutional review mechanism should be required prior to court intervention. The list of those having standing as interested persons to bring such actions (e.g., attending physician, hospital administrator, close relatives, etc.) should be narrowly defined in the statute. It would be advisable to also provide standing to a "close friend" as defined in the New York health care proxy law²⁴⁵ to accommodate persons in non-traditional relationships.

²⁴⁴ OHIO REV. CODE ANN. § 1337.12(A)(3) (Baldwin 1990) (a durable power must be re-executed every seven years unless a shorter time is specified in the instrument since it expires seven years after the date of its execution).

²⁴⁵ See *supra* note 229.

7. The standard of review in the absence of a durable power or living will should be whether there is clear and convincing evidence that the incompetent patient would have desired treatment to be terminated under circumstances. The statute should make clear that prior statements by the patient can constitute clear and convincing evidence where the fact-finder is so persuaded. In addition, evidence other than statements, such as a person's behavior and activity level, should be admissible as well as an invalid directive executed by the patient. While prior statements made with knowledge of a particular life-threatening condition should be given greater weight, it should be made clear that such knowledge is not an absolute requirement for a prior statement to satisfy the clear and convincing standard.

8. There should be no grant of immunity for a health care provider who refuses to terminate care unless (i) the health care provider questions in good faith either the validity of a durable power or living will or whether there is clear and convincing evidence of the patient's desires absent the same, or (ii) there is a dispute among the statutorily designated class of relatives authorized to give consent as to whether consent should be given. This would hopefully eliminate the "Catch-22" situation currently presented by the *Leach I* and *Leach II* decisions.

VI. CONCLUSION

The adoption of additional piecemeal legislation (such as a new living will statute) will not resolve the ambiguities and constitutional issues presented by the current common law and statutory scheme in Ohio. Only the adoption of comprehensive legislation as described above will resolve such issues and eliminate such ambiguity, while at the same time protecting the constitutional right of previously competent persons to have their desire to refuse or terminate treatment carried out.

Since, man, through his ingenuity has created a new state of human existence - minimal human life sustained by man-made life supports - it must now devise and fashion rules and parameters for that existence. That is the business [Ohio] is faced with.²⁴⁶

This task has been "entrusted" to the states by the United States Supreme Court.²⁴⁷ Fulfillment of this public trust requires nothing less than pas-

²⁴⁶ *Leach v. Akron Gen. Medical Center (Leach I)*, 68 Ohio Misc. 1, 6, 426 N.E.2d 809, 812 (Summit Cty. 1980).

²⁴⁷ *Cruzan v. Director, Missouri Dept. of Health*, 110 S.Ct. 2841, 2859 (1990) (O'Connor, J., concurring).

sage of a clear, comprehensive statutory mechanism to address the issues raised in this article. The adoption of Senate Bill 1 in its "as introduced" form would be a giant step in that direction. The Ohio legislature should not wait for another tragic case like Nancy Beth Cruzan's to occur in this state before taking action.