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Ohio's New Durable Power of Attorney

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OHIO'S NEW DURABLE POWER OF ATTORNEY

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I. INTRODUCTION

Mentally competent patients have the right to give or refuse informed, voluntary consent[1] to proffered medical interventions, including life-sustaining treatments.[2] This right is firmly established in American jurisprudence.[3] Indeed, the law presumes adults to be capable of mak-

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1. On the doctrine of informed consent in medical care, see generally R. FADEN & T. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT (1986).

2. Carlson, *Ohio's New Durable Power of Attorney for Health Care Decisions*, 1 HEALTH L.J. OHIO 93, 93 (1990). *See generally* OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, LIFE-SUSTAINING TECHNOLOGIES AND THE ELDERLY (1987) (discussing the life-sustaining medical technologies of cardiopulmonary resuscitation, mechanical ventilation, renal dialysis, nutritional support and hydration, and antibiotics).

3. *See, e.g.*, Bartling v. Glendale Adventist Medical Center, 184 Cal. App. 3d 961, 229 Cal. Rptr. 360 (1986); Satz v. Perlmutter, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980); ALA. CODE §§ 22-8A-1 to -10 (1984); ALASKA STAT. §§ 18.12.010–.100 (1986); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210 (1986); ARK. STAT. ANN. §§ 20-17-201 to -218 (Supp. 1987); CAL. HEALTH & SAFETY CODE §§ 7185–7195 (West Supp. 1988); COLO. REV. STAT. §§ 15-18-101 to -113 (1987); CONN. GEN. STAT. ANN. §§ 19a-570 to -575 (West Supp. 1988); DEL. CODE ANN. tit. 16, §§ 2501–2509 (1983); D.C. CODE ANN. §§ 6-2421 to -2430 (Supp. 1987); FLA. STAT. ANN. §§ 765.01–.05 (West 1986); GA. CODE ANN. §§ 31-31-1 to -12 (1985 & Supp. 1988); HAW. REV. STAT. §§ 327D-1 to -27 (Supp. 1987); IDAHO CODE §§ 39-4502 to -4509 (Supp. 1988); ILL. ANN. STAT. ch. 110 ½, para. 701–710 (Smith-Hurd Supp. 1988); IND. CODE ANN. §§ 16-8-11-1 to 16-8-22 (Burns Supp. 1988); IOWA CODE ANN. §§ 144A.1–.11 (West Supp. 1988); KAN. STAT. ANN. §§ 65-28,101 to ,109 (1985); LA. REV. STAT. ANN. §§ 40:1299.58.1–.10 (West Supp. 1988); ME. REV. STAT. ANN. tit. 22, §§ 2921–2931 (Supp. 1987); MD. HEALTH-GEN. CODE ANN. §§ 5-601 to -614 (Supp. 1987); MINN. STAT. ANN. §§ 145B.01–.17 (West Supp. 1989); MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1987); MO. ANN. STAT. §§ 459.010–.055 (Vernon Supp. 1988); MONT. CODE ANN. §§ 50-9-101 to -206 (1987); NEV. REV. STAT. ANN. §§ 449.540–.690 (Michie 1986); N.H. REV. STAT. ANN. §§ 137-H:1 to :10 (Supp. 1987); N.M. STAT. ANN. §§ 24-7-1 to -11 (1986); N.C. GEN. STAT. §§ 90-320 to -323 (1985); N.D. CENT. CODE §§ 23-06.4-01 to -14 (Supp. 1989); OKLA. STAT. ANN. tit. 63, §§ 3101–3111 (West Supp. 1988); OR. REV. STAT. §§ 97.050–.090 (1985); S.C. CODE ANN. §§ 44-77-10 to -160 (Law. Co-op. Supp. 1987); TENN. CODE ANN. §§ 32-11-101 to -110 (Supp. 1988); TEX. REV. CIV. STAT. ANN. art. 4590h(1)–(11) (Vernon Supp. 1988); UTAH CODE ANN. §§ 75-2-1101 to -1118 (Supp. 1988); VT. STAT. ANN. tit. 18, §§ 5251–5262 (1987); VA. CODE ANN. §§ 54.1.2981–.2992 (1988); WASH. REV. CODE ANN. §§ 70.122.010–.105 (Supp. 1987); W. VA. CODE §§ 16-30-1 to -10 (1985); WIS. STAT. ANN. §§ 154.01–.15 (West Supp. 1987); WYO. STAT. §§ 35-22-101 to -109 (Supp. 1987).

ing and expressing autonomous decisions.[4] But the absence of decision-making capacity[5] on the patient's part does not relieve the physician of the obligation to obtain voluntary, informed consent concerning medical decisions that need to be made for that patient. The presence of a decisionally incapable patient confronts the physician with the issue of who has the power to give or refuse informed consent on the patient's behalf. When the patient cannot speak for himself, the physician must ask who has the legal authority to act as the substitute decisionmaker for the patient.

A variety of approaches to the question of substitute decisionmaking authority for medical treatment has evolved in the various states.[6] For instance, of the forty-one jurisdictions with living will statutes,[7] eighteen authorize a substitute decision by advance designation of a decisionmaker or specify a priority list of decisionmakers when no living will document has been previously executed by the patient.[8] Ohio is among the states that have not adopted living will legislation.[9]

Fourteen states have health care consent statutes that authorize informed consent from family members for medical interventions without resort to the courts in individual cases.[10] These statutes identify a

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4. On the presumption of mental capacity, see, e.g., Alexander, *Remaining Responsible: On Control of One's Health Needs in Aging*, 20 SANTA CLARA L. REV. 13 (1980). A full discussion of the concept of decisionmaking capacity and its assessment is beyond the scope of this article.

5. The term "competence" usually refers to a court's formal adjudication of a person's need for a surrogate decisionmaker. In this article, unless otherwise specified, the term "capacity" is used instead to signify *de facto* as well as *de jure* functional inability to engage in a rational decisionmaking process. *See* PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING MEDICAL TREATMENT: ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS 43-45 (1983) [hereinafter PRESIDENT'S COMMISSION, DECIDING TO FOREGO]; PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS: A REPORT ON THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP 56 (1982).

6. *See generally* Vignery, *Legislative Trends in Nonjudicial Surrogate Health Care Decision Making*, 23 CLEARINGHOUSE REV. 422 (1989). A number of mechanisms also exist for delegating decisionmaking authority to another person in financial matters, including joint banking accounts, living or inter vivos trusts, and ordinary powers of attorney. *See, e.g.*, Gilfix, *Legal Strategies for Patient and Family*, 9 GENERATIONS 46 (1984).

7. *See supra* note 3.

8. ARK. STAT. ANN. § 20-17-202; COLO. REV. STAT. § 15-18-104; CONN. GEN. STAT. ANN. § 19a-575; DEL. CODE ANN. tit. 16, § 2502; FLA. STAT. ANN. § 765.04; HAW. REV. STAT. § 327D-3; IDAHO CODE § 39-4504; IND. CODE ANN. § 16-8-11-11; IOWA CODE ANN. § 144A.3; LA. REV. STAT. ANN. § 40:1299.58.3; MINN. STAT. ANN. § 145B.03; N.M. STAT. ANN. § 24-7-3; N.D. CENT. CODE § 23-06.4-03; OR. REV. STAT. § 97.055; TEX. REV. CIV. STAT. ANN. art. 45490h(2); UTAH CODE ANN. § 75-2-1104; VA. CODE ANN. § 54.1.2983; WYO. STAT. § 35-22-102.

9. Carlson, *supra* note 2, at 112. A living will bill was pending in the Ohio legislature at the end of 1989. H. 56, 118th Leg. (1989).

10. ARK. STAT. ANN. § 20-9-602 (1987); D.C. CODE ANN. § 21-2210 (Supp. 1989); GA.

substitute decisionmaker, based on the assumption that a family member knows best what decision should be made on behalf of the patient and should act as the decisionmaker unless the patient has designated someone else. Generally, the range of family members who are legislatively authorized to make substitute decisions is more restricted than under the informal consent practices that physicians frequently use, albeit without explicit legal authority. Most of these family consent statutes specify a process for the determination, documentation, and review of the patient's incapacity to speak for himself.[11] The Ohio legislature, however, has not enacted a family health care consent statute.

But an important mechanism for clarifying the status and role of substitute medical decisionmakers has been the subject of recent Ohio legislation. This article concentrates on this mechanism, namely, the durable power of attorney for health care, as applied to medical practice in Ohio.[12]

II. BACKGROUND

Although its utility has been largely overlooked until recently,[13] the durable power of attorney for health care is a potentially valuable legal device for designating substitute decisionmakers and authorizing substitute decisionmaking. It is an extension of the ordinary power of attorney concept.[14]

In essence, the ordinary power of attorney is a written agreement, usually with a close relative, a lawyer, a business associate, or a financial advisor, authorizing that person (designated the agent or attorney in fact) to sign documents and conduct transactions on the delegating individual's (principal's) behalf. The principal can delegate as much (general power of attorney) or as little (special or limited power of attorney) power as desired and can end or revoke the arrangement at any time. But the power of attorney in its traditional form has two major drawbacks. First, the person creating the power must, at the time of

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CODE ANN. § 31-9-1 (1985); IDAHO CODE § 39-4303 (1985); IND. CODE ANN. § 16-8-12-4 (Burns Supp. 1988); LA. REV. STAT. ANN. § 40:1299.53 (West 1977); ME. REV. STAT. ANN. tit. 24, § 2905 (Supp. 1988); MD. HEALTH-GEN. CODE ANN. § 20-107(d) (1987); MISS. CODE ANN. § 41-41-3 (Supp. 1988); N.Y. PUB. HEALTH LAW § 2965.59(4)(a) (McKinney Supp. 1989) (restricted to "do not resuscitate" decisions); UTAH CODE ANN. § 78-14-5(4) (1987); VT. STAT. ANN. tit. 12, § 1909 (c)(3), (d) (Supp. 1985); WASH. REV. CODE ANN. § 7.70.065 (Supp. 1988); W. VA. CODE § 16-5C-5a (Supp. 1988) (restricted to nursing home and personal care home residents).

11. *E.g.*, D.C. CODE ANN. § 21-2204 (Supp. 1989); MD. HEALTH-GEN. CODE ANN. § 20-107(e) (1987); W. VA. CODE § 16-5c-5a.

12. 1989 Ohio Legis. Serv. 5-91 (Baldwin) (to be codified at OHIO REV. CODE ANN. § 1337.12(A)(1)).

13. *See* PRESIDENT'S COMMISSION, DECIDING TO FOREGO, *supra* note 5, at 146.

14. *See* OHIO REV. CODE ANN. § 1337.01–.10 (Baldwin 1988).

signing, have the capacity to make a contract.[15] Should there be any doubt as to the individual's mental capacity at that time, the validity of the power of attorney is open to challenge. If the challenge is successful, any transaction completed under the agreement is subject to being cancelled. Second, the ordinary power of attorney ends automatically upon the death or mental incapacity of the person who assigned it.

In an effort to overcome at least this latter deficiency, the durable power of attorney has evolved as a legal device for advance planning by individuals who are currently decisionally capable but who anticipate a future time of incapacity and the need for decisions to be made. This device creates a "penultimate will"[16] that allows a principal to confer decisionmaking authority on an agent.

Several advantages accrue when a capable individual appoints an agent to make future medical decisions for him in the case of subsequent incapacity.[17] The durable power of attorney affords a measure of flexibility that is unavailable when only a living will is utilized; all future medical treatment circumstances and treatment choices do not need to be anticipated before the onset of an incapacitating illness.[18] Additionally, unlike a living will, the appointment of an agent would provide an advocate to enforce the person's treatment preferences and to ensure that these preferences are not disregarded or forgotten by family members or physicians. Further, the agency approach would enhance personal autonomy[19] by permitting the principal to choose the person whom he most trusts to represent his views. Equally important, the principal can prevent critical decisions from being made by a relative whom the principal considers unreliable or to whom decisionmaking power might otherwise automatically devolve, either as a matter of law or medical custom.[20]

From the perspective of the physician and the health care facility

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15. 1989 Ohio Legis. Serv. 5-91 (Baldwin) (to be codified at OHIO REV. CODE ANN. § 1337.12(B)).

16. Libow, *The Interface of Clinical and Ethical Decisions in the Care of the Elderly*, 48 MOUNT SINAI J. MED. 480 (1981).

17. Note, *Appointing an Agent to Make Medical Treatment Choices*, 84 COLUM. L. REV. 985 (1984).

18. *See In re* Westchester County Medical Center, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988) (court ordered continuation of life-sustaining medical treatment because the patient had not anticipated with precision the exact medical circumstances that would envelop her, and she had failed to execute a durable power of attorney).

19. For a discussion of the ethical principle of autonomy or self-determination, see Callopy, *Autonomy in Long Term Care: Some Crucial Distinctions*, 28 THE GERONTOLOGIST 10 (1988).

20. On the preferences of individuals regarding the identity of their substitute decisionmakers, see High, *Standards for Surrogate Decision Making: What the Elderly Want*, 17 J. LONG-TERM CARE ADMIN. 8 (1989); High & Turner, *Surrogate Decision Making: The Elderly's Familial Expectations*, 8 THEORETICAL MED. 303 (1987).

treating the patient, there are clear advantages to encouraging mentally capable patients to appoint a decisionmaking agent, especially in jurisdictions without family consent statutes. Unambiguously identifying the patient's chosen representative in advance affords a measure of legal protection and certitude not currently provided either by a living will or the informal consent of a relative who happens to be available. Uncertainty about who is authorized to consent for the incapacitated patient would be resolved, as would problems relating to decisionmaking, when relatives disagree among themselves. As a result, health care professionals and relatives would have less incentive to resort to the courts for legal immunity or problem settlement.

An agent becomes someone who is empowered to make decisions and who should be able to provide insight regarding the values and preferences of the patient. Also, since in the course of face-to-face conversation with the agent the physician can impart the same sort of information that would have been shared with the patient under the informed consent doctrine,[21] there is at least some assurance that decisions will be based on knowledge of the specific facts concerning the patient's current condition.

Because of these advantages, the idea of the durable power of attorney for health care has received widespread endorsement.[22] The National Conference of Commissioners on Uniform State Laws (NCCUSL) has proposed, as part of the Uniform Probate Code, a Durable Power of Attorney Model Law.[23] Other uniform acts proposed by the NCCUSL attempt to accomplish the same thing by providing for the appointment of a "health care representative."[24] The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research[25] is in firm support of this advance planning mechanism, as are, among numerous others, the American Medical Association[26] and the New York State Task Force on Life and the Law.[27]

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21. 1989 Ohio Legis. Serv. 5-92 (Baldwin) (to be codified at OHIO REV. CODE ANN. § 1337.13(A)(3)).

22. *See, e.g.*, Peters, *Advance Medical Directives: The Case for the Durable Power of Attorney for Health Care*, 8 J. LEGAL MED. 437, 451–52 (1987); Note, *supra* note 17, at 1012–13.

23. UNIF. DURABLE POWER OF ATTORNEY ACT, 8A U.L.A. 275 (1983).

24. LeBlang, *Uniform Law Commissioners' Model Health-Care Consent Act: An Overview*, 4 J. LEGAL MED. 479, 488 (1983).

25. PRESIDENT'S COMMISSION, DECIDING TO FOREGO, *supra* note 5, at 44.

26. AMERICAN MEDICAL ASSOCIATION, COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CURRENT OPINIONS (1989); AMERICAN MEDICAL ASSOCIATION, REPORT OF THE BOARD OF TRUSTEES No. A-89, LIVING WILLS, DURABLE POWERS OF ATTORNEY, AND DURABLE POWERS OF ATTORNEY FOR HEALTH CARE 5 (1989) ("[t]he Board of Trustees recommends that: 1. State medical associations strongly encourage the 40 legislatures that have not yet enacted a durable power of attorney for health care statute to enact the model state bill adopted by the AMA in 1986").

The virtues of the durable power of attorney for health care also have been extolled in a Congressional Information Paper.[28]

Every state has legislatively authorized some version of a durable power of attorney instrument.[29] These acts generally provide that, in contrast to the traditional power of attorney, the durable power of attorney, given proper indication by a competent delegating individual, may endure beyond that individual's later incapacity or may become effective only upon the incapacity's onset.[30] The statutes explicitly provide for revocation of the instrument at any point before incapacity occurs, and in some states,[31] it may be revoked even if incompetence is clear.

The power of attorney, in both its ordinary and durable forms, has traditionally been used for purposes of financial asset management. However, under the common law, there would seem to be no reason why the power may not be granted for purposes of controlling medical treatment decisions following the onset of incapacity.[32] No statutes expressly prohibit such use and no judicial decisions express principled opposition to the idea.[33] In 1989, Ohio[34] became the latest of many states[35] to enact legislation specifically authorizing the delegation of health care decisionmaking authority through a durable power of attorney. Several other jurisdictions recognize the validity of the health care

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27. NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, LIFE-SUSTAINING TREATMENT: MAKING DECISIONS AND APPOINTING A HEALTH CARE AGENT (1987); *see also* Miller & Swidler, *Legislative Initiatives on Life-Sustaining Treatment: The Do-Not-Resuscitate Law and the Health Care Proxy Proposal*, N.Y. ST. B.J., Feb. 1989, at 30; Swidler, *The Health Care Agent: Protecting the Choices and Interests of Patients Who Lack Capacity*, 6 N.Y.L. SCH. J. HUM. RTS. 1 (1988).

28. SENATE SPECIAL COMM. ON AGING, 99TH CONG., 2d SESS., A MATTER OF CHOICE: PLANNING AHEAD FOR HEALTH CARE DECISIONS 33–34 (Comm. Print 1986) (an information paper prepared by B. Mishkin).

29. *E.g.*, § 1337.09.

30. *E.g.*, § 1337.12.

31. *See, e.g.*, Steinbrook & Lo, *Decision Making for Incompetent Patients by Designated Proxy: California's New Law*, 310 NEW ENG. J. MED. 1598, 1599 (1984).

32. F. COLLIN, J. LOMBARD, A. MOSES, & H. SPITLER, DRAFTING THE DURABLE POWER OF ATTORNEY: A SYSTEMS APPROACH (1987); PRESIDENT'S COMMISSION, DECIDING TO FOREGO, *supra* note 5, at 154.

33. *See* N. CANTOR, LEGAL FRONTIERS OF DEATH AND DYING 122–23 (1987).

34. 1989 Ohio Legis. Serv. 5-90 to -94 (Baldwin) (to be codified at OHIO REV. CODE ANN. §§ 1337.11–.17).

35. *See, e.g.*, ALASKA STAT. §§ 13.26.332–.344 (1988); CAL. CIV. CODE §§ 2430–2444 (West. Supp. 1989); COLO. REV. STAT. §§ 15-14-501 to -502 (Supp. 1986); D.C. CODE ANN. §§ 21-2201 to -2213 (Supp. 1989); IDAHO CODE § 39-4505 (Supp. 1988); IND. CODE ANN. § 16-8-12-6 (Burns Supp. 1988); ME. REV. STAT. ANN. tit. 18A, § 5-501 (Supp. 1988); NEV. REV. STAT. ANN. §§ 449.800–.860 (Michie Supp. 1988); N.M. STAT. ANN. § 45-5-501(b) (1989); PA. STAT. ANN. tit. 20, §§ 5601–5607 (Purdon Supp. 1988); R.I. GEN. LAWS §§ 23-4.10-1 to -2 (Supp. 1989); UTAH CODE ANN. §§ 75-2-1105 to -1106 (Supp. 1988); VT. STAT. ANN. tit. 14, §§ 3451–3467 (Supp. 1989).

durable power through reference in other health care legislation.[36] All of these laws have come about since 1982. Similar legislation has been introduced in a number of other states.[37]

III. OHIO'S DURABLE POWER OF ATTORNEY STATUTE

A. General Provisions

On June 28, 1989, Ohio Governor Richard Celeste signed into law Amended Substitute Senate Bill 13 (S. 13).[38] S. 13 enacts sections 1337.11 through 1337.17 of the Ohio Revised Code.[39] S. 13 provides extensive guidance, regarding delegations to attorneys in fact, on the power to permit or refuse health care on behalf of an incapacitated principal.[40] This bill enables the execution of a durable power of attorney for health care.[41] An attorney is authorized to make health care decisions for the principal "at any time that the principal has lost the capacity to make informed health care decisions for himself."[42] No guidance is offered regarding substantive standards of decisionmaking capacity or of procedures for assessing these standards. The bill empowers the attorney in fact, except as otherwise provided in the statute, to give, refuse, or withdraw informed consent to any health care that is being or could be provided to the principal.[43]

The bill also sets forth certain procedural formalities required when executing the durable power of attorney for health care document.[44] These include signing and dating by the principal, and witnessing.[45]

The eligibility criteria for attorneys in fact for health care decisionmaking purposes are found in section 1337.12(A)(2). Any competent adult may be selected, except the physician treating the principal, the physician's employees or agents, and the employees or agents of any health care facility in which the principal is being treated.[46] Pre-

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36. HAW. REV. STAT. § 327D-26 (1986) (living will statute refers to durable power for health care); IOWA CODE ANN. § 144A.7 (West Supp. 1988); MD. HEALTH-GEN. CODE ANN. § 20-107(d) (1987) (health care consent statute refers to durable power for health care).

37. *See, e.g.*, H. 7152, 1989 Leg. (Conn.); H. 999, 1989 Leg. (Ga.); S. 900, 1989 Leg. (Fla.); S. 1256 & S. 1999, 1989 Leg. (Haw.); S. 683 & H. 643, 1989 Leg. (Md.); H. 3825, H. 5296 & H. 5572, 1989 Leg. (Mass.).

38. Am. Sub. S.B. 13, 118th Leg., 1989 Ohio Legis. Serv. 5-90 (Baldwin).

39. 1989 Ohio Legis. Serv. 5-91 to -94 (Baldwin) (to be codified at OHIO REV. CODE ANN. §§ 1337.11-.17).

40. OHIO REV. CODE ANN. §§ 1337.11-.17 (Baldwin 1989).

41. *Id.* § 1337.12(A)(1).

42. *Id.* § 1337.12(A)(1).

43. *See id.* § 1337.13(B)-(F).

44. *Id.* § 1337.12(A)(1).

45. *Id.* § 1337.12(A)(1)(a)-(b).

46. *Id.* § 1337.12(A)(2).

sumably, the rationale for these exclusions is the avoidance of conflict-of-interests, both real and apparent, concerning the attorney in fact's motivations and loyalties. Under this logic, employees and agents of non-institutional health care providers—such as home health agencies[47] and community-based hospices—ought to be excluded as well.

The length of effectiveness of the instrument is set at a maximum of seven years from the date of execution; the principal may specify a shorter period.[48] If, however, at the time of expiration the principal lacks the current capacity to execute a renewal, the instrument automatically continues in effect until such time that capacity to make health care decisions is restored.[49] No legislative guidance on assessing the principal's current capacity to renew the instrument is given.

B. *Scope of the Agent's Authority*

Guidance concerning the extent of the attorney in fact's scope of authority is found in section 1337.13. The first part of this section[50] limits the attorney in fact to making health care decisions for the principal only when the principal has lost the capacity to make informed health care decisions for himself. In other words, the statute authorizes the execution of a "springing,"[51] rather than an immediate, durable power of attorney for health care. As long as the principal retains decisionmaking capability, he retains (and must retain)[52] decisionmaking authority personally; power "springs" only from the principal to the agent upon the former's incapacity.

This part of the section enunciates as the standard for exercising authority, that the attorney in fact must act consistently with the desires of the principal or, if the desires of the principal are unknown, consistently with the best interests of the principal.[53] This reflects a legislative preference for the substituted judgment standard that has evolved through case law[54] and through actions of other state legislatures—that is, a subjective standard that aims to honor the autonomous values and preferences[55] of the individual patient. Under substituted

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47. On home health care, see generally A. HADDAD & M. KAPP, ETHICAL AND LEGAL ASPECTS OF HOME HEALTH CARE (1990).

48. § 1337.12(A)(3).

49. *Id.*

50. *Id.* § 1337.13(A)(1).

51. *See generally* A. MEISEL, THE RIGHT TO DIE 395–96 (1989).

52. Regarding the question of a competent adult's right to delegate away or waive his present decisionmaking authority, see Kapp, *Medical Empowerment of the Elderly*, HASTINGS CENTER REP., July-Aug. 1989, at 5.

53. § 1337.13(A)(1).

54. *See, e.g., In re* Hier, 18 Mass. App. Ct. 200, 464 N.E.2d 959, *appeal denied*, 392 Mass. 1102, 465 N.E.2d 261 (1984).

55. Parry, *A Unified Theory of Substitute Consent: Incompetent Patients' Right to Individ-*

judgment, the attorney in fact is expected to " 'don the mental mantle of the [principal]' "[56] and to ask what course of conduct the principal, if currently competent for one miraculous instant,[57] would choose under the circumstances.[58] The attorney in fact's determination of what would be in the principal's best interests[59] is referred to as an objective standard, frequently analogized to the law's traditional "reasonable person" standard. The Ohio statute clearly relegates this test to secondary or fall-back status, to be invoked only when sufficient evidence of the principal's own desires is absent.[60]

The Ohio statute provides that the authority delegated to an attorney in fact through a durable power of attorney is intended to supplement, and not to supplant, any right the attorney in fact may possess, apart from the instrument, to participate in the making of health care decisions on behalf of the principal.[61] This provision acknowledges that, even in the absence of statutory authority, the courts have steadily enunciated a body of constitutional[62] and common law[63] supporting the power of an incompetent patient to exercise medical decisionmaking

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ualized Health Care Decision-Making, 11 MENTAL & PHYSICAL DISABILITY L. REP. 378 (1987); *see also* Parry, *Psychiatric Care and the Law of Substitute Decison-Making*, 11 MENTAL & PHYSICAL DISABILITY L. REP. 152 (1987) (applying consent to involuntary treatment in mental institutions).

56. Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 752, 370 N.E.2d 417, 431 (1977) (quoting *In re* Carson, 39 Misc. 2d 544, 545, 241 N.Y.S.2d 288, 289 (Sup. Ct. 1962)).

57. For critiques of this intellectual exercise, see Annas, *The Case of Mary Hier: When Substituted Judgment Becomes Sleight of Hand*, HASTINGS CENTER REP., Aug. 1984, at 23; Gutheil & Appelbaum, *Substituted Judgment: Best Interests in Disguise*, HASTINGS CENTER REP., June 1983, at 8. *But see In re* Gannon, No. 0189-017460 (N.Y. Sup. Ct. Albany County Apr. 3, 1989), *vacated*, No. 0189-017460 (N.Y. Sup. Ct. Albany County Apr. 11, 1989) (miraculous case where patient regained consciousness while petition to remove life supports was on appeal).

58. *See* A. MEISEL, *supra* note 51, at 267-77.

59. *Id.* at 264–67.

60. On the burden of proof regarding the principal's own values and preferences in relation to the specific medical decisions at hand, compare *In re* Conroy, 188 N.J. Super. 523, 457 A.2d 1232, *rev'd*, 190 N.J. Super. 453, 464 A.2d 303 (1983), *rev.'d*, 98 N.J. 321, 486 A.2d 1209 (1985) (establishing "subjective," "limited objective," and "objective" tests) with *In re* Westchester County Medical Center, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988) (setting a very difficult-to-attain evidentiary standard of "clear and convincing" proof). The *Westchester County Medical Center* standard, however, has not proved impossible to meet. *See* Elbaum v. Grace Plaze of Great Neck, No. 2503E (N.Y. App. Div. 2d Dept. Aug. 2, 1989); *In re* Hallahan, No. 16338 (N.Y. Sup. Ct. Bronx County Aug. 28, 1989); *In re* Kruczlnicki, No. 26796 (N.Y. Sup. Ct. Warren County Feb. 15, 1989).

61. § 1337.13(A)(2).

62. *See, e.g.*, Gray v. Romeo, 697 F. Supp. 580 (D.R.I. 1988) (constitutional right to privacy).

63. *See, e.g.*, Delio v. Westchester County Medical Center, 134 Misc. 2d 206, 510 N.Y.S.2d 415 (Sup. Ct. 1986) (building on the common law informed consent doctrine), *rev'd*, 129 A.D.2d 1, 516 N.Y.S.2d 677 (1987).

rights through a proxy.[64]

S. 13 recognizes that proper substitute decisionmaking by an attorney in fact cannot take place in an informational vacuum.[65] There is a natural parallel between access to and utilization of relevant data. Unless the principal expressly limits the right, the attorney in fact is empowered by the durable power of attorney to receive information about proposed health care,[66] to review health care records,[67] and to consent to the disclosure of health care records to third-parties such as insurers.[68]

C. *Limitations on the Agent's Authority*

Having nominally conferred authority to a competent adult to plan for the day of decisionmaking incapacity, the Ohio legislature then proceeded in a series of broad statutory limitations on the prerogative of the agent to deprive the principal of the purported advance planning authority.[69] These statutory limitations[70] restrict the ability of the principal to delegate power to his chosen agent in precisely those life circumstances where personal control is of the highest importance.

Much of the purported value of the durable power of attorney for health care statute is abrogated by section 1337.13(B), which affirmatively disempowers the attorney in fact from refusing or withdrawing informed consent to health care "that is necessary to maintain the life of the principal, unless the principal is in a terminal condition."[71] Terminal conditions are defined earlier in section 1337.11(I) as those likely to result in "imminent death,"[72] a rather unhelpful definition in the light of the legislature's failure to explicate its meaning of "imminent." Assuming that imminence is intended to refer to a short period of time,[73] this provision effectively disenfranchises large numbers of peo-

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64. *See* Leach v. Akron Gen. Medical Center, 68 Ohio Misc. 1 (Ct. C.P. Summit County 1980) (incompetent patient's wishes exercised through her husband/guardian); *see also* Kapp, *Non-Treatment of the Terminally Ill Incompetent Patient: Ohio Adds It's Blessing*, DAYTON MEDICINE, Mar. 1981, at 35.

65. *See* § 1337.13(A)(3).

66. On the doctrine of informed consent, see generally R. FADEN & T. BEAUCHAMP, *supra* note 1.

67. On the right to review one's own medical (hospital) records, see, e.g., OHIO REV. CODE ANN. § 3701.74(C) (Baldwin 1988).

68. On the release of medical records, see generally W. ROACH, S. CHERNOFF, & C. ESLEY, MEDICAL RECORDS AND THE LAW (1985).

69. § 1337.13(B)–(F).

70. *Id.*

71. *Id.* § 1337.13(B).

72. *Id.* § 1337.11(I).

73. *See In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987); *In re* Storar, 106 Misc. 2d 880, 433 N.Y.S.2d 388 (Sup. Ct.), *aff'd*, 78 A.D.2d 1013, 434 N.Y.S.2d 46, *rev'd*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1980), *cert. denied*, 454 U.S. 858 (1981).

ple, particularly those who are in persistent vegetative states,[74] who may survive for long stretches of time through the application of life-prolonging medical technology, but with no realistic hope of regaining cognitive, sapient functioning.[75] It is exactly this fate that most people wish to avoid by planning ahead. This legislative limitation of decision-making authority flies in the face of case law holding that the imminence of an incurable patient's death is determinative neither of the decisionmaking right of the patient or surrogate nor of the state's legitimate interests in preserving human life.[76]

The next limitation, however, is non-controversial.[77] Section 1337.13(C) imposes an obligation on the attorney in fact to consent to the continued provision of "comfort care" to the principal.[78] But it is odd to speak of "consent" where there is no option to refuse. Although the statute is silent on the definition of "comfort care," in clinical practice comfort or palliative care ordinarily encompasses the following: relieving symptoms such as pain, confusion, anxiety, hunger, thirst, or restlessness; skin care; bladder and bowel care; and grooming.[79] High dose narcotic agents and sedatives may be used, despite the risk of suppressed cerebral function and respiratory depression.[80]

Pregnant women are the topic of section 1337.13(D). This section forbids an attorney in fact from making decisions that limit health care to a pregnant woman when termination of the pregnancy would result.[81] This provision arguably infringes on the fundamental privacy, liberty, and bodily integrity rights of the pregnant woman, penalizing her on the basis of her pregnant status.[82]

Ohio's treatment of the artificial nutrition and hydration issue[83] is

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74. *See* A. MEISEL, *supra* note 51, at 138–40; Cranford, *Termination of Treatment in the Persistent Vegetative State*, 4 SEMINARS IN NEUROLOGY 36 (1984).

75. Karen Quinlan survived for a decade after her mechanical respirator was removed. *In re* Quinlan, 137 N.J. Super. 227, 348 A.2d 647, *cert. denied*, 429 U.S. 922 (1976). Also, Nancy Cruzan has an estimated life expectancy of another thirty years if artificial feeding is maintained. Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988), *cert. granted sub. nom.* Cruzan v. Director of Miss. Dep't of Health, 109 S. Ct. 3240 (1989).

76. *See, e.g.*, Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987); *see also* Abrams, *Withholding Treatment When Death is Not Imminent*, 42(5) GERIATRICS 77 (1987).

77. § 1337.13(C).

78. *Id.*

79. *See* M. KAPP, PREVENTING MALPRACTICE IN LONG-TERM CARE: STRATEGIES FOR RISK MANAGEMENT 175 (1987).

80. Rango, *The Nursing Home Resident With Dementia: Clinical Care, Ethics, and Policy Implications*, 102 ANNALS INTERNAL MED. 835 (1985).

81. § 1337.13(D).

82. *Cf.* Annas, *Pregnant Women as Fetal Containers*, HASTINGS CENTER REP., Dec. 1986, at 13; V. Kolder, J. Gallagher & M. Parsons, *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192 (1987).

83. § 1337.13(E).

consistent with the manner in which a number of other states have proceeded.[84] Section 1337.13(E) expressly denies to an attorney in fact the authority to refuse or withdraw informed consent to the provision of nutrition[85] and hydration[86] to the principal, unless, before the refusal or withdrawal of that informed consent, several conditions are met:

> (1) In the opinion of the principal's attending physician and at least one other physician, the provision of nutrition or hydration to the principal would not provide comfort to the principal; (2) In the opinion of the principal's attending physician and at least one other physician, either of the following situations exists: (a) The death of the principal is imminent whether or not nutrition or hydration is provided to the principal, and the nonprovision of nutrition or hydration to the principal is not likely to result in the death of the principal by malnutrition or dehydration; (b) If nutrition or hydration were provided to the principal, the nutrition or hydration either could not be assimilated or would shorten the life of the principal.[87]

In the extremely unlikely event that the conditions for refusal or removal of feeding and hydration tubes were satisfied, no non-feeding or hydration decision could be implemented until the attending physician and other physicians involved in the patient's evaluation had entered their opinions in the health care record.[88]

The limitations concerning an agent's prerogatives in the realm of artificial feeding and hydration are overbroad and inherently counterproductive. While Ohio joins a number of other states in seeking generally to foreclose proxy decisions to remove nutrition and hydration support once they have been initiated, Ohio endeavors to prevent agents from *withholding* artificial feeding and hydration in the first place. Interpreted literally, this provision could accomplish the perverse result of depriving many incompetent patients of their self-determination rights by commanding the forcible insertion of feeding and hydration tubes into persons who previously would have been permitted, as a matter of

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84. ARIZ. REV. STAT. ANN. § 36-3201(4) (1986); ARK. STAT. ANN. § 20-17-206(b) (Supp. 1987); FLA. STAT. ANN. § 765.03(3) (West 1986); GA. CODE ANN. § 31-32-2(5)(A) (1985 & Supp. 1988); HAW. REV. STAT. § 327D-2 (Supp. 1987); ILL. ANN. STAT. ch. 110 ½, para. 702(2)(d) (Smith-Hurd Supp. 1988); IND. CODE ANN. § 16-8-11-4 (Burns Supp. 1988); IOWA CODE ANN. § 144A.2(5) (West Supp. 1988); MD. HEALTH-GEN. CODE ANN. § 5-605(1) (Supp.1987); MO. ANN. STAT. § 459.010(3) (Vernon Supp. 1988); MONT. CODE ANN. § 50-9-202(2) (1987); N.H. REV. STAT. ANN. § 137-H:2 (Supp. 1987); OKLA. STAT. ANN. tit. 63, § 3102(4) (West. Supp. 1988); OR. REV. STAT. § 97.050(3) (1985); UTAH CODE ANN. § 75-2-1103(6)(b) (Supp. 1988); WIS. STAT. ANN. § 154.01(5) (West Supp. 1987); WYO. STAT. 35-22-101(a) (Supp. 1987).

85. OHIO REV. CODE ANN. § 1337.11(G).

86. *Id.* § 1337.11(E).

87. *Id.* § 1337.13(E)(1)–(2).

88. *Id.* § 1337.13(E)(3)

common medical practice, to forego such initial insertion through the advocacy of a substitute decisionmaker.[89]

Some state statutes affirmatively permit the proxy removal of feeding and hydration mechanisms.[90] Furthermore, the strong trend of judicial decisions is toward characterizing artificial means of nutrition and hydration as forms of medical treatment that may be withheld or withdrawn legally from an incompetent patient under the same conditions as of those that may justify the limitation of other forms of medical treatment.[91] Several recent judicial decisions, though, have substantially confused the picture by swimming against the emerging legal stream[92] and by upholding the authority of a state to compel the continuation of artificial feeding and hydration for persistently vegetative patients in opposition to the patient's substituted judgment as presented through a proxy.[93] Ohio has now joined this fray, in a case that illustrates the mischief and counterproductivity wrought by the legislature in using the durable power of attorney for health care statute as a vehicle for forcing artificial hydration and nutrition upon helpless patients.[94]

IV. THE COUTURE CASE

In *Couture v. Couture*,[95] twenty-nine year old Daniel Lloyd Couture went into a persistent vegetative state on April 20, 1989, allegedly as a result of medicine he had been prescribed.[96] Initially, Daniel was maintained as a patient at Miami Valley Hospital in Dayton, Ohio, on a respirator and received nourishment and hydration through a feeding tube.[97] Subsequently, the respirator was removed and Daniel breathed on his own.[98]

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89. For a description of the various mechanisms of artificial nutrition and hydration, see American Dietetic Association, *Issues in Feeding the Terminally Ill Adult*, 87 J. AM. DIETETIC A. 78 (1987).

90. *See* ALASKA STAT. § 18.12.040(b) (1986); IDAHO CODE § 39-4504(1) (Supp. 1988).

91. *See* A. MEISEL, *supra* note 51, at 369–70; Annas, *Fashion and Freedom: When Artificial Feeding Should Be Withdrawn*, 75 AM. J. PUB. HEALTH 685 (1985); Dresser & Boisaubin, *Ethics, Law, and Nutritional Support*, 145 ARCHIVES INTERNAL MED. 122 (1985); Lynn & Childress, *Must Patients Always Be Given Food and Water?*, HASTINGS CENTER REP., Oct. 1983, at 17.

92. Siegler & Weisbard, *Against the Emerging Stream: Should Fluids and Nutritional Support Be Discontinued?*, 145 ARCHIVES INTERNAL MED. 129 (1985).

93. *In re* Estate of Longeway, No. 67318 (Ill. Sup. Ct. Nov. 1989); Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988), *cert. granted sub. nom.* Cruzan v. Director of Miss. Dep't of Health, 109 S. Ct. 3240 (1989).

94. Couture v. Couture, 48 Ohio App. 3d 208 (1989).

95. *Id.*

96. *Id.* at 209.

97. *Id.*

98. *Id.*

Both Clarence and Bertha Couture, Daniel's divorced parents, filed applications to be appointed guardian of Daniel because of his disability.[99] A guardianship hearing before the Montgomery County Probate Court took place on May 30, 1989.[100] At the conclusion of the hearing, the Probate Court appointed Bertha Couture as guardian.[101]

At the time of her appointment, Bertha Couture testified that it would be in Daniel's best interests to terminate use of the respirator and intertubal nutrition and hydration.[102] Her position was taken with the advice and guidance of Daniel's physician and the agreement of other family members.[103] Clarence Couture objected and instituted legal proceedings to oppose and prevent the proposed treatment withdrawal.[104] The probate court issued a temporary restraining order the following day, to remain in effect until June 28, 1989.[105]

A hearing before the probate court took place on June 26, 1989.[106] The court heard evidence from Bertha Couture and her son, James, in support of the position that Daniel would oppose the use of life-prolonging medical care in these circumstances.[107] It also heard testimony from physicians concerning Daniel's illness and prognosis.[108] The probate court denied the motion of Clarence Couture seeking to have his former wife removed as guardian.[109] His requests for preliminary and permanent injunctions were dismissed.[110] In an entry dated June 27, 1989, the probate court stated: "Bertha J. Couture, as such Guardian, is entitled to make those decisions for further treatment and care, after consulting with the ward's doctors, and which would be best for the ward and in accordance with the desires of the ward."[111]

On June 28, 1989, Clarence Couture filed three notices of appeal, which were later consolidated.[112] On August 2, 1989, Bertha Couture withdrew as guardian and was replaced by Clarence Couture.[113] The case then proceeded to oral argument.[114]

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99. *Id.*
100. *Id.*
101. *Id.*
102. *Id.*
103. *Id.*
104. *Id.*
105. *Id.*
106. *Id.*
107. *Id.*
108. *Id.*
109. *Id.*
110. *Id.*
111. *Id.*
112. *Id.*
113. *Id.* at 210.
114. *Id.*

In a unanimous opinion, the Court of Appeals for Montgomery County modified the actions of the probate court.[115] In short, the court's decision forbade the guardian, hospital, or any other party to direct, permit, or take any steps to withdraw nutrition or hydration from Daniel Couture.[116] The court reached this decision by looking to newly enacted S. 13,[117] even though the case involved a court-appointed and monitored guardian, as opposed to an attorney in fact who would not be subject to oversight by a court or other external body.[118] And this newly enacted statute had not become effective.[119] Nonetheless, the court reasoned that the Ohio legislature had, as a matter of public policy, gone on record in favor of severe limitations on the authority of a substitute decisionmaker to remove nutrition and hydration tubes.[120] But two of the necessary conditions set forth in the statute to allow nutrition and hydration discontinuance—namely, that the patient's death be "imminent" with or without artificial sustenance and that removal of nutrition and hydration not result in death by malnutrition or dehydration—were not satisfied.[121] The case was not appealed.

As the *Couture* case illustrates, S. 13, if strictly applied, may have the effect of preventing the removal (or even the non-initiation) of nutrition and hydration tubes from all decisionally incapacitated patients.[122] While the statute has some reasonableness and flexibility in the form of conditions under which an attorney in fact is authorized to consent to the withholding or withdrawal of nutrition or hydration tubes,[123] the practical utility of these conditions is non-existent.

The first stated condition, that in the opinion of the principal's attending physician and at least one independent physician, the provision of nutrition or hydration to the principal would not provide comfort to the principal,[124] is not problematic for most patients. The courts have been overwhelmingly persuaded by medical testimony that persons in persistent vegetative states are physically incapable of experiencing pain or pleasure, and therefore that continued provision of artificially administered means of nutrition and hydration serve no value in terms

115. *See id.* at 214.
116. *Id.*
117. 1989 Ohio Legis. Serv. 5-91 to -94 (Baldwin) (to be codified at OHIO REV. CODE ANN. §§ 1337.11–.17).
118. *See Couture*, 48 Ohio App. 3d at 212–13.
119. *See id.* at 212.
120. *Id.* at 213.
121. *See id.*
122. *See id.*
123. § 1337.13(E)(1)–(2); *see supra* notes 85–86 and accompanying text.
124. § 1337.13(E)(1).

of such patients' comfort.[125]

The second condition, though, is severely restrictive—to the point of being internally contradictory—in both of its alternative parts. Refusal of nutrition and hydration by the agent is countenanced only when the patient's death is imminent with or without such intervention and when the nonprovision of nutrition and hydration is not likely to result in the death of the patient by malnutrition or dehydration, or the nutrition and hydration could not be assimilated or would shorten the patient's life.[126] As already noted, many of the most appropriate candidates for discontinuation of nutrition and hydration tubes are not imminently dying, although existing in a vegetative state with no realistic possibility of regaining upper brain function. It is precisely the apprehension of remaining in a persistent vegetative state for a long period of time that motivates individuals to execute a durable power of attorney for health care.

It would be the rare case indeed where nonprovision of nutrition and hydration would *fail* to result in the death of the principal by malnutrition or hydration.[127] Such a result is the only logical and intended outcome of tube feeding removal. The legislature appears to confuse the very different concepts of malnutrition/dehydration on the one hand and hunger/thirst on the other.[128] The former relates to physiological functioning, while the latter refers to sensations. Since the prevailing clinical view is that patients in persistent vegetative states are incapable of sensory perceptions, malnutrition and dehydration for such patients do not imply the pain of hunger or thirst that persons normally experience. Hence, the second condition serves no legitimate social purpose.

The final condition, that of medical futility as a ground for nonprovision of nutrition or hydration, is similarly unhelpful. The determination of medical futility in particular fact situations is highly controversial. Even under the most liberal formulation is likely to apply to a minute percentage of the total patient population. Some bare physiological benefit from artificial nutrition and hydration can be demonstrated, at least in theory, for almost any patient.

Thus, S. 13 may create far more difficulties than it solves when decisions concerning artificial nutrition and hydration are implicated. Challenges to this portion of the statute are inevitable.

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125. *See, e.g.*, Brophy v. New England Sinai Hosp., 398 Mass. 417, 497 N.E.2d 626 (1986).

126. § 1337.13(E)(2).

127. OHIO REV. CODE ANN. § 2108.3 (Baldwin 1987).

128. *See* Lynn & Childress, *supra* note 91.

V. CHANGING MEDICAL ORDERS, REVOCATION, AND IMMUNITIES

Sections 1337.13 through 1337.15 of the Ohio Revised Code[129] address questions of changing medical orders,[130] revocation of the durable power instrument,[131] and the potential liabilities and immunities of those parties concerned with carrying out the actions authorized by the instrument.[132] Section 1337.13(F) provides:

> An attorney in fact under a durable power of attorney for health care does not have authority to withdraw informed consent to any health care to which the principal previously consented, unless at least one of the following applies: (1) a change in the physical condition of the principal has significantly decreased the benefit of that health care to the principal; (2) the health care is not, or is no longer, significantly effective in achieving the purposes for which the principal consented to its use.[133]

This section is in conformity with the agent's fiduciary responsibilities to the principal under either the substituted judgment or best interests standards of decisionmaking.

A durable power of attorney for health care instrument may be revoked by the principal, who is presumed to have the mental capacity to accomplish revocation.[134] Revocation is accomplished by notifying the attorney in fact orally or in writing of an intent to revoke the power;[135] by notifying orally or in writing the principal's physician, with the physician becoming thereby obliged to make the notification a part of the principal's medical records;[136] by canceling, obliterating, or destroying the instrument with the intent to revoke it;[137] by doing any other (unspecified) act in which the principal clearly communicates an intent to revoke the instrument;[138] and by executing a subsequent durable power of attorney for health care instrument.[139]

Disputes over the capacity of a principal to revoke a durable power of attorney for health care made earlier are easily foreseeable. While a presumption of capacity to revoke "unless there is evidence to the contrary"[140] is stated, the statute is completely silent on the nature or

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129. 1989 Ohio Legis. Serv. 5-91 to -92 (Baldwin) (to be codified at OHIO REV. CODE ANN. §§ 1337.13–.15).
130. OHIO REV. CODE ANN. § 1337.13 (Baldwin 1989).
131. *Id.* § 1337.14.
132. *Id.* § 1337.15.
133. *Id.* § 1337.13(F).
134. *Id.* § 1337.14(A)(1).
135. *Id.*
136. *Id.* § 1337.14(A)(2).
137. *Id.* § 1337.14(A)(3).
138. *Id.* § 1337.14(A)(4).
139. *Id.* § 1337.14(B).
140. *Id.* § 1337.14(A).

weight of evidence needed to rebut that presumption. The probate courts inevitably will be called upon to adjudicate conflicts over revocatory capacity on a case-by-case basis.

S. 13 provides legal immunities for parties involved with durable powers of attorney for health care.[141] Section 1337.15 protects the attending physician against criminal, civil, or professional disciplinary liability for actions taken in good faith when a decision is made by the attorney in fact on the basis of valid informed consent and the physician believes the agent is acting with proper authority;[142] the physician believes that the agent's decision is consistent with the principal's substituted judgment or, if the principal's wishes under the circumstances are not known, with the principal's best interests;[143] and, if the agent's decision is to withhold or withdraw life-prolonging intervention, the physician attempts as far as possible to ascertain the principal's preferences and he documents that attempt.[144]

In section 1337.15(B), however, the legislature undermines the rights it purports to create by excusing the principal's physician from any criminal, civil, or professional disciplinary liability for ignoring an attorney in fact's decision to withhold or withdraw life-prolonging health care. This provision abrogates Ohio common law. The common law holds that a health care provider may be held liable for battery for inflicting unwanted (as expressed for an incompetent patient through a proxy) life-prolonging medical intervention on a patient.[145] The new statute thus leaves compliance with the attorney in fact's decisions, even if they unambiguously represent the wishes of the principal, to the unaccountable discretion of the individual physician.[146]

To exacerbate the ordinary predilection of most physicians to overtreat rather than undertreat in situations involving artificial life support,[147] the legislature has underscored in S. 13 that the physician continues to be legally exposed for negligent acts or omissions that cause or contribute to any injury to "or the wrongful death" of the principal.[148] The statute's admonition to physicians and health care facilities, who are unwilling to comply with an attorney in fact's refusal of life-

141. *Id.* § 1337.15.
142. *Id.* § 1337.15(A)(1).
143. *Id.* § 1337.15(A)(2).
144. *Id.* § 1337.15(A)(3).
145. Estate of Leach v. Shapiro, 13 Ohio App. 3d 393, 469 N.E.2d 1047 (1984); *see also* Note, *Toward an Ohio Natural Death Act: The Need for Living Will Legislation*, 46 OHIO ST. L.J. 1019 (1985).
146. § 1337.15(B).
147. *See* M. Kapp & B. Lo, *Legal Perceptions and Medical Decision Making*, 64 MILBANK Q. 163 (1986).
148. § 1337.15(F).

prolonging health care, to refrain from interference with attempts to transfer the principal to more compliant health care providers[149] is likely to have little practical value in the absence of providers vying within the health care delivery system for the opportunity to accept transferred patients for the purpose of discontinuing treatment.

Several miscellaneous provisions appear near the end of S. 13. The statute protects individuals from being compelled to create or to refrain from creating a durable power of attorney for health care by any provider or insurer.[150] S. 13 is not intended to limit the authority of a health care provider to render health care to any person without that person's consent in emergency situations where consent usually is implied.[151] Section 1337.17 of the Ohio Revised Code,[152] the final section of the statute, prescribes specific language that must accompany any printed durable power of attorney for health care form that is distributed in Ohio. This language is intended to notify potential principals of their legal rights and limitations.[153]

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149. 1989 Ohio Legis. Serv. 5-93 (Baldwin) (to be codified at OHIO REV. CODE ANN. § 1337.16(B)).

150. *Id.* § 1337.16(A).

151. *Id.* § 1337.16(C).

152. 1989 Ohio Legis. Serv. 5-93 (Baldwin) (to be codified at OHIO REV. CODE ANN. § 1337.17).

153. *Id.* § 1337.17.

This is an important legal document. Before executing this document, you should know these facts: This document gives the person you designate (the attorney in fact) the power to make most health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when you lose the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself. You may include specific limitations in this document on the authority of the attorney in fact to make health care decisions for you. Subject to any specific limitations you include in this document, if you do lose the capacity to make an informed decision on a health care matter, the attorney in fact *generally* will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the attorney in fact to make health care decisions for you *generally* will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. *However*, even if the attorney in fact has general authority to make health care decisions for you under this document, the attorney in fact *never* will be authorized to do any of the following: (1) refuse or withdraw informed consent to health care necessary to maintain your life (unless you are suffering from an illness or injury that is likely to result in imminent death, regardless of the type, nature, and amount of health care provided); (2) refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if he is not prohibited from doing so under (4) below, the attorney in fact could refuse or withdraw informed consent to the provision of nutrition or hydration to you); (3) refuse or withdraw informed consent to health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would

VI. CONCLUSION

The passage of a durable power of attorney for health care statute[154] will facilitate advance health care planning and medical decision-

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pose a substantial risk to your life, or unless your attending physician and at least one other physician determine, to a reasonable degree of medical certainty that the fetus would not be born alive); (4) refuse or withdraw informed consent to the provision of nutrition or hydration to you, unless, prior to the refusal or withdrawal of that informed consent, your attending physician and at least one other physician record their opinions that the provision of nutrition or hydration would not provide comfort to you, and additionally that either of the following situations exists: your death is imminent whether or not nutrition or hydration is provided to you, and the nonprovision of nutrition or hydration to you is not likely to result in your death by malnutrition or dehydration; or if nutrition or hydration were provided to you, it could not be assimilated or would shorten your life; (5) withdraw informed consent to any health care to which you previously consented, unless a change in your physical condition has significantly decreased the benefit of that health care to you, or unless the health care is not, or is no longer, significantly effective in achieving the purposes for which you consented to its use.

Additionally, when exercising his authority to make health care decisions for you, the attorney in fact will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the attorney in fact by including them in this document or by making them known to him in another manner. When acting pursuant to this document, the attorney in fact *generally* will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose. Generally, you may designate any competent adult as the attorney in fact under this document. However, you *cannot* designate a physician who is treating you, an employee or agent of a physician who is treating you, or an employee or agent of a health care facility at which you are being treated as the attorney in fact under it. Unless you specify a shorter period in this document, the document and the power it grants to the attorney in fact will be in effect for seven years from the date of its execution. However, if you lack the capacity to make informed health care decisions on the date that the document and the power it grants to the attorney in fact otherwise would expire, the document and the power it grants will continue in effect until you regain the capacity to make informed health care decisions for yourself. You have the right to revoke the designation of the attorney in fact by giving him oral or written notice of the revocation. you have the right to revoke the authority of the attorney in fact to make health care decisions for you by giving oral or written notice of the revocation to your physician or another physician who is providing you with health care. You have the right to revoke this document and the authority granted to the attorney in fact under this document by canceling, obliterating, or destroying it with the intent to revoke it, or by doing anything else that clearly communicates your intent to revoke the document. If you execute this document and create a valid durable power of attorney for health care with it, it will revoke any prior, valid durable power of attorney for health care that you created, unless you indicate otherwise in this document. This document is not valid as a durable power of attorney for health care unless it either is acknowledged before a notary public or it is attested and signed by at least two adult witnesses who personally know you and who are present when you sign or acknowledge your signature. No person who is related to you by blood, marriage, or adoption, and no person who is entitled to benefit in any way from your death may be a witness. The attorney in fact, physicians, and employees or agents of a physician or a health care facility are ineligible to be witnesses. If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.

Id.

154. 1989 Ohio Legis. Serv. 5-91 to -94 (Baldwin) (to be codified at OHIO REV. CODE ANN.

making in many instances involving decisionally incapacitated patients. This planning instrument can promote patient autonomy, relieve family anxiety, assist physicians and other health care providers to engage in better clinical and ethical patient care, and, perhaps, keep questions relating to medical decisionmaking out of the judicial sphere.[155] But S. 13 must be improved in its handling of the concept of terminal illness, the withholding and withdrawal of artificial nutrition and hydration, the standards for assessing evidence of incapacity of the principal to make his own health care decisions or to revoke the durable power instrument, and the inevitable failure of immunized physicians to honor decisions enunciated by attorneys in fact to limit life-prolonging interventions. The most likely benefit of this statute will be in educational terms. Ideally, the existence of, and publicity surrounding, Ohio's new durable power of attorney for health care statute will encourage citizens to think more deeply about their values and preferences concerning alternative medical futures, and to discuss those values and preferences earlier and more openly with their family members and health care providers.[156] If such communication is engendered, the legislation may well serve its chief social aims despite its technical deficiencies.

§§ 1337.11–.17).

155. *Cf.* Kapp, *Law, Medicine, and the Terminally Ill: Humanizing Risk Management Advice*, 12 HEALTH CARE MGMT. REV. 37 (1987).

156. On the need for this sort of communication, see generally Schneiderman & Arras, *Counseling Patients to Counsel Physicians on Future Care in the Event of Patient Incompetence*, 102 ANNALS INTERNAL MED. 693 (1985).