OHIO'S NEED TO ENACT A LIVING WILL STATUTE AND RECOGNIZE THE TERMINALLY ILL PATIENT'S RIGHT TO DEATH WITH DIGNITY

INTRODUCTION

Without natural death, human societies and the human race itself would certainly be unable to thrive. Perhaps when we realize this we may come to realize at the same time that there is a point in the degeneration of our bodies when life loses its value, and we may then be prepared voluntarily to leave the scene to our successors.¹

Advancing and upholding the "sanctity or preservation of life is a paramount state interest."² The common law regards life as "sacred and unalienable" and prohibits anyone from committing suicide or "licensing his own destruction."³ Today's advanced medical technology, which enables an individual's life to be prolonged for an indefinite period of time,⁴ is mandating a reanalysis of the meaning of "sanctity of life."⁵ Technology can "ventilate a corpse or prolong death when life as we know it has long passed."⁶ Society is now forced to acknowledge and address the issues created by technological advancements.

A terminally ill patient may decide to forego or terminate life-sustaining medical treatment and allow the "natural processes of death" to occur.⁷ This paramount decision has been variously referred to as the right to die, death with dignity, and passive euthanasia.⁸ Several moral, medical, and legal issues are intertwined in recognizing and permitting the terminally ill patient to make his decision.

Society must determine the circumstances in which a terminally ill patient will be permitted to terminate life-sustaining treatment. If a terminally ill patient is incompetent, for example, the question arises as to who can make this decision.

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⁴ Clarke, supra note 3, at 815; see also, Dufraine, Living Wills — A Need For Statewide Legislation or a Federally Recognized Right, 1983 DET. C.L. REV. 781 [hereinafter cited as Dufraine]. The technological devices include respirators, heart lung machines, pacemakers, antibiotics, defibrillators, chronic dialysis, apheresis, artificial or transplanted organs, and extensive drug therapy. Comment, The Living Will: Ready a Practical Alternative, 55 TEX. L. REV. 665, 666 (1977) [hereinafter cited as Living Will].
⁵ Tagle, Medical Technology as it Exists Today, 27 BAYLOR L. REV. 31 (1975).
⁶ Dufraine, supra note 4, at 666.
⁸ STATE PLANNING STUDIES, A MATTER OF LIFE AND DEATH (October 1985) (Available from National City Bank, Trust Division).
decision on behalf of the patient. In response to this uncertainty, many states have enacted legislation establishing procedures and guidelines for the medical profession, legal profession and the terminally ill patient when confronted with this life and death decision. Thirty-five states and the District of Columbia have enacted Natural Death and “Living Will” statutes.

A “living will” is a document which constitutes an affirmative directive to medical personnel to withhold life-sustaining medical treatment in certain instances. The “living will” statutes permit a terminally ill patient to refuse life-sustaining treatment in the event such treatment will have no “restorative” effect. Terminally ill patients are given the assurance that their decision concerning life-sustaining treatment will be effectuated without the need of judicial intervention. The Ohio Legislature is considering a “living will” or natural death act, but as yet no such legislation has been enacted.

This article discusses the use of “living wills” as a method for permitting a terminally ill patient to forego or terminate life-sustaining treatment. First, the constitutional issues, description, and medical and legal considerations of “living wills” will be explored. Secondly, alternative methods to forego or terminate life-sustaining treatment will be discussed. Finally, this article will analyze Ohio’s proposed “living will” statute, and offer corresponding recommendations.

**Constitutional Considerations**

The right to accept or refuse medical treatment is predicated on common law principles. This right protects one’s interests both in the “integrity of his

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12 Right to Terminate, supra note 9, at 10.

"body" and in freedom from "unpermitted physical contact."" Each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery or other medical treatment."

The right to privacy has been the basis for courts to acknowledge and uphold a terminally ill patient's right to refuse medical treatment, whether expressed by a competent adult, or in the case of an incompetent, through a guardian. No constitutional provision explicitly enunciates a "right to privacy." In *Olmstead v. United States*, the right to privacy received its first judicial recognition as a possible constitutional right in the dissenting opinion of Justice Brandeis. In *Griswold v. Connecticut*, the Supreme Court of the United States held that the right to privacy was included in the "penumbras" of the Bill of Rights. The United States Supreme Court has not yet applied the constitutionally-protected right to privacy to terminally ill patients. However, state courts have held that the decision of a terminally ill patient to refuse life-prolonging treatment is protected by the right to privacy.


Justice Brandeis stated:

"[t]he makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man's spiritual nature, of his feelings and of his intellect. They knew that only a part of the pain, pleasure and satisfaction of life are to be found in material things. They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred as against the Government, the right to be left alone — the most comprehensive of rights and the right most valued by civilized men."

*Id.* at 478 (Brandeis, J., dissenting).

Re Quinlan,24 the court discussed the state’s interest concerning a terminally ill patient’s25 decision to refuse life-sustaining treatment, stating “We think that the state’s interest [in the preservation of life] weakens and the individual’s right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual’s rights overcome the state interest.”26 The recognized state interests include protecting innocent third parties, preventing suicide, preserving life, and protecting the ethical integrity of the medical profession.27 A thorough analysis and discussion of these state interests is beyond the scope of this article.28

A terminally ill patient has the right to forego life-sustaining treatment. However, a question remains as to whether courts are adequately prepared to make decisions and set guidelines concerning a terminally ill patient’s desire to terminate life-sustaining treatment. There is widespread recognition that the judicial setting is not the proper forum for making treatment decisions.29 Resorting to the courts to confirm the patient’s decision to forego life-sustaining treatment is inappropriate, not only because it is an “encroachment upon the medical profession’s field of competence, but because it would be impossibly cumbersome.”30

25Miss Quinlan, in addition to being comatose, was in a “chronic and persistent vegetative state,” having no awareness of anything or anyone around her and existing at a “primitive reflex level.” Id. at 19, 355 A.2d at 655.
26Id. at 41, 355 A.2d at 664.
27Saikewicz, 373 Mass. 738, 737, 370 N.E.2d 417, 425 (1977). In addressing the state’s interest in the preservation of life and the right of privacy, the court in Saikewicz states:

[It is clear that the most significant of the asserted State interest is that of the preservation of human life. . . . The interest of the State in prolonging a life must be reconciled with the interest of an individual to reject the traumatic cost of that prolongation. There is a substantial distinction in the State’s insistence that human life be saved where the affliction is curable, as opposed to the State interest where, as here, the issue is not whether but when, for how long, and at what cost to the individual that life may be briefly extended. . . . We believe it is not inconsistent to recognize a right to decline medical treatment in a situation of incurable illness.

Id. at 737, 370 N.E.2d at 425. In Saunders v. State, ___ Misc. 2d ___, 492 N.Y.S.2d 510 (1985), the court held that it is certainly not against public policy to permit a terminally ill patient to choose not to delay the inevitable and imminent termination of his or her life. Id. at 514.

29For a thorough discussion of the state’s interest, see comment, A Proposed Amendment to the California Natural Death Act to Assure the Statutory Right to Control Life Sustaining Treatment Decisions, 17 U.S.F.L. REV. 579 (1983).
30Medial Treatment, supra note 14, at 995; see also Rosoff, Living Wills and Natural Death Acts. Legal and Ethical Aspects of Treating Critically and Terminally Ill Patients, 186-89 (1982) (judicial proceedings are “no way to make life or death decisions”) [hereinafter cited as Rosoff]. Contra, Saikewicz, 373 Mass. 728, 759, 370 N.E.2d 417, 435 (1977). (Courts are uniquely qualified to make determinations which require “detached but passionate investigation”).
31In re Quinlan, 70 N.J. 10, 50, 355 A.2d 647, 669 (1976). In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985), involved an eighty-four year old patient who was mentally incompetent and terminally ill. The case presented the issue of whether a feeding tube could be removed from the patient. In discussing the appropriateness of judicial resolution of the issue, the court stated:

Perhaps it would be best if the legislature formulated clear standards for resolving requests to terminate life-sustaining treatment for incompetent patients. As an elected body, the legislature is better able than any other single institution to reflect the social values at stake. In addition, it has the resources and ability to synthesize vast quantities of data and opinions from a variety of fields and to
Legislation is the answer to the many issues created by the terminally ill patient's choice to forego life-sustaining treatment. Courts are simply not adequately prepared to handle the issues involving such far-reaching "political, moral and ethical dimensions." Legislation is the most appropriate way to resolve the difficult issues in society, since the legislative process allows input from all segments of the society.

HISTORY AND DEVELOPMENT

Luis Kutner is credited with having developed the concept of the "living will." He described the reason why a "living will" is essential:

The law provides that a patient may not be subjected to treatment without his consent. But when he is in a condition in which his consent cannot be expressed, the physician must assume that the patient wishes to be treated to preserve his life. His failure to act fully to keep the patient alive in a particular instance may lead to liability for negligence. But it may well be that a patient does not desire to be kept in a state of indefinite vegetated animation. How then can the individual patient retain the right of privacy over his body — the right to determine whether he should be permitted to die, to permit his body to be given to the undertaker?

Living wills have been referred to by many names. The "living will" has been defined as "a directive to [one's] family and physician acknowledging [one's] preference for a dignified death as opposed to an artificial or mechanical prolongation of life when no reasonable hope of recovery remains." It must be pointed out that a "living will" may not authorize the commission of euthanasia. Living wills are analagous to a revocable or conditional trust.

formulate general guidelines that may be applicable to a broad range of situations. Id. at 344, 355 A.2d at 1220-21 (footnote omitted).


"Kutner, supra note 1.

"Id.

"Kutner, supra note 1.

"Id. at 550.


"Kutner, supra note 1, at 553. "While a patient may determine the type of medical treatment he may receive, he may not use the living will as a means for directing a doctor or another individual to act affirmatively to terminate his life. A living will authorizing mercy killing is contrary to public policy." Id. Euthanasia has been defined as the taking of positive action to end the life of an incurable patient. S. SHINDELL, THE LAW IN MEDICAL PRACTICE 118 (1966). Euthanasia must be distinguished from antidyshystaniasia which has been defined as the "failure to take positive action to prolong the life of an incurable patient with intractable pain." Id.

The patient's body is the res, the patient is the beneficiary and grantor, and the physician and hospital are the trustees. Under a "living will," "the doctor is given authority to act as the trustee of the patient's body by virtue of the patient's consent to treatment."

**Legislative enactment**

A legislative movement to clarify the status of "living wills" was initiated by the California Natural Death Act of 1976. California's "living will" statute constructed the foundation upon which other states could enact legislation. In the years immediately following 1976, few states enacted "living will" statutes. By the end of 1982, only fourteen states granted their citizens the right to terminate life-sustaining treatment. A total of twenty states proposed and enacted legislation validating "living wills" in 1984 and 1985. This recent surge has increased the number of states which have enacted "living will" statutes to thirty-five plus the District of Columbia.

**Statutory requirements**

Statutes which recognize the "living will" as legally binding adopt the same procedural requirements as those found in testamentary will provisions. These procedural requirements reduce the possibility of mistake or fraud. In addition, the declarant is alerted to the fact that this is an important document being signed.

Just as capacity is essential to the making of a testamentary will, it is also needed to execute a "living will." Capacity to execute a "living will" is dependent upon the capacity to consent to treatment. A majority of the statutes

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9 Id.

10 Id.


12 Dufraine, supra note 4, at 800. For a more detailed analysis of the states adoption of "living will" legislation, see Dufraine, at 800-05; SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF LIVING WILL LAWS 1981-84 (1984).

13 See authorities cited supra note 10.


15 SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF LIVING WILL LAWS 1981-84 (1984). Arkansas' statute states "[a]ny person, with the same formalities as are required by the laws of this state for the execution of a will, may execute a document." ARK. STAT. ANN. §§ 82-3802 (Supp. 1985). Execution requires that the document be signed, dated and witnessed. Two adult witnesses are required, and these witnesses may not be individuals who have an interest in the declarant's estate, who might have a claim against the estate or who might be able to exert undue influence on the document. ARK. STAT. ANN. §§ 60.401 to 403 (1971).

16 "Capacity has been defined to be a soundness of mind which renders the maker able to mentally understand, in general terms, the nature and extent of his property and an understanding of the acts he is performing when he makes the will." Dufraine, supra note 4, at 805.

17 Kutner, supra note 1, at 552. "[a] person who is a minor, institutionalized, or adjudged incompetent could not make such a declaration. A guardian should not be permitted to make such a declaration on behalf of his ward nor a parent on behalf of his child." Id.
enacted require that the declarant be of "sound mind." Thus, the declarant must be competent in order to have the capacity to sign a "living will."

One advantage to the "living will" is that it enables one to make a competent determination before becoming incapacitated. It gives a terminally ill patient an opportunity to refuse future treatment at a time when competency is not in question, and at a time when the patient is not making an ultimate life and death decision. Some statutes have removed this advantage by requiring the terminally ill patient to reexecute the "living will" fourteen days after being informed of the terminal condition. This renders a comatose patient and other incompetents unable to effectively execute a living will.

All of the statutes contain a definition section which sets forth the conditions for the document's use. The defined terms often create ambiguities. These ambiguities create difficulties in interpreting and strictly adhering to the legislation. The "ordinary" versus "extraordinary" treatment terms have been the basis for much debate. Many statutes use the term "imminent" to define the period in which a patient's death will occur. These terms must be more precisely defined to assure a more consistent interpretation of the statutes. Courts' interpretation of these terms may defeat the purpose behind the legislation. The statutes are enacted to allow a terminally ill patient to forego or terminate life-sustaining medical treatment without judicial intervention.

A provision stating the procedures to revoke or modify a "living will" is found in every statute. Allowing the declarant to revoke or modify the "living will" document grants the declarant some flexibility in her decision. The existing statutes generally provide for revocation by the execution of a subsequent instrument expressing an intent to revoke, or by a physical act or ver-

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49Note, supra note 36, at 514. Several factors can affect the competency of a patient in critical condition: First, the patient's wishes may be affected by "what he thinks his relatives want, by the emotional stress caused by the illness, by the doctor's attitude, by the relatives' attitudes, and even by financial considerations." Second, psychological studies have indicated that all persons have a suppressed longing for death — the death wish, or "thanos." Since that desire can manifest itself on a conscious level when a person is seriously ill, the patient must be protected from this temporary manifestation. Third, the patient may not know his true condition.

45Id. at 513 (footnotes omitted).


51See authorities cited supra note 10.

52"A workable definition of the term 'ordinary' is any medical treatment which offers a reasonable hope of recovery while 'extraordinary' is that treatment which does not offer a reasonable hope of recovery in the patient." Dufraine, supra note 4, at 786.

53Ordinary means are 'all medicines, treatment and operations which offer a reasonable hope of benefit, and which can be obtained and used without excessive expense, pain or other inconvenience,' while extraordinary means are 'those which do involve these factors, or which, if used, would not offer a reasonable hope of benefit.'

54Note, supra note 36, at 495.

55See Right to Die supra note 35, at 125.

bal expression of the declarant, or an individual acting on his behalf, communicated to the attending physical. Many of the statutes permit revocation without determining the mental state or competency of the declarant. This is deemed necessary because "[o]ne of the greatest fears of a client about a "living will" is the fear of an inability to change one’s mind during terminal illness simply because others consider him or her incompetent."

In a majority of states, the “living will” is effective until revoked. Some states require that the “living will” document be reexecuted every certain number of years. There are advantages in having the declarant review, sign and redate the document. However, requiring that the declarant reexecute the document may result in a “living will,” which expresses the precise desires of the terminally ill patient, being declared invalid. The declarant is thus burdened with the responsibility of reexecuting the document regardless of whether his attitude concerning life-sustaining medical treatment has remained the same. Physicians, attorneys, and family members often retain copies of the declarant’s “living will.” The declarant will be required to insure that all individuals possess a current copy of the “living will.”

Physicians and health care personnel perform the major role in carrying out the directive of the terminally ill patient. Physicians are concerned with possible liability arising from procedures involving a “living will.” Actions against physicians are often based on the lack of consent to treatment by the patient. “The possible liability for continuing life prolonging treatment without consent emphasizes the practical effect of the living will.” Physicians and health care professionals are granted both civil and criminal immunity when they “in good faith” withhold or withdraw life-sustaining treatment from a terminally ill patient in accordance with the patient’s “living will.” However, physicians and health care professionals are not exempt from claims of negligence. “Living wills” are the method to “free physicians, in the pursuit

6Living Will, supra note 4, at 704; Note, supra note 36, at 517.
8IDAHO CODE §§ 39-4506 (1982) (five years); WIS. STAT. ANN. §§ 154.03(1) (West Supp. 1985) (Five years); GA. CODE ANN. §§ 31-32-6 (1985) (Seven years).
9RÓSOFF, supra note 29, at 315.
10Dufraine, supra note 4, at 819.
11Id.

A physician who ignores the patient’s refusal of consent may increase the damage award in a successful suit against him by the patient’s estate for prolonging the patient’s suffering. When faced with the choice of either increasing his potential liability or following the instructions of the living will, most reasonable physicians will probably follow the directive.

Id. at 820.
12Cohn, The Living Will From the Nurses Perspective, 11 L., MED. AND HEALTH CARE, 121 (1983).
13Comment, To Die or Not to Die: The New York Legislature Ponders a Natural Death Act, 13 FORDHAM URB. L.J. 639, 671 (1985) [hereinafter cited as Natural Death Act]. Immunity is inapplicable “if it is shown by a preponderance of the evidence that the person authorizing or effectuating the withholding or withdrawal of life-sustaining procedures was negligent or did not in good faith comply with the provisions of this act.” S.B. 2387, 201st. Leg., 1st Ann. Sess. (New Jersey Nov. 19, 1984).
of their healing vocation, from possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgment for the well-being of their dying patients.”

A majority of physicians do not consider it morally or legally wrong to “withdraw extraordinary life-support systems in hopeless situations.” In jurisdictions where “living wills” are given legal status, physicians are generally required to either comply with the directive or transfer the patient to another physician. A majority of states require the noncomplying physician to make a “reasonable effort” to transfer the patient to another physician. Placing a strict responsibility on the physician to transfer the patient may result in physicians becoming apprehensive about accepting patients who have executed “living wills” and a general uneasiness in the medical profession.

In some instances the existence of a “living will” statute may actually have a chilling effect on doctors; they may hesitate to terminate treatment where previously they would have done so in the exercise of their own medical judgment and discretion. This is particularly true where a terminal patient has not executed a directive. The doctor may assume that the failure to execute a directive means that the patient does not want life-sustaining procedures to be withdrawn or withheld, or that terminating treatment in the absence of a directive signed by the patient could result in legal liability.

Many statutes now provide that the failure of a patient to make a “living will” creates no presumption as to his wishes regarding the use, withholding or discontinuing of life-sustaining medical treatment. This provision enables the physician to make a professional judgment based on his medical training, and without the worry of legal implications. The “chilling effect” may be of some concern, but it does not outweigh the benefit of the “living will” to the medical profession.

Placement and safekeeping of the “living will” is a concern. It is the patient’s responsibility to make sure the proper parties are cognizant of his inten-
Some statutes require that the “living will” be placed in the patient’s medical file. Registering the document with the Bureau of Vital Statistics is required in some jurisdictions. A maker of a “living will” should have ready access to the document in the event a review of the document’s contents is necessary or revocation is desired. Friends and relatives should be notified of one’s execution of a “living will” and its contents. This will assure the patient that a search for the document will be conducted if necessary. If the document is not found, the notification of the friends and relatives can be represented as evidence of the patient’s intentions.

Major concerns with “living wills” are that they can not be executed by incompetents, that there must be a declaration that the patient is terminally ill and death is imminent, and that they only give directives pertaining to life-sustaining treatment. “Living wills,” no matter how broadly or specifically worded, can not anticipate the full range of medical decisions. They can not be used to appoint an agent or enunciate specific instructions regarding medical care. When the patient is individually unable to refuse medical treatment, the courts have permitted the patient’s right to be exercised by another. However, this procedure to have another exercise one’s right to refuse treatment can not be accomplished by a majority of “living will” statutes.

**The “Durable Power of Attorney”**

A “power of attorney” is a document by which one person (the principal) confers upon another person (the agent) the legally recognized authority to perform certain acts on the principal’s behalf. The general “power of attorney” becomes inoperative when the principal becomes incapacitated. All fifty

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9Physicians should not be required to spend time ascertaining whether the patient has executed a living will. Note, supra note 36, at 515.


12All statutes require the declarant of a “living will” to be competent. The law has recognized certain rights of incompetents: (1) they are said to possess all the rights attributable to competent adults; (2) the law requires them to be permitted to participate in decisions regarding their care and treatment to the greatest possible extent; and (3) the right to have someone make the decision for them. Clarke, supra note 3, at 806.

13Martyn, supra note 11, at 790.

14Id. at 787.

15Medical Treatment, supra note 14, at 999.


19President’s Commission for the Study of Ethical Problems in Medicine and Biomedical Behavioral Research, Deciding to Forego Life-Sustaining Treatment: Ethical, Medical, and Legal Issues in Treatment Decisions 146 (1983) [hereinafter cited as Treatment Decisions].

20Id.
states have enacted “durable power of attorney” statutes which permits the agent’s authority to continue after the principal has become incapacitated.

Executing a durable power of attorney may be the procedure to make certain a patient’s decision concerning medical treatment is respected. However, a majority of the statutes do not explicitly provide that the agent can make medical decisions for the principal. In the recent case of Saunders v. State the court was presented with the issue of whether a durable power of attorney is applicable to medical treatment decisions and held, “the application of the durable power to making health care decisions on behalf of principals has not been widely used and is not completely certain.” Permitting the agent to make health care decisions for the principal in the absence of explicit statutory language has not been uniformly supported by the courts.

A “durable power of attorney” is uncomplicated and inexpensive to create. It can be specifically drafted to meet the needs of the principal. The durable power of attorney can be revoked at any time by the principal. By enunciating “specific and unambiguous delineated powers and guidelines,” the agent, the family, and the principal’s wishes. In jurisdictions which do not recognize the “living will” as legally effective, the durable power of attorney at least assures the principal that an individual of his choice will be making the medical treatment decisions.

Ohio’s “durable power of attorney” statute does not specifically authorize the agent or “attorney-in-fact” to make health care decisions on behalf of the principal. No cases have been decided which address this issue. The

8A “Durable Power of Attorney” helps to facilitate the management of one’s affairs without court intervention in the event of one’s incompetency. It can be an effective estate planning tool which could be an alternative to conservatorship or guardianship. Comment, Court Enforcement of a Durable Power of Attorney, 17 U.S.F.L. REV. 611, 612 (1983) [Durable Power of Attorney].


8Living Wills are not applicable when one suffers a disability which requires medical treatment but the patient is not terminally ill. Statistics have shown that at age twenty-two one is 7.5 times more likely to suffer a disability of ninety days or more than he or she is to die. At age sixty-two, one is 4.5 times more likely to suffer a ninety day disability than he or she is to die. Bos, The Durable Power of Attorney, 64 MICH. B.J. 690 [July 1985].

8See, e.g., OHIO REV. CODE ANN. § 1337.09 (Page 1984).

8Id. at 516. Medical decisions may fall within the narrow category of exceptions to the general rule that one may do through an agent whatever he is empowered to do in his own proper person. Medical Treatment, supra note 14, at 1009.

8See, e.g., OHIO REV. CODE ANN. § 1337.09 (Page 1984).

8Right to Terminate, supra note 9, at 12.

8OHIO REV. CODE ANN. § 1337.09 (Page 1984).

8Attorney-in-fact is the term the Ohio Legislature has designated for the agent of the “durable power of attorney.”

8OHIO REV. CODE ANN. §§ 1337.09 (Page 1984) provides in relevant part: All acts done by the attorney-in-fact pursuant to the instrument during any period of disability, incapacity or adjudged incompetency of the principal shall have the same effect and inure to the benefit of and bind the principal or his heirs, devisees, and personal representatives as if the principal were competent and not disabled or incapacitated. ...
statute's current language leaves the medical treatment decision subject to interpretation and judicial review. This ambiguity may cause the courts in Ohio to spend their limited time in addressing the issue. The Ohio legislature can eliminate the ambiguity by enacting a statute which specifically provides that an agent of a durable power of attorney can make medical treatment decisions for the principal. This will give the principal additional assurance that their medical treatment decisions will be acknowledged and carried out. Health care professionals will have guidelines and procedures to follow when their patient is the principal of a durable power of attorney. The durable power of attorney can therefore be a very forceful method to assure one that his decisions concerning medical treatment will be honored after he has become incapacitated.

When a durable power of attorney is used in addition to a "living will," it provides a means by which the patient's personal affairs and decisions concerning medical treatment can be monitored "subsequent to the development of incapacity and prior to death." Advantages of the joint use of the "living will" and durable power of attorney are:

(1) they avoid the cumbersome difficulties involved in setting up revocable living trusts; (2) they are more efficient than a general power of attorney-living will combination; (3) they relieve the family of having to resort to a public determination of the rights of an individual in court; and (4) they provide an inexpensive and flexible planning alternative of a guardian or conservator.

If a court must determine whether an agent of a durable power of attorney acted in accordance with the desires or best interests of the principal, a "living will" could provide a "more complete expression of the principal's desires."

The "proxy appointment" is another method whereby a terminally ill patient's decision concerning life-sustaining treatment can be honored. A proxy appointment allows a patient to appoint an agent to make health care decisions on the patient's behalf. The proxy appointment is closely analagous to the durable power of attorney. Five of the recent "living will" statutes contain a proxy appointment provision. An agent can extend the scope of a patient's

9Ohio should adopt legislation like the Durable Power of Attorney for Health Care Decisions Act in California. This act grants immunity from civil and criminal liability as well as from "professional censure" for health care professionals who act on the basis of a good faith belief that the attorney-in-fact is authorized by the statute to make health care decisions. Uniform Durable Power of Attorney for Health Care Decisions Act, CAL. CIV. CODE § 2400 (West 1983). The health care provider must believe, in good faith, that the decision is not inconsistent with the principal's wishes, and, if the decision is to withhold or withdraw health care necessary to keep the principal alive, the provider must make a "good faith" effort to determine the desires of the principal. Id.

*Death with Dignity, supra note 36, at 205.

*Id. at 204-05.

*Martyn, supra note 11, at 797.

*TREATMENT DECISIONS, supra note 80, at 146-47.
"self-determination" further than a written directive by making decisions consistent with the patient's desires in situations which may not have been foreseen. The agent can conduct the decision-making process in much the same manner as the patient. "Where the patient himself has actually designated someone to represent him, there is greater assurance that the personal values that will come into play in making the medical decision will be those of the patient."

Proxy appointments and durable powers of attorney are not risk-free and the potential risk may outweigh the advantages. There is the possibility that an agent will make an irrational decision. Physicians may prematurely classify a patient as incompetent in order to receive consent from the agent to perform certain medical procedures. Appointing an agent who does not act in accordance with the patient's wishes is the paramount risk. A patient should therefore select the agent only after careful thought and deliberation, since the proxy appointment and durable power of attorney give great power to the agent.

Do Not Resuscitate (DNR) or "No Code" orders permit a patient to refuse life-sustaining treatment in a limited situation. For example, these procedures will permit a patient not to be resuscitated in the event of cardiac failure. A full discussion of the medical and legal ramifications of "DNR" and "No Code" orders is beyond the scope of this article.

JURISDICTIONS WITHOUT LIVING WILL LEGISLATION

Living wills can be advantageous in jurisdictions such as Ohio which do

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9 Medical Treatment, supra note 14, at 1001.

10 Id. "An agent could ask questions, assess risks and costs, speak to friends and relatives of the patient, consider a variety of therapeutic options, seek the opinions of other physicians and evaluate the patient's condition and prospects for recovery." Id.

11 Meisel, The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking, 1979 Wis. L. Rev. 413, 480.

12 Medical Treatment, supra note 14, at 1005; Treatment Decisions, supra note 80, at 147-53.

13 Id.

14 Id. at 1006.

15 Orders not to resuscitate are orders issued in anticipation of inevitable death, instructing the hospital staff that in the event of cardiac or respiratory failure, "aggressive medical care" is to be withheld. Comment, Medico-Legal Implications of "Orders Not to Resuscitate," 31 Cath. U.L. Rev. 515 (1982).

16 "No-Code Order" occurs when "the attending physician directs the nursing staff, by rotation in the patient's medical records, that in the event of cardiac arrest, the hospital's CPR team should not be summoned." Allan, No Code Orders v. Resuscitation: The Decision to Withhold Lifeprolonging Treatment From the Terminally Ill, 26 Wayne L. Rev. 139, 143 (1979) [hereinafter cited as Allan].

17 "Cardiopulmonary resuscitation is a standard hospital procedure in which trained personnel promptly respond to emergency codes and attempt to restore circulation and breathing in a cardiac arrest victim with the use of defibrillators, electrical shock, chest compressors, translaryngeal intubation, and cardiac massage." Allan, supra note 106, at 141. See also, Treatment Decisions, supra note 80, at 231.

18 For a more detailed analysis, See, Allan, supra note 106; Medico-Legal Implications, supra note 105; President's Commission, supra note 79, at 238-53; Comment, A Structural Analysis of the Physician-Patient Relationship in No-Code Decisionmaking, 93 Yale L.J. 362 (1983); Comment, Physician Liability for Failure to Resuscitate Terminally Ill Patients, 15 Ind. L. Rev. 905 (1982).
not have a statute recognizing living wills as legally valid. They constitute a request, directed to family and physicians, to honor the directions of the declarant as to the form and extent of medical treatment when the declarant is no longer able to do so. The living will may be morally persuasive to the patient's family members who experience guilt feelings when confronted with the decision to withdraw or withhold life-sustaining treatment.\(^1\) The "living will" is documented evidence written by the patient when competent. This strong indicator should assure the family members that they are only expressing the views of the patient. The directive may also indirectly affect the family if a life insurance company refuses to pay upon the insured's death.\(^2\)

Physicians and hospitals can be affected by a "living will" in a jurisdiction where the documents are not recognized as legally valid. Physicians and hospitals are particularly cautious when determining whether to withdraw or withhold life-sustaining treatment from a terminally ill patient.\(^3\) Civil liability or criminal prosecution against physicians and hospitals for following a "living will" directive is remote.\(^4\) There is some authority permitting health care professionals to follow the instructions of a "living will" without judicial intervention and absent legislation. In John F. Kennedy Memorial Hospital, Inc. v. Bludworth,\(^5\) a terminally ill patient stopped breathing and was placed on a mechanical ventilator.\(^6\) The patient's wife gave the physicians a document entitled "Mercy Will and Last Testament" which was signed by the patient and two witnesses.\(^7\) The document stated that the patient did not wish to be kept alive through the use of extraordinary life equipment such as a respirator.\(^8\) A petition was filed requesting the life-sustaining treatment be terminated.\(^9\) In determining whether the document could be considered in making the decision to withdraw the life-sustaining treatment from a terminally ill and incompetent patient, the court held, "If such a person, while competent, had executed a so-called 'living' or 'mercy' will, that will would be persuasive evidence of that incompetent person's intention and it should be given great weight by the per-

\(^{10}\)Right to Terminate, supra note 9, at 9.

\(^{11}\)Right to Die, supra note 35, at 126. Executing the living will may act to ease the strain on a patient's family who might otherwise hesitate to suggest withdrawing treatment because of guilt feelings. Living Will, supra note 4, at 669. See also, Death with Dignity, supra note 36, at 167.

\(^{12}\)Living Will, supra note 4, at 669; Death with Dignity, supra note 36, at 167. (Some insurance companies make no remuneration for intentional death, regardless of the patient's terminal condition.)

\(^{13}\)Right to Die, supra note 35, at 126.

\(^{14}\)Dufraine, supra note 4, at 820, 822. No physician has even been convicted of euthanasia. Id. Many commentators believe that "any fear of incurring legal liability for acquiescing to a living will is unwarranted and the likelihood of actual suit is practically nonexistent." Living Will, supra note 4, at 670.

\(^{15}\)452 S.2d 921 (Fla. 1984).

\(^{16}\)Id. at 922. When placed on the ventilator, the patient was suffering from acute respiratory failure, chronic interstitial fibrosis and gastrointestinal bleeding. The patient could not be weaned from the respirator and his mental status was deteriorated.

\(^{17}\)Id.

\(^{18}\)Id.
son or persons who substitute their judgment on behalf of the terminally ill incompetent." The court went on to hold that judicial intervention is not always required.

Where a comatose and terminally ill individual has executed a "living" or "mercy" will, it is not necessary that a court-appointed guardian of his person obtain approval of a court of competent jurisdiction before terminating extraordinary life support systems in order for the consenting family members, attending physicians, and hospital and its administrators to be relieved of civil and criminal liability; such parties need only act in good faith.

In *Saunders v. State*, a declarant of a living will petitioned the court to determine the validity of the "living will" in New York. The declarant wanted the "living will" to be operative without further court determination, if the events stated in the document occur. The declarant further argued that it was the exclusive function of the legislature to declare the "living will" valid. The court did find the "living will" executed by the declarant to be in the nature of an "informed medical consent statement." No civil or criminal liability would attach to the physicians or hospitals if they act in good faith. In addition, the court followed a line of cases in finding the living will to be very persuasive evidence of the patient's intent. Living wills executed in...

119 *Id.* at 926.
120 *Id.*
121 *Id.* at 922. For the physicians, hospitals or family members to be civilly or criminally liable, there must be a showing that their actions were not in good faith but were intended to harm the patient. *Id.* at 926. The court expressed its willingness to always hear these matters if requested by the family. *Id.* In *In re Peterson*, No. E117,982, slip op. (Tex. Dist. Ct. Aug. 4, 1983), the court based its decision to remove life support systems from a comatose patient on a living will and the fact that all family members with standing supported the decision to terminate treatment. *Id.* at 3.
123 The declarant, Selma Saunders, was seventy years of age and suffered from both emphysema and lung cancer. She had oxygen administered to her almost continually. Mrs. Saunders' condition was described as being progressive and without current known medical care.
124 *Saunders, _ Misc.* 2d at __, 492 N.Y.S.2d at 512.
125 *Id.*
126 *Id.* at 516.
127 *Id.* at 517.
128 *Id.*
130 *Saunders, _ Misc.* 2d at __, 492 N.Y.S.2d at 517.

The document executed by the petitioner is evidence of the most persuasive quality and is a clear and convincing demonstration that while competent the petitioner clearly and explicitly expressed an informed, rational and knowing decision to decline certain medical treatment by artificial means and devices while in a terminally ill state or condition and it should be given great weight by the hospital
jurisdictions which do not recognize the document as legally valid can therefore remain advantageous to a limited extent.

OHIO'S PROPOSED LEGISLATION

A "living will" statute was introduced into the Ohio Legislature early in 1985. The bill proposed to enact sections 2108.31-.41 of the Ohio Revised Code. A definition of terms provision is contained in the statute. "Non-communicative" and "terminal condition" are two terms which are subject to interpretation. Two physicians must, in writing, be of the judgment that the patient's condition will result in "imminent death," or that the patient is unconscious with a "negligible possibility" of ever regaining consciousness. The statute uses the term "medical measures" instead of making the ordinary-extraordinary medical treatment distinction. All of these terms create ambiguities and may require the courts to develop more specific definitions.

The statute permits an oral directive by a "communicative" patient to be made to a nurse or physician. Physicians are under a duty to be sure the directive is entered into the patient's medical record. This practice should be utilized by physicians to indicate that they acted pursuant to the patient's instructions.

authorities and treating physicians attending her.

Id. at § 1.

Id. at § 2108.31.

Id. at § 2108.31(N) "Noncommunicative' means that a person is not able to make, convey to others, or comprehend the import of his decisions regarding his medical treatment. A person's rejection of medical measures or the fact that he is in severe pain does not in itself indicate that the person is noncommunicative." Id.

Id. at § 2108.31(P).

"Terminal Condition means an illness, injury, or disease that, in the written judgment of a person's attending physician and at least one other physician who personally have examined the person, meets either of the following criteria:

(1) There is a virtual certainty that the condition will result in the imminent death of the person regardless of what medical measures are used;

(2) The condition has associated with it a state of unconsciousness and there is a negligible possibility of the person's ever regaining consciousness.

Id. at § 2108.31(L). "Medical Measures means any medicines, procedures, or devices a physician prescribes, administers, performs, or authorizes." Id.

Id. at § 2108.31(C). "Communicative means that a person is able to make and to convey to others his decisions regarding his medical treatment and is able to comprehend the import of those decisions." Id.

Id. at § 2108.32. If the adult attempts to give a directive to a nurse, the nurse shall with reasonable promptness alert the attending physician to the patient's wishes . . . " Id.

Id.

Id.

Id.
Only life-sustaining medical treatment for terminally ill patients is addressed by the proposed legislation. This is in accord with most "living will" statutes, but it is considered by many to be a drawback since a majority of medical decisions are not addressed. The legality of a clause instructing the physician to administer pain-relieving drugs to the patient, even though such an action may hasten the moment of death, is not addressed. A majority of states do not have such a provision since many consider the administration of such drugs to be the equivalent of condoning or permitting euthanasia.

The proposed legislation permits a "communicative" adult to execute a living will, which must be signed by two witnesses. The legislation does not establish qualifications for the witnesses. The statute should be amended to disallow family members, individuals who may have an interest or claim against the patient's estate, or the physician and medical personnel from acting as witnesses. This will reduce the possibility or appearance of improper influences. Living wills executed prior to the statute's enactment will be recognized as legally valid. This will avoid the needless task of having all declarants re-execute their "living wills."

Execution of a subsequent "living will" constitutes a revocation of the previous document. Giving a directive conflicting with the terms of the "living will" will also be construed as a revocation. This provision allows the "living will" to be revoked orally. While an oral revocation may create litigation, it more fully protects the patient who can not obtain or prepare a written directive.

A general consent to treatment is superseded by the "living will." Failing to execute a "living will" does not create a presumption as to whether treatment is desired. Thus, one who has not executed a living will does not have his or her right to refuse treatment subjected to a different standard. The proposed legislation does not require the "living will" to be reexecuted every certain number of years or reexecuted a certain number of days after the patient is declared terminally ill. This benefits the terminally ill and unconscious patient who has previously executed a "living will" while competent.

The proposed legislation grants medical personnel immunity from civil or criminal liability. One provision of the statute which may be the subject of

144 See Note, supra note 36, at 519.
145 Id.
147 Id.
148 Id. at 2108.34(A).
149 Id. at § 2108.34(B).
150 Id. at § 2108.35.
151 Id. "The failure of a person to make a directive or living will creates no presumption as to his wishes regarding the use, withholding, or discontinuing of medical measures when he is terminal." Id.
152 Id. at § 2108.36.
debate and criticism states “[n]othing in Sections 2108.31 to 2108.41 of the Revised Code shall be construed to grant immunity for withholding or discontinuing comfort care unless a ‘living will’ or directive expressly instructs against the use of specific kinds of comfort care.” One might conclude from cursory reading of this provision that certain life-sustaining procedures, such as a respirator, can only be discontinued if it is so specifically stated in the directive. This provision attempts to require some specificity in the directives, and prevent the use of a general “blanket clause.” Although a general “blanket clause” should not be effective, requiring the inclusion of the specific treatment may create an unreasonable burden. Protecting the patient’s decision is a concern of the state, but this clause may have taken the concern beyond reasonableness.

The statute does not subject medical personnel to civil or criminal liability for withholding or discontinuing medical measures from a terminally ill patient who has not executed a “living will,” if consent is obtained from specified family members or a court order is obtained. This provision creates the assumption that the immediate family is best suited to make the treatment decision. A family member not agreeing to the treatment decision can petition the probate court for an order.

Mercy killing is not condoned by the statute. It is not suicide to withdraw or withhold the treatment. Criminal sanctions are imposed against any person who foregoes or willfully and falsely attests to the making of a living will. These provisions are found in all of the “living will” statutes and can be considered “boiler plate” provisions.

CONCLUSION

Today’s technology can extend the life of a terminally ill patient indefinitely. Terminally ill patients must be given the right to determine how the processes of death will occur. A majority of states have granted the terminally ill patient that right. Ohio should join the majority and recognize the “dignity of dying.”

The “living will” is the most effective method in deciding whether a terminally ill patient wants to forego or terminate life-sustaining medical treatment. Legislation is needed in all states to declare the “living will” a legally valid document. Ohio is now contemplating enacting a “living will” statute. Enacting the statute is necessary for the patient, his family members, and the medical profession.

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101 Id.
104 Id. at § 2108.38.
103 Id. at § 2108.38(B).
106 Id. at § 2108.40(B).
105 Id. at § 2108.40(A).
108 Id. at § 2108.41. Whoever violates the statute is guilty of a felony of the fourth degree.