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A Time To Live, A Time To Die

Linda Shields-Stiefel

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A TIME TO LIVE, A TIME TO DIE

INTRODUCTION

[T]he liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual’s deeply personal decision to reject medical treatment, including the artificial delivery of food and water.¹

For the past ten years,² the Ohio General Assembly has struggled to pass a living will statute. Legislators have introduced bills in both the Senate and the House of Representatives during each of the last five sessions.³ Unfortunately, none of these bills has become law, and Ohio’s part-time legislators⁴ will try again to enact a living will statute during the 119th General Assembly. The 132 legislators⁵ are valiantly attempting to pass such a bill during this General Assembly. Rep. Guthrie⁶ introduced H.B. 70 in the House of Representatives during this term. Sen. Montgomery⁷ introduced S.B. 1 in the Ohio Senate. On February 5, 1991, this bill successfully passed in the Senate with a vote of 28 to 5. S.B. 1 was referred to the House of Representatives on February 7, 1991.

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² The first living will legislation was introduced in the Ohio Legislature in 1981.
³ The following bills have been introduced in the House of Representatives:


The following bills have been introduced in the Senate:

116th General Assembly, 1985-86, S.B. 72, Sen. Snyder
118th General Assembly, 1989-90, S.B. 379, Sen Nettle

S.B. 380, Sen. Zimmers
S.B. 383, Sen. Hobson

⁴ Each General Assembly lasts for two years--from January of one year through December of the next. The legislators usually begin their session on the first Monday after the first Tuesday in January, and meet on Tuesday, Wednesday and Thursday of scheduled weeks. (Telephone interview with the Legislative Information Office (January 29, 1991).
⁵ There are 99 State Representatives and 33 State Senators in the Ohio Legislature.
⁶ Representative Marc Guthrie, one of the major proponents of living wills, was elected to the Ohio Legislature in 1982. He is the Assistant Majority Whip. During his tenure in office, Representative Guthrie has served as the Vice Chairman of the Elections and Townships Committee and as a member of the Ways and Means, House Insurance, and House Health and Retirement Committees. (Telephone interview with Representative Guthrie’s office (January 28, 1991).
⁷ Senator Betty Montgomery was first elected to the Ohio State Senate during the 118th General Assembly. Senator Montgomery is from Perrysburg, Ohio and represents the Second Senate District. This is the first living will legislation that Senator Montgomery has proposed. (Telephone interview with Senator Montgomery’s office (February 6, 1991).
The purpose of this Comment is to review S.B. 1 and to compare it to other states living will statutes and to the proposed Uniform Rights of Terminally Ill Act. Part I briefly overviews the American history of living wills. Part II reviews living will/right to die statutes in effect and major court decisions. Part III discusses Ohio's position on the right to die, both statutory and judicial. Part IV reviews S.B. 1 and suggests several changes. The conclusion recommends that a uniform living will statute be enacted to guarantee equal treatment for patients in all jurisdictions.

PART I: BRIEF OVERVIEW OF LIVING WILLS

State Legislation

California passed the first living will statute in 1976. The term "living will" was first used by Luis Kutner in 1969. It denotes a document in which a person can make advance directives concerning the use or non-use of life support systems. In contrast, a durable power of attorney is a document in which one person (referred to as "principal") appoints a named individual (referred to as "agent") to make health care decisions for him if he becomes incompetent.

Living will statutes were originally enacted to permit persons in a persistent
vegetative state (PVS)\(^{15}\) or in a terminal\(^{16}\) condition to die a natural death rather than to be kept alive by artificial means. This is a very commendable goal.

As of March, 1990, forty states plus the District of Columbia have enacted living will/right to die statutes.\(^{17}\) Twelve of these statutes authorize the appointment

In order that the rights of patients may be respected even after they are no longer able to participate actively in decisions about themselves, the legislature hereby declares that the laws of the State of Hawaii shall recognize the right of an adult person to make a written declaration instructing his or her physician to provide, withhold, or withdraw life-sustaining procedures in the event of a terminal condition.

\(^{15} A\) persistent vegetative state is one in which the patient is awake, but unconscious. He is unable to attend to or provide for any of his needs. He is unable to sense pain.” Couture v. Couture, 48 Ohio App. 3d 208, 209, 549 N.E.2d 571, 573 (1989).

\(^{16} A\)lthough Ohio does not have a living will statute, it does have a Durable Power of Attorney Statute, Ohio REV. CODE ANN. §§ 1337.09 to 1337.17 (Anderson 1989). In that statute, “terminal condition” is defined as “any illness or injury that is likely to result in imminent death, regardless of the type, nature, and amount of health care that is provided.” Ohio Rev. Code Ann. § 1337.11(I) (Anderson 1989).

of health care proxies or surrogates. Over half the states have enacted both living will and durable power of attorney for health care statutes. Nine states have enacted only durable power of attorney for health care statutes. Only Nebraska has failed to enact a living will or durable power of attorney for health care statute.


Federal Legislation

The federal government now has attempted to insure a patient’s right to die. The Omnibus Budget Reconciliation Act of 1990 was passed on November 6, 1990. Title IV (Medicare, Medicaid, and Other Health-Related Programs) contains section 4206 which solidifies a patient’s right to make health care decisions. This section has been called the Federal Patient’s Self-Determination Act. It amends 42 U.S.C. sections 1395cc(a)(1) and 1866(a)(1) by directing that all hospitals, skilled nursing facilities, home health agencies, hospice programs, prepaid health organizations, and providers of service must:

(A) provide written information to each such individual concerning--

(i) an individual’s right under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives . . . .

(3) In this subsection, the term “advance directive” means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.

In view of this new legislation, it appears that most patients (with the possible exception of those in Nebraska, which does not have a statute in place) will be informed of their rights to make advance medical care decisions. Although this is an excellent first step, it will not eradicate the problem of patients being treated differently in each state.

PART II: STATE STATUTES

Although no two statutes are identical, all statutes address similar aspects. Every state requires the document to be executed with some formality. All statutes require the declarant to sign the document (or to authorize someone to sign in his stead). At least two witnesses are required in every state; however, each state

23 Id.
25 See supra note 17.
26 “Declarant” has been defined as “a mentally competent adult who executes a declaration” or a person “who has executed a living will”. See, e.g., Colo. Rev. Stat. § 15-18-103(4) (1990) and Ga. Code Ann. § 31-32.2(3) (1990).
27 See supra note 17.
imposes different qualifications for these witnesses.\textsuperscript{28} Some jurisdictions do not restrict the "identity" of qualified witnesses.\textsuperscript{29} While some jurisdictions only restrict age,\textsuperscript{30} others use blood or marital relationship, financial relationship or doctor/patient relationship as the criteria.\textsuperscript{31} Several states also require the signatures to be notarized.\textsuperscript{32}

Every state grants immunity to doctors, nurses, or facilities which honor the declarant’s written request.\textsuperscript{33} Every state also requires the declarant to notify the health care providers of his decision.\textsuperscript{34} Further, every state allows the declarant to revoke the document.\textsuperscript{35} Finally, every state indicates that observation of the patient’s directives will not be considered suicide or euthanasia.\textsuperscript{36}

The states treat several aspects differently. These differences form the basis of the problem propounded in this comment; that is, based upon the differences among statutes, patients are treated dissimilarly. Perhaps the new federal legislation will be the first step in passing a uniform living will statute. The major differences among the state statutes are discussed below.

\textsuperscript{28}Id.


\textsuperscript{30}Ill. Rev. Stat. ch. 110 1/2, ¶ 703 (1990) (witnesses must be over 18 years of age); Mo. Ann. Stat. § 459.015(1) (Vernon 1989) (witnesses must be over 18 years of age).


\textsuperscript{33}See supra note 17.

\textsuperscript{34}Id.

\textsuperscript{35}Id.

\textsuperscript{36}Id.
Pregnancy Clauses

Only twelve states\(^7\) did not incorporate a pregnancy clause into their statutes. A majority of them nullify a declaration’s effect if the declarant is pregnant.\(^8\) Other statutes nullify the declaration’s effect if the fetus could develop to the point of live birth with the assistance of life-prolonging procedures.\(^9\) Kentucky requires terminally ill adult women who have executed a declaration to undergo a pregnancy test.\(^40\) New Hampshire nullifies the declaration’s effect when the physician knows of the pregnancy.\(^41\) However, New Hampshire does not require a pregnancy test be performed.\(^42\)

This clause, in particular, raises a very important constitutional issue. Since a woman has a right to have an abortion during the first trimester,\(^43\) can a state protect that fetus when the mother has declared that she not be kept alive by artificial means? Does a terminally ill, yet competent, woman have the right to obtain an abortion so that her living will can be honored? Courts must answer these questions as they decide future cases.

Penalty for Physician’s Failure to Follow Patient’s Directive

Most states do not penalize a physician or health care facility for disregarding a patient’s directive to withhold or withdraw medical treatment.\(^44\) Several states

\(^{7}\) States having no pregnancy clause include: California, District of Columbia, Illinois, Louisiana, Maine, New Mexico, North Carolina, Oregon, Tennessee, Vermont, Virginia, and West Virginia.


\(^{9}\) States which do not penalize physicians or health care facilities include: Alabama, Arizona, California, Connecticut, Delaware, Florida, Georgia, Idaho, Iowa, Kentucky, Louisiana, Maryland, Minnesota, Mississippi, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

\(^{10}\) Roe v. Wade, 410 U.S. 113, 163-164 (1973). Jane Doe sued for injunctive relief, challenging the constitutionality of the Texas criminal abortion statute. Id. at 113. The United States Supreme Court held that the Texas statute was unconstitutional. It established the following guidelines for states to follow in abortion cases: (1) the state cannot interfere during the first trimester; (2) the state may regulate to protect maternal health during the second trimester; and (3) the state may prohibit the abortion during the third trimester. Id. at 164.
provide that the physician is guilty of only unprofessional conduct.45 Two states subject the physician to disciplinary sanctions.46 Three states may subject the physician to criminal penalties.47 Alaska's penalty is unique.48 The Alaska statute directs that the attending physician who disregards the patient's directive has no right to compensation for unwanted medical services and that the doctor may be liable to the patient or his heirs for up to a $1,000 civil penalty.49

If the doctor or health care provider is not punished for ignoring the patient's directive, then there will be no incentive to follow the patient's wishes. Although each state requires the doctor to transfer the patient to another facility if he will not allow a patient to die, the doctor may transfer the patient only under the threat of a penalty. If the statute imposes sanctions against recalcitrant doctors, the legislature will be sending a strong message to doctors that patients are entitled to make these decisions.

Withholding or Withdrawing Hydration and Nutrition

Most states do not address specifically whether hydration and nutrition can be withheld or withdrawn from a patient who has executed a living will.50 Several statutes direct that nutrition and hydration are not "life prolonging procedures," but, rather, are necessary for comfort care.51 Three states permit nutrition and hydration to be withdrawn or withheld if the patient will not die of starvation or dehydration.52


45 ARIZ. REV. STAT. ANN. § 20-17-209(a)(b) (1989) (Class A misdemeanor); ME. REV. STAT. ANN. tit. 18a § 5-710(A) (1990) (Class E crime); MONT. CODE ANN. § 50-9-206(1)(2) (1989) (Misdemeanor punishable by fine up to $500, or one year in county jail, or both).


47 Id.


52 States which permit nutrition and hydration to be withdrawn or withheld if the patient will not die of starvation or dehydration include: IDAHO CODE § 39-4504 (1990); ILL. REV. STAT. ch. 110 1/2, § 702(d) (1988); TENN. CODE ANN. § 32-11-103(5) (1990).
In Alaska, Maine, and Minnesota, the patient can direct that nutrition and hydration be withheld or withdrawn. Two states allow nutrition and hydration to be withdrawn or withheld if it is not necessary to relieve pain or provide comfort care, or if it could not be physically assimilated. Colorado allows nutrition and hydration to be withdrawn or withheld if it is the patient’s only treatment. However, the physician can override this directive if, in his opinion, the nutrition and hydration are necessary to relieve pain.

Again, this is an important restriction of the patient’s right to die. The conflict among statutes means that a patient in a PVS in one state can be allowed to die, whereas a similarly-situated patient in another state can be forced to endure artificial nutrition and hydration for years. Even if both patients had executed identical living will documents, one state would honor her wishes, while the other state would ignore them. All states should protect a fundamental right. Citizens should not be required to examine the differences among state statutes as they choose in which state to reside. Their wishes should be honored in every jurisdiction throughout the United States. A uniform living will statute would alleviate this problem.

**COURT DECISIONS**

In addition to the various statutes, courts have decided many cases based upon the common law and constitution. This section will briefly overview these major cases.

**Right to Privacy/Right to Die**

In Union Pac. Ry. Co. v. Botsford, the United States Supreme Court recognized an individual’s right to privacy when it held: “[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others....” The Supreme Court also recognized the right to privacy...
in *Olmstead v. United States.* In his dissenting opinion, Justice Brandeis stated, "[t]he makers of our constitution... conferred as against the Government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized man."  

This right was further expanded in *Griswold v. Connecticut* where Justice Douglas, writing for the majority, found that there is a constitutional right to privacy that can be found in the penumbra of the First, Third, Fourth, and Fifth Amendments. In *Roe v. Wade,* the Court found that the "right of privacy... is broad enough to encompass a woman's decision whether or not to terminate pregnancy." However, the Court acknowledged that privacy rights are not absolute. Therefore, privacy rights may yield to a state's "compelling" interests. The *Roe* Court held that the state cannot interfere during the first trimester, that the state may regulate to protect maternal health during the second trimester, and that the state may prohibit the abortion during the third trimester.

The states have extended this fundamental right to privacy (now also interpreted as the right to "bodily integrity") to right to die cases. In *In re Conroy,* the 84-year old patient suffered from severe organic brain syndrome and several other ailments. She totally depended upon a nasogastric tube for nutrition and hydration. The court held that "[t]he right to make certain decisions concerning one's body is also protected by the federal constitutional right of privacy."  

**Competent Patients**

Kathleen Farrell, a 37-year old competent woman, suffered from terminal amyotrophic lateral sclerosis (ALS), commonly called Lou Gehrig's disease. In

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63 Id. at 478.
65 Id. at 483-486. This "penumbra" theory has been frequently criticized. In his concurring opinion, Justice Goldberg found that the right of marital privacy is protected under the Ninth Amendment since it is a liberty not specifically enumerated in the first eight amendments. Id. at 487. Justice Harlan rejected both approaches in his concurring opinion and held that the Connecticut statute infringed the Due Process Clause and violated the basic value of liberty. Id. at 500.
67 Id. at 153.
68 Id. at 154.
69 Id. at 163-164.
71 Id. at 326, 486 A.2d 1216.
72 Id.
73 Id. at 348, 486 A.2d at 1222.
November 1985, three years after being diagnosed with ALS and two years after undergoing a tracheotomy and being connected to a respirator, Kathleen told her husband she wanted to be disconnected from the machine. 76 The husband petitioned the court for permission to disconnect the machine. 77 The trial court granted his request. 78 Kathleen died while her guardian’s appeal was pending. 79 The court reaffirmed the “well-recognized common-law right of self-determination that ‘[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body . . . .’” 80 The court then established the following guidelines to follow when a competent patient living at home requests the discontinuance of life-support systems: (1) the patient must be deemed to be competent, (2) the patient must be deemed to have voluntarily made his choice without coercion, and (3) the patient’s right to choose must be balanced against the four countervailing state interests: preserving life, preventing suicide, safeguarding the integrity of the medical profession, and protecting third persons. 81 The court held that “[a] competent person’s interest in her or his self-determination generally outweighs any countervailing interest the state might have.” 82

In Lane v. Candura 83 the Appeals Court of Massachusetts allowed a 77-year old patient to refuse to have her leg amputated, even though the operation probably would have saved her life. 84 The court stated that “[t]he law protects her right to make her own decision to accept or reject treatment, whether that decision is wise or unwise.” 85 The court further determined that “[a] person is presumed to be competent unless shown by the evidence not to be competent.” 86

Abe Perlmutter, 73-years old, also suffered from Lou Gehrig’s disease. 87 The trial court granted his request to have the respirator removed. 88 The district court affirmed that decision. 89 The court determined that since the patient is entitled to initially refuse treatment, that patient is also entitled to discontinue treatment when he so chooses. 90 The court concluded that:

It is all very convenient to insist on continuing Mr. Perlmutter’s life so that there can be no question of foul play, no resulting civil liability and...
no possible trespass on medical ethics. However, it is quite another matter to do so at the patient's sole expense and against his competent will, thus inflicting never ending physical torture on his body until the inevitable, but artificially suspended, moment of death. Such a course of conduct invades the basic constitutional right of privacy, removes his freedom of choice and invades his right to self-determine.  \textsuperscript{91}

\textit{Incompetent Patients} \textsuperscript{92}

The most well-known decisions are those in which the families of artificially-sustained incompetent patients have petitioned the courts to remove the life-sustaining procedures. These are the cases which made the headlines and brought this issue before the American public.

In the seminal case of \textit{In re Quinlan}, \textsuperscript{93} Karen Ann Quinlan, 22-years old, lapsed into a PVS for reasons unclear. \textsuperscript{94} The trial court refused to permit Karen's father to withdraw the life support system. \textsuperscript{95} However, the New Jersey Supreme Court immediately modified and remanded the case. It ordered the trial court to appoint Karen's father her guardian and to grant him full power to make Karen's health care decisions. \textsuperscript{96} The court relied upon the doctrine of substituted judgment, stating "[t]he only practical way to prevent destruction of the right [to privacy] is to permit the guardian and family of Karen to render their best judgment . . . as to whether she would exercise it in these circumstances." \textsuperscript{97} The Court also noted, "[t]he State's interest \textit{contra} 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's interest." \textsuperscript{98}

The Supreme Judicial Court of Massachusetts also applied the substituted judgment doctrine to determine whether medical treatment could be withheld from a 67-year-old severely retarded patient with leukemia. \textsuperscript{99} The court weighed the patient's wishes against the following state interests:

(1) the preservation of life;

\textsuperscript{91} \textit{Id.} at 164.  
\textsuperscript{94} \textit{Id.} at 23, 355 A.2d at 653.
\textsuperscript{95} \textit{Id.} at 22, 355 A.2d at 653.
\textsuperscript{96} \textit{Id.} at 55, 355 A.2d at 671.
\textsuperscript{97} \textit{Id.} at 41, 355 A.2d at 664.
\textsuperscript{98} \textit{Id.}
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(2) the protection of the interests of innocent third parties;
(3) the prevention of suicide; and
(4) maintaining the ethical integrity of the medical profession.100

The court held that "the decision in cases such as this should be that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person."101

The only right to die case to come before the United States Supreme Court is Cruzan v. Director, Missouri Dept. of Health.102 Nancy Cruzan was 25 years old when she was in an automobile accident in 1983.103 Nancy lacked oxygen for approximately 13 minutes. She subsequently lapsed into a coma, then into a PVS.104 The trial court allowed her parents to discontinue nutrition and hydration.105 However, the Missouri Supreme Court disagreed.106 The United States Supreme Court affirmed the Missouri Supreme Court decision.107 It also held that due process would not require a state to accept the substituted judgment of close family members, absent clear and convincing proof of the incompetent patient’s wishes.108 The Court conceded that "the United States Constitution would grant a competent person a constitutionally protected right to refuse life saving hydration and nutrition."109

Following the United States Supreme Court decision, Nancy’s parents requested a new evidentiary hearing before the original trial court and introduced new witnesses.110 A new hearing was held in November 1990.111 On December 14, 1990, Judge Charles E. Teel, Jr., of the Jasper County, Missouri Probate Court ruled that the parents could stop the artificial feedings.112 Nancy died at the Missouri Rehabilitation Center on December 26, 1990.113

100 Id. at 741, 370 N.E.2d at 425.
101 Id. at 752-53, 370 N.E.2d at 431.
103 Id. at 2844.
104 Id. at 2845.
105 Id. at 2846.
106 Id.
107 Id. at 2855.
108 Id. at 2854.
109 Id. at 2852.
The dicta in *Cruzan* has been widely interpreted to mean that a patient’s wishes will be followed if a living will is executed or, in the alternative, that a duly appointed surrogate can make these decisions on behalf of the patient. Unfortunately, the majority holding only concerns the standard of proof a state can require and whether the state has to adopt the substituted judgment of the patient’s family. The Court did not determine that a patient who has not executed a prior directive automatically has a constitutional right to die.

Since the *Cruzan* Court failed to face the right to die issue head-on, the courts of the various jurisdictions will continue to establish their own criteria. A uniform living will statute would promote uniformity and certainty and would preserve to all patients the fundamental right to decide.

**PART III: OHIO’S TREATMENT**

Thus far, the State of Ohio has failed to pass a living will statute and to thereby extend the fundamental right to make medical decisions to its citizens. Ohio’s lower courts have decided three major right to die cases. However, to date, the Ohio Supreme Court has not addressed the issue.

*Court Decisions*

Ohio’s first right to die case was *Leach v. Akron Gen. Medical Center* (*Leach I*). The Court of Common Pleas of Summit County considered whether a 70 year-old ALS patient’s life support system could be terminated. Edna Leach was diagnosed with ALS on June 11, 1980. She entered the hospital on July 27, 1980. On July 29, 1980 Edna suffered cardiac arrest, was resuscitated, was placed on life support systems. Edna’s husband requested that the support system be terminated. On October 13, 1980, her doctor attested that her condition was “hopeless” and that “her ultimate demise [was] only a matter of time.” However, the doctor insisted that the life support could only be terminated by court order. A legal guardian was appointed, and a hearing was held. Seventeen witnesses recalled conversations that they had with Edna prior to her illness. Three doctors

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115 See Introduction, supra.
116 See Court Decisions, infra.
118 Id. at 2, 426 N.E.2d at 810.
119 Id.
120 Id.
121 Id.
122 Id. at 3, 426 N.E.2d at 810.
123 Id. at 3, 426 N.E.2d at 811.
124 Id.
125 Id.
126 Id.
testified that Edna’s condition was terminal and that there was no known cure.\(^{127}\)

The Court of Common Pleas relied upon decisions from other jurisdictions, such as \textit{In re Quinlan}\(^{128}\) and \textit{Matter of Eichner},\(^{129}\) to extend the constitutionally guaranteed right of privacy to right to die cases.\(^{130}\) The court next performed a balancing test similar to that followed in \textit{Roe v. Wade}.\(^{131}\) Under this test, the court balanced the patient’s constitutionally protected right against the state’s interests: preservation of life, protection of third parties, maintenance of the ethical integrity of the medical profession, and prevention of suicide.\(^{132}\) The court concluded that Edna’s constitutional right outweighed the state’s interests.\(^{133}\) The court further held that clear and convincing proof was required.\(^{134}\) The court allowed the respirator to be disconnected only if certain conditions were met:

1. two doctors must examine Edna and certify that she continued to be in a permanent vegetative state;
2. the Summit County Coroner and Prosecutor must receive 48 hours’ notice of the examination and could have a witness present;
3. after the examination, there was to be a 48 hour waiting period before the act of discontinuance and the Coroner and Prosecutor could have a witness present.\(^{135}\)

The second Ohio case was \textit{Estate of Leach v. Shapiro, (Leach II)}.\(^{136}\) Edna’s respirator was disconnected on January 6, 1981, and she died.\(^{137}\) In July, 1982, Edna’s heirs filed an action for damages for the time that Edna was forced to endure the life support system.\(^{138}\) The trial court granted the defendant’s motion for summary judgment and dismissed the complaint.\(^{139}\) The court of appeals reversed and remanded the case for the following reasons:

1. Plaintiffs did state a cause of action in their complaint, and the motion for summary judgment was improperly granted.

\(^{127}\) \textit{Id.} at 4, 426 N.E.2d at 811.
\(^{133}\) \textit{Id.} at 10, 426 N.E.2d at 815.
\(^{134}\) \textit{Id.} at 11, 426 N.E.2d at 815.
\(^{135}\) \textit{Id.} at 12-13, 426 N.E.2d at 816.
\(^{137}\) \textit{Id.} at 394, 469 N.E.2d 1051.
(2) A physician who treats a patient without consent commits a battery and the patient may recover for battery if his refusal is ignored.

(3) There is a requirement of informed consent by which the doctor has a duty to obtain the patient’s informed consent to any medical treatment.

(4) Where the patient is not competent to consent, an authorized person may consent in the patient’s behalf.

(5) Until such time as the legislature provides more efficient means of protecting the rights of patients, there must be judicial approval before a life support system can be withdrawn, and Plaintiff may not recover for ordinary medical expenses incurred during the time reasonably required to obtain court permission.

(6) The doctors should have received consent from someone acting on the patient’s behalf before placing her on the life support system unless it was an emergency.

(7) There were genuine issues of fact, and the complaint should not have been dismissed.\footnote{Id. at 394-95, 469 N.E.2d 1051-1054 (1984).}

The Ohio Court of Appeals has decided only one case since Ohio’s Durable Power of Attorney for Health Care Act was enacted.\footnote{Id. at 209, 549 N.E.2d 571 (1989).} David Couture was 29 years old when he lapsed into PVS in reaction to medication he had taken.\footnote{Id. at 209, 549 N.E.2d at 572.} Daniel’s mother was originally appointed his guardian.\footnote{Id.} She asked Daniel’s caretakers to withdraw his artificial nutrition and hydration.\footnote{Id.} Daniel’s father opposed the request.\footnote{Id.} However, after a hearing on June 26, 1989, the probate court allowed the guardian to make any future treatment decisions.\footnote{Id.} Daniel’s father appealed the decision.\footnote{Id.} The probate court granted a temporary restraining order from which the hospital appealed.\footnote{Id.} Finally, on August 2, 1989, Daniel’s mother voluntarily withdrew as guardian.\footnote{Id.} His father was appointed in her stead.\footnote{Id.}
expectancy was only one to two months at the time of the June 26 hearing. 151

The court held that nutrition and hydration could not be withdrawn from a patient. 152 It based its decision solely upon the Durable Power of Attorney for Health Care Act, more specifically Ohio Rev. Code Ann. section 1337.13. 153 The court's decision was quite surprising since the case was decided two months prior to the effective date of the statute, and Daniel had not executed a Durable Power of Attorney for Health Care. Based upon section 1337.13(E), the court held that: (1) Daniel's death was not imminent; (2) withdrawal of the nutrition and hydration would result in death by malnutrition or dehydration; and (3) the public policy of Ohio, as determined by the General Assembly, opposed this type of action, regardless of the patient's or his surrogate's wishes. 154

Based upon this decision, at least in the Second Appellate District, patients will not enjoy their fundamental right to make health care decisions. Consequently, they will not be permitted to die with dignity.

Interestingly, State Senator Richard Pfeiffer, Jr., chief sponsor of the Durable Power of Attorney for Health Care Act observed, "the [Couture] court is wrong . . . . Clearly the court did not interpret the intent of the law correctly . . . . It was not our intent to stop that practice." 155

151 Id.
152 Id. at 212, 549 N.E.2d at 574.
153 Ohio Rev. Code Ann. § 1337.13(E) (Anderson 1989) provides:

(E) An attorney in fact under a durable power of attorney for health care does not have authority to refuse or withdraw informed consent to the provision of nutrition or hydration to the principal, unless, prior to the refusal or withdrawal of that informed consent, all of the following apply:

(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, the non provision 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;

(3) The principal's attending physician and the other physicians involved enter their opinions as described in divisions (E)(1) and (2) of this section in the health care records of the principal.

(Emphasis added) (effective September 27, 1989)

154 Couture v. Couture, 48 Ohio App. 3d 208, 213, 549 N.E.2d 571, 575.
Ohio’s Durable Power of Attorney for Health Care Act became effective on September 27, 1989. This statute was passed while the Ohio General Assembly attempted to pass a living will statute. Although this statute is a first step in protecting the patient’s right to die, it is not the final answer. In fact, this statute could create more problems than it solves.

The main difference between the living will and a durable power of attorney for health care is that through a living will, the patient articulates his own directives; conversely, through a durable power of attorney for health care, the patient merely appoints an agent to make medical decisions for him. Because the agent may not follow the principal’s wishes, the principal may still be denied his fundamental right to decide. A living will statute and durable power of attorney for health care statute that work together to protect the patient under all circumstances would be the ideal solution. Alternatively, a combined act that contains a living will section and a section for appointment of proxy or surrogate would be helpful.

The Durable Power of Attorney for Health Care Act was narrowly drafted and is very restrictive. Some of the major areas of concern are as follows:

Section 1337.11(I) defines “terminal condition” as “any illness or injury that is likely to result in imminent death, regardless of the type, nature, and amount of health care that is provided.” The term “imminent” is not defined. Moreover, the Act apparently excludes anyone who is in a PVS.

Section 1337.11(E) defines “hydration” and section 1337.11(G) defines “nutrition.” However, the definitions do not indicate whether they are considered to be part of “comfort care” (which also is not defined). If they are, then they cannot be withheld from the patient.

Section 1337.12 articulates execution requirements. Inter alia, section 1337.12 requires the declarant to sign and date the instrument
before two witnesses (with similar restrictions as discussed in Part I), or before a notary public. This section also provides that the document expires after seven years. This time limitation can cause serious problems. Most people do not carefully order and manage their documents. Once a person executes an important document, he files it away, knowing that he has taken care of the business. To expect people to renew their declaration every seven years burdens them, especially older individuals who have faced the issue, made their decision, and executed the appropriate document. Regular powers of attorney and last wills and testaments do not lapse after a certain timeframe. Any logical reasons raised for imposing these restrictions (such as fraud, duress, forgetfulness) would equally apply to other powers of attorney and wills. Therefore, there is no apparent reason to restrict the duration of the durable power of attorney for health care.

Section 1337.13 delineates the agent’s authority. Subsection (B) provides that the document is effective if the principal is in a terminal condition. Subsection (D) provides that if the principal is pregnant, care cannot be withdrawn or withheld unless the pregnancy or health care would pose a substantial risk to the life of the principal or unless two doctors certify that the fetus would not be born alive. Subsection (E) restricts the withholding of nutrition and hydration unless death is imminent and the cause of death will not be malnutrition or dehydration. The Couture Court relied upon this subsection. Again, this subsection greatly restricts a PVS patient’s and a pregnant woman’s fundamental right to reject health care.

The statute also discusses requirements for revocation, immunity for physicians and other persons, and transfer of patient to a willing facility.

Section 1337.17’s last provision requires the use of a special printed form which must contain a lengthy, detailed, legalistic notice to the principal. From the language of the statute, it appears that this notice must be printed on the form. This section also does not reveal whether a form executed by an individual in another state would be honored in Ohio.

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161 See supra notes 25 to 32.
162 See supra note 153 and accompanying text.
The inability to deal with the issue of PVS patients, the restrictive time limit, the special form requirement, and the failure to consider patients who have not executed a durable power of attorney for health care all combine to make this statute very restrictive. If the Ohio courts will rely only upon this statute to make their decisions, potentially all PVS patients will end up like Daniel Couture.

PART IV: PROPOSED LIVING WILL STATUTE

The National Conference of Commissioners on Uniform State Laws has drafted a proposed Uniform Rights of the Terminally Ill Act (1989). The American Bar Association has approved the statute for adoption by all the states.

No states have adopted the Uniform Rights of the Terminally Ill Act in its entirety. Rather, they have used it as a guideline for creating their own statutes. This is unfortunate. Realistically, probably no act could address every single issue in connection with a patient's right to make medical decisions. However, if the states had been willing to adopt the Uniform Act, at least all patients would be similarly treated.

The best feature of this proposed legislation is its simplicity. Each section includes extensive explanatory comments. States should adopt not only the sections, but also the comments, to make their statutes as clear as possible.

Under the definitions, "terminal condition" is defined as "an incurable and irreversible condition that, without the administration of life-sustaining treatment will, in the opinion of the attending physician, result in death within a relatively short time." This language has eliminated the problem of defining the term "imminent" which appears in most of the state statutes.

The Uniform Act does not require a specific form, but instead, offers a one-paragraph sample. Two individuals must witness the declaration. However, the Uniform Act does not restrict the "identity" of qualified witnesses. This relieves the patient from the chore of finding witnesses who qualify under some complicated set of rules. The Uniform Act also provides for appointment of a surrogate to make medical decisions for the patient. Again, the form is optional, and the witnesses are not restricted.

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168 See Id.
170 Uniform Rights of the Terminally Ill Act § 2(b) (1989).
171 Id.
172 Id.
173 Uniform Rights of the Terminally Ill Act § 2(c) (1989).
The Uniform Act also considers a patient who has not executed a declaration concerning health care. The Act provides the following hierarchy of persons who are entitled to make the decision for the patient:

(1) the spouse of the individual;
(2) an adult child of the individual or, if there is more than one adult child, a majority of the adult children who are reasonably available for consultation;
(3) the parents of the individual;
(4) an adult sibling of the individual or, if there is more than one adult sibling, a majority of the adult siblings who are reasonably available for consultation; or
(5) the nearest other adult relative of the individual by blood or adoption who is reasonably available for consultation.

The Uniform Act also imposes penalties upon doctors and other individuals who fail to follow the patient’s directives. Unfortunately, the penalties have been left blank for each state to establish. This failure to establish penalties could protect doctors from punishment for failing to follow the patient’s wishes. Again, penalties should be imposed, even if only sanctions or charges of unprofessional conduct, to assure that the doctors will honor the directives.

Unfortunately, the Uniform Act implies that nutrition and hydration may be necessary for comfort care. Moreover, the Act prohibits withdrawal from a pregnant patient if the fetus could develop to the point of live birth. The comment to this section suggests that the withdrawal or withholding of nutrition and hydration should be decided on a case-by-case basis, but also suggests that the declarant can issue specific directions in the declaration. The declaration should include a section wherein the patient can check whether he wants this type of treatment withheld or withdrawn. The previous version of the Act provided, “[u]nless the declaration provides otherwise,” life-sustaining treatment could not be withheld from a pregnant woman. The comment suggests that states may follow the earlier version, thus giving pregnant women the same rights as other patients in their health care decisions.
Even with these few drawbacks, the Uniform Act is far superior to many of the state statutes which are presently in force. It is unfortunate that the states have failed to recognize and adopt the Uniform Act, thus ensuring equal treatment to patients in every state.

**Senate Bill 1**

The proposed statute that passed the Ohio Senate on February 5, 1991, combines a living will statute with Ohio’s DPA/HC statute. The act contains many of the Uniform Act’s best features.

The proposed act defines “terminal condition” as “a condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined by a principal’s attending physician and one other physician who has examined the principal, both of the following apply:

1. there can be no recovery,
2. there is a permanently unconscious state, or death is likely to occur within a relatively short time if life-sustaining treatment is not administered.”

By adopting the “relatively short time” standard, Ohio will not need to judicially define the term “imminent.”

By amending Ohio Rev. Code section 1337.12(A)(3), the legislature has removed the seven-year time limit. The proposed amendments to section 1337.12(B) simplify the execution requirements by allowing any adult who is not related to the principal, who is not the attorney-in-fact named in the instrument, and who is not the attending physician to serve as a witness. Section 1337.13(E) forbids the attorney-in-fact to withdraw nutrition or hydration unless the principal is in a terminal condition and has authorized the attorney-in-fact to withdraw such support. This authorization must appear in the declaration in capital letters and must be initialed by the principal.

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3. Sub. S.B. 1, 119th Gen. Ass. (1991). Any person who is related to the principal by blood, marriage, or adoption, any person who is designated as the attorney-in-fact in the instrument, and any attending physician are ineligible to be witnesses.
5. Sub. S.B. 1, 119th Gen. Ass. (1991). “Including a statement in capital letters that the attorney in fact may refuse or withdraw informed consent to the provision of nutrition or hydration to the principal if he is in a terminal condition, or checking or otherwise marking a box or line that is adjacent to a similar statement on a printed form of a durable power of attorney for health care.”
Unfortunately, the legislature’s proposed amendments to Ohio Rev. Code section 1337.13(D) provide that health care cannot be withheld or withdrawn from a pregnant patient unless such care would pose a substantial risk to the principal’s life, or the fetus would not be born alive. The legislature has also failed to enumerate penalties for doctors who ignore the patient’s directives. It has also retained the complicated instructions to the patient.

S.B. 1 provides for the enactment of new section 2133.01, which will become the Modified Rights of the Terminally Ill Act. Section 2133.02(A)(1) allows the patient to request that nutrition or hydration be withheld or withdrawn if the patient checks the appropriate box. Thus, the legislature is allowing the patient, not the doctor, to make this choice. Section 2133.05(A)(2)(a)(ii) provides the following hierarchy of persons who can decide for the patient if he has not executed either a living will or a durable power of attorney for health care:

a) declarant’s guardian, if any;
b) declarant’s spouse;
c) an adult child of the declarant or, if there is more than one adult child, a majority of the declarant’s adult children who are available within a reasonable period of time for consultation with the declarant’s attending physician;
d) the declarant’s parents;
e) an adult sibling of the declarant or, if there is more than one adult sibling, a majority of the declarant’s adult siblings who are available within a reasonable period of time for consultation with the declarant’s attending physician; or
f) the nearest adult who is not described in the previously described priority classes of individuals, who is related to the declarant by blood or adoption, and who is available within a reasonable period of time for consultation with the declarant’s attending physician.

Section 2133.06(C) includes the same restrictions for pregnant women as the Durable Power of Attorney for Health Care Act. Sub. S.B. 1 imposes no penalties upon physicians who fail to follow directives. However, even with these limitations, the proposed legislation’s strengths far outweigh its weaknesses.

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187 Sub. S.B. 1, 119th Gen Ass. (1991). "If the decision pertains to a principal who is pregnant and if the withholding or withdrawal of health care would terminate the pregnancy, the attending physician makes, in good faith and to a reasonable degree of medical certainty, a determination whether or not the pregnancy or health care involved would pose a substantial risk to the life of the principal, or a determination whether or not the fetus would be born alive."
Finally, the last section of Sub. S.B. 1 notes that S.B. 13 (Durable Power of Attorney for Health Care Act) was not intended to affect the ability of competent adults or guardians to make “informed health care decisions for themselves or their wards.”\(^{192}\) This statement corrects the Couture court’s erroneous interpretation of that statute and insures that courts will not repeat the Couture mistake.\(^ {193}\)

**CONCLUSION**

The legal profession must keep pace with medical technology in order to protect the rights of individuals. There are as many as 10,000 patients across the country lying in persistent vegetative states being kept “alive” by artificial means.\(^ {194}\) The oldest of these patients is purported to be Rita Green, who has been unconscious since 1951.\(^ {195}\) The right to die has become the abortion issue of the 1990’s. There are dedicated, active, and sometimes militant groups on both sides of the issue.

Many polls indicate that Americans believe that they should be allowed to make their own health care decisions.\(^ {196}\) Only comprehensive legislation can guarantee an individual’s right to control his health care.

As can be seen from this Comment, the states have boldly attempted to implement legislation that will allow persons to make their own health care decisions. However, many of these statutes are very narrow and create serious problems. This patchwork method should not continue. The American Bar Association and the American Medical Association should jointly attempt to persuade all states to adopt the Uniform Rights of the Terminally Ill Act. It is the best solution to the present problem. Even though the Act permits minor discrepancies among the states, they are not so broad and sweeping as to deny most patients the right to die with dignity.


\(^ {193}\) Sub. S.B. 1 has been referred to the Ohio House of Representatives, and the first meeting of the Civil and Commercial Law Committee was scheduled for February 12, 1991, at 1:30 p.m. At that time Senator Montgomery was scheduled to give Sponsor Testimony concerning Sub. S.B. 1. At the same time Representative Guthrie was scheduled to give Sponsor Testimony concerning H.B. 70. The Committee will also discuss the case law in this area at the same meeting. The testimony on these bills has been adjourned twice; and, as of March 28, 1991, the bill is still in Committee. Perhaps the Legislature will finally pass a comprehensive version of a living will bill, such as Sub. S.B. 1 appears to be.


\(^ {195}\) Id.

\(^ {196}\) Poll by American Medical Association in 1986 indicated 73% of respondents approved “withdrawing life-support systems, including food and water, from hopelessly ill or irreversibly comatose patients if they or their families request it.” A 1985 Gallup poll indicated that 81% of respondents would like to see a ruling in their state which finds that all life-sustaining medical treatment may be withheld or withdrawn from terminally ill patients, provided that is what the patients want or would want if they were able to express their wishes. ABC’s news program “Nightline,” conducted a poll in 1986, and 70% of the respondents strongly agreed that the immediate family, not the courts, should decide whether to refuse life-support measures for incompetent patients, and the same 70% favored advance directives. (Society for the Right to Die Legislative Backgrounder, compiled July 1990.)
When the Federal Patient Self-Determination Act goes into effect on December 1, 1991, patients will be informed of their rights to execute living wills and durable powers of attorney. This will affect many people. However, there are many people who lapse into unconsciousness before they ever see the doctor or get to the hospital. These individuals also must be provided for, and the states must enact legislation that guarantees to everyone the right to die in a dignified manner.

POST SCRIPT

Five months after Sub. S. B. 1 passed the Senate, the State of Ohio finally joined the ranks of other states that grant patients the “right to die.” Although Am. Sub. S. B. 1 underwent fourteen amendments while in committee, the basic framework remained unchanged. This Post Script identifies the significant changes to Am. Sub. S. B. 1.

In Am. Sub. S. B. 1, the legislature opted to distinguish between a patient who is in a “permanently unconscious state” and one who is in a “terminal condition.” Even though “permanently unconscious state” is no longer synonymous with “terminal condition,” the statute applies to patients in either condition. Although this change appears insignificant, it may have far reaching repercussions as discussed below.

Another seemingly minor change involves who may make health care decisions for a patient. Under section 2133.05(A)(2)(a)(ii), the legislature removed the catch-all category of “any person related by blood or adoption” from the hierarchy of classes of persons capable of making health care decisions for the

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198 Telephone interview with Senator Montgomery’s office (June 27, 1991).

199 Am. Sub. S. B. 1, 119th Gen. Ass. (1991) § 1337.11(T) provides:

“Permanently unconscious state” means a state of permanent unconsciousness in a principal that, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by the principal’s attending physician and one other physician who has examined the principal, is characterized by both of the following:

1. The principal is irreversibly unaware of himself and his environment.
2. There is a total loss of cerebral cortical functioning, resulting in the principal having no capacity to experience pain or suffering.

200 Am. Sub. S. B. 1, 119th Gen. Ass. (1991) § 1337.11(Y) provides:

“Terminal condition” means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a principal’s attending physician and one other physician who has examined the principal, both of the following apply:

1. There can be no recovery
patient.201 By removing the remote class of any relative, a patient who is not survived by an individual from one of the named classes may not be afforded the same rights under this section as the patient would have had under Sen. Montgomery’s version of the bill. Even though the Probate Court can appoint a guardian to make a decision for the patient, this procedure can be time consuming and expensive. There simply does not seem to be any valid reason why the legislature removed this class of persons from the hierarchy. Perhaps this class will be reinstated as the courts test this law.

The legislature substantially changed the provision for pregnant patients under the Living Will section.202 Under the revised section, treatment can only be withheld from a pregnant patient if two physicians determine that the fetus will not be born alive.203 This section no longer considers whether the pregnancy is dangerous to the patient. In the Living Will section, the legislature eliminated the balancing which takes place under the Durable Power of Attorney section.204 Under the Durable Power of Attorney section, the legislature has recognized that the life of the patient is paramount.205 Nevertheless, the legislature has failed to afford pregnant patients comparable dignity and rights under the Living Will section. This distinction may form the basis for much litigation in the future as the husbands and families of pregnant patients challenge this inequity.

The most significant change in Am. Sub. S. B. 1 appears in the addition of the No Document section.206 This section allows the life-sustaining treatment to be withdrawn or withheld from a patient who has not executed or has improperly executed a declaration.207 In order to invoke this section, the patient must either be in a terminal condition or have been in a permanently unconscious state for the preceding twelve months.208 The legislature set forth a hierarchy of persons who can consent to withholding or withdrawing treatment:

1) patient’s guardian, if any;

(2) Death is likely to occur within a relatively short time if life-sustaining treatment is not administered.

201 Am. Sub. S. B. 1, 119th Gen. Ass. (1991) § 2133.05(A)(2)(a)(i),(ii) provides that the hierarchy is as follows:
   a) the person declarant designated in the declaration;
   b) declarant’s guardian, if any;
   c) declarant’s spouse;
   d) declarant’s adult children;
   e) declarant’s parents;
   f) declarant’s adult siblings, or a majority thereof.

2) patient’s spouse;
3) adult child(ren) or a majority thereof;
4) patient’s parents;
5) adult sibling(s) or a majority thereof; or
6) nearest adult who is related to the patient by blood or adoption.

This section may only be activated if the court is satisfied that one of two conditions are met. First, the court must be presented with sufficient evidence demonstrating that the patient had previously expressed his wishes concerning the continuation or withholding of life-sustaining treatment in the event the patient became unable to make an informed decision. In the alternative, the section would become effective if the decision concerning life-sustaining treatment “is consistent with the type of informed consent decision that the patient would have made if he previously had expressed his intention...” This decision can be “inferred from the lifestyle and character of the patient, and from any other evidence of the desires of the patient, prior to his becoming no longer able to make informed decisions regarding the administration of life-sustaining treatment.”

The No Document section also contains a provision consistent with the Living Will section regarding pregnant patients. Treatment will only be withheld or withdrawn from a pregnant patient if two doctors agree that the fetus would not be born alive. Again, the court will not take into consideration the wishes of the husband or family of the patient; the welfare of the fetus is paramount.

The legislature added specific conditions under which nutrition and hydration may be withdrawn from patients who have been in a permanently unconscious state for the preceding twelve months. Nutrition and hydration can only be withdrawn if one of the following conditions are satisfied:

1) written consent is given by appropriate individuals;
2) the Probate Court has not reversed the consent;
3) two doctors determine that nutrition or hydration will not provide comfort or alleviate pain;
4) written consent is witnessed by two individuals and given to the doctor;
5) the informed consent would have been given by the patient if he were competent to make it; or

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6) the Probate Court issues an order to withhold or withdraw the care.\textsuperscript{217}

The legislature also added a provision which formally recognizes that a validly executed document from another state is valid in Ohio.\textsuperscript{218} Under section 2133.14(A), declarations executed anywhere prior to the effective date of this statute\textsuperscript{219} will be given effect as if they had been executed after the effective date of the statute.\textsuperscript{220} If the declaration does not contain the requisite language that the patient desires that nutrition or hydration be withdrawn or withheld, the attending physician must apply to the Probate Court for an order authorizing this treatment.\textsuperscript{221} While the legislature has honorably chosen to recognize both out-of-state declarations and improperly executed declarations, the legislature has unfortunately placed an additional burden on the families of these patients to obtain a court order before treatment can be terminated. The actual hearing under this section can take place "no sooner than the thirtieth business day, and no later than the sixtieth business day" after the necessary parties have received formal notice from the Probate Court.\textsuperscript{222} Requiring families to wait an additional thirty to sixty days may unnecessarily inflict undue financial and emotional burdens.

Lastly, the new statute provides for an extensive appeal process under all three sections: the Durable Power of Attorney; Living Will; and No Document. Under the Durable Power of Attorney section, only persons in the two highest classes of the hierarchy can appeal the decision.\textsuperscript{223} The individuals appealing the decision must notify the physician within two days and file their appeal within two business days thereafter.\textsuperscript{224} The Probate Court must then serve notice on all interested parties within three days and hold a hearing within three business days thereafter.\textsuperscript{225} The statute requires the Probate Court to make an immediate decision.\textsuperscript{226}

The legislature also enumerated the grounds for appeal of the Probate Court's decision under the Durable Power of Attorney section:

a) the principal has not lost capacity to decide for himself;

\textsuperscript{219}October 10, 1991.
\textsuperscript{223}Am. Sub. S. B. 1, 119th Gen. Ass. (1991) § 1337.16(D). For example, if the patient has a guardian and a spouse, then those persons from the two classes can appeal. If the patient has no guardian, then his spouse and his adult children would form the two highest classes. No one other than the members from the two highest classes can appeal, including the State of Ohio. [The hierarchy in descending order includes: guardian, if any; spouse; adult children; parents; or adult siblings, or a majority thereof.]
The burden of proof rests with the party objecting to the medical decision. The objecting party must present clear and convincing evidence if the Probate Court's decision concerns the use or continuance of life-sustaining treatment. If the party's objection concerns the decision to withhold or withdraw life-sustaining treatment, then the opposing party must prove the grounds for objection by a preponderance of the evidence. Thus, the declarant's wishes carry a greater weight, and the party who seeks to overturn the declarant's wishes bears the heavier burden.

The Living Will section utilizes the same appellate process as in the Durable Power of Attorney section. The legislature enumerated the following grounds for appeal:

a) the declarant is not in a terminal condition or in a permanently unconscious state;
b) the declarant is able to make an informed decision;
c) there is a reasonable possibility that the declarant will regain the capacity to make informed decisions;
d) the course of action proposed to be undertaken is not authorized by the declarant's declaration;
e) the declarant was not of sound mind or was under duress, fraud, or undue influence;
f) the declaration does not substantially comply with the statute.


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The Living Will appeal process is similar to the Durable Power of Attorney appeal process, except that the hierarchy is slightly different. Again, only those members named in the first two classes of the hierarchy can appeal. Neither other family members nor the State of Ohio can appeal the decision. The same standards for burden of proof apply in this section as were established under the Durable Power of Attorney section.

The legislature placed the fewest restrictions on the potential appellants under the No Document section. Under this section, any member of the classes named in the hierarchy can appeal the decision. The same appellate procedure and burdens of proof apply as under the Durable Power of Attorney and Living Will sections.

The elected officials worked over ten years to pass this legislation. The Ohio statute comports with the Federal Patient Self-Determination Act which goes into effect on December 1, 1991. Unfortunately, Am. Sub. S. B. 1 appears to be a compromise. Sen. Montgomery’s original bill was a strong and equitable proposal for the citizens of Ohio. The amended bill allows egregious situations to occur. The amended bill places the life of the fetus paramount to that of the patient and forces a patient who has not executed documents to remain in a permanent unconscious state for at least twelve months before treatment can be terminated. These restrictions will probably form the basis of much litigation over the next few years.

Despite these major defects, this legislation is far superior to the former Durable Power of Attorney statute. After October 10, 1991, a majority of the individuals who have executed a Durable Power of Attorney or Living Will document, as well as loved ones of those who have not, will be able to make their own health care decisions. Their voices will be heard and their wishes will be followed. At last, in Ohio, at least some patients will be allowed to die with dignity.

LINDA SHIELDS STIEFEL

232 Am. Sub. S. B. 1, 119th Gen. Ass. (1991) § 2133.05(A)(2)(i) and (ii). [Thus the hierarchy consists of anyone the declarant named to make the decision; the declarant’s guardian, if any; the declarant’s spouse; the declarant’s adult children; the declarant’s parents; and the declarant’s adult siblings, or a majority thereof.]
234 Am. Sub. S. B. 1, 119th Gen. Ass. (1991) § 2133.05(B)(4)(b) and (c).
236 Am. Sub. S. B. 1, 119th Gen. Ass. (1991) § 2133.08(B) provides that the hierarchy shall be:
   a) the patient’s guardian, if any;
   b) the patient’s spouse;
   c) the patient’s adult children, or a majority thereof;
   d) the patient’s parents;
   e) the patient’s adult siblings, or a majority thereof;
   f) the patient’s nearest relative by blood or adoption.
237 Am. Sub/S. B. 1, 119th Gen. Ass. (1991) § 2133.08(E)(2) and (3).
APPENDIX
UNIFORM RIGHTS OF THE TERMINALLY ILL ACT (1989)

Section 1. DEFINITIONS. As used in this [Act], unless the context otherwise requires:

(1) “Attending physician” means the physician who has primary responsibility for the treatment and care of the patient.

(2) “Declaration” means a writing executed in accordance with the requirements of Section 2(a).

(3) “Health-care provider” means a person who is licensed, certified, or otherwise authorized by the law of this State to administer health care in the ordinary course of business or practice of a profession.

(4) “Life-sustaining treatment” means any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the process of dying.

(5) “Person” means an individual, corporation, business trust, estate, trust, partnership, association, joint venture, government, governmental subdivision or agency, or any other legal or commercial entity.

(6) “Physician” means an individual [licensed to practice medicine in this State].

(7) “Qualified patient” means a patient [18] or more years of age who has executed a declaration and who has been determined by the attending physician to be in a terminal condition.

(8) “State” means a State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States.

(9) “Terminal condition” means an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time.

COMMENT

The Act’s definitions of “life-sustaining treatment” and “terminal condition” are interdependent and must be read together. This has caused drafting problems in many existing acts, and the Act has been drafted to avoid the problems detected in existing legislation.

Most of the “life-sustaining treatment” and “terminal condition” definitions in existing statutes were considered problematical in that they (1) were tautological, defining “terminal condition” with respect to “life-sustaining treatment” and vice versa, and (2) defined terminal condition as requiring “imminent” death “whether or not” or “regardless of” the application of life-sustaining treatment. Strictly speaking, if death is “imminent” even with the full application of life-sustaining treatment, there is little point in having a statute permitting withdrawal of such procedures. The Act’s definitions have attempted to avoid these problems.

The “life-sustaining treatment” definition found in many statutes inserts the clause “and when, in the judgment of the attending physician, death will occur whether or not such procedure or intervention is utilized,” after the phrase “will serve only to prolong the dying process” found in the Act’s provision. Because the Act’s life-sustaining treatment definition concerns only those procedures or interventions applied to “qualified patients” (i.e., those who have been determined to be in a terminal condition), and because a terminal condition is defined as “incurable and irreversible” with death resulting “in a relatively short time,” the requirement that death be “inevitable” has been satisfied by the presence of “qualified patient” in the life-sustaining treatment definition. Therefore, this additional clause was excluded because it was considered repetitious and possibly confusing.

The Act defines “life-sustaining treatment” in an all-inclusive manner, dealing with those procedures necessary for comfort care or alleviation of pain separately in Section 6(4), where it is provided that such procedures need not be withdrawn or withheld pursuant to a declaration. Most existing statutes incorporate “comfort care” as an exclusion from the definition of life-sustaining treatment. Because many such procedures are life-sustaining, however, the Act avoids definitional confusion by treating them in a separate provision that reflects the Act’s policy more clearly, and better reflects the fact that comfort care does not involve a fixed group.
§ 1 UNIFORM RIGHTS OF THE TERMINALLY ILL ACT (1989)

of procedures applicable in all instances.

Subsection (9) of Section 1 is the "terminal condition" definition. The difficulty of trying to express such a condition in precise, accurate, but not unduly restrictive language is obvious. A definition must preserve the physicians' professional discretion in making such determinations. Consequently, the Act's definition of terminal condition incorporates not only selected language from various state acts, but also suggestions from medical literature in the field.

The Act employs the term "terminal condition" rather than terminal illness, and it is important that these two different concepts be distinguished. Terminal illness, as generally understood, is both broader and narrower than terminal condition. Terminal illness connotes a disease process that will lead to death; "terminal condition" is not limited to disease. "Terminal illness" also connotes an inevitable process leading to death, but does not contain limitations as to the time period prior to death, or potential for nonreversibility, as does "terminal condition."

The terminal condition definition requires that the condition be "incurable and irreversible." These adjectives were chosen over the similar phrase, "no possibility of recovery," because of possible ambiguity in the term "recovery" (i.e., recovery to normal or to some other stage). A number of state statutes now use "incurable and/or irreversible," and the terms appear to comport with the criteria applied by physicians in terminal care situations. The phrase "incurable and irreversible" is to be read conjunctively as long as the circumstances warrant. A condition which is reversible but incurable is not a terminal condition.

Subsection (9) also requires that the condition result in the death of the patient with a "relatively short time... without the administration of life-sustaining treatment." This requirement differs to some degree from the language employed in most of the statutes. First, the decision that death will occur in a relatively short time is to be made without considering the possibilities of extending life with life-sustaining treatment. The alternative is that required by a number of states—that death be imminent whether or not life-sustaining procedures are applied. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research has noted that such a definition severely limits the group of terminally-ill patients able to qualify under these acts. It is precisely because life can be prolonged indefinitely by new medical technology that these acts have come into existence. Though the Act intends to err on the side of prolonging life, it should not be made wholly ineffective as to the actual situation it purports to address. The provisions which require that death be imminent regardless of the application of life-sustaining procedures appear to have that effect. Therefore, such provisions have been excluded in the Act.

The terminal condition definition of subsection (9) requires that death result "in a relatively short time." Rejecting the "imminency" language employed in a number of statutes, this alternative was chosen because it provides needed flexibility and reflects the balancing character of the time frame judgment. Though the phrase, "relatively short time," does not eliminate the need for judgment, it focuses the physician's medical judgment and avoids the narrowing implications of the word "imminent."

The "relatively short time" formulation is employed to avoid both the unduly constraining meaning of "imminent" and the artificiality of another alternative—fixed time periods, such as six months, one year, or the like. The circumstances and inevitable variations in disorder and diagnosis make unrealistic a fixed time period. Physicians may be hesitant to make predictions under a fixed time period standard unless the standard of physician judgment is so loose as to be unenforceable. Under the Act's standard, considerations such as the strength of the diagnosis, the type of disorder, and the like can be reflected in the judgment that death will result within a relatively short time, as they are now reflected in judgments physicians must and do make.

The life-sustaining treatment and terminal condition definitions exclude certain types of disorders, such as kidney disease requiring dialysis, and diabetes requiring continued use of insulin. This is accomplished in the requirement that terminal conditions be "irreversible," and that life-sustaining procedures serve "only to prolong the dying process." For purposes of the Act, diabetes treatable with insulin is "reversible," a diabetic person so treatable is not in the "dying process," and insulin is a treatment the benefits of which foreclose it serving "only" to prolong the dying process.

Section 2. Declaration Relating to Use of Life-Sustaining Treatment.

(a) An individual of sound mind and [18] or more years of age may execute at any time a declaration governing the withholding or withdrawal of life-sustaining treatment. The
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declarant may designate another individual of sound mind and [181 or more years of age to make decisions governing the withholding or withdrawal of life-sustaining treatment. The declaration must be signed by the declarant, or another at the declarant's direction, and witnessed by two individuals.

(b) A declaration directing a physician to withhold or withdraw life-sustaining treatment may, but need not, be in the following form:

DECLARATION

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Uniform Rights of the Terminally Ill Act of this State, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

Signed this ___________________________ day of ___________________________.

Signature ___________________________.

Address ___________________________.

The declarant voluntarily signed this writing in my presence.

Witness ___________________________.

Address ___________________________.

Witness ___________________________.

Address ___________________________.

(c) A declaration that designates another individual to make decisions governing the withholding or withdrawal of life-sustaining treatment may, but need not, be in the following form:

DECLARATION

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I appoint ___________________________, or, if he or she is not reasonably available or is unwilling to serve, ___________________________, to make decisions on my behalf regarding withholding or withdrawal of treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain, pursuant to the Uniform Rights of the Terminally Ill Act of this State.

[If the individual(s) I have so appointed is not reasonably available or is unwilling to serve, I direct my attending physician, pursuant to the Uniform Rights of the Terminally Ill Act of this State, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.]

Strike out bracketed language if you do not desire it.

Signed this ___________________________ day of ___________________________.

Signature ___________________________.

Address ___________________________.

The declarant voluntarily signed this writing in my presence.

Witness ___________________________.

Address ___________________________.

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Witness ____________________________________________

Name and address of designee.

Name ____________________________________________

Address __________________________________________

(d) The designation of an attorney-in-fact [pursuant to the Uniform Durable Power of Attorney Act or the Model Health-Care Consent Act], or the judicial appointment of an individual [guardian], who is authorized to make decisions regarding the withholding or withdrawal of life-sustaining treatment, constitutes for purposes of this [Act] a declaration designating another individual to act for the declarant pursuant to subsection (a).

(e) A physician or other health-care provider who is furnished a copy of the declaration shall make it a part of the declarant's medical record and, if unwilling to comply with the declaration, promptly so advise the declarant and any individual designated to act for the declarant.

COMMENT

Section 2 sets out the minimal requirements regarding the making and execution of a valid declaration. "Sample" declaration forms are offered in this section. The forms are not mandatory, as some acts require: they "may, but need not, be" followed. The forms provided also are not as elaborate as others. The drafters rejected more detailed declarations for two reasons. First, the forms are to serve only as examples of a valid declaration. More elaborate forms may have erroneously implied that a declaration more simply constructed would not be legally sufficient. Second, the sample forms' simple structure and specific language attempt to provide notice of exactly what is to be effectuated through these documents to those persons desiring to execute a declaration and the physicians who are to honor it.

Sections 2(a) and (c) of the Act authorize an individual by a declaration to designate another person to make decisions governing the withholding or withdrawal of life-sustaining care. The designated person must be an adult of sound mind, but no other restrictions are placed on the designation other than the requirements of form contained in Section 2(a). The designated person may be an attorney-in-fact who is so designated in the declaration or in another writing that conforms with the applicable requirements of each state for durable powers of attorney.

Section 2(c) provides a model form of declaration by which the designation of another decision-maker may be accomplished. The bracketed language in the Section 2(c) form of declaration is intended to allow a declarant two choices when designating another person to make treatment decisions. First, by striking the bracketed language, an individual may make an exclusive designation of another decision-maker, and if that person is not available to fulfill the responsibility, the declaration will have no effect. It is intended, in such an event, that the substituted decision-makers who are authorized to make treatment decisions in Section 7 will be able to exercise decision-making authority pursuant to the terms of Section 7. The execution of a declaration exclusively designating another person to make treatment decisions, in other words, should not itself be construed as an "expressed intention of the individual" not to have life-sustaining treatment withheld or withdrawn under Section 7(d).

The second choice available in the Section 2(c) form of declaration would make the declaration directly effective by its terms in the event that the substituted decision-maker were unavailable. This would be accomplished by not striking the bracketed language.

Other than the requirement that designees be adults of sound mind, no limitation is placed in Section 2 on the person(s) who may be designated to make decisions about the withholding or withdrawal of treatment for the declarant. It is specifically anticipated, for example, that some people may choose to appoint their physician to make such decisions and, absent any ethical restrictions on such an appointment, Section 2 anticipates that the physician may act in the appointed capacity.

Persons may be appointed to make decisions for a declarant through a declaration in substantially the form contained in Section 2(c), through appointment of an attorney-in-fact pursuant to a durable power of attorney, or through a judicially appointed guardian. In all cases, the designee has full power to make the rele-
vunt decisions called for in the Act, and func-
tions as the agent of the declarant. No specific standards, other than good faith, apply to deci-
sions of the designee. Designation of another to-
make decisions pursuant to a durable power of
attorney or judicially-appointed guardianship
is treated as a declaration under the Act, so
that, for example, decisions of the designee
"govern" treatment decisions by the physician,
and a physician who is unwilling to abide by
such decisions (if medically reasonable) must
transfer the patient to the care of another
physician.

Designation by a durable power of attorney
or judicially-appointed guardianship must be
based on a sufficiently specific reference to
health care or terminal care treatment deci-
sions, as required by state law governing such
appointments, to trigger application of the Act.
No specific formulation of the terms of appoint-
ment is required, however. If appointment for
purposes of health-care decisions would be suf-
cient under state law to include withholding or
withdrawal of treatment for a person in a termi-
nal condition, that will suffice under the Act.

The Act's authorization for specific decisions
does not in any way restrict authority that
exists under state law. The Act is in this respect
additive only. Thus, for example, if an attorney-
in-fact would have the authority independent
of this Act to authorize withdrawal of treat-
ment for a person in a persistent vegetative
state not covered by the terms of the Act, the
Act's limitations would not circumscribe the
attorney-in-fact's authority under other law.

In designating another person to make treat-
ment decisions, it is assumed that a declarant
will identify only a single decision-maker. In
view of this assumption, Sections 2(a) and (c)
permit designation of an individual, rather than
individuals, as the problems associated with
identifying, locating, and communicating with
multiple decision-makers are substantial and
the drafters did not want to encourage the
practice.

The Act does not expressly prohibit multiple
designees, however, and a declaration contain-
ing a multiple designation is not invalid under
the Act. The absence of any provision permit-
ting a majority of such designees to act in the
case of a disagreement, however, means that
the refusal of one member of a designee group
to agree to direct the withholding or withdrawal
of treatment will foreclose any action under the
Act unless the declaration specifically provides
otherwise. Because of the difficulties associ-
ated with multiple designees under the Act,
declarants should be discouraged from the prac-
tice and, if such designations are made and any
result other than the one stated above is de-
sired, the declaration should so specify.

The Act's provisions governing witnesses to
a declaration are simplified. Section 2 provides
only that the declaration be signed by the de-
clarant in the presence of two witnesses. The
Act does not require witnesses to meet any
specific qualifications for two primary reasons.
First, the interest in simplicity mandates an
uncomplicated a procedure as possible. It is
intended that the Act present a viable alterna-
tive for those persons interested in participat-
ing in their medical treatment decisions in the
event of a terminal condition.

Second, the absence of more elaborate wit-
ness requirements relieves physicians of the
inappropriate and perhaps impossible burden
determination whether the legalities of the
witness requirements have been met. Many
physicians understandably and rightly would
be hesitant to make such decisions and, there-
fore, the effectiveness of the declaration might
be jeopardized. It should be noted, as well, that
protection against abuse in these situations is
provided by the criminal penalties in Section
10. The attending physicians and other health-
care professionals will be able, in most circum-
stances, to discuss the declaration with the
patient and family and any suspicion of duress
or wrongdoing can be discovered and handled
by established hospital procedures.

Section 2(e) requires that a physician or
health-care provider who is given a copy of the
declaration record it in the declarant's medical
records. This step is critical to the effectuation
of the declaration, and the duty applies regard-
less of the time of receipt. If a copy of the same
declaration is already in the record, its re-
recording would not be necessary, but its re-
ceipt should be noted as evidence of its contin-
ued force. Section 2(e) is not duplicative of
Section 5 which requires recording the terms of
the declaration (or the document itself, when
available, in the event of telephonic communi-
cation to the physician by another physician,
for example) at the time the physician makes a
determination of terminal condition. It was
deemed important that knowledge of the decla-
ration and its continued force be specifically
noted at this critical juncture.

Section 2(e) imposes a duty on the physician
or other health-care provider to inform the
declarant of his or her unwillingness to comply
with the provisions of the declaration. This will
provide notice to the declarant that certain terms
may be deemed medically unreasonable (Section
11(1)), or that the declarant should decide whe-
ther to select another attending physician who
is willing to carry out the Act (Section 8).
§ 3.

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Section 3. When Declaration Operative. A declaration becomes operative when (i) it is communicated to the attending physician and (ii) the declarant is determined by the attending physician to be in a terminal condition and no longer able to make decisions regarding administration of life-sustaining treatment. When the declaration becomes operative, the attending physician and other health-care providers shall act in accordance with its provisions and with the instructions of a designee under Section 2(a) or comply with the transfer requirements of Section 8.

COMMENT

Section 3 establishes the preconditions to the declaration becoming operative. Once operative, Section 3 provides that the attending physician shall act in accordance with the provisions of the declaration or transfer care of the patient under Section 8. This provision is not intended to eliminate the physician's need to evaluate particular requests in terms of reasonable medical practice under Section 11(f), nor to relieve the physician from carrying out the declaration except for any specific unreasonable or unlawful request in the declaration. Transfer of the patient under Section 8 is to occur if the physician, for reasons of conscience, for example, is unwilling to carry out the Act or to follow medically reasonable requests in the declaration.

Section 4. Revocation of Declaration.

(a) A declarant may revoke a declaration at any time and in any manner, without regard to the declarant's mental or physical condition. A revocation is effective upon its communication to the attending physician or other health-care provider by the declarant or a witness to the revocation.

(b) The attending physician or other health-care provider shall make the revocation a part of the declarant's medical record.

COMMENT

Section 4 provides for revocation of a declaration and is modeled after North Carolina's similar provision. Virtually every other statute sets out specific examples of how a declaration can be revoked—by physical destruction, by a signed, dated writing, or by a verbal expression of revocation. A provision that freely allowed revocation and avoided procedural complications was desired. The simple language of Section 4 appears to meet these qualifications. It should be noted that the revocation is, of course, not effective until communicated to the attending physician or another health-care provider working under a physician's guidance, such as nursing facility or hospice staff. The Act, unlike many statutes, also does not explicitly require that a person relaying the revocation be acting on the declarant's behalf. Such a requirement could impose an unreasonable burden on the attending physician. The communication is assumed to be in good faith, and the physician may rely on it.

In employing a general revocation provision, it was intended to permit revocation by the broadest range of means. Therefore, for example, it is intended that a revocation can be effected in writing, orally, by physical defacement or destruction of a declaration, and by physician sign communicating intention to revoke.

Section 5. Recording Determination of Terminal Condition and Declaration. Upon determining that a declarant is in a terminal condition, the attending physician who knows of a declaration shall record the determination and the terms of the declaration in the declarant's medical record.

COMMENT

Section 5 of the Act requires that an attending physician record the determination that the patient is in a terminal condition in the patient's medical records. The section provides that an attending physician must know of the declaration's existence. It is anticipated that knowledge may in some instances occur through oral communication between physicians. If the attending physician determines that the patient is in a terminal condition, and has been notified of the declaration, the physician is to make the determination of terminal condition, as defined in Section 1(8), part of the patient's medical records.
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requirement that the physician inform the patient of the terminal condition. That decision is to be left to the physician's professional discretion under existing standards of care. The Act also does not require, as do many statutes, that a physician other than the attending physician concur in the terminal condition determination. It appears to be the established practice of most physicians to request a second opinion or, more often, review by a panel or committee established as a matter of hospital procedure, and the Act is not intended to discourage such a practice. Requiring it, however, would almost inevitably freeze in a single process or set of processes for review in this evolving area of medicine. Because existing policies and regulations typically address the review issue, requiring a specific form of review in the Act was viewed as an unnecessary regulation of normal hospital procedures. Moreover, in smaller or rural health facilities a second qualified physician or review mechanism may not be readily available to confirm the attending physician's determination.

The physician must record the terms of the declaration in the medical record so that its specific language or any special provisions are known at later stages of treatment. It is assumed that "terms" of the declaration will be a copy of the declaration itself in most instances, although cases of an emergency character may arise, for example, in which the contents of a declaration can be reliably conveyed, and where obtaining a copy of the declaration prior to making decisions governed by it will be impracticable. In such cases, the terms of the declaration will suffice for recording purposes under Section 5.

Section 6. Treatment of Qualified Patients.
(a) A qualified patient may make decisions regarding life-sustaining treatment so long as the patient is able to do so.
(b) This [Act] does not affect the responsibility of the attending physician or other health-care provider to provide treatment, including nutrition and hydration, for a patient's comfort care or alleviation of pain.
(c) Life-sustaining treatment must not be withheld or withdrawn pursuant to a declaration from an individual known to the attending physician to be pregnant so long as it is probable that the fetus will develop to the point of live birth with continued application of life-sustaining treatment.

COMMENT
Section 6(a) recognizes the right of patients who have made a declaration and are determined to be in a terminal condition to make decisions regarding use of life-sustaining procedures. Until unable to do so, such patients have the right to make such decisions independently of the terms of the declaration. In affording patients a "right to make decisions regarding use of life-sustaining procedures," the Act is intended to reflect existing law pertaining to this issue. As Sections 11(e) and (f) indicate, qualifications on a patient's right to force the carrying out of those decisions in a manner contrary to law or accepted standards of medical practice, for example, are not intended to be overridden.

In Section 6(b) the Act uses the term "comfort care" in defining procedures that may be applied notwithstanding a declaration instructing withdrawal or withholding of life-sustaining treatment. The purpose for permitting continuation of life-sustaining treatment deemed necessary for comfort care or alleviation of pain is to allow the physician to take appropriate steps to insure comfort and freedom from pain, as dictated by reasonable medical standards. Many existing statutes employ the term "comfort care" in connection with the alleviation of pain, and the Act follows this example. Although the phrase "to alleviate pain" arguably is subsumed within the term comfort care, the additional specificity was considered helpful for both the doctor and layperson.

Section 6(b) does not set out a separate rule governing the provision of nutrition and hydration. Instead, each is subject to the same considerations of necessity for comfort care and alleviation of pain as are all other forms of life-sustaining treatment. If nutrition and hydration are not necessary for comfort care or alleviation of pain, they may be withdrawn. This approach was deemed preferable to the approach in a few existing statutes, which treat nutrition and hydration as comfort care in all cases, regardless of circumstances, and exclude comfort care from the life-sustaining treatment definition.

It is debatable whether physicians or other
professionals perceive the providing of nourishment through intravenous feeding apparatus or nasogastric tubes as comfort care in all cases or whether such procedures at times merely prolong the dying process. Whether procedures to provide nourishment should be considered life-sustaining treatment or comfort care appears to depend on the factual circumstances of each case and, therefore, such decisions should be left to the physician, exercising reasonable medical judgment. Declarants may, however, specifically express their views regarding continuation or noncontinuation of such procedures in the declaration, and those views will control.

Section 6(c) addresses the problem of a qualified patient who is pregnant. The states which address this issue typically require that the declaration be given no force or effect during the pregnancy. Because this requirement inadvertently may do more harm than good to the fetus, Section 6(c) provides a more suitable, if more complicated, standard. It is possible to hypothesize a situation in which life-sustaining treatment, such as medication, may prove fatal to a fetus which is at or near the point of viability outside the womb. In such cases, the Act's provision would permit the life-sustaining treatment to be withdrawn or withheld as appropriate in order best to assure survival of the fetus. Also, for example, if the qualified patient is only a few weeks pregnant and the physician, pursuant to reasonable medical judgment, determines that it is not probable that the fetus could develop to a point of viability outside the womb even with application of life-sustaining treatment, such treatment may also be withheld or withdrawn. Thus, the pregnancy provision attempts to honor the terminally-ill patient's right to refuse life-sustaining treatment without jeopardizing the likelihood of life for the fetus.

In the original Rights of the Terminally Ill Act, adopted by the Conference in 1985, Section 6(c) included the introductory phrase "Unless the declaration otherwise provides." In the current Act the phrase has been eliminated from Section 6(c) in order to conform with a similar provision in Section 7. Under the current provision, life-sustaining treatment may not be withdrawn from a woman known to be pregnant if it is probable that the fetus will develop to live birth with continuation of the treatment, notwithstanding expressed views of the patient to the contrary. In view of the requirement that development to birth be probable, and the frequently complicating impact of prolonged life-sustaining treatment for a terminal patient, the provision is likely to have an impact in relatively narrow circumstances.

Nevertheless, in states that wish to accommodate the declaration of a pregnant woman, the wording from the prior version of the Act may be used. Differences from the Uniform Act in this specific application would not undermine the interest in uniformity served by the Act.

Section 7. Consent by Others to Withdrawal or Withholding of Treatment.

(a) If written consent to the withholding or withdrawal of the treatment, witnessed by two individuals, is given to the attending physician, the attending physician may withhold or withdraw life-sustaining treatment from an individual who:

1. has been determined by the attending physician to be in a terminal condition and no longer able to make decisions regarding administration of life-sustaining treatment; and

2. has no effective declaration.

(b) The authority to consent or to withhold consent under subsection (a) may be exercised by the following individuals, in order of priority:

1. the spouse of the individual;

2. an adult child of the individual or, if there is more than one adult child, a majority of the adult children who are reasonably available for consultation;

3. the parents of the individual;

4. an adult sibling of the individual or, if there is more than one adult sibling, a majority of the adult siblings who are reasonably available for consultation; or

5. the nearest other adult relative of the individual by blood or adoption who is reasonably available for consultation.

(c) If a class entitled to decide whether to consent is not reasonably available for consultation and competent to decide, or declines to decide, the next class is authorized to
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declare, but an equal division in a class does not authorize the next class to declare.

(d) A decision to grant or withhold consent must be made in good faith. A consent is not valid if it conflicts with the expressed intention of the individual.

(e) A decision of the attending physician acting in good faith that a consent is valid or invalid is conclusive.

(f) Life-sustaining treatment must not be withheld or withdrawn pursuant to this section from an individual known to the attending physician to be pregnant so long as it is probable that the fetus will develop to the point of live birth with continued application of life-sustaining treatment.

COMMENT

Section 7 provides a procedure by which an attending physician may obtain consent to the withholding or withdrawal of life-sustaining treatment in the absence of an effective declaration. It draws upon the definitions of the Act, as well as those sections bearing on the process for and the legal effect of withholding or withdrawal of treatment, but in most other respects it is free-standing. It can therefore simply be inserted as a new section in existing statutes that follow the original 1985 Uniform Act. For states that might want to adopt the Section 2 amendments, but not the Section 7 amendments, Section 7 can simply be deleted.

The purpose of Section 7 is to authorize persons other than the patient who are in a close familial relationship to the patient to consent to the withholding or withdrawal of life-sustaining treatment when the patient has no prior declaration, or when a prior declaration is not effective. Prior declarations might not be effective for a variety of reasons, including for example the expiration of a time limit, the failure to have the declaration properly witnessed, or the absence of a condition precedent contained in the declaration, such as the death or disability of a designated decision-maker.

Section 7 authorizes binding consent to the withholding or withdrawal of life-sustaining treatment for qualified patients. Members of the patient's family in designated priority order may consent to withholding or withdrawal of life-sustaining treatment, and such consent will be treated as if the individual had given it. Consent by the designated family members, however, must be given in good faith, and is not valid if it would conflict with the expressed intention of the patient.

The consent provision of Section 7 differs from the designation of another to make decisions under Section 2. Because the "consent" does not constitute a declaration under the Act, provisions that impose an obligation on the physician to seek out a designee under a declaration, that make the designee's decisions "govern" treatment, and that require transfer by a physician under Section 8, do not apply. Section 7, in short, is not a full alternative to a declaration, but is rather a means by which the attending physician can obtain legally reliable consent to the withholding or withdrawal of treatment for individuals in a terminal condition, should that be needed in the circumstances. Section 7 neither constitutes a de jure appointment of family to make such decisions in all cases, nor does it limit treatment authority authorized under other law.

Section 8. Transfer of Patients. An attending physician or other health-care provider who is unwilling to comply with this [Act] shall take all reasonable steps as promptly as practicable to transfer care of the declarant to another physician or health-care provider who is willing to do so.

COMMENT

Section 8 is designed to address situations in which a physician or health-care provider is unwilling to make and record a determination of terminal condition, or to respect the medically reasonable decisions of the patient or designee regarding withholding or withdrawal of life-sustaining procedures, due to personal convictions or policies unrelated to medical judgment called for under the Act. In such instances, the physician or health-care provider must promptly take all reasonable steps to transfer the patient to another physician or health-care provider who will comply with the applicable provisions of the Act.
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Section 9. Immunities.

(a) A physician or other health-care provider is not subject to civil or criminal liability, or discipline for unprofessional conduct, for giving effect to a declaration or the direction of an individual designated pursuant to Section 2(a) in the absence of knowledge of the revocation of a declaration, or for giving effect to a written consent under Section 7.

(b) A physician or other health-care provider, whose action under this [Act] is in accord with reasonable medical standards, is not subject to criminal or civil liability, or discipline for unprofessional conduct, with respect to that action.

(c) A physician or other health-care provider, whose decision about the validity of consent under Section 7 is made in good faith, is not subject to criminal or civil liability, or discipline for unprofessional conduct, with respect to that decision.

(d) An individual designated pursuant to Section 2(a) or an individual authorized to consent pursuant to Section 7, whose decision is made or consent is given in good faith pursuant to this [Act], is not subject to criminal or civil liability, or discipline for unprofessional conduct, with respect to that decision. 

COMMENT

Section 9 provides immunities for persons acting pursuant to the declaration and in accordance with the Act. Immunities are extended in Sections 9(a)-(c) to physicians as well as persons operating under the physician's direction or with the physician's authorization, to facilities in which the withholding or withdrawal of life-sustaining procedures occurs, and to designees or persons authorized to consent under Sections 2 or 7. Section 9(b) serves both to immunize physicians from liability as long as reasonable medical judgment is exercised, and to impose "reasonable medical standards" as the criterion that should govern all of the specific medical decisions called for throughout the Act. Section 9(b), in conjunction with Section 11(f), therefore, avoids the need to restate the medical standard in each section of the Act requiring a medical judgment.

Section 10. Penalties.

(a) A physician or other health-care provider who willfully fails to transfer the care of a patient in accordance with Section 8 is guilty of [a class ___________________ misdemeanor].

(b) A physician who willfully fails to record a determination of terminal condition or the terms of a declaration in accordance with Section 5 is guilty of [a class ___________________ misdemeanor].

(c) An individual who willfully conceals, cancels, defaces, or obliterates the declaration of another individual without the declarant's consent or who falsifies or forges a revocation of the declaration of another individual is guilty of [a class ___________________ misdemeanor].

(d) An individual who falsifies or forges the declaration of another individual, or willfully conceals or withholds personal knowledge of a revocation under Section 4, is guilty of [a class ___________________ misdemeanor].

(e) A person who requires or prohibits the execution of a declaration as a condition for being insured for, or receiving, health-care services is guilty of [a class ___________________ misdemeanor].

(f) A person who coerces or fraudulently induces an individual to execute a declaration is guilty of [a class __________________, misdemeanor].

(g) The penalties provided in this section do not displace any sanction applicable under other law.

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SECTION 10. Criminal Penalties for Specific Conduct

Section 10 provides criminal penalties for specific conduct that violates the Act. Subsections (a) and (b) provide that a physician's failure to transfer a patient or record the diagnosis of terminal condition constitutes a misdemeanor. Subsection (c) makes certain willful actions which could result in the unauthorized prolongation of life a misdemeanor. Subsection (d) governs acts which are intended to cause the unauthorized withholding or withdrawal of life-sustaining treatment, thereby advancing death. Subsections (e) and (f) concern situations that may be coercive, and therefore are against public policy.

Some of the criminal penalties—particularly subsection (d)—depart significantly from most existing statutes. Most statutes provide penalties for intentional conduct that actually causes the death of a declarant, and define such conduct as murder or a high degree felony. The Act does not take this approach. Assuming that such conduct will already be covered by a state's criminal statutes, the Act only addresses the situations in which the actor falsifies or forges the declaration of another or willfully conceals or withholds knowledge of revocation. To be criminally sanctioned as a misdemeanor under the Act the circumscribed conduct need not cause the death of a declarant. The approach taken by most states, that of providing a felony penalty for those acts that actually caused death, was considered unnecessary, as existing criminal law will also apply pursuant to Section 10(g). A specific penalty for the conduct described in Section 10(d), however, was deemed appropriate, as existing criminal codes may not adequately address it.


(a) Death resulting from the withholding or withdrawal of life-sustaining treatment in accordance with this Act does not constitute, for any purpose, a suicide or homicide.

(b) The making of a declaration pursuant to Section 2 does not affect the sale, procurement, or issuance of a policy of life insurance or annuity, nor does it affect, impair, or modify the terms of an existing policy of life insurance or annuity. A policy of life insurance or annuity is not legally impaired or invalidated by the withholding or withdrawal of life-sustaining treatment from an insured, notwithstanding any term to the contrary.

(c) A person may not prohibit or require the execution of a declaration as a condition for being insured for, or receiving, health-care services.

(d) This Act creates no presumption concerning the intention of an individual who has revoked or has not executed a declaration with respect to the use, withholding, or withdrawal of life-sustaining treatment in the event of a terminal condition.

(e) This Act does not affect the right of a patient to make decisions regarding use of life-sustaining treatment, so long as the patient is able to do so, or impair or supersede a right or responsibility that a person has to effect the withholding or withdrawal of medical care.

(f) This Act does not require a physician or other health-care provider to take action contrary to reasonable medical standards.

(g) This Act does not condone, authorize, or approve mercy-killing or euthanasia.

SECTION 12. When Health-Care Provider May Presume Validity of Declaration

In the absence of knowledge to the contrary, a physician or other health-care provider may assume that a declaration complies with this Act and is valid.

SECTION 13. Recognition of Declaration Executed in Another State

A declaration executed in another state in compliance with the law of that state or of this State is valid for purposes of this Act.

COMMENT

Section 13 provides that a declaration executed in another state, which meets the execution requirements of that other state or the enacting state (adult, two witnesses, voluntary), is to be treated as validly executed in the enacting state, but its operation in the enacting state shall be subject to the substantive policies in the enacting state's law.
§ 14 UNIFORM RIGHTS OF THE TERMINALLY ILL ACT (1989)

Section 14. Effect of Previous Declaration. An instrument executed anywhere before the effective date of this [Act] which substantially complies with Section 2(a) is effective under this [Act].

Section 15. Uniformity of Application and Construction. This [Act] shall be applied and construed to effectuate its general purpose to make uniform the law with respect to the subject of this [Act] among states enacting it.

Section 16. Short Title. This [Act] may be cited as the Uniform Rights of the Terminally Ill Act (1989).

Section 17. Severability Clause. If any provision of this [Act] or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this [Act] which can be given effect without the invalid provision or application, and to this end the provisions of this [Act] are severable.

Section 18. Effective Date. This [Act] takes effect on ____________________.

Section 19. Repeal. The following acts and parts of acts are repealed:

(1)  
(2)  
(3)