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Ohio's New Living Will Statute: Will It Survive?

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LEGISLATIVE NOTE

OHIO'S NEW LIVING WILL STATUTE: WILL IT SURVIVE?

I. INTRODUCTION

When the 119th Ohio General Assembly enacted Amended Substitute Senate Bill 1 (Am. Sub. S.B. 1)[1] on October 10, 1991, it joined a majority of other jurisdictions that have implemented living will legislation.[2] While doing so, the Ohio Legislature additionally modified its

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1. The general purpose of S.B. 1 was to amend sections 1337.11-.17 and 2101.24 and to enact sections 2133.01-.15 of the Ohio Revised Code in order to modify provisions of the Durable Power of Attorney for Health Care Law, to adopt a modified version of the Uniform Rights of the Terminally Ill Act, and to clarify the legislative intent underlying S.B. 13 (Ohio's 1989 Durable Power of Attorney for Health Care Law) of the 118th Ohio General Assembly.

2. Including Ohio's new living will bill, forty-five states and the District of Columbia have incorporated living will or natural death legislation into their health care laws. *See* ALA. CODE §§ 22-8A-1 to 22-8A-10 (1990) (Alabama Natural Death Act of 1981); ALASKA STAT. §§ 18.12.010-.100 (1986) (Alaska Rights of Terminally Ill Act of 1986); ARIZ. REV. STAT. ANN. §§ 36-3201 to 36-3210 (Supp. 1990) (Arizona Medical Treatment Decision Act of 1985); ARK. CODE ANN. §§ 20-17-201 to 20-17-218 (Michie Supp. 1987) (Arkansas Rights of the Terminally Ill or Permanently Unconscious Act of 1987); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1989) (California Natural Death Act of 1976); COLO. REV. STAT. §§ 15-18-101 to 15-18-113 (Supp. 1988) (Colorado Medical Treatment Decision Act of 1985); CONN. GEN. STAT. ANN. §§ 19a-570 to 19a-575 (West Supp. 1990) (Connecticut Removal of Life Support Systems Act of 1985); DEL. CODE ANN. tit. 16, §§ 2501-2509 (1983) (Delaware Death with Dignity Act of 1982); D.C. CODE ANN. §§ 6-2421 to 6-2430 (Supp. 1989) (District of Columbia Natural Death Act of 1981); FLA. STAT. ANN. §§ 765.01-.17 (West Supp. 1990) (Florida Life-Prolonging Procedure Act of 1984); GA. CODE ANN. §§ 31-32-1 to 31-32-12 (Michie 1985 & Supp. 1988) (Georgia Living Wills Act of 1984, 1986, 1987); HAW. REV. STAT. §§ 327D-1 to 327D-27 (Supp. 1988) (Hawaii Medical Treatment Decisions Act of 1986); IDAHO CODE §§ 39-4502 to 3945-09 (Supp. 1990) (Idaho Natural Death Act of 1977, 1986); ILL. ANN. STAT. ch. 100 ½, para. 701-710 (Smith-Hurd Supp. 1990) (Illinois Living Will Act of 1984); IND. CODE ANN. §§ 16-8-11-1 to 16-8-11-22 (Burns Supp. 1988) (Indiana Living Wills and Life-Prolonging Procedures Act of 1985); IOWA CODE ANN. §§ 144A.1-.11 (West 1989) (Iowa Life-Sustaining Procedures Act of 1985, 1987); KAN. STAT. ANN. §§ 65-28,101 to 65-28,109 (1985 & Supp. 1989) (Kansas Natural Death Act of 1979); KY. REV. STAT. ANN. §§ 311.622-.644 (Baldwin Supp. 1990) (Kentucky Living Will Act of 1990); LA. REV. STAT. ANN. §§ 40:1299.58.1-.10 (West Supp. 1989) (Louisiana Life-Sustaining Procedures Act of 1984, 1985); ME. REV. STAT. ANN. tit. 18A §§ 5-701 to 5-714 (West Supp. 1990) (The Uniform Rights of the Terminally Ill Act) (Supplemented by *In re* Gardner, 534 A.2d 947 (Me. 1987)), which held that the right to refuse the administration of artificial nutrition and hydration is protected by common law, despite the statute); MD. HEALTH-

newly existing Durable Power of Attorney for Health Care law (HC-DPA),[3] thus creating a more uniform body of statutory law governing health care decisions made by patients or their surrogate decisionmakers.[4]

GEN. CODE ANN. §§ 5-601 to 5-614 (Supp. 1990) (Maryland Life-Sustaining Procedures Act of 1985, 1986); MINN. STAT. ANN. §§ 145B.01-.17 (West Supp. 1991) (Minnesota Adult Health Care Decisions Act of 1989); MISS. CODE ANN. §§ 41-41-101 to 41-41-121 (Supp. 1988) (Mississippi Withdrawal of Life-Saving Mechanisms Act of 1984); MO. ANN. STAT. §§ 459.010-.055 (Vernon Supp. 1991) (Missouri Life Support Declarations Act of 1985); MONT. CODE ANN. §§ 50-9-01 to 50-9-206 (1989) (Montana Living Will Act of 1985); NEV. REV. STAT. ANN. §§ 449.540-.690 (Michie 1987) (Nevada Withholding or Withdrawing of Life-Sustaining Procedures Act of 1977); N.H. REV. STAT. ANN. §§ 137-H:1 to 137-H:10 (1990) (New Hampshire Terminal Care Document Act of 1985); S. 1211 (New Jersey Advanced Directive For Health Care Act, signed July 11, 1991) (not codified); N.M. STAT. ANN. §§ 24-7-1 to 24-7-11 (Michie Supp. 1988) (New Mexico Right to Die Act of 1977, 1984); N.C. GEN. STAT. §§ 90-320 to 90-323 (1990) (North Carolina Right to Natural Death Act of 1977, 1979, 1981, 1983); N.D. CENT. CODE §§ 23-06.4-01 to 23-06.4-14 (Supp. 1989) (North Dakota Uniform Rights of Terminally Ill Act); OKLA. STAT. ANN. tit. 63, §§ 3101-3111 (West Supp. 1991) (Oklahoma Natural Death Act of 1985); OR. REV. STAT. §§ 127.605-127.650 (1989) (Oregon Rights With Respect to Terminal Illness Act of 1977) (renumbered); R.I. GEN. LAWS 23-4.11.1 -.13 (1991) (HB 5924-4A) (Rhode Island Rights of the Terminally Ill Act June 1991); S.C. CODE ANN. §§ 44-77-10 to 44-77-160 (Law. Co-op. Supp. 1988) (South Carolina Death With Dignity Act of 1986); S.D. CODIFIED LAWS ANN. §§ 43-12D-12-22 (1991 Supp.) (South Dakota Living Will Act); TENN. CODE ANN. §§ 32-11-101 to 32-11-110 (Supp. 1988) (Tennessee Right to Natural Death Act of 1985); TEX. REV. CIV. STAT. ANN. art. 4590h §§ 1-11 (West Supp. 1989) (Texas Natural Death Act of 1977, 1979, 1983, 1985); UTAH CODE ANN. §§ 75-2-1101 to 75-2-1118 (Supp. 1989) (Utah Personal Choice and Living Will Act of 1985); VT. STAT. ANN. tit. 18, §§ 5251-5262 (Supp. 1988) (Vermont Terminal Care Document Act of 1982); VA. CODE ANN. §§ 54.1-2981 to 54.1-2992 (Michie 1988 & Supp. 1990) (Virginia Natural Death Act of 1983); WASH. REV. CODE ANN. §§ 70.122.010-.905 (West Supp. 1989) (Washington Natural Death Act of 1979); W. VA. CODE §§ 16-30-1 to 16-30-10 (Supp. 1987) (West Virginia Natural Death Act of 1984); WIS. STAT. ANN. §§ 154.01-.15 (West Supp. 1989) (Wisconsin Natural Death Act of 1984, 1986); WYO. STAT. §§ 35-22-101 to 35-22-108 (1988 & Supp. 1990) (Wyoming Act of 1984); *see also* SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF LIVING WILL LAWS (1987 & Supp. 1988) [hereinafter LIVING WILLS].

Subsequent to the major writing of this article, a federal statute was enacted which requires virtually every health care facility to notify a patient, on admission, of that patient's right to create an advanced directive, or living will. According to the statute, health care facilities are required:

> (A) to provide written information to each [patient] concerning —
>
> (i) an individual's rights under state law . . . to make decisions concerning . . . medical care, including the right to accept or refuse medical treatment and the right to formulate advanced directives, and,
>
> (ii) the provider's or organization's written policies respecting the implementation of such rights.

Budget Reconciliation Act, Pub. L. No. 101-508, §§ 4206, 4751, 104 Stat. 1388, 115, 204 (1990). This statute illustrates Congress' intent to make advanced directives and integral part of health care law.

3. OHIO REV. CODE ANN. 1337.11 to 1337.17 (Anderson 1989) (enacted June 28, 1989).

4. The phrase surrogate decisionmaker refers to an individual who becomes the primary actor in making health care decisions for a patient who is otherwise incapable of making such decisions for himself. In Ohio, the phrase "durable power of attorney for health care" is used to

Prior legislative history[5] has indicated the Ohio Assembly's intent to provide every individual with the autonomous decision-making right recognized by most courts in this country today.[6] This note discusses the effectiveness of Am. Sub. S.B. 1, also known as Ohio's new Modified Uniform Rights of the Terminally Ill Act (MURTIA),[7] as a tool for health care patients to exercise their autonomous decisionmaking rights, focusing primarily on what type of impact Am. Sub. S.B. 1 will have on Ohio's health care community. First, this note briefly discusses what type of legal foundations exist for the right to refuse medical treatment and the right to make decisions regarding self-determination. Second, the note explores the history of Ohio's case law both prior to the enactment of its first Durable Power of Attorney for Health Care law (HC-DPA) and during the hiatus between Ohio's 1989 HC-DPA and the subsequent enactment of MURTIA. Finally, the note analyzes the strengths and weaknesses of Ohio's new living will statute and suggests possible changes to correct some of the weaknesses and problems inherent in MURTIA.

The note concludes that although Ohio's version of the Uniform Rights of the Terminally Ill Act[8] is not without criticism, on the whole, it serves as a substantive, progressive piece of legislation which will provide an adequate preliminary foundation to address the ever-growing need for a uniform body of law to guide Ohio health care patients. The new statute allows all Ohio health care patients an opportunity to ensure that their health care preferences and choices are honored under any medical circumstance.

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define a substitute or surrogate decisionmaker. *See also* Marshall B. Kapp, *Ohio's New Durable Power of Attorney*, 14 U. DAYTON L. REV. 541 (1989).

5. Kapp, *supra* note 4, at 542 n.9. A living will bill was pending in the Ohio legislature at the end of 1989, but was never passed. H. 56, 118th Ohio Gen. Ass., Reg. Sess. (1989).

6. *See, e.g., In re* Conroy, 486 A.2d 1209, 1225 (N.J. 1985) (right to self-determination ordinarily outweighs any countervailing state interests and competent persons generally are permitted to refuse medical treatment, even at risk of death); *In re* Quinlan, 355 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976) (right of incompetent in persistent vegetative state to refuse medical treatment not disregarded solely on basis that condition prevents conscious exercise of the choice); *In re* Milton, 505 N.E.2d 255 (Ohio), *cert. denied*, 484 U.S. 820 (1987) (legally competent inpatient at mental hospital had right to refuse life-saving medical treatment even though decision was based on delusion); Estate of Leach v. Shapiro, 469 N.E.2d 1047 (Ohio 1984) (patient has cause of action in common law battery for initiation of life-sustaining treatment measures against patient's express wishes).

7. Chapter 2133 of the Ohio Revised Code, as enacted by S. 1, shall be entitled the Modified Uniform Rights of the Terminally Ill Act (MURTIA). S. 1, 119th Ohio Gen. Assembly, Reg. Sess., § 2133.15(2) (1991).

8. UNIF. RIGHTS OF THE TERMINALLY ILL ACT, §§ 1-18, 9A U.L.A. 456 (Supp 1986). Drafted and approved for enactment in all states by the National Conference of Commissioners on Uniform State Laws (NCCUSL). *See, e.g.*, LIVING WILLS, *supra* note 2, at 135.

II. BACKGROUND

Prior to the recent insurgence of living will and durable power of attorney for health care legislation, courts relied primarily upon common law principles of informed consent, battery, and negligence as bases for providing health care law to those patients making health care decisions.[9] Courts struggled in cases where a patient was incompetent,[10] incapable of making a medical choice, or unable to give informed consent to certain treatment.[11] Such cases primarily arose when the patient was permanently unconscious[12] and the patient had no reasonable possibility of regaining consciousness in order to make a treatment decision.

Because of the difficulties inherent in common law health care principles, state legislatures recognized a need for living will legislation. Before addressing the adoption of living will legislation, however, it is important to explore more adequately the history of common law as it relates to patient health care decisions. By contrasting common law with more recent statutory legislation, the significant and important impact of living will legislation on health care law becomes very apparent.

A. Foundation for the Right to Refuse Medical Treatment

1. Common Law

The doctrine of informed consent requires health care personnel to receive the informed consent of the patient prior to performing any

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9. *See infra* notes 13-22 and accompanying text (discussion of informed consent, battery and negligence).

10. *See infra* note 21 and accompanying text (explanation of patient incompetence).

11. *See, e.g.*, Gray v. Romeo, 697 F. Supp. 580, 587 (D.R.I. 1988) ("The right to refuse medical treatment 'must extend to the case of an incompetent, as well as competent, patient because the value of human dignity extends to both' ") (quoting Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626, 634 (Mass. 1986)). *Id. But see* LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW 1364 (2d ed. 1988) "[A]ttributing 'rights' to these patients is somewhat problematic . . . in the face of the recognition that they could make no decisions about how to exercise any such rights. . . ." *Id.* at 1368 n.25.

12. The Ohio Revised Code states:

> "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.

OHIO REV. CODE ANN. § 1337.11(I) (Anderson 1991).

medical procedures.[13] Inherent in the doctrine of informed consent is the common law principle of self-determination or individual autonomy.[14] Historically, courts enforce the doctrine of informed consent with the common law tort theories of battery and negligence.[15] For example, if a doctor provides any form of medical treatment without the consent of the patient, the doctor has committed a battery.[16] Some commentators note that courts have departed from the tort theory of battery and have focused instead on the negligence theory of liability in order to avoid labelling doctors as having committed a battery.[17] The negligence theory of liability is limited, however, in that a patient can only recover and be compensated for physical injuries that directly result from the medical treatment.[18] If no physical injury has occurred or if the benefits of the treatment outweigh the harm to the patient, then it may be difficult to recover using a negligence theory.[19] Courts in most states, including those jurisdictions that prefer the negligence theory of informed consent, have agreed that an action for common law battery exists whenever the patient being treated does not consent to the procedure.[20]

These common law theories of battery and negligence do not fare well in informed consent cases where the patient is an incompetent individual.[21] The doctrine of informed consent is difficult to apply in

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13. *See* W. PAGE KEETON ET. AL, PROSSER AND KEETON ON THE LAW OF TORTS § 32, at 190-91 (5th ed. 1984).

14. *See, e.g.*, Comment, *Developments in the Law - Medical Technology and the Law*, 103 HARV. L. REV. 1522, 1672 (1990) [hereinafter *Medical Technology*].

> A majority of courts find the right to refuse medical treatment and sustenance under the common law doctrine requiring that medical personnel receive the 'informed consent' of the patient prior to performing any medical procedure. Based on the common law principle of individual autonomy, the [common law] doctrine seeks to vindicate the right of every person to determine what will be done to his body.

Id.

15. *Id.*

16. *Id. See, e.g.*, RESTATEMENT (SECOND) OF TORTS § 907 & cmt. a (1979); KEETON, *supra* note 13, § 9, at 40.

17. *See* PAUL S. APPELBAUM, ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE, 118 (1987); KEETON, *supra* note 13, § 32, at 190.

18. KEETON, *supra* note 13, § 32, at 190.

19. *Id.*

20. *See* APPELBAUM, *supra* note 17, at 118.

21. Certain individuals may be incompetent for a number of reasons. Through genetic or other mental deficiencies, they may not possess adequate cognitive reasoning ability to make an informed decision. Otherwise competent individuals also may be unconscious and not able to make health care choices. Courts are confronted with especially difficult situations when a physician determines that there is no reasonable or likely possibility that a patient will gain or regain the competence necessary to make an informed decision. Where no patient competence exists or is not likely to exist, courts are often placed precariously in the position of second guessing what a patient's decision would be if such a patient were able to choose. Herein lies the difficulty of

those situations where a patient has no ability to form an opinion with regard to the consent of certain medical procedures. In such a case, the patient is unable to fulfill the consent element of the doctrine. In cases where a patient has neither the ability to consent nor to refuse certain treatment, commentators have noted that physicians are required to obtain the consent of an authorized third party before initiating treatment.[22] Although such a requirement may work as a proper safeguard against unwanted treatment in certain cases, common law principles cannot guarantee that the wishes of the incompetent individual will assuredly be followed in every case. This is particularly so when no specific third party has been authorized to make health care decisions for the incompetent patient.

Case law illustrates the difficulties that courts face when trying to decide appropriate action under varying circumstances.[23] Courts tried to establish arbitrary standards of care and attempted to create decisionmaking hypotheses as a basis for making treatment decisions with respect to incompetent patients.[24] In certain cases, the medical profession has had difficulty clarifying what constitutes "extraordinary treatment"[25] or "invasive technique."[26] Consequently, court decisions reflect the uncertainty that permeates cases involving health care decisions. As a result of the common law doctrine of informed consent, a physician's

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relying upon common law principles of informed consent. *See generally Medical Technology, supra* note 14.

22. RUTH R. FADEN ET AL., A HISTORY AND THEORY OF INFORMED CONSENT 36 (1986).

23. Lane v. Candura, 376 N.E.2d 1232 (Mass. App. Ct. 1978) (although trial judge concluded that patient's decision to forego surgery was irrational, the judge failed to make a "clear cut finding" that patient lacked "requisite legal competence"); *see also In re* Milton, 505 N.E.2d 255, *cert. denied*, 484 U.S. 820 (1987) (legally competent patient at mental hospital had right to refuse life-saving medical treatment even though her decision was based on a delusion).

24. *See, e.g.*, Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977) (court rationalized decision by postulating what a profoundly retarded man might have chosen to do if he had ever been competent); *In re* Quinlan, 355 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976) (court tried to balance "invasive technique" of procedure to patient's privacy with "extraordinary care" necessary to keep patient alive, as means of making treatment decisions); *see also infra* note 25 and accompanying text.

25. *Quinlan*, 355 A.2d at 654. The court established terminology such as "extraordinary treatment" and "invasive technique" in order to describe situations where a patient was kept alive exclusively by extraordinary health care means. The most typical examples would be a patient who is kept alive on a life-support system such as a respirator or by means of tube feeding food and water. Under these examples, a patient would not be able to eat, drink, breathe or summarily survive on his own without the extraordinary treatment. Under such circumstances, some form of patient informed consent is a necessary requirement.

26. *In re* Storar, 420 N.E.2d 64, 68 (N.Y.), *cert. denied*, 454 U.S. 858 (1981); *see also supra* notes 24-25 (comparing "invasive technique" and "extraordinary treatment.").

fear of not only civil[27] but also criminal[28] liability for either foregoing treatment or for implementing treatment without patient consent, can obscure the express wishes of the patient. The use of common law doctrines as a means of effectuating health care decisions has created uncertainty and apprehension where consistency and confidence are needed.

2. The Constitutional Basis: State Interests v. Autonomy

When courts attempt to apply the common law concepts of battery, negligence, and informed consent to the refusal of treatment context, they balance the patient's interest in autonomy against the four state interests recognized in the due process context.[29] The state interests involved are: (1) preserving life; (2) protecting innocent third parties (e.g. children); (3) preventing suicide; and (4) maintaining the ethical integrity of the medical profession.[30] It is in this context that courts have found a constitutional basis for the right to refuse medical treatment.

a. The Privacy Right and the Due Process Clause

The New Jersey Supreme Court in *In re Quinlan*, cited the right to privacy as a basis for the right to refuse life-sustaining treatment.[31] The *Quinlan* court's doctrinal analysis was minimal, however, primarily focusing on the statement made by the court that just as the right of privacy encompasses a woman's abortion decision, "[p]resumably [it] is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances."[32] Although a number of states have since adopted the *Quinlan* court's approach,[33] recent United States Supreme Court decisions restricting the right of privacy, as well as the liberty right in the Due Process Clause,[34] have personal choice

27. *See* Leach v. Akron Gen. Medical Ctr., 426 N.E.2d 809, 814-15 (Ohio 1980). Fear of civil liability usually arises in a malpractice case where it can be argued that any reasonable doctor would have continued treatment. *Id.*

28. *See* Barber v. Superior Court, 195 Cal. Rptr. 484, 491-92 (Cal. Ct. App. 1983). Criminal tort liability may arise in cases where a physician commits a battery by initiating treatment against a non-consenting patient. *Id.*

29. *See, e.g., In re* Conroy, 486 A.2d 1209, 1223-26 (N.J. 1985); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 425 (Mass. 1977).

30. *Conroy*, 486 A.2d at 1223-26; *Saikewicz*, 370 N.E.2d at 425.

31. 355 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976).

32. *Id.* at 663.

33. *See, e.g.*, State v. McAfee, 385 S.E.2d 651 (Ga. 1989) (competent quadriplegic's right to privacy and liberty outweigh any state interest); Leach v. Akron Gen. Medical Ctr., 426 N.E.2d 809 (Ohio Ct. C.P. 1980) (terminally ill incompetent patient's right to choose medical treatment outweighs state interests).

34. *See, e.g.*, Webster v. Reproductive Health Servs., 492 U.S. 490 (1989); Cruzan v. Harmon, 760 S.W.2d 408, 423-24 (Mo. 1988) (en banc), *aff'd*, 110 S. Ct. 2841 (interim ed. 1990)

proponents[35] looking elsewhere for adequate protection of the right to make health care decisions. Courts after *Quinlan* continue to struggle with the fine distinctions between terms such as ordinary care and extraordinary care, life-saving and life-sustaining, and withholding versus withdrawing of medical treatment.[36]

The United States Supreme Court, in *Cruzan v. Director, Missouri Department of Health*,[37] addressed the issue of what constitutional rights actually exist with regard to medical decisions. Petitioner, Nancy Beth Cruzan, was an incompetent patient as a result of injuries sustained in an automobile accident.[38] She was diagnosed as being in a persistent vegetative state.[39] The Court refused to address the privacy issue. Instead, Chief Justice Rehnquist stated in the majority opinion that the Due Process Clause protects a citizen's interest in life, as well as the corollary interest in refusing life-sustaining medical treatment.[40] This recognition by the Court was directed toward a competent individual only, resulting in the Court's adoption of a different approach to dealing with incompetent persons. [41]

b. Standards Applied to Incompetent Individuals

The Supreme Court in *Cruzan* adopted a clear and convincing evidence standard[42] when addressing the petitioner's argument that in-

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(refusing to allow withdrawal of feeding tubes because continued artificial feeding was not burdensome to the vegetative patient).

35. Personal choice proponents are those individuals who believe in the right to make health care choices through the doctrines of self-determination and self-autonomy.

36. *See supra* notes 23-26 and accompanying text; Martha Norton Mullins, Comment, *The Need for Guidance in Decisionmaking for Terminally Ill Incompetents: Is the Ohio Legislature in a "Persistent Vegetative State"?*, 17 OHIO N.U. L. REV. 827, 832-33 n.33.

37. 110 S. Ct. 2841 (interim ed. 1990).

38. *Id.* at 2844.

39. *Id.* at 2845. The Court described a persistent vegetative state as "a condition in which a person exhibits motor reflexes but evinces no indications of significant cognitive function [e.g. brain function]." *Id.*

40. *Id.* at 2853.

41. *Id.* at 2851.

42. *Id.* at 2853. Under this standard, an authorized third party or surrogate decisionmaker must establish by clear and convincing evidence that any decision she makes on behalf of the patient accurately reflects the patient's own wishes. The clear and convincing evidence standard of proof, as defined by the Court, was "proof sufficient to persuade the trier of fact that the patient held a firm and settled commitment to the termination of life supports under the circumstances like those presented." *Id.* at 2855 n.11 (quoting *In re* Westchester County Medical Ctr. *ex rel.* O'Connor, 531 N.E.2d 607, 613 (N.Y. 1988); *see also infra* notes 44-45 and accompanying text; *In re* Jobes, 529 A.2d 434, 441 (N.J. 1987). Clear and convincing evidence is defined as evidence which

> produces in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, evidence so clear, direct and weighty and convincing as to enable [the trier of fact] to come to a clear conviction, without hesitancy, of the truth of the precise facts in issue.

competent persons had a right to refuse treatment through a surrogate decisionmaker.[43] The Court reasoned that such a strict evidentiary standard was necessary under circumstances where (1) the decision was particularly important (preservation of human life) and (2) such a decision would have all of the elements of finality and irrevocability attached to it.[44] As a result, the wishes of an incompetent patient need to be clearly indicated before the individual becomes incapacitated. Evidentiary problems arise under such scrutiny since very few people have the foresight to execute advance directives, or even contemplate death or incompetence.[45]

In order to address the problems associated with incompetent patients, courts have formulated two standards that allow third parties or surrogate decisionmakers to exercise the rights of the incompetent to refuse treatment. These standards are referred to as the "substituted judgment"[46] and the "best interests"[47] standards. The substituted judgment standard allows a surrogate decisionmaker to make a decision that the incompetent patient would make if he were able to do so.[48] Many courts have adopted a clear and convincing evidence standard for the substituted judgment approach.[49]

Although the substituted judgment approach has been the most widely accepted,[50] it is not without criticism. It is often difficult to obtain clear indications of a patient's actual wishes, unless the incompetent individual created some sort of advance directive, for example, a living will, prior to her incapacity. Particularly in cases where evidentiary requirements are more relaxed, or where financial burdens cloud a surrogate decisionmaker's thoughts, substituted judgment standards can be undermined.[51] In addition, the substituted judgment standard

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Id.

43. *Id.* at 2853.

44. *Id.*

45. *Medical Technology, supra* note 14, at 1646-47.

46. *See In re* Conservatorship of Drabick, 245 Cal. Rptr. 840 (Cal. Ct. App.), *cert. denied*, 109 S. Ct. 399 (1988); *In re* Conservatorship of Torres, 357 N.W.2d 332 (Minn. 1984) (en banc).

47. *See* Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 427, 431, 434 (Mass. 1977).

48. *See* PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE & BIOMEDICAL & BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 132 (1983) [hereinafter DECIDING TO FOREGO].

49. *See supra* note 42 and accompanying text; *see also Cruzan*, 110 S. Ct. at 2854-55.

50. *See* ALAN MEISEL, THE RIGHT TO DIE § 9.10, at 268 (1989).

51. *Medical Technology, supra* note 14, at 1646-47; *see also* Gray v. Romeo, 697 F. Supp. 580 (D.R.I. 1988) (federal court accepted lessened evidentiary standard as basis for allowing termination of treatment, relying upon conversations dating back eleven years between patient and both husband and sister-in-law about *Quinlan* case which resulted in husband promising not to provide her with life-sustaining treatment in similar circumstances).

fails in cases involving patients who were never competent.[52] In such cases, there is no possible way to determine what the patient would decide if competent since the patient was never competent. Substituted judgment, therefore, becomes mere speculation when no reliable evidence of the patient's intent can be found. In *Cruzan*, the Supreme Court held that the substituted judgment of close family members need not be accepted by a court in the absence of substantial proof that their views reflect the views of the patient.[53]

The "best interests" standard has been adopted by a minority of courts.[54] This approach allows the surrogate decisionmaker to evaluate medical options for the patient according to "societally shared criteria," regardless of whether the medical treatment in question serves the patient's best interests.[55] A surrogate decisionmaker must take into account a variety of factors when assessing what treatment, if any, is best for the patient.[56] Such factors include the patient's current condition, loss of dignity, degree of pain and suffering, family situation and the benefits of each treatment option.[57]

The best interests standard has the same infirmities found in the substituted judgment standard. The best interests standard assumes that the surrogate decisionmaker can and will make a reasonably well-balanced decision regarding the interests of the patient. What may seem reasonable by society's perspective (e.g. societally shared criteria) primarily depends on the surrogate decisionmaker's view of societal values.[58] In some cases, it is plausible that the patient and the surrogate decisionmaker have somewhat different perspectives with regard to societal values. The result may lead to surrogate decisions that do not completely reflect the best interests of the patient.[59]

When comparing the substituted judgment and best interests standards, only a semantic distinction exists. After all, a patient's own judgment is the clearest proof of what treatment is in her best interests. Absent such judgment, courts try to fashion a set of societal balancing

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52. *See* DECIDING TO FOREGO, *supra* note 48, at 133.

53. 110 S. Ct. at 2855. The Court required that a clear and convincing evidence standard must be met when trying to exercise a substituted judgement procedure. *Id.*

54. *See In re* Conroy, 486 A.2d 1209, 1229-33 (N.J. 1985); *In re Quinlan*, 355 A.2d at 361-68.

55. *See* DECIDING TO FOREGO, *supra* note 48, at 134-35; *Medical Technology, supra* note 14, at 1651.

56. *See* DECIDING TO FOREGO, *supra* note 48, at 180.

57. *Id.*

58. *Medical Technology, supra* note 14, at 1653.

59. *Id.* at 1653 (best interests may be shifted to best interests of family rather than patient, or in other cases, healthy and vibrant individuals who are surrogate decisionmakers may undervalue the worth of a debilitated person or his existence).

factors to establish which course of treatment is best for the patient.[60] Both the substituted judgment and best interest standards try to establish the intent and wishes of the patient. Substituted judgment relies on clear and convincing evidence of what an incompetent patient would choose to do, if able. When no clear and convincing evidence exists, some courts prefer to use the best interests standard by trying to determine what is best for the patient based on societally shared criteria.[61] Under either standard, courts and surrogate decisionmakers are burdened with the difficult task of determining an incompetent patient's wishes, since such wishes most accurately reflect what is best for the patient.

The inconsistent and often illogical results reached through both constitutional and common law standards have led many jurisdictions to enact living will statutes in order to define health care options for both competent and incompetent patients.[62] With the enactment of Am. Sub. S.B. 1, Ohio has joined those jurisdictions in adopting statutory guidelines as a means of better anticipating the needs of its medical patients.

B. Ohio's Health Care History

Ohio's case law history regarding health care decisions reflects the inherent need for uniform statutory guidelines to equip physicians, patients and their families with better options to make appropriate health care decisions. Ohio precedent suggests that the Ohio Supreme Court and the Ohio General Assembly have been reluctant to address topics on the use or refusal of life support treatment with regard to medical patients.

Ohio courts first discussed the topic in *Leach v. Akron General Medical Center*.[63] Edna Leach was a seventy year old woman who, on June 11, 1980, entered a hospital and was diagnosed as having amyotrophic lateral sclerosis, a progressively deteriorating disease which affected the nervous system.[64] Mrs. Leach was later admitted to Akron General Medical Center where she suffered a cardiac arrest on July 29, 1980, and subsequently lapsed into a chronic vegetative state.[65] Expert testimony revealed that Mrs. Leach's likelihood of recovery to a cognitive state[66] was highly improbable.[67] In light of these facts, the court

60. *See supra* notes 55-57 and accompanying text.
61. *Id.*
62. *See supra* notes 2-8 and accompanying text.
63. 426 N.E.2d 809 (Ohio Ct. C.P. 1980).
64. *Id.* at 810.
65. *Id.*; *see supra* note 39.
66. *See supra* note 39.
67. Leach v. Akron Gen. Medical Ctr., 426 N.E.2d at 811.

adopted the approach of the New Jersey Supreme Court in *Quinlan* and ruled that the constitutional right to privacy affords a patient, such as Mrs. Leach, a right to refuse life-sustaining medical treatment.[68] The court also used the clear and convincing evidence standard as a means for determining whether the patient would prefer to forego treatment if she were able to make a choice, and found that removal of Mrs. Leach's respirator was warranted.[69]

Although the *Leach* court established a constitutional basis to refuse medical treatment in Ohio, it also illustrated some inconsistencies that have plagued courts with respect to Ohio health care decisions.[70] *Leach* was a case of first impression and its holding is not binding on the Ohio courts since it is a trial court decision.[71] *Leach* also fails to address the essential issue of whether a patient may refuse life-sustaining treatment before it is given, or must wait until such treatment is given before seeking court-administered intervention.[72] Finally, *Leach* reopens common law and constitutional problems facing physicians who are concerned with seeking a probate court order before discontinuing treatment for fear of civil or criminal liability.[73]

Under the same factual circumstances presented in *Leach v. Akron General Medical Center*, an Ohio appeals court addressed the issue of Mrs. Leach's right to refuse life-sustaining treatment prior to its initial use.[74] In this corollary to the first *Leach* case, the court applied the common law doctrines of battery and informed consent rather than the constitutional right to privacy approach found in the first *Leach* decision.[75] Although the court recognized the right of a terminally ill

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68. *Id.* at 816.

69. *Id.*

70. *See, e.g.*, Couture v. Couture, 549 N.E.2d 571 (Ohio Ct. App. 1989) (strictly applying the provisions of Ohio's 1989 Durable Power of Attorney for Health Care law, the court misconstrued intent of Ohio General Assembly and consequently denied withdrawal of treatment to patient); Estate of Leach v. Shapiro, 469 N.E.2d 1047 (Ohio Ct. App. 1984) (the court failed to define who would be considered an authorized person for the purposes of making health care decisions for an incompetent patient); Leach v. Akron Gen. Medical Ctr., 426 N.E.2d 809 (Ohio Ct. C.P. 1980) (the court did not determine whether patient may refuse medical treatment prior to its inception, or whether patient must wait until treatment is administered before refusal can be sought). *See generally* James M. Jones, Note, *Toward an Ohio Natural Death Act; The Need for Living Will Legislation*, 46 OHIO ST. L.J. 1019, 1021 (1985). The *Couture* decision basically eliminated the effectiveness of Ohio's 1989 HC-DPA and demonstrates how the *Couture* court misconstrued the intent of the Ohio General Assembly with respect to the 1989 HC-DPA. *See infra* note 95.

71. *Leach*, 426, N.E.2d at 816.

72. *Id.*

73. *Id.* at 814-15; *see also supra* notes 27-28 and accompanying text.

74. *Estate of Leach*, 469 N.E.2d at 1050.

75. *Id.* at 1051-52; *see also supra* notes 13-22 and accompanying text.

patient, either competent or incompetent, to refuse life-sustaining treatment, it ultimately failed to fill the existing gaps in Ohio health care law.

The second *Leach* decision is riddled with vague dicta and holdings. The court's holding allows a terminally ill patient to recover in tort from a physician who provides treatment against the express wishes of the patient.[76] Although other courts have provided an explanation of the term "express wish," the second *Leach* court never articulated what constitutes an express wish.[77] The court was again vague when it determined that an incompetent patient may consent to treatment through an authorized person, but failed to state who might be considered or defined as an authorized person.[78]

The two *Leach* cases illustrate the inherent problems in dealing with health care decisions by applying constitutional and common law standards. Mere case by case analyses without legislative guidelines often leave Ohio courts trapped in the position of speculators.[79] The only case in which the Ohio Supreme Court ruled on the right to refuse life-sustaining treatment was predicated on constitutionally based religious freedom[80] and fell outside the specific scope of health care issues raised in the *Leach* cases.

Until 1989, Ohio citizens relied primarily on the poorly enunciated holdings of the *Leach* cases. On June 28, 1989, however, the Ohio Legislature enacted its first Durable Power of Attorney for Health Care law (HC-DPA),[81] primarily in response to the lack of pertinent legal authority on the issue, but also as a means of modernizing Ohio health care law.[82] Over the past decade, the Ohio legislature considered a variety of living will legislation, but none successfully made it through both houses until Am. Sub. S.B. 1.[83] Until Am. Sub. S.B. 1, the only

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76. *Estate of Leach*, 469 N.E.2d at 1053.

77. *See, e.g.*, Jones, *supra* note 70, at 1025.

78. *Id.*; *see also Estate of Leach*, 469 N.E.2d at 1052.

79. Without a clear legislative provision, such as a living will statute, courts must resort to subjective standards of evidence and proof when trying to determine the wishes of the patient.

80. *In re* Milton, 505 N.E.2d 255 (Ohio), *cert. denied*, 484 U.S. 820 (1987) (although patient had long-time delusion that she was wife of a Reverend Jenkins and that he would, perhaps, heal her infirmities, her belief in spiritual healing stood on its own, without regard to delusion, as means for refusing medical treatment).

81. OHIO REV. CODE ANN. §§ 1337.11-.17 (Anderson 1989).

82. *See generally* Kapp, *supra* note 4.

83. *See generally* Mullins, *supra* note 36. Living will legislation that has failed to pass through both houses includes: H. 137, 114th Ohio Gen. Assembly (1981-1982); H. 331, 115th Ohio Gen. Assembly (1983-1984); H. 220, 116th Ohio Gen. Assembly (1985-1986); S. 383, 118th Ohio Gen. Assembly (1989-1990). *Id.*

other legislation to address health care decisionmaking was the 1989 version of Ohio's HC-DPA law.[84]

The 1989 Durable Power of Attorney for Health Care law has been called a "poorly drafted stopgap measure"[85] by one detractor; another commentator has pointed to numerous deficiencies within the legislation.[86] *Couture v. Couture* illustrated the problems inherent in Ohio's 1989 HC-DPA law.[87] The *Couture* case involved twenty-nine-year old Daniel Couture who was diagnosed as being in a persistent vegetative state.[88] The medical testimony revealed that Daniel was in a persistent vegetative state with "no medically recognized prospect of recovery."[89] The court subsequently pronounced that "Bertha J. Couture, as such Guardian, is entitled to make those decisions for further treatment and care . . . which would be best for the ward and in accordance with the desires of the ward."[90] Additional evidence revealed the patient's intent to forego medical treatment under such circum-

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84. OHIO REV. CODE ANN. §§ 1337.11-.17.

85. Jones, *supra* note 70, at 1034.

86. Kapp, *supra* note 4, at 550-57. The limitations concerning an agent's (surrogate decisionmaker's) prerogatives in the realm of artificial feeding and hydration are overbroad and inherently counterproductive. Ohio's HC-DPA law not only seeks to foreclose surrogate decisions to remove nutrition and hydration once they have been initiated, but it also attempts to prevent agents from withholding or refusing nutrition and hydration in the first place. As a result, many incompetent patients may be forced to receive nutrition and hydration in cases where they normally could forego such treatment through a substitute decisionmaker. *Id.*; *see also* OHIO REV. CODE ANN. § 1337.13.

Under Ohio Revised Code section 1337.13(E)(2), the second condition necessary before nutrition and hydration can be withdrawn makes the act unduly restrictive. The agent's or surrogate decisionmaker's right to refuse nutrition and hydration on behalf of the patient is initiated only when death of the patient is imminent and when the withholding of nutrition and hydration is not likely to result in the death of the patient by malnutrition or dehydration, or when the patient's life would be shortened by such action. The logic here is contradictory since the patient's death by removal of the feeding tubes is the intended outcome of the procedure. Such death will proximately result from the lack of nutrition and hydration to the patient. Kapp, *supra* note 4, at 552-58.

In terms of revocation, Ohio Revised Code section 1337.14(A) provides that revocation of a durable power of attorney designation can be done orally or in writing to either the attending physician or the designated attorney in fact (surrogate decisionmaker), or by doing any other act (e.g. destroying the instrument) which constitutes an intent to revoke. This section presumes the principal's (patient's) capacity to revoke "unless there is evidence to the contrary." The statute is completely silent with respect to the nature and weight of evidence necessary to rebut the presumption of capacity.

Section 1337.15(B) presents contradictory language when discussing the immunities afforded to physicians who provide or fail to withdraw life-sustaining treatment. Such immunities completely undermine the already established common law principals of battery and informed consent by allowing the physician the opportunity to contravene completely the attorney in fact's decisions regarding express patient wishes. Kapp, *supra* note 4, at 558.

87. 549 N.E.2d 571 (Ohio Ct. App. 1989).

88. *Id.*

89. *Id.* at 572.

90. *Id.*

stances.[91] Despite both the court's assignment of Mrs. Couture as guardian and the uncontroverted medical testimony, Bertha Couture was unsuccessful in her attempts to withdraw nutrition and hydration care from her son, Daniel.[92] The Ohio Court of Appeals used a strict application of the public policy standards set forth by the Ohio legislature in Am. Sub. S.B. 13,[93] otherwise known as Ohio's 1989 HC-DPA law. Adhering to Am. Sub. S.B. 13's strict standards for refusal of nutrition and hydration treatment, the *Couture* court found that the conditions set forth in the bill to allow the discontinuance of nutrition and hydration "namely, that the patient's death be 'imminent' with or without artificial sustenance and that the removal of nutrition and hydration not result in death by malnutrition or dehydration—were not satisfied."[94]

The *Couture* decision created a question of whether a person can rely on the 1989 version of the HC-DPA law to assure that her health care preferences will be honored under any circumstance. Ohio Senator Richard H. Finan suggested that the *Couture* decision illustrated the inconsistencies between the intent of the Ohio General Assembly with respect to the 1989 HC-DPA law, and the *Couture* court's subsequent interpretation of that intent.[95] Senator Finan explained that, as courts in Ohio and other states became more significantly involved with making health care decisions for incompetent patients, the Ohio General Assembly recognized the need for living will legislation coupled with a conforming durable power of attorney for health care law.[96]

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91. *Id.* at 576. Bertha Couture testified that Daniel had made statements after viewing television programs that he would not want his life prolonged by the extraordinary means of life support systems. *Id.* She also testified that his statements had been made on several occasions over four or five years and with the knowledge that his own medical problems posed that risk. *Id.*

92. *Id.* at 577.

93. Ohio's new HC-DPA law sections 1337.11-.17 of the Ohio Revised Code had not been officially enacted at the time of the *Couture* case. The appeals court in *Couture*, nevertheless, adopted the Ohio Legislature's policy intent, which it determined as being opposed to the withdrawal of nutrition or hydration under circumstances where the result would be death by malnutrition or dehydration despite the wishes of the patient or his surrogate decisionmaker. *Id.* at 575; *see also* Kapp, *supra* note 4, at 555.

94. *See* Kapp, *supra* note 4, at 555; *see also Couture*, 549 N.E.2d at 575.

95. Telephone interview with Senator Richard H. Finan, Ohio General Assembly and sponsor of MURTIA (Oct. 3, 1991). Senator Finan stated that the *Couture* decision basically "killed" Ohio's 1989 HC-DPA and that the *Couture* court's definitions were obviously different from those which the Ohio General Assembly intended when it enacted the 1989 HC-DPA law. *Id.*

Cf. In re Guardianship of Crum, 580 N.E.2d 876 (Ohio Prob. 1991) (court used the impending enactment of Am. Sub. S.B. 1 as a means of determining the legislative intent of the Ohio General Assembly when it allowed coguardians to discontinue the tubular administration of nutrition and hydration to their incompetent ward who was in a vegetative state).

III. SUMMARY OF MODIFIED HC-DPA LAW AND MURTIA PROVISIONS

A. General Provision

Am. Sub. S.B. 1[97] authorizes the execution at any time of a declaration in which the declarant specifies whether he wishes life-sustaining treatment to be used, continued, withheld, or withdrawn by his attending physician if he should be in a terminal condition or in a permanently unconscious state.[98] This declaration is commonly referred to as a living will. The attending physician must also determine that the patient is no longer able to make informed decisions regarding the administration of the treatment and that there is no reasonable possibility the patient will regain the capacity to make those decisions.[99]

B. MURTIA (Provisions for Individuals who Execute a Living Will Document)

Ohio's new Modified Uniform Rights of the Terminally Ill Act (MURTIA)[100] is found in sections 2133.01 through 2133.15 of the Ohio Revised Code.[101] The act permits an adult who is of sound mind to execute a voluntary declaration that will govern the use, continuation, withholding, or withdrawal of life-sustaining treatment and may include a designation by the declarant of one or more persons who are to be notified by the attending physician any time that life-sustaining treatment will be withheld or withdrawn.[102] Although the language in section 2133.02 implies that a patient, by her own discretion, "may include a designation . . . of one or more persons who are to be notified" of treatment decisions, the statute later *requires* physicians to notify specified family members of treatment decisions, regardless of whether such notification was designated by the patient in her declara-

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97. OHIO REV. CODE ANN. §§ 1337.11-.17 and 2101.24 amended, §§ 2133.01-.15 enacted.

98. S. 1 (Preliminary Summary July 1991), 119th Ohio Gen. Ass., Reg. Sess., at 1 (1991). Persistent vegetative state would fall under this category as well.

99. *Id.*

100. As adopted from the Uniform Rights of the Terminally Ill Act. *See supra* note 8.

101. MURTIA was codified at Ohio Revised Code sections 2133.01-.15 (Anderson 1991).

102. OHIO REV. CODE ANN. § 2133.02(A)(1). A similar notification provision is set out in Ohio Revised Code section 1337.16 of the 1991 HC-DPA law. Both MURTIA and the HC-DPA law's notification provisions are mandatory. Both the HC-DPA law and MURTIA provide a descending order of priority list of who is to be notified: (1) if any, the guardian of the patient; (2) the patient's spouse; (3) the principal's adult children who are available within a reasonable period of time for consultation with the principal's attending physician; (4) the principal's parents; (5) an adult sibling of the principal or, if there is more than one sibling, a majority of the patient's adult siblings who are located within a reasonable period of time for such consultation. OHIO REV. CODE ANN. §§ 1337.16, 2133.05(A)(2)(a)(ii).

tion.[103] Life-sustaining treatment means any medical procedure, treatment, intervention, or other measure that, when administered to a patient, will serve principally to prolong the process of dying.[104]

1. Form Requirements

The statute requires that a declaration must be signed by its declarant or by another individual at the declarant's discretion, state the date of execution, and be witnessed or acknowledged before a notary public.[105] Each witness must be an adult and subscribe his signature on the declaration.[106] Section 2133.02 therefore requires either a notary public or two witnesses to certify or attest to the patient's living will document.

In order to clarify whether the declarant intends her declaration to apply to circumstances where she is in a terminal condition, in a permanently unconscious state, or in both circumstances, her declaration must so state the terms "terminal condition" and "permanently unconscious state" as defined by the terminology provisions of MURTIA.[107] When a terminal patient authorizes the withholding or withdrawal of life-sustaining treatment, the comfort care provisions of the MURTIA will govern the subsequent treatment.[108] When the declarant is in a permanently unconscious state, he must have specified in the declara-

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103. *See* OHIO REV. CODE ANN. § 2133.02 (A)(1).

104. *Id.* § 2133.02(A)(2).

105. *Id.*

106. *Id.* The two witnesses cannot be related by blood, adoption or marriage to the declarant, patient, nor can they be the attending physician or administrator of the health facility in which the patient resides. *Id.*

107. *Id.* The MURTIA defines a terminal condition as:

> 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 patient's attending physician and one other physician who has examined [him] (e.g. consulting physician), there can be no recovery [and] death is likely to occur within a relatively short time if life-sustaining treatment is not administered.

Id. § 2133.01. A permanently unconscious state is defined as "a state of permanent unconsciousness in a patient that, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards . . . by the patient's attending physician and [a consulting physician]", is characterized by the patient being "irreversibly unaware of himself and his environment [and] . . . a total loss of cerebral cortical functioning, resulting in the . . . patient having no capacity to experience pain or suffering." *Id.* § 2133.01(U).

108. *Id.* § 2133.02(A)(3)(b). MURTIA defines comfort care as nutrition or hydration "when administered to diminish the pain or discomfort of . . . a patient, not to postpone his death, [and] any other medical or nursing procedure, treatment, intervention, or other measure that is taken to diminish the pain or discomfort of [the] . . . patient, not to postpone his death." *Id.* § 2133.01(E).

tion that he authorizes the withdrawal or withholding of nutrition or hydration.[109]

2. When the Declaration Takes Effect

A declaration becomes operative when (1) it is communicated to the declarant's attending physician; (2) the attending physician and a consulting physician determine that the declarant is in a terminal condition or in a state of permanent unconsciousness; (3) the attending physician determines that the declarant is no longer able to make informed decisions; and (4) the attending physician determines, in good faith, and to a reasonable degree of medical certainty and standards, there is no reasonable possibility that the declarant will ever regain the ability to make informed decisions.[110] It is important to note that the declaration will only become operative if all four of the above mentioned criteria are satisfied. Therefore, it is essential that the attending physician know of the existence of a living will.

The living will also does not become automatically operative when a patient is in a terminal or permanently unconscious condition. First, the physician must determine to a reasonable degree of medical certainty that the patient will never regain the ability to make her own health care decisions. As long as a patient can make health care decisions, or may be able to make informed health care decisions some time in the reasonably foreseeable future, then the declaration continues to have no effect.

When a declaration becomes operative, a physician has three basic responsibilities: (1) to record medical determinations in conjunction with any record of the declaration; (2) to make a good faith effort to notify individuals designated in the declaration of any decision to withhold or withdraw life-sustaining treatment; and (3) to allow time for the notified individuals to object to such treatment decisions.[111] This section of MURTIA requires that statutorily specified family members be notified regardless of whether the patient requested such notification.[112]

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109. *Id.* " 'Nutrition' means sustenance that is artificially or technologically administered." OHIO REV. CODE ANN. § 1337.11(T). Hydration is defined as "fluids that are artificially or technologically administered. *Id.* § 1337.11(N).

110. *Id.* § 2133.03.

111. *Id.* § 2133.05.

112. *See supra* note 102 and accompanying text.

3. Revocation

A declarant may revoke a declaration at any time and in any manner.[113] A revocation generally becomes effective when the declarant expresses his intent to revoke, but, if the attending physician is aware of the declaration, then the declarant must convey the revocation to: (1) the attending physician; (2) a witness to the revocation; or (3) health care personnel who are informed of the revocation by the witness[114] in order for the revocation to become effective. The revocation provisions in the 1991 HC-DPA law and MURTIA also allow the attending physician to rely on witness information of alleged patient revocation as a means for invalidating an existing living will declaration.[115] The attending physician has discretionary power to act either in accordance with the revocation information provided by the witness or to disregard it and honor the provisions of the declaration.[116]

4. Limitations

According to the statute, there are three limitations with respect to the operation of declarations: (1) as long as a declarant who has been determined to be in either a terminal condition or permanently unconscious state can make informed decisions, she can continue to do so; (2) the responsibility of a physician or other authorized health care personnel to provide comfort care is unaffected; and (3) life-sustaining treatment cannot be withdrawn or withheld from a pregnant declarant if such treatment will result in the death of the fetus.[117] If the fetus, to a reasonable medical certainty, will not be born alive, then this limitation is void.[118]

5. Objection Procedure

Notified individuals[119] have the option to object to the treatment decisions of the health care facility or of the declarant's surrogate decisionmaker.[120] Within forty-eight hours after the receipt of a notice from the patient's attending physician, a notified individual must advise

113. OHIO REV. CODE ANN. § 2133.04, § 1337.14(A). Both MURTIA and the 1991 HC-DPA law eliminate all statutory language referring to a patient's capacity to revoke, thus avoiding complication with defining the nature and weight of evidence necessary to rebut the presumption of capacity. *See supra* note 86 and accompanying text.

114. *Id.* §§ 2133.04, 1337.14(A).

115. *Id.*

116. *Id.*

117. *Id.* § 2133.06.

118. *Id.*

119. *See supra* note 102 and accompanying text.

120. OHIO REV. CODE ANN. § 2133.05(B). *See generally* OHIO REV. CODE ANN. § 2133.05 (extensive explanation of the objection procedure).

the patient's physician whether he objects to the physician's medical determinations with regard to the patient.[121] The reasons that can be given for the objection are limited to the following: (1) that the course of action proposed by the attending physician is not authorized by or within the scope of the declaration; (2) that the declaration was executed when the patient was not of sound mind, or was subject to duress, fraud, or undue influence; or (3) that the declaration does not substantially comply with the provisions of MURTIA.[122]

Once the objection is communicated to the attending physician, then the objecting individual must file a specified complaint within two business days after the communication in the probate court of the county in which the patient lives.[123] The specified complaint is limited to the objections enunciated above, but may also include an objection to: (1) the physician's determination that the patient is in a terminal or permanently unconscious state; (2) the physician's determination that the patient is no longer able to make informed decisions regarding the administration of life-sustaining treatment; or (3) the physician's determination that there is no reasonable possibility that the patient will regain the capacity to make informed decisions.[124] The failure to file the complaint with the probate court voids the objection.[125]

C. MURTIA (Provisions for Individuals who did not Execute a Living Will Document)

The statute also permits a decision by appropriate individuals[126] to consent to the use or continuation, or the withholding or withdrawal of life-sustaining treatment for an individual who has not executed a living will. A consent decision by an appropriate individual must be made in good faith and conform to any previously expressed desires by the nondeclarant regarding treatment in terminally ill or permanently unconscious situations. If no such prior expression of intent exists, then a consent is generally only valid if it is consistent with the type of informed consent decision that the nondeclarant would have made if she

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121. *Id.* § 2133.05.

122. *See* S. 1 (Preliminary Summary), 119th Ohio Gen. Ass., Reg. Sess., at 4-5 (1991).

123. OHIO REV. CODE ANN. § 2133.05.

124. *Id.*

125. *Id.*

126. The order of priority for appropriate consenting individuals is as follows: (1) the nondeclarant's guardian, (2) spouse, (3) adult child, or children of the nondeclarant, (4) parents of nondeclarant, (5) adult sibling, or siblings of the nondeclarant, (6) the nearest adult blood relative not listed above. *Id.* § 2133.08.

had previously expressed her treatment desires, or as inferred from the declarant's lifestyle and character.[127]

1. Limitations

In connection with a decision to consent to the use or continuation, or the withholding or withdrawal, of life-sustaining treatment for a nondeclarant, MURTIA prescribes comfort care and pregnant women limitations that are similar to those discussed in connection with a declarant.[128] A similar objection procedure exists for nondeclarants as for declarants.[129]

2. Exception (Nutrition-Hydration)

MURTIA specifies one exception with respect to nondeclarants and the right to continue or refuse life-sustaining treatment. The exception pertains to the withholding or withdrawal of nutrition and hydration.[130] Under circumstances where a nondeclarant has been in a permanently unconscious state for twelve months or more, the physician can withhold or withdraw nutrition and hydration if all of the following apply: (1) a written consent to the treatment or withdrawal of such treatment has been given by a priority individual; (2) a probate court has not reversed the consent via a complaint proceeding; (3) the attending and consulting physicians can determine to a reasonable degree of medical certainty that comfort care will no longer alleviate pain; (4) a written consent to the withholding or withdrawing of nutrition and hydration, witnessed by two individuals, is given to the nondeclarant's attending physician by a priority individual; (5) the latter consent satisfies similar consent requirements found above[131] in nondeclarant standards for the withholding or withdrawing of life-sustaining treatment; and (6) the probate court issues an order to withhold or withdraw the nutrition and hydration.[132]

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127. *Id.* § 2133.08. MURTIA has adopted the substituted judgment standard recognized in the common law doctrine of informed consent. *See supra* notes 49-53 and accompanying text. With respect to standards of evidence, however, MURTIA states that the rules of evidence do not apply to this section. *Id.* § 2133.08(D)(3). Therefore, the traditional clear and convincing evidence standard is moot. The statute leaves courts to their own discretion with respect to which standards of evidence are applicable under Ohio Revised Code section 2133.08(D).

128. *See supra* notes 108-109 and accompanying text.

129. *See* OHIO REV. CODE ANN. § 2133.05 (detailed explanation of objection procedures); *see also supra* notes 119-125 and accompanying text.

130. *See* S. 1 (Preliminary Summary), 119th Ohio Gen. Ass., Reg. Sess., at 11 (1991).

131. *See supra* notes 102-103 and accompanying text.

132. OHIO REV. CODE ANN. § 2133.09.

D. Other General Provisions of MURTIA

MURTIA also provides immunities from criminal prosecution of certain parties,[133] as well as provisions for transfers of patients who are unable to receive the proper treatment from certain health care facilities.[134] Also included in MURTIA are a reciprocity clause[135] and a grandfather clause[136] which allow other living will documents to be effective under MURTIA if certain conditions are met.[137]

E. HC-DPA (Modified Version)

When the Ohio General Assembly enacted MURTIA, it also amended its 1989 HC-DPA law to conform to the MURTIA provisions. Under the new HC-DPA, no expiration date exists for the declaration unless specified by the principal or patient in the document.[138] The act also redefines a "terminal condition" and defines a "permanently unconscious state" and "life-sustaining treatment" in a manner conforming to the definition of those same phrases in MURTIA.[139] One significant change in the new HC-DPA law is that it eliminates the "imminent" death standard with respect to the provision or nonprovision of nutrition and hydration to the principal.[140] This change makes the new HC-DPA less restrictive for physicians and health care facilities who had been reluctant to stop nutrition-hydration provisions unless the principal was likely to die in a very short period of time. The uncertainty of what constitutes "imminent" was eliminated as well.

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133. *Id.* § 2133.11. Those certain parties include the attending physician, the consulting physician, the health care facility, and health care personnel acting under the direction of the attending physician. It also includes an individual authorized to give consent or a surrogate decisionmaker. *Id.* § 2133.11(C)(2).

134. *Id.* § 2133.10. The transfer provision allows the patient to be moved to another facility where the provisions of her declaration may be properly followed with respect to health care procedures. *Id.*

135. *Id.* § 2133.14. A declaration or living will "executed under the law of another state in compliance with that law or in substantial compliance with this chapter shall be considered to be valid for the purposes of this chapter." *Id.*

136. *Id.* § 2133.15. MURTIA shall apply to any written document that was executed anywhere prior to the effective date of this statute, that was voluntarily executed by an adult of sound mind and signed by that adult, and that specifies the adult's intention with respect to the use, withholding or withdrawing of life-sustaining treatment. *Id.* Such specificity must include, whether the adult refers to a terminal condition or permanently unconscious state, or both, when she is no longer able to make informed health care decisions. *Id.* If these specifics are met, then the document will be effective as if it had been executed on or after the effective date of MURTIA in accordance with its provisions. *Id.*

137. *See supra* notes 135-136 and accompanying text. The grandfather clause requires that a living will document meet stricter criteria than those criteria found in the reciprocity clause.

138. *Id.* § 1337.12. The old HC-DPA had a seven-year expiration date. *See also* S. 1 (Preliminary Summary), 119th Ohio Gen. Ass., Reg. Sess., at 20 (1991).

139. *See* S. 1 (Preliminary Summary) at 20; *see also supra* note 84.

140. *See* S. 1 (Preliminary Summary) at 21.

The new HC-DPA law amends its revocation provisions and contains a number of other provisions with regard to immunities, reciprocity, and coverage by insurance companies. The new HC-DPA law repeals the capacity requirement with regard to revocation and subsequently allows a principal to revoke at any time and in any manner.[141] This revision, however, fails to address those individuals who are incompetent and may not be able to revoke, irrespective of their wishes. The new HC-DPA also provides immunities for physicians and other specified individuals from criminal and civil liability[142] as well as transfer provisions[143] and notification-objection procedures[144] similar to those found in MURTIA. The new HC-DPA provides clauses against prejudice by insurance companies[145] as well as reciprocity and grandfather clauses[146] similar to those in the MURTIA provisions.

IV. ANALYSIS

MURTIA is a substantive, progressive response to the inconsistencies and unsettled case law surrounding health care law in Ohio.[147] It is not, however, without criticism.[148] This section explores the factors prompting the passage of MURTIA and discusses its strengths and weaknesses with respect to Ohio health care law. This section also provides possible solutions to the problems facing MURTIA.

Three basic factors prompted the Ohio General Assembly to enact MURTIA. These factors included: (1) the growing involvement of courts in the health care decisionmaking process; (2) the *Couture* decision; and (3) Ohio voters' concerns, particularly from the elderly community, over the lack of statutory guidance in health care law.[149] Senator Richard H. Finan, a sponsor of MURTIA, stated that "leading cases such as *Cruzan*, combined with the increased involvement in health care decisionmaking by state courts across the nation, made the

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141. OHIO REV. CODE ANN. § 1337.14.

142. *Id.* § 1337.15; *see also supra* note 133 and accompanying text.

143. *Id.* § 1337.16; *see also supra* note 134.

144. *Id.*; *see also supra* notes 119-125 and accompanying text.

145. *Id.* This provision prohibits any entity engaged in the insurance business from requiring an individual to create or refrain from creating a living will, or revoke or refrain from revoking an existing living will.

146. *Id.*; *see also supra* notes 135-137 and accompanying text.

147. *See, e.g.*, Kapp, *supra* note 4; Jones, *supra* note 70; Mullins, *supra* note 36; Couture v. Couture, 549 N.E.2d 571 (vague inconsistencies inherent in the 1989 HC-DPA law illustrated by court's seemingly illogical holding); *see supra* notes 63-69 and accompanying text.

148. *See infra* notes 157-173 and accompanying text.

149. Telephone interview with Senator Richard H. Finan, sponsor of MURTIA (Oct. 3, 1991). Senator Finan stated these factors were instrumental in the passage of living will legislation.

passage of living will legislation an essential priority."[150] According to Senator Finan, many Ohio voters had asked why Ohio was without a living will law.[151] MURTIA was a response to these concerns. The *Couture* decision "basically killed" the 1989 HC-DPA law according to Senator Finan.[152] The Ohio General Assembly responded by modifying the 1989 HC-DPA law and by conforming it to the provisions of MURTIA.

Another "impetus for the creation of Ohio's living will legislation is the gap which exists in common law."[153] The Ohio General Assembly heard a number of diverse viewpoints when it was dealing with issues as sensitive as life and death.[154] One drafter of the statute regarded its provisions as "a product of compromises necessary to achieve consensus on the enactment of this legislation."[155] Herein lies the major weakness of MURTIA. It is a confusing piece of legislation with so many safeguards, exceptions, and compromises that it will invite confusion and litigation. One critic called it " 'a 77-page monstrosity' loaded with so many exceptions 'only God will understand the bill.' "[156] Although such a comment is exaggerated, it does illustrate the major infirmities associated with MURTIA.

MURTIA is a compromise of competing social and ethical viewpoints.[157] As a result, many of the provisions in the statute are confusing and inadequate. One of the major difficulties associated with the statute is its objection provisions.[158] Senator Finan explained that the General Assembly felt significant safeguards were necessary to ensure

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150. *Id.*

151. *Id.*

152. *Id.*

153. *See, e.g.*, William M. Todd, *Directing Health-Care Choices*, OHIO LAWYER, September/October 1991, at 11. William Todd is a partner at the law firm of Porter, Wright, Morris & Arthur and one of the primary drafters of MURTIA. *See also supra* notes 9-62 and accompanying text.

154. Some varying interests included, the Catholic Conference of Ohio, Ohio's Right to Life Society, the Ohio Medical Association, and the Ohio Bar Association. Telephone Interview with Sen. Richard H. Finan, sponsor of MURTIA (Oct. 3, 1991). Right to life advocates expressed concern that the statute might lack enough safeguards and consequently allow too many improper deaths to occur. *Id.* The Catholic Conference of Ohio, on the other hand, felt the time had come to deal with living will legislation. *Id.*

Some of the Ohio Medical Association's concerns revolved around professional liability and the effect MURTIA would have on the ability of health care professionals to adequately service the needs of MURTIA-type patients. *Id.* The Ohio Bar Association's concerns generally focused on the structure of the statute and how effective and easily applicable it would be in practice. *Id.*

155. *See, e.g.*, Todd, *supra* note 153, at 10.

156. Jim Bland, *Living-Will Law Called Death Warrant for Some*, DAYTON DAILY NEWS, Sept. 30, 1991, at 1A, 6A (quoting C. Terry Johnson, attorney at Porter, Wright, Morris & Arthur and drafter of the legislation).

157. *See supra* note 154 and accompanying text.

158. *See supra* notes 119-125 and accompanying text.

proper treatment decisions were made.[159] The result is a three-way decisionmaking proxy which includes the patient's doctor(s), family members, and the courts. Since both MURTIA and HC-DPA require that certain family members receive notice[160] when a physician makes a medical decision regarding the withdrawal of life-sustaining treatment from the patient, objection provisions are available to be exercised in any given case.

Although limitations[161] exist on the types of objections that can be filed with the probate court, it is conceivable that a patient's treatment preferences, no matter how clearly expressed in a living will, may nevertheless be delayed or even supplanted by objections from family members. Arguments can be easily made charging that a patient was under duress, subjected to undue influence, or of unsound mind[162] when he executed a living will. It is also possible, however, that without such notification safeguards, a patient's wishes and treatment may fall to the sole discretion of an attending physician who may disregard patient wishes due to MURTIA immunity clauses. Although MURTIA provides immunity clauses for physicians, in order to avoid liability under such clauses physicians are required to meet standards of: (1) "good faith;" (2) "reasonable degree of medical certainty" when making decisions; and (3) must make treatment decisions "in accordance with reasonable medical standards."[163] Therefore, physician conduct is properly safeguarded by the provisions of the immunity clauses.

The General Assembly could have better framed the objection provisions to include an *optional* notification-objection provision. Under this optional notification-objection provision, a patient would choose whether she wants certain family members to receive notice of her treatment decisions for the sole purpose of objecting to those treatment decisions. The objection would be limited to those specific types already outlined in MURTIA.[164] This optional notification-objection procedure would eliminate the automatic triggering of the objection provision, and thereby avoid the likelihood or possibility of additional unreasonable litigation by family members. The Ohio General Assembly seems to allude to this type of optional notification-objection provision in section 2133.02 of the Ohio Revised Code, but later *requires* physicians to no-

159. Telephone Interview with Senator Richard H. Finan, sponsor of MURTIA (Oct. 3, 1991).

160. OHIO REV. CODE ANN. §§ 2133.05(A)(2)(a)(ii), 1337.16(D)(1)(b); *see also supra* notes 119-125 and accompanying text.

161. *See supra* notes 122-24 and accompanying text.

162. *See, e.g.*, S. 1 (Preliminary Summary), 119th Ohio Gen. Ass., Reg. Sess., at 4-5. (1991); *see also supra* note 122.

163. *See* OHIO REV. CODE ANN. §§ 2133.11(A)(5) and 2133.11(B).

164. *See supra* note 122 and accompanying text.

tify specified family members irrespective of the patient's notification wishes.[165]

Since the immunity clauses set out in sections 2133.11(A)(5) and 2133.11(B) of MURTIA hold physicians to "reasonable medical standards" and a "reasonable medical certainty" when making treatment decisions for MURTIA patients, these immunity clauses actually serve as safeguards to ensure proper medical practice and conduct by physicians. As a result, notice provisions for the sole purpose of an objection should be at the discretion of the patient rather than mandatory, since the conduct of physicians is adequately safeguarded by the standards of conduct that they must adhere to in the immunity clauses.[166] Of course, notification provisions for the purpose of allowing family members an opportunity to visit with a patient before life-sustaining treatment is withdrawn, should automatically be required.

Additionally, there seems to be a statutory language construction problem in the reciprocity and grandfather clauses of MURTIA. The grandfather clause encompasses:

> any written document that was executed anywhere . . . and that specifies the adult's intention with respect to the use, continuation, withdrawal, or withholding of life-sustaining treatment if he is at any time in a terminal condition or permanently unconscious state, or both, and is no longer able to make informed decisions regarding health care decisions, nor will he ever gain the capacity to do so again.[167]

Ohio's grandfather clause will thus accept any document from presumably any state as long as the document comports with the specific provisions and standards enunciated in Ohio's MURTIA.[168] MURTIA clearly requires that its specific provisional standards be met by any document attempting to use the grandfather clause.[169]

On the other hand, MURTIA's reciprocity clause will accept "a declaration executed under the law of another state *in compliance with that law or* in substantial compliance with this chapter . . . ."[170] The reciprocity clause will allow any document from any state to comply either with the law of another state, presumably the one in which the document was drafted, or comply with the law and provisions of Ohio's MURTIA.[171] While MURTIA's grandfather clause allows a living will document from another state to comport *only* with the provisions of

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165. *See* OHIO REV. CODE ANN. § 2133.05(A)(2)(a)(ii).
166. *See id.* §§ 2133.11(A)(5) and 2133.11(B).
167. *Id.* § 2133.15(A).
168. *Id.* § 2133.15.
169. *Id.*
170. *Id.* § 2133.14 (emphasis added).

MURTIA for it to be effective in Ohio, the reciprocity clause in MURTIA allows a living will document to be effective in Ohio if it comports with *either* Ohio's MURTIA provisions *or* another state's statutory living will provisions. Therefore, the statutory language of section 2133.14 is inconsistent with the statutory language found in section 2133.15 of the Ohio Revised Code.

The revocation provisions in MURTIA allow a patient to revoke his living will "at any time and in any manner."[172] This standard replaces the 1989 HC-DPA revocation provision which presumed a patient's capacity to revoke "unless there is evidence to the contrary."[173] While MURTIA avoids the problem of defining the nature or weight of evidence necessary to rebut the presumed capacity assumption, it fails to address those incompetent individuals who may not be capable of revoking, irrespective of their wishes. Unless such an incompetent patient regains the competency to revoke, that patient's treatment will consist of what is stated in his living will. The Ohio General Assembly may want to amend this revocation section and allow family members, health care personnel, and other witnesses an opportunity to provide evidence of an incompetent patient's intention to revoke, although no actual revocation occurred. If the Ohio General Assembly were to adopt such a measure, it should also establish and require a clear and convincing evidence standard of the patient's intent to revoke before any such revocation occurs. This strict evidentiary standard is necessary to ensure that the wishes of the patient are followed to the highest degree of certainty possible.

While the aforementioned weaknesses in MURTIA may cause some litigation, the statute is preferable to the inconsistencies which plague common law health care concepts. The weaknesses in MURTIA can be corrected. The objection procedure is too cumbersome and will lead to excessive litigation among family members, health care providers, and probate courts. The General Assembly should amend the objection provisions to include an optional rather than mandatory notification-objection provision for the patient. The patient may then control which family members, if any, have the right to file an objection. For example, if a patient chooses not to exercise the notice option, then no family members are notified and the forty-eight hour objection provision is not triggered. In other words, the ability to use the forty-eight hour objection procedure is contingent upon receiving notice.

The immunity provisions allow physicians to avoid liability only if their decisions are made in "good faith," with "reasonable medical cer-

172. *Id.* §§ 1337.14, 2133.04.

173. *Id.* § 1337.14(A); *see also* Kapp, *supra* note 4, at 557.

tainty," and "in accordance with reasonable medical standards."[174] These standards provide adequate safeguards against medical malpractice and misconduct. Additionally, such standards further enhance the idea of an optional notification-objection provision. With the immunity clauses holding physicians' treatment decisions to standards of "good faith," "reasonable medical certainty," and "in accordance with reasonable medical standards," there is no need for access to a mandatory objection procedure by family members. An optional notification-objection provision would be more appropriate under the existing provisions of MURTIA.

MURTIA provides a transfer provision that allows the patient an opportunity to be transferred to another health care facility in the event that her current facility cannot or does not want to follow the treatment decisions set out in her living will or enunciated by a surrogate decisionmaker.[175] This type of transfer option will lead to excessive health care costs. The General Assembly should mandate that all health care facilities adhere to any properly executed living will directives. If certain facilities, for some extraordinary or legitimate reason as determined by the court, cannot adhere to living will directives, then such facilities must give notice to the public that such a restriction exists in its policies. Therefore, patients will know in advance where living will directives are accepted.

The contradictory language in the reciprocity and grandfather clauses is an easy problem to remedy. The General Assembly should delete the phrase, "in compliance with that law . . .,"[176] thus requiring any reciprocal living will document to conform to the specific standards of Ohio law. Such an amendment would make the language in MURTIA more uniform and consistent and also make the language used in all Ohio living will documents consistent with the MURTIA provisions. Finally, the Ohio General Assembly should allow family members, health care personnel, and other witnesses an opportunity to provide evidence of an incompetent patient's intention and desire to revoke his living will document under the MURTIA revocation provisions. A requirement of clear and convincing evidence should apply in situations where courts must make a determination of whether a patient intended to revoke his declaration, even though no such revocation actually occurred.

MURTIA provides statutory guidelines for the decisionmaking process of all Ohio health care patients. There are some inherent

174. OHIO REV. CODE ANN. §§ 2133.11(A)(5) and 2133.11(B).

175. *See id.* § 2133.11.

176. *Id.* § 2133.11(A)(5). *See also supra* notes 150-141 and accompanying text.

problems, however, in MURTIA. The most notable of these problems is its objection provisions. In order for MURTIA to function as an effective statutory guideline for Ohio health care patients, the General Assembly needs to amend the objection provision to allow for an optional notification-objection provision.

The optional notification-objection provision gives health care patients a choice of whether they wish to have any family member or other individual notified before treatment decisions are pursued. This type of amendment is essential because it guarantees the avoidance of additional litigation by possibly unreasonable family members or other individuals. At the very least, the Ohio General Assembly should consider amending the existing mandatory objection provisions in order to provide for a more effective and consistent set of statutory guidelines for Ohio health care patients.

V. CONCLUSION

The enactment of MURTIA begins a new era of health care law in Ohio. The litany of problems in this area of the law have illustrated the need for statutory guidance to help courts better address the difficult decisions inherent in topics such as the right to die, the right to self-determination, and the right to forego medical treatment. Decisions such as *Couture v. Couture* and the *Leach* cases further accentuate the Ohio courts' troubles in dealing with this very sensitive subject area.

Ohio's MURTIA addresses these troubles and paves the way for a more consistent body of case law in the future. The difficulties inherent in MURTIA can be remedied. Given some time, amendments, and subsequent case law, MURTIA will effectively fill the gaps left by common law health care history. "Perhaps no one will be content with all of the provisions of [MURTIA]. But these are not easy issues, and in many cases there are no clear-cut answers."[177] MURTIA provides a foundation on which a uniform system of health care law can be built.

Richard J. Casey

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[177] *See, e.g., Health Care Choices, supra* note 153, at 10.